THE *JECH* GALLERY

Do we need them? Working with traditional birth attendants in the Andes

Fifty two per cent of deliveries at Ayacucho department (south central Peruvian Andes) occur at home, and at rural settings this number is expected to be higher. The main actor involved with pregnant women in those communities are the traditional birth attendants (TBAs) and they are usually "occult" to foreign people. Some years ago, the health personnel became aware of a new baby when parents came to health facilities asking for a birth certificate for the child. In this context, it becomes evident that an integrated working relationship between health personnel and TBAs was needed: for the health personnel to learn from the TBA's position in the community, and for the TBAs to increase their knowledge about safe pregnancy and referral issues. The picture shows a TBA learning about clean delivery with a simulated baby (connected to the umbilical cord and placenta). Now, both TBAs and health personnel increasingly work together at home and at health facilities.

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SPEAKER'S CORNER

Power, politics, and social class

The recent growth of health disparities scholarship has not been accompanied by a parallel development in its key construct: social class. Rather, new research has kept the "social" in social inequalities to a minimum. With few exceptions,[1] social class understood as a power and political relation (managerial control, property relations, labour unions, political parties, class based social movements) is absent from social epidemiology. As suggested by the Whitehall study and several other analyses,[2] power relations can be a major mechanism by which health disparities are generated.

The typical pattern of relying on a single ordering of income does not tap into the social mechanisms that explain how individuals arrive at different levels of material resources.[3] Occupational measures cannot account for social inequalities either because occupation refers to the technical aspects of work, rather than to power relations (such as asset ownership or managerial control).[4] Thus, somebody who drives an automobile for a living could be a self employed owner of her cab, a supervisory worker of a taxicab chain, the owner of a taxicab chain, a cab driver renting a car, or some combination of the above. Power heterogeneity within occupation may lead to variations in multiple exposures via working conditions, income, wealth, health behaviours, and access to health care.[3] These differences are not captured by usual occupational measures.[5]

Class politics are also absent from emerging areas of social epidemiology such as the areas of "globalisation"or "social capital".[6] For example, the working classes have no influence over the international financial institutions that outline developing countries' health policy reforms. Again, without assessing social class power and political relations we fail to generate mechanisms and explanations to further health disparities research.

We can begin to understand the mechanisms that generate differences in income, wealth, or credentials if we use social class measures that capture power relations (property relations, managerial control).[2] We can add even more complexity when class power is mediated (via one's family), part of a trajectory (higher education), involves simultaneous positions,[3] and is measured at multiple levels or with continuous indicators (rate of exploitation, value of productive assets owned, number of workers supervised).[4]

We also need to confront the causes of the neglect of power relations in social class research. By focusing on the properties of social positions rather than persons, power relations clash with the lay assumption that a person's social class reflects some intrinsic attribute ("will power", "talent", "effort"). That's why power relations are simultaneously intriguing and unsettling.

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