Chapter 11: Practicing Local Listening with Village Midwives in Sudan: A Case Study for Theological Ethics

Meghan J. Clark

In April 2016, I arrived at the University of Notre Dame for the *From Aid to Accompaniment* book workshop with significant trepidation. A junior scholar and a theologian, I felt out of place in a room of public health and medical experts, but more than anything, I was nervous to meet Dr. Paul Farmer in person. From the moment I picked up *Pathologies of Power* in 2004, he inspired and influenced my approach to human rights as well as my commitment to bring theology into wider conversations about global health, human rights, and development. It was that inspiration that led me to travel to Khartoum, Sudan, in 2013 to observe an Irish/Sudanese/American medical training program for village midwives. After Khartoum, I struggled to write about the experience in a way that brought theology into conversation with global health and human rights until I was introduced to Jennie Block and eventually Paul. An earlier version of this essay was to be published in that book that was waylaid by global health crises and Paul's shocking death. Resurrecting it for this volume, I offer this case study, which benefitted from Farmer's own advice, on practicing local listening with the village midwives of Sudan.

Paul Farmer fought tirelessly for the health and human rights of those on the margins of power. The very idea "that some lives matter more than others" was for him, "the root of all that is wrong with the world."[1] In order to interrogate, spotlight, and begin to dismantle this idea, Farmer developed a holistic account of structural violence in order "to identify the forces conspiring to promote suffering, to discern the causes of extreme

[1] A frequently cited remark by Dr. Farmer, see the documentary *Bending the Arc: The Friendship that Changed the World*, bendingthearcfilm.com/.

suffering and also the forces that put some at risk for human rights abuses, while others are shielded from risk."[2] The concept of structural violence seeks to frame the inequity and injustice that is embedded in our social reality as violence "because they result in avoidable deaths, illness, and injury; and they reproduce violence by marginalizing people and communities, constraining their capabilities and agency, assaulting their dignity, and sustaining inequalities."[3] The first treatment for structural violence, according to Farmer, is local listening. In the documentary *Bending the Arc*, one sees a young Farmer recognize that to provide quality medical care to the people in Cange, Haiti, he needed to ask them what they need. As he recounts with humor the response of Fr. Fritz, "well OK, but they're just going to tell you they want a hospital" and a school and better road, and so on, the path to addressing structural violence is revealed.[4] For Farmer, "The experiences of those who are sick and poor remind us that inequalities of access and outcome constitute the chief drama of modern medicine."[5]

Applied outside medicine, I contend, local listening, or prioritizing the voices of those excluded from access and thus from outcomes, must also be centered in our moral and theological analysis. Local listening as a constitutive component for social, medical, and moral analysis in response to the complexities of structural violence underpins Farmer's work and his import for the practice of theological ethics. This practice of local listening must be embedded in both our analyses, programs, and implementation of health, human rights, and development programs if they are to combat underlying structural violence.

---

[2] Paul Farmer, *Pathologies of Power: Heatlh, Human Rights and the New War on the Poor* (Los Angeles: University of California Press, 2005), 50.

[3] Barbara Rylko-Bauer and Paul Farmer, "Structural Violence, Poverty, and Social Suffering," in *The Oxford Handbook of the Social Science of Poverty,* ed. David Brady and Linda M. Burton (London: Oxford Academic, 2017), 5.

[4] *Bending the Arc*.

[5] Paul Farmer, "Listening for Prophetic Voices in Medicine," *America*, July 5, 1997, 8–9.

Having the correct intellectual argument or the proper protocol is only one component of a successful medical development program. The right science or medical program on its own does nothing to dismantle the idea that some lives are worth more than others. While many development and global health programs operate with a focus on top-down structure, Paul Farmer, and Partners In Health consistently argued for local listening as the starting point. The practice of local listening is one of accompaniment, which became a foundation of PIH's own community health worker programs (called *accompagnateurs*). "Great failures of policy and governance," according to Farmer, "usually occur because of *failures of implementation,* and accompaniment is good insurance against such failures."[6] By definition, the act of accompaniment "suggests going with another on an equal basis" and, thus, "implies the transgression of discriminatory barriers," notes liberation theologian Roberto Goizueta, for "only in and through the concrete act of accompaniment do we love others as 'others, as equals, and are we, in turn, loved by them.'"[7] Accompaniment necessarily involves local listening rooted in a shared human dignity. From there, partnerships for global health, human rights, and development are able to also work to dismantle structural violence. In particular, local listening and accompaniment act as a resistance to instrumentalizing the other or dismissing the knowledge of those who experience poverty and exclusion first-hand.[8] For Christian theology, Goizueta notes, accompaniment is rooted in the narrative of Jesus of Nazareth for whom "to accompany the poor and the outcasts was to transgress the established and accepted boundaries which separate 'us' from 'them.'"[9]

---

[6] Paul Farmer, *To Repair the World: Paul Farmer Speaks to the Next Generation* (Berkeley: University of California Press, 2013), 244.

[7] Roberto Goizueta, *Caminemos Con Jesús* (Maryknoll: Orbis Books, 2005), 206.

[8] Theologically, notes Goizueta, "An essential element of God's own identification with the poor is, thus, the transgression of the spatial, geographical boundaries which separate rich and poor where they live. The violation of these physical, geographical barriers is a virtually absolute precondition for loving the poor" (*Caminemos con Jesús*, 201).

[9] Goizueta, *Caminemos con Jesús*, 203.

In structuring and scaling up local listening and accompaniment in dismantling structural violence and addressing urgent concerns of global health (like maternal health or newborn mortality), the next necessary component is participation. For a change in protocol or culture to occur, there must be a mutual or shared ownership of the program. Health, human rights, and development programs, if they are to be effective, must be participatory. Participation here is not completion of a medical training or treatment program but something deeper. It is an active role in the process and goals by those who are affected. If we begin with local listening, the interpretation and voices of those on the margins must have the ability to change or shape the priorities, scope, and goals of the partnership. This deeper view of participation serves as the basis for an ethics of participation and creates the capacity for accompaniment. The level of participation required for accompaniment begins with the equal dignity of all persons and therefore it requires "relationships of empathy and interdependence among the arguers."[10] A key component of full participation then is openness to the perspectives of others, even when that challenges one's own beliefs or conclusions. Local listening is an essential practice of this ethics of participation in global development. It fosters participation as mutual cooperation such that "all peoples should be able to become the principal architects of their own economic and social development,"[11] including public health.

This essay is a case study of Helping Babies Breathe Sudan, the launching training for a national program to train village midwives in basic newborn care. While different from community health workers, Sudanese village midwives or traditional birth attendants are responsible for accompanying and caring for most women and newborns in Sudan. Bringing forty-two doctors and nurses and forty-two village midwives from nineteen states across Sudan, including Darfur, the Khartoum-based

[10] Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, Change* (Washington, DC: Georgetown University Press, 2005), 38.

[11] World Synod of Bishops, *Justice in the World*, www.cctwincities.org/wp-content/uploads/2015/10/Justicia-in-Mundo.pdf.

initiative held two training sessions over four days. Focused on local listening and participation, this article examines lessons from this case for thinking about ethical partnerships for health and development. For theological ethics, and especially Catholic social teaching, both Farmer's own work and this case provide concrete examples that the option for the poor can be put into practice through prioritizing participation and local listening.

A Theological Ethicist in Khartoum: Helping Babies Breathe National Initiative

In January 2013, I traveled to Khartoum, Sudan, to observe the launch of the Sudan Helping Babies Breathe National Initiative, a new program for combatting newborn death developed through a unique Sudanese/Irish/American partnership. Unlike the other attendees, I was not a medical professional. I am an ethicist, a moral theologian who researches human rights and solidarity. With the permission of the organizers, I accompanied the program launch to investigate how we can structure and enact international partnerships for global health that empower local community health workers.[12] The program's successes and challenges offer important lessons about the process of developing partnerships for accompaniment. Moving from aid to accompaniment requires beginning with the personal; the success or failure of Helping Babies Breathe depended on personal relationships as much as, if not more than, on medicine.

[12] This ethics analysis would not have been possible without the permission and cooperation of Dr. C.A. Ryan (Ireland), Dr. Sami Ahmed (Ireland), Dr. Abdelomoniem (Sudan), and Dr. Lisa McCarthy-Clark (USA). Thank you also to Sister-Nurse Hind Waly and Abeer Hamid (Sudan) for assistance onsite and in translation. This ethics fieldwork was also made possible by a Summer Support of Research Grant from St. John's University and had IRB approval.

Newborn death[13] was and is an urgent global health crisis. In 2012, nearly three million babies died within their first twenty-eight days of life.[14] Addressing how and why these babies die is no easy task given the lack of complete birth/death records and unclear distinctions between newborn mortality and stillbirths. At the time, the World Health Organization estimated "one million babies die each year from birth asphyxia (inability to breathe immediately after delivery)"[15] and birth asphyxia or birth trauma account for 23 percent of neonatal deaths. Globally, including in developed countries, an estimated 10 percent of babies need some assistance breathing at delivery (such as clearing the airway). This percentage is higher within developing countries with severely limited resources and access to prenatal or primary preventative care. Therefore, addressing birth asphyxia or the inability of babies to breathe immediately at delivery is crucial to lowering neonatal mortality. Medically, the diagnosis is a matter of helping babies breathe.[16] Socially, it requires tackling complicated structural violence, "a rubric which includes a host of offences against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality,"[17] including

[13] Newborn death or mortality is defined as within the first twenty-eight days of birth. For more detailed definition see: World Health Organization, "Newborn Mortality," www.who.int/news-room/fact-sheets/detail/levels-and-trends-in-child-mortality-report-2021.

[14] Georgina Msemo, Augustine Massawe, Donan Mmbando, Neema Rusibamayila, Karim Manji, Hussein Lesio Kidanto, Damas Mwizamuholya, Prisca Ringia, Hege Langli Ersdal, and Jeffrey Perlman, "Newborn Mortality and Fresh Stillbirth Rates in Tanzania After Helping Babies Breathe Training," *Pediatrics* 131, no. 2 (2013): e353–e360. 10.1542/peds.2012-1795.

[15] World Health Organization, "Global Disease Burden 2004," www.who.int/whosis/whostat/EN_WHS09_Table1.pdf.

[16] John Kattwinkel, Jeffrey M. Perlman, Khalid Aziz, Christopher Colby, Karen Fairchild, John Gallagher, Mary Fran Hazinski, Louis P. Halamek, Praveen Kumar, George Little, Jane E. McGowan, Barbara Nightengale, Mildred M. Ramirez, Steven Ringer, Wendy M. Simon, Gary M. Weiner, Myra Wyckoff, and Jeanette Zaichkin "Part 15: Neonatal Resuscitation 2010: American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care," *Circulation* 122, no. 18, supp. 3 (2010): circ.ahajournals.org/content/122/18_suppl_3/S909.full.

[17] Paul Farmer, *Pathologies of Power*, 8.

disparities in access to preventative and emergent medical care during pregnancy and birth.

In 2010, a global alliance of partners launched Helping Babies Breathe[18] (HBB) to train community health workers in basic newborn care using a picture flip chart, simulations, and a practice doll. Its goal was to encourage birthing practices to devote the first sixty seconds after delivery, nicknamed the *Golden Minute™*[19] to helping the baby breathe, thus effectively treating the aforementioned 10 percent of all babies who simply need a bit help.[20] The program was designed for countries like Sudan in which health resources remain limited. Sudan has made significant progress on development markers over the last two decades, but in recent years, progress had slowed. In 2011, neonatal mortality was high, hovering between 31 and 41 per 1000 live births.[21] Two-thirds of the nation's 38 million citizens live outside of the urban centers and continue to rely heavily on traditional village midwives for maternal/child health.[22] Transportation around the country is hazardous, and active conflict zones remain a constant presence. The country's estimated 14,000 village midwives facilitate more than 80 percent of births. In Sudan, village

[18] The American Academy of Pediatrics, US AID, the World Health Organization, Save the Children, and Laerdal among others developed this evidence-based education program for low-resource settings. American Academy of Pediatrics, Helping Babies Breathe (2010), www.aap.org/en/aap-global/helping-babies-survive/our-programs/helping-babies-breathe. This program has since expanded and been rebranded as Helping Babies Survive www.aap.org/en/aap-global/helping-babies-survive/.

[19] "Saving Lives in the Golden Minute," National Institute of Health Newsroom, June 30, 2012, www.nichd.nih.gov/newsroom/resources/spotlight/062112-golden-minute.

[20] Kattwinkel et al., "Part 15: Neonatal Resuscitation 2010."

[21] According to the World Bank 2011 Development Indicators, infant mortality in Sudan remains at 57 per 1000 births and neonatal mortality at 31 per 1000 births. However, the reality on the ground in Sudan may be significantly worse. The last Sudan Household Survey (2006) approved by the government before the project placed infant mortality at 81 per 1000 births and neonatal mortality at 41 per 1000 births. See also "Sudan Household Survey" www.unicef.org/sudan/health_4284.html and "Road Map for Reducing Maternal and Newborn Mortality in Sudan."

[22] United Nations Development Program, "2014 Country Profile: Sudan," hdr.undp.org/en/countries/profiles/SDN.

midwives or traditional birth attendants are incorporated into the health care system, receiving government-sponsored medical training.[23] Effective village midwives may then later be selected for more training, promoted to Health Visitor, and function in a supervisory role over a rural area of village midwives.[24] Despite limited resources, Sudan does have several regional health services centers, known as CPD (continuing professional development) centers, which offer continuing professional development programs and coordinate ongoing training for village midwives and other health professionals.

Sudanese and Irish doctors had been engaged in an ongoing and successful partnership between the University College Cork and Ombdurman maternity hospitals since 2002.[25] However, impacting

[23] In general village midwives "have completed one-year midwifery course which focuses on practical trainings rather than lectures. The majority of them, however, are illiterate because they receive only primary education or even drop out of elementary school. Therefore, practical guidance is very important. On the other hand, health visitors received one-year professional training after three-years nursing course. They are assigned at midwifery schools and other government agencies as supervisors of village midwives." Japan International Cooperation Agency, "In-service Training for Village Midwives," October 2, 2011, www.jica.go.jp/project/english/sudan/005/news/general/111002.html/. For more information see The World Bank, "Rising to the Challenges: Sudan's Trained Village Midwives Contribute to Better Health for Mothers," June 11, 2012, www.worldbank.org/en/news/feature/2012/06/11/rising-to-the-challenge-sudans-trained-village-midwives-contribute-to-better-health-for-mothers.

[24] For more information on the training of Village Midwives and Health Visitors see: Kumiko Nakano, Yasuhide Nakamura, Akiko Shimizu, and Sojoud Mohamed Alamer, "Exploring Roles and Capacity Development of Village Midwives in Sudanese Communities," *Rural and Remote Health* 18 (2018): 4668.

[25] In 2002, Cork University Maternity Hospital entered into partnership with Omdurman Maternity Hospital in Khartoum, Sudan. Over the next ten years, this partnership provided Omdurman with financial, technical (equipment) and educational support. The hospital alliance as it emerged received approval for good governance from the European Union. In 2012, the Cork-Omdurman Partnership was recognized by the ESTHER alliance, which is a cooperative directed to solidarity-based hospital alliances. V.M. Carlson, M.I. Omer, S.A. Ibrahim, S.E. Ahmed, K.J. O'Byrne, L.C. Kenny, and C.A. Ryan. "Fifty Years of Sudanese Hospital-Based Obstetric Outcomes and an International Partnership," *BJOG: An International Journal of Obstetrics and Gynaecology* 118, no. 13 (2011): 1608–1616.

maternal and newborn health required thinking beyond a hospital-to-hospital partnership. Sudan's own proposal submitted in 2010 to United Nations Population Fund (UNFPA) on MDG 4 and MDG 5 points out many village midwives were not literate and did not have sufficient training in antenatal or basic newborn care to meet the United Nations definition of skilled attendance.[26] For these reasons, Helping Babies Breathe caught the attention of the Irish and Sudanese doctors. Unlike the previous collaborations, Helping Babies Breathe did not assume that practitioners had extensive education or access to many resources or a hospital at delivery, and it was easy to disseminate after an initial launch without the constant need for international personnel. It involved coordination and participation of the health infrastructure in Sudan. The Irish/Sudanese doctors developed a national plan centered on the village midwives securing the support of the Ministry for Health. Echoing the methodological approach of Farmer and PIH that health programs must be locally embedded and build up public infrastructure, this partnership brought together all segments of the Sudanese health sector—from the maternity hospital to the continuing professional development centers, to the Ministry of Health.

After two years of planning, six international medical and nursing educators from Ireland and the United States of America joined Sudanese doctors in Khartoum. International neonatal experts and master-trainers certified by Helping Babies Breathe lectured, facilitated, and supported the courses. Over the week, two sets of trainings were completed, and trainers were then sent home to begin training village midwives in their home regions. The first training was an English-speaking master trainer's course

[26] Republic of the Sudan, "Road Map for Reducing Maternal and Newborn Mortality in Sudan (2010–2015)," fmoh.gov.sd/Reports/ROAD-MAP-FOR-REDUCING-MATERNAL2010-2015.PDF. See also World Health Organization, "Saving the Lives of Mothers and Children: Rising to the Challenge Sudan," for more on the national strategic plan targeting expanding education for village midwives, apps.who.int/iris/handle/10665/116145.

for doctors and university-educated nurses,[27] followed by an Arabic-speaking version, which included some translation. Thirty doctors and twelve "sister" nurses were trained as master trainers to oversee ongoing trainer education; some from these top participants were selected to take the lead in the second training. Offered in Arabic, with some translation, the second course was a trainers' program for forty-two Health Visitor/Village midwives led by newly certified Sudanese master trainers with the ongoing supervision and support of the international team. It is the second training session upon which this case study focuses.

Hearing Voices from the Margins: Local Listening as Method

Over the course of the two days, my primary goal was to listen to the village midwives' experiences and reception of the program. Did they feel Helping Babies Breathe addressed their primary concerns for newborn health? Did it address the realities of giving birth in rural Sudan? Using Farmer's integrated approach, addressing newborn mortality requires examining the context of childbirth both medically and socially. Lack of access to medical resources is interwoven with the complex realities of social and gender inequalities, including poverty and lack of education. This is the complex and interdependent web which Farmer calls structural violence.[28]

When considering issues of global health and poverty, policymakers' and activists' first instinct has often been to seek a universal solution, overlooking local reality. In this case, village midwives were adept at navigating the possibilities and limits of their local reality; thus, it was necessary to listen to their counsel. Listening sounds easy and obvious. Everyone listens. You cannot have a conversation without listening. And yet, we have all fallen victim to *selective hearing* in which we only truly hear

[27] Obstetricians, neonatologists, pediatricians, nurse-midwives, and nurse-infection specialists made up the students in the master trainer course.
[28] Farmer, *Pathologies of Power,* 8.

that which confirms our assumptions or desires. Local listening as an ethical principle requires us to engage the participants as persons who ground us in their reality, distancing us from our abstractions or assumptions.

HBB itself is structured to be a participatory learning experience focused around simulations and practical skills. Both courses integrated specific components to enhance participation but also encountered challenges which potentially hindered this goal. From the outset, the structure was designed to move quickly from instruction by the international team to instruction by Sudanese participants. Yet power and social dynamics can often present barriers to participation by all in this kind of educational endeavor. When achieved, integrated participation during the trainings respected individual contexts and provided the necessary foundation for long term sustainability.

In the master trainer's course, the program directors took several steps to ensure maximum participation and sustainability. The atmosphere in the course was one of engagement and collaboration as doctors and nurses from Sudan interacted with the Irish, American, and Sudanese program directors. The Sudanese participants in this first group, therefore, engaged the international doctors and nurses as peer-mentors. This was clearest during both the role-play learning and the question periods. One clear example of this was the light-hearted correction by the Sudanese participants of certain assumptions within the HBB program which were incorrect for Sudanese culture. For instance, in the West and other parts of the world, fathers are commonly present for the delivery; however, it is quite rare that the father is present for home deliveries in Sudan. Village midwives rely on other female family members as the primary assistants in childbirth. Dr. Salah Ibrahim, Professor of Pediatrics at the University of Khartoum and a leading researcher in maternal/child community-based health, was invited to provide concrete descriptions of home births in Sudan. Engaged participation by noted Sudanese professionals as trainees along with their younger and less experienced colleagues lent credibility and weight to the program.

This level of integrated participation and collaboration demonstrated by Sudanese professionals' presentations enhanced the usefulness of the training program by providing instruction that related to the concrete available resources (an element that would be even more crucial in the second course for village midwives). All of this contributed to greater ownership of the HBB program by the Sudanese participants, and it is their adoption of the program in practice that will determine the sustainability of HBB in Sudan. By selecting participants from across Sudan, the Cork/Sudan partnership was not conducting a limited or pilot study. Instead, beginning with already established and basic newborn care, the courses sought widespread implementation across all the states of Sudan, including a participating doctor from Darfur and other conflict zones.

During the second training for Health Visitors and village midwives, it was also clear that tensions exist between rural village midwives and the mostly male doctors, as well as with female, university educated nurse-midwives. These tensions were most evident as everyone convened at the beginning of the second program. Many Sudanese doctors were highly skeptical of the village midwives' willingness to engage a new protocol and examine their practices. *They won't do it,* was a common sentiment from male doctors in the master trainer course. This suspicion was reminiscent of general compliance tropes about those living in poverty, which PIH has combatted for decades. Notably, despite the village midwives occupying a privileged position within their own local communities, the imbalance of knowledge and power between these mostly illiterate rural village midwives and the university-educated medical professionals positioned the village midwives as closely aligned with the women they served, which cast suspicion over their desire to learn a new protocol.

The Sudanese village midwives I observed were strong, confident women who clearly saw their role in childbirth as essential. In a crowded conference room, instructors and participants examined the tying off the umbilical cord. They conferred in their small groups and began to call out: "*We have cord clamps; we do not need to use string ties."* Global protocols

can seem dry and abstract. The HBB protocol suggested using a bit of string to tie off the umbilical cord, as that is essentially the lowest common denominator resource. The midwives' abrupt interjection and subsequent conversation focused everyone's attention on the reality in rural Sudan. When the midwives declared "*We have cord clamps*," they asserted their participation and refocused attention on the need for the Helping Babies Breathe program to adapt to Sudan's context. Without this participation, aid programs aimed at human rights reinforce the power structures of neo-colonialism and dis-empower marginalized groups. Despite its understandable practical focus on universal applicability in low resource settings, the protocol reinforced an assumption of scarcity that did not apply to the Sudanese context. The village midwives' interjection then also represented an active resistance to what Farmer calls the socialization for scarcity by asserting their own resilience and competency. Similarly, their assertion reminds us that it is not only in assuming resource availability but also by assuming deprivation that programs can set up community health workers for failure.

The presence of non-Sudanese trainers helped to disrupt traditional power dynamics around gender, education, and class between the groups. In particular, the participation of the American women in small group role play and skill practice appeared to energize conversation. American nursing education tends to be very hands-on skills based, so the nurse practitioners easily joined small groups. Their shared gender allowed them to bond with the village midwives disrupting some tensions. The American women did not presume anything about traditional gender roles, power, or the village midwives. Despite the language barrier, the international team was actively involved in the second course through both translation and several village midwives who spoke English.

Acting out childbirth is a profoundly human and equalizing exercise. One person played the role of pregnant woman, a first-time mother in the throes of labor. Another was the village midwife and finally, the father or family member who is not quite sure what to do. The classroom erupted in laughter as they simulated labor pains and questions from the soon-to-

be mother's husband. As noted above, the presence of a father at delivery is presented in the HBB flipchart caused laughter from the village midwives.[29] Fathers were of little use to the village midwives in delivery. Traditionally, a female family member will help if needed; the father, they acknowledged, could be useful in calling transport if something goes wrong. During the master trainers' class, traditional divisions of gender and power led to a few tables of male-only doctors. Here too the role playing accomplished more than the transmission of a protocols—as one of those male doctors needed to play the role of pregnant woman, and another the rural village midwife.

The role play and dialogue itself allowed the village midwives to learn, question, and adopt HBB as their own. Acting out the experience in rural Sudan created space for discussion that a sterile presentation of the steps of a protocol, albeit a medically necessary one, could not. Even though the village midwives did not have much formal education, they had significant practical knowledge and experience. Their questions showed a command of what they already knew and a desire for skills to do their job better. This was clearest when training turned to umbilical cord care, and objections immediately emerged around treatment of the umbilical cord. The Helping Babies Breathe program instituted a new WHO recommendation to wait one to three minutes before cutting the cord, to allow extra blood to flow to the baby.[30] At the time, this was a significant global change. In

[29] Despite a previous discussion in the master trainer course that in Sudan, fathers are not present at delivery, the father appears in the role-playing directions and chart; therefore, the newly trained Sudanese master trainers followed its prompts in the session with the midwives.

[30] For more information on the umbilical cord debate, see World Health Organization, "Care of the Cord: Review of the Evidence," 1999, apps.who.int/rht/documents/MSM98-4/MSM-98-4.htm; E. Abalos, "Effect of Timing of Umbilical Cord Clamping of Term Infants on Maternal and Neonatal Outcomes," *The WHO Reproductive Health Library* (2009), www.sciepub.com/reference/209552; Amit Upadhyay, Sunil Gothwal, Rajeshwari Parihar, Amit Garg, Abhilasha Gupta, Deepak Chawla, and Ish K. Gulati, "Effect of Umbilical Cord Milking in Term and Near Term Infants: Randomized Controlled Trial," *American Journal of Obstetrics and Gynecology* 208, no. 2 (2013): 120.e1–6; and Anup C. Katheria, "Umbilical Cord Milking: A Review," *Frontiers in Pediatrics* 6 (2018): 335.

most countries, including the US, standard practice had long been to cut the cord immediately. In 2013, many US hospitals had not fully changed to the new WHO guidelines to wait one to three minutes. In Sudan, however, the long-standing cultural practice is to "milk the cord"—rhythmically squeeze it—to send the extra blood to the baby and not immediate cutting. The HBB protocol presented asked them to stop milking the cord and just leave it for one to three minutes. The village midwives raised significant objection to changing their practice. From their perspective, they were already delivering extra blood to the baby. The dialogue quickly broke down due to both medical disagreements and power dynamics.

Evidence-based medicine is a powerful and necessary standard for establishing global guidelines for public health and human rights. Yet there are significant power dynamics involved in the assertion of evidence-based medicine as self-evidently normative, desirable, or superior in cross-cultural global partnerships. In partnerships, no partner is above question or invulnerable. Listening, participation, and accompaniment require that everyone be willing to say *I don't know.* HBB proposed waiting in contrast to immediate clamping. Sudan happens to be one of the few countries where the tradition is not to immediately clamp the cord but instead to milk it. The research on waiting versus immediate cutting is clear; however, international peer-reviewed research is vague and inconclusive with respect to waiting versus milking the cord, as it is done in this part of East Africa. The midwives raised a different concern than that which the protocol answered, and the midwives knew that simply asserting the protocol or WHO guidelines did not answer their question. They were claiming their own experience as a relevant source.

Active listening, as we saw, involves making oneself vulnerable, such that both the 'expert' and the 'student' are open to development and the need to adapt. Equality, dialogue, and encounter all seek to reduce differences of power and create mutual cooperation. The fundamental principle is that my humanity is bound up in yours. I cannot build a relationship of equal human dignity unless I begin from that starting

point, and it is only from that starting point that accompaniment is possible. This is a key component of human rights, especially in situations where there are stark imbalances of power. Accompanying those on the margins involves mindfully employing equality as one's interpretive lens. With respect to the Sudanese village midwives, listening to their perspectives meant acknowledging the need to adapt, and to view the protocol as a starting framework rather than as an established canon.

While there were at times tensions between Sudanese physicians and the village midwives, vigorous participation by noted Sudanese professionals facilitated listening by all to the perspectives of the village midwives on the concrete realities in Sudan. Dr. Marwan Ibrahim Omer, Director of Omdurman Hospital and trusted advocate for the village midwives in his area, actively participated in simulations of childbirth, disarming men who did not want to "play women." Additionally, the presentations needed to accurately reflect the availability of local resources for cleaning. For example, an infection control protocol that recommends cleaning solvents that local health workers cannot access not only hinders the implementation and success of a health program; it also disempowers the community health workers. A Sudanese sister-midwife pursuing a doctorate in infection control was invited to conduct the presentation on cleaning, instructing not only her fellow Sudanese participants but also the international team on the specific infection concerns, protocols, and available resources within Sudan. During her presentation the international experts became students alongside everyone else. Prioritizing local listening and engaged participation not only ensured that the voices of all participants were respected but grounded this conceptual global health program in concrete reality.

Whenever the Helping Babies Breathe protocol seemed counter-intuitive or contrary to practices believed to be effective, the midwives persistently sought explanations detailing the medical reasons for the protocol. One such area was the *Golden Minute*™ which asks midwives to focus the first sixty seconds on the newborn, then return attention to the mother. When there is only one skilled birth attendant, a delivery can

quickly become precarious if anything goes wrong. Medically, devoting sixty seconds to immediately helping the baby breathe does not harm the mother, but can mean life or death for the infant. However, the testimony of the international partners alone could not replace the spoken and unspoken concerns of the village midwives. Maternal mortality is also high in Sudan, and the midwives attending the training frequently cited obstructed labor and hemorrhage as their highest concerns going into a delivery. The presence of Sudanese doctors and nurses, some of whom were from rural states, changed the conversation revealing both the concerns for obstructed labor and the limits of this one protocol at addressing those deeper concerns. The village midwives needed to be convinced that enacting the *Golden Minute*™ would not negatively affect the mother's health. This is one place where the fluidity between groups of the women nurse practitioners helped explain and alleviate anxiety. A more open and deeply participatory dialogue occurred. In the end, the practice of Helping Babies Breathe rests on the acceptance by the village midwives who will be both the primary practitioners and peer-trainers in their regions.

Participation and Empowerment: Steps Toward Solidarity and Accompaniment

Establishing participation as a fundamental ethical principle for successful development and implementation of development programs means emphasizing mutuality and agency. I may be able to take part in a development or health program for human rights, but if I have no voice, that program does not meet the standard of active participation necessary for justice. Participation is not satisfied by simple procedural assent. Agency "is central to recognizing people as responsible persons," and participation is understood as both individual and social.[31] Reflecting on the social advances made through women's empowerment, economist and philosopher Amartya Sen notes that "any practical attempt at enhancing

[31] Amartya Sen, *Development as Freedom* (New York: Anchor Books, 2000), 190.

the well-being of women cannot but draw on the agency of women themselves in bringing about change."[32] Focusing on participation empowered the village midwives to help babies breathe. Yet participation is challenging, as it heightens vulnerability on both sides. International health workers must share knowledge of evidence-based medicine, but they also must be prepared for elements of that knowledge to be challenged. Listening requires being open to learning from others.

An effective partnership for global health based upon participation breaks down traditional categories of teacher/student and envisions a community of learners in which everyone has knowledge and perspectives to share. Without this understanding, evidence-based medicine can easily if inadvertently strengthen the existing balance of power dynamics which disempower those in the developing world. It also creates a long-term dependency upon international experts as the authority. In the Sudan Helping Babies Breathe National Initiative, participation was a guiding principle practiced through local listening. This is the relationship sought in accompaniment, one that "requires recognition of real world complexities, acknowledging the asymmetry of power and privilege and being willing to address these while walking together."[33] Once again, mutual cooperation is the mark of a just partnership.

The challenges for lowering neonatal mortality in Sudan are great, as is the reality of structural violence faced by many of the village midwives. Lack of infrastructure, allocation of resources, communication, and the presence of conflicts are all elements of structural violence which Helping Babies Breathe does not address. However, structuring the program around participation empowered the midwives, not only by giving them knowledge but through dialogical interaction. Attacking neonatal mortality as a global health crisis requires understanding all the broader structural elements. It requires, in Farmer's catch phrase, an approach that

[32] Sen, *Development as Freedom*, 190.

[33] Stephen Reifenberg, "Afterward," in *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutiérrez*, ed. Michael Griffen and Jennie Weiss Block (Maryknoll, NY: Orbis Books, 2013), 194.

is geographically broad and historically deep. Our gaze is on the people, not the particular program. In global health, this involves the dialectic of integrating both evidence-based medicine and the genuine need for global protocols, with the local reality and lived experience of community health workers. Local Listening then is a subversive tactic in combating the structural violence which is so often a lived reality for those most at risk for early death.

At the end of the course, all of the eighty-four newly certified trainers were excited about Helping Babies Breathe. In the three years following the initial launch, hundreds of trainers have been certified and thousands of village midwife providers successfully trained in all eighteen states, including hundreds in Darfur. It was a powerful start.[34] Systemic studies by the project team of skills retention one year later were positive.[35] The last ten years in Sudan have illustrated the deep complexity of addressing global health, poverty, and human rights issues. Positively, newborn mortality has steadily declined in Sudan to 27 per 1,000 live births in 2020.[36] At the same time, political turmoil continues to complicate the lives of those living in Sudan, as well as those who seek to provide medical care. Additionally, the American Academy of Pediatrics and World Health Organization have broadened and reimagined their efforts into a Helping Babies Survive initiative aiming to be more integrative by addressing newborn health beyond delivery.[37] This new version was adopted by

[34] See A.M.E. Arabi, S.A. Ibrahim, A.R. Manar, M.S. Abdalla, S.E. Ahmed, E.P. Dempsey, and C.A. Ryan, "Perinatal Outcomes Following Helping Babies Breathe Training and Regular Peer-Peer Skills Practice Among Village Midwives in Sudan," *Arch Dis Child* 103, no. 1(2018): 24–27, doi.org/10.1136/archdischild-2017-312809. And A.M.E. Arabi, S.A. Ibrahim, S.E. Ahmed, F. MacGinnea, G. Hawkes, E. Dempsey, and C.A. Ryan, "Skills Retention in Sudanese Village Midwives One Year Following Helping Babies Breathe Training," Archives of Disease in Childhood 101 (2016): 439–442.

[35] Arabi et al., "Skills Retention in Sudanese Village Midwives One Tear Following Helping Babies Breathe Training."

[36] The World Bank, "Morality Rate, Neonatal (per 1,000 Live Births)—Sudan," data.worldbank.org/indicator/SH.DYN.NMRT?locations=SD.

[37] Helping Babies Survive, www.aap.org/en/aap-global/helping-babies-survive/.

Sudan in 2017, and trainings of rural midwives around the country continued at least through 2020.[38]

Hope and Solidarity: Farmer's Lessons for Moral Theology

In "Rethinking Medical Ethics: A View from Below," Farmer and Nichole Gastineau Campos ask "Whose interests are [medical ethics] intended to protect? What ends do they serve?"[39] These questions should be asked of theological ethics as well. Farmer and Campos suggest, "One of the ways of rethinking medical ethics is to place the 'outcome gap' front and centre as an ethical issue."[40] A focus on equity must always be multifaceted, must build systems and not be satisfied only with low hanging fruit. This is what I saw in Sudan—an international group of doctors and nurses committed to system building via the village midwives alongside efforts to increase access to better resourced hospitals, especially obstetric and NICU care. It was done to prevent newborn death, a particularly tragic example of what Farmer calls "stupid deaths."

When reflecting on hope, Dr. Farmer noted that giving into despair by those who are not "poor, sick, or dying" is "giving up on behalf of other people."[41] It is this commitment to the dignity of the vulnerable, to a preferential option for the poor, that led Farmer to emphatically reject a lesser "cost-effective" standard of care for the poor.[42] When speaking about his own belief in a human right to health care, Paul centered his answer on the integrated problem of structural violence but also on the fact that the poor and excluded themselves believe in and call for the recognition of

---

[38] Sudanese American Medical Association, "Past Projects: Update from Sennar State 2020," sama-sd.org/past-projects/wmc/helping-babies-breathe/.

[39] Paul Farmer and Nicole Gastineau Campos, "Rethinking Medical Ethics: A View from Below," *Developing World Bioethics* 4, no. 1 (2004): 23.

[40] Farmer and Campos, "Rethinking Medical Ethics," 26.

[41] Partners In Health, "Dr. Paul Farmer On Hope," www.youtube.com/watch?v=PINxZQwde54.

[42] For more on this see *Bending the Arc*. Of note is the resistance from WHO global health experts at virtually every stage. In particular, the question of providing cancer care in Rwanda is an inflection point that draws out the division on standards of care.

their own dignity and rights.[43] One powerful example is the Cange Declaration by Partners In Health patients in Haiti. In the Cange Declaration, PIH patients condemned the stereotypes and lies perpetuated in order to justify denying lifesaving HIV treatment to the poor in the Global South. They stated,

> We pledge to remain steadfast in this fight and never to tire of fighting for the right of everyone to have necessary medications and adequate treatment. We also have a message for the big shots—for those from other countries as well as from Haiti, and from big organizations like the World Bank and USAID. We ask you to take consciousness of all that we continually endure. We too are human beings, we too are people.[44]

Like the village midwives I met in Khartoum, lack of access to education and the reality of poverty did not mean that they were not able to stand up and claim their rights.

Catholic social teaching has long called for an integral human development approach to human rights, including for a right to health care, yet it is often critiqued or dismissed as impractical, naïve, and utopian. The concrete accomplishments of Partners In Health demonstrate that these commitments are not naïve or utopian. Instead, they require imagination, determination, and a deep abiding attention to the structural violence people endure. Catholic moral theology can and should be in a relationship of mutual learning and refinement with public health, global health, and related social science. It should be a resource for those who work on health and human rights, as it was for Farmer himself. He engaged theology directly through personal and intellectual collaborations with Gustavo Gutiérrez, OP, Roberto Goizueta, James Keenan, SJ, and others. His example then is an invitation to theological

[43] Partners In Health, "Paul Farmer, This I Believe," www.youtube.com/watch?v=xJpZnUjtorI.
[44] "Cange Declaration: PIH's First HIV Patients Advocate for Equal Access to Treatment," www.pih.org/article/cange-declaration-pihs-first-hiv-patients-advocate-for-equity-in-access-to.

ethics to be part of interdisciplinary conversations with medicine, public health, etc. It calls for Catholic moral theology to continue to engage the social and health sciences in a dialogue where we learn from each other while centering the voices of those otherwise ignored. It is perhaps only through local listening and practical collaboration and conversation that moral theology can make sure its reflections on medical ethics center the concerns of those who bear the brunt of the outcome gap and structural violence.

In Khartoum, through conversations with Sudanese doctors, nurses, village midwives, and the young women medical students who served as my translators, I learned just how much of the context never quite made it into medical, political, or the social scholarship used to drive global health and sustainable development conversations. It was their advocacy for the health of women and girls that led me to pursue more fieldwork—this time in contexts where I could more freely include religion in the conversation, as in Sudan I was there as purely as a social ethicist. In 2015 and 2018, I conducted fieldwork in Kenya, Ethiopia, and Tanzania, looking at the role of women religious on these issues of women and development.[45] For me, the impact of local listening and a crucial legacy of Farmer's work for theological ethics, is the unapologetic and continual challenge—to whom are we accountable?

This same question, framed a little differently, has been raised by Pope Francis in a call for the Catholic Church to go out of "our own comfort zone in order to reach all the "peripheries" (*Evangelii Gaudium*, no. 20) of power in the Church and society. In 2022, I was part of "Doing Theology from the Existential Peripheries" of the Migrant and Refugee Section of the Dicastery for the Promotion of Integral Human Development. "The project is built on the belief that those who have been marginalized, whether socioeconomically, socially, or in other ways, hold a wisdom capable of reopening discourse, especially where there are

[45] Meghan J. Clark, "Charity, Justice, and Development in Practice: A Case Study of the Daughters of Charity in East Africa," *Journal of Moral Theology* 9, no. 2 (2020): 1–14.

tensions."[46] Teams of theologians in six regional working groups sought to listen to and record the stories of faith, hope, pain, joy, and experiences of the Church of those living on the margins of power. One particularly moving witness that I interviewed was Josefa, a recycler in Brooklyn, NY. An immigrant from Mexico, Josefa makes a living by collecting cans and, as part of a workers cooperative, represents her community to the international waste pickers association. Explaining her job, she said, "We recyclers...we help to clean up the planet a little bit, in all the continents where there is a recycler, we help to clean the planet, because if we did not exist who would collect the garbage from the streets?"[47] Through local listening, Josefa's witness reveals that her strength and contribution to the community is far greater than perceptions of her economic status. Ultimately, Pope Francis and Paul Farmer both challenge theological ethics to interrogate and often recalibrate our focus, asking, whose lives and concerns are considered worthy enough to place them at the center of our questions and the inequities to which we devote our time to fighting?

Meghan J. Clark, **PhD**, is an associate professor of moral theology at St John's University (NY). In 2015, Dr. Clark was a Fulbright Scholar at the Hekima Institute for Peace Studies and International Relations at Hekima University College, Nairobi, Kenya. She has conducted fieldwork on human rights and solidarity in Sudan, Kenya, Ethiopia, and Tanzania. In May 2018, she was a Visiting Residential Research Fellow at the Centre for Catholic Studies at the University of Durham (UK). In 2022, she was Assistant Coordinator/Organizing Secretary for the North American

[46] "Doing Theology from the Existential Peripheries," Migrants & Refugee Section, Dicastery for the Promotion of Integral Human Development, migrants-refugees.va/theology-from-the-peripheries/.

[47] Stan Chu Ilo and Meghan Clark, "What We Have Seen and Heard," North American Report, "Doing Theology from the Existential Peripheries," migrants-refugees.va/wp-content/uploads/2022/10/North-America-Final-Report-FORMATTED-1.pdf.

Working Group of the "Doing Theology from the Existential Peripheries" project of the Migrant & Refugee Section of the Dicastery for the Promotion of Integral Human Development of the Holy See. She is author of *The Vision of Catholic Social Thought: The Virtue of Solidarity and the Praxis of Human Rights* (Fortress Press, 2014) as well as numerous articles and chapters. Active in public theology, she is a columnist for *US Catholic* and contributes to *NCR*, *America*, and other outlets.