

Daughters of Time: The Shifting Identities of Contemporary Midwives

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Imagine anthropologist Robbie Davis-Floyd's surprise when she rounded a corner in a birth center owned by Doña Facunda, a *partera tradicional* (traditional midwife)¹ who works in Morelos, Mexico, and encountered a flat marble delivery table complete with metal stirrups. Laughing as the anthropologist expressed her amazement (¡Ay, Doña Facunda! ¿que hace una partera tradicional con una mesa así [My goodness, Doña Facunda! What's a traditional midwife doing with a table like that?]), Doña Facunda, with a mischievous glint in her eye, pointed out that the fathers, mothers-in-law, and grandmothers who accompany her clients believe in the efficacy of the hospital and its procedures, including giving birth in the lithotomy position. "If they want me to act like a little doctor (*mini-médico*)," she said, holding up her blue hat and booties, "I can do that! But when the mother-in-law says, 'Shouldn't she get up on the table now?' I say, 'No, it's not time yet,' and I encourage her to keep walking around or to rest comfortably in my big double bed. Most of my mothers give birth sitting, kneeling, or squatting. Very few want the table. It's here if they do, but its main use is just for show!" She added, "If having an IV makes them feel safer, for an extra 100 pesos I'm happy to insert it. But I really hate for women to give birth flat on their backs and hooked up to an IV. So I encourage them to wait before they get up on the table, until they are really pushing well, and then they find they like being upright." Grabbing the handles from which the IV bag would be suspended, and using them to support herself in the birth position known as a hanging squat, Doña Facunda added, "So this is what we mostly use the IV pole for!"

This manipulation of biomedical artifacts to reinforce a traditional birthing system is replete with irony. Other ironies abound in changing patterns of birth practices that are taking place elsewhere. In the United States and Canada, the dawn of the lay midwifery renaissance in the 1970s, generated by white women of mostly middle-class origins responding to a growing demand for home birth, paralleled the twilight of older forms of folk midwifery, which had largely served marginalized rural women. Although most folk midwives were eliminated in the United States and Canada by a systematic medical campaign (see Fraser 1995; Smith and Holmes 1996; Susie 1988), in a few places the two strands of midwifery have merged. Gladys Milton, a black "granny" midwife from northern Florida, is a case in point. For 30 years she attended births in Florida and Alabama. Most of her counterparts throughout the rural South were phased out of practice by the 1970s. As long as she stuck to attending the births of poor black women, Milton was largely ignored by the state health care system. But in the early 1980s she started to be sought out by middle-class white women who were part of the home birth renaissance. At that point the state paid attention and tried to phase Milton out of practice too. However, by then "discrimination" by race, class, and gender was working both ways: Milton's white middle-class clients and the new home birth midwives of Florida -- who had organized, lobbied for legislation, and started midwifery schools -- rallied around Gladys and her daughter Maria, helping them to gain licensure under the new 1984 law. Thus, instead of disappearing, Milton became the first traditional granny midwife to achieve professional licensure (Bovard and Milton 1993; Milton and

Fulwylie 1997), thus cementing what Florida midwives lovingly refer to as “the alliance between the grannies and the granolas” (Berino 2000). Davis-Floyd first had the honor of meeting Gladys Milton at a Midwifery Today conference in Hawaii, where she and Milton lunched with Ina May Gaskin, one of the founding mothers of professional direct-entry (formerly “lay”) midwifery in the United States, and Doña Hermila, a 60-year-old traditional midwife from the state of Oaxaca, Mexico.² Doña Hermila served for many years as a community midwife in a small mountain town with no running water or electricity; today she lives in Oaxaca City, where she appears on a weekly call-in television show disseminating herbal recipes and remedies to a statewide viewing audience.

Examples such as these — as well as the case studies in the articles included in this volume — confound the overdetermined association between “midwife” and “tradition.” They confront us with novel combinations; unexpected juxtapositions, ironies, and reversals of what was once touted as medical “progress”; and implosions of competing systems that seem surprising in relation to common Western assumptions about childbirth. They highlight the fact that exchanges of knowledge and technology across locales increasingly muddle our attempts to find “authentic,” culturally specific practices and monolithic value systems. Most of all, they underscore the inadequacy of the modernist tale of linear progress that has for so long been used by Western health care officials and development planners to narrate the relationship between midwifery and the biomedical management of birth.

In medical anthropology, childbirth and reproduction have emerged as vibrant areas of ethnographic research, with the anthropology of midwifery being a thriving subspecialty. We now have a wealth of studies not only of local birthing customs, but also of the complex negotiations that take place among birthing women, their families, birth attendants, and health care professionals trained in biomedicine.³ Taken together, the diversity documented by these studies challenges the essentializing Western stereotypes of midwives. One such stereotype involves the overly romantic view that all midwives are woman-centered, caring, and technically superior; the flip side of this picture is the institutionally embedded demonization of all forms of non-biomedical birth assistance as harmful and medically dangerous. Clearly neither of these over-simplifications does justice to the complicated circumstances surrounding care-giving in childbirth, as the papers in this volume will show.

At stake are basic issues of health and survival. The disparities in the rates of maternal mortality among various regions of the world are staggering. Many women carry and bear children under difficult conditions, which, over the long term, compromise their health. This suffering begs for ethical solutions, of which biomedical knowledge and technical intervention would form a part (although they often constitute stop-gap measures and do little to address the desperate need for large-scale social reforms). Although the cultural/moral stakes involved in childbirth are less easily gauged via public health statistics than are the physical stakes, birth can go “wrong” in the cultural/moral realm as well as in the physical realm, causing yet other kinds of pain and suffering. Safety, survival, physical and emotional comfort, control, respect, status, values, and auspiciousness may all be involved in childbirth in tangled, culturally specific ways. What is “best” for birthing families cannot be determined by one-size-fits-all programs and evaluations. When knowledge systems diverge, women and families must sometimes make trade-offs between their assessment of how to ensure the survival of mother and baby and their assessment of how to achieve the comfort of a socially valued form of birth; and they don’t always make the choices that fit the worldviews of their caregivers, health planners, or the state-supported medical system that organizes the possibilities available to them.

The debate that pits “medicalized” childbirth against “midwifery” simplifies the matter on several levels. It has been difficult for anthropologists to write about midwifery in a way that avoids these value-laden polarities, however crude they are recognized to be. One reason for this is that the judgments embedded in them undergird many of the concrete efforts made around the world either to foster midwifery practice or to replace it with obstetrically managed systems. These are real political battles

over the legitimacy of certain childbirth practices. They are, therefore, part of what needs to be described ethnographically. As the articles in this volume amply illustrate, midwifery (in whatever form it takes) is not neutral practice but, rather, something that is to be acknowledged, legitimated, revived, reinvented, co-opted, or combated, depending on what is perceived to be at stake.

This volume addresses the shifting identities and practices of midwives as they attend to birthing women in the midst of these cross-cutting value judgments. The articles herein take the midwife's role as emergent and ever-changing within contexts that are themselves dynamic. Our aim is to capture, through case studies, the "openness" of the role of midwife by analyzing the ways in which midwives in different locations have sought, or been forced, to rethink and to reinvent their modes of practice in relation to changing contexts and the institutional backing of a given style of childbirth. Usually, it is biomedical birth that is institutionally backed, but in Canada and in the Netherlands, as our contributors show, midwifery can also be backed by both the government and the medical system. As these articles demonstrate, flat accommodation/resistance frameworks for talking about midwives in relation to biomedicine do not capture the flexibility of contemporary midwives or the subtleties of the adjustments they make as they adapt their practices to the demands of their institutional backers (or detractors) and the complexities of the contemporary world.

Daughters of Time?

Images of the past, present, and future infuse these stances on midwifery. Our ethnographic accounts of shifting midwifery identities and practices in today's world must, therefore, address temporal imaginaries -- pictures of the past, assessments of present conditions, dreams for the future. These images of time and change guide the projects, aspirations, and motives of the social actors whose actions and views we describe. They also guide our own analyses. The title for this volume, "Daughters of Time," springs from a formative moment in the history of the new midwifery in the United States. Santa Cruz midwife Karen Erlich (personal communication, 2000) described that moment to Davis-Floyd as follows:

The First International Conference of Practicing Midwives was held in El Paso in January of 1977. It was an amazing, emotional gathering, the first ever, of homebirth midwives who had sprung up all over the continent, thinking they were the only ones who existed. Among the concerns expressed was whether we wanted to stay as iconoclastic, outside-the-system lay care givers, or allow a process of professionalization ... During the open mike, women spoke passionately, eloquently, angrily, tactfully and not tactfully, about this calling and the political issues already confronting us. In the midst of this hot, compelling, fascinating, provocative session, Mary Offermann got up and, instead of politicizing, sang this song. It was fantastic! The conference ended awash in the true emotions of birth and womankind.

Daughters of Time

I am a daughter of time
My mother walked these hills in years gone by.
Her mother too once watched these trees
In blossom, bearing fruit and losing leaves.
We are the daughters, the daughters of time.

...
Last night I held a woman who was giving birth
She brought another daughter here to earth.
I feel happy with my man and with our son
But I wonder if a little girl will ever come to me
To join the daughters, the daughters of time.⁴

For these midwives, the poetic trope of "daughters of time," with its image of birth as the moment that embodies the continuity of generations of women, helped solidify a sense of what their project was

about. The image expresses a hope that women today will be empowered to recuperate knowledge and skills maintained by women in the past, to revitalize them for the present, and to preserve them for the future. The phrase was further cemented in midwifery lore in the early 1980s through a film entitled *Daughters of Time*, which focuses on nurse-midwives (Durrin 1982).⁵

Here we borrow the image “daughters of time” for a somewhat different purpose: to reflect on the shifting practices and identities of midwives in locations around the world. We wish to query the images of past, present, and future that lend midwifery its meaning in various locales even as we document the continuities and changes in midwifery practice as a variety of creative responses to biomedical encroachment, constraints, and possibilities. Can the image “daughters of time” be as meaningful, or as politically efficacious, for midwives elsewhere as it was for the group of U.S. midwives who were so moved by it? A comparative perspective (so central to anthropology) is of renewed importance as we attempt to understand the relation between a resurgence of positive interest in midwifery in some countries and the marginalization, displacement, and/or medicalization of midwifery in others.

The “Postmodern Midwife” as an Ideal Type

This special issue began with an invitation to midwifery researchers (six anthropologists and one sociologist) to write about a phenomenon that Robbie Davis-Floyd has been calling “postmodern midwifery.” She and midwife Elizabeth Davis first defined this term in print in 1997, and it has had an impact on subsequent anthropological discourse about contemporary midwives.

This phenomenon which we have labeled *postmodern midwifery* -- midwives who are educated, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance -- is increasingly emergent all over the world. Our juxtaposition of “postmodern” (a charged word in the anthropological lexicon) with “midwifery” is far from casual. With that juxtaposition, we are trying to make salient the qualities emergent in the praxis, the discourse, and the political engagement of a certain kind of contemporary midwife -- [one who often constructs a “radical critique” (Marcus 1993:6) of unexamined conventions and monological assumptions]. (Davis-Floyd and Davis 1997:319-320).

Our original idea with this issue was to discuss the shifting identities of postmodern midwives through presenting ethnographic case studies from cultures around the world. However, as the papers came in, it became increasingly clear to us that, while some of them do directly address postmodern midwifery as defined by Davis-Floyd and Davis (1997), others offer reflections on, and critiques of, both the advantages and the limitations of this definition. As we went through these articles, it occurred to us that it would be useful to think of postmodern midwifery as an “ideal type” to which some of the midwives described in these pages conform while others do not. Here we use the term ideal type in the standard Weberian sense; that is, as an analytical model that has been constructed with a view to making comparisons and developing explanations. As should be obvious, an ideal type is a purely heuristic device and is not to be confused with the common-sense notion of the ideal as something denoting perfection (Bullock and Stallybrass 1977; Bendix 1977; Weber 1964). In this section we flesh out the notion of the postmodern midwife as an ideal type and show how, in enabling us to distinguish between those midwives who fall into this category and those who do not, it also enables us to recognize the nuances and complexities of various forms of midwifery.

Davis-Floyd’s awareness of what she came to call postmodern midwifery began to dawn upon her during the 1991 annual conference of the Midwives’ Alliance of North America (MANA) in El Paso. Jeannine Parvati Baker, a conference participant who calls herself a “shamanic midwife,” organized and facilitated a Blessingway Ceremony for which she asked a group of traditional Mexican midwives (who were attending the conference for the first time) to serve as honorees. In full indigenous attire, they were formally seated on chairs in the center of the ritual circle while the American midwives

showered them with songs, chants, blessings, and small gifts, washing their feet and crying with emotion. As the ceremony ended, Doña Enriqueta Contreras, better known as Doña Queta, was the first to speak. Rising to her feet, she said: “In truth, we didn’t know what we signify for all of you. Perhaps we form the connection to the past which you lack, to our ancestors in midwifery and to the earth, in which we still live. With all our hearts, we give you thanks for honoring us so.”

The multiple juxtapositions, ironies, and subtleties embedded in this event fueled Davis-Floyd’s curiosity about contemporary midwives and their transnational interlinkages -- a curiosity that was richly stimulated in subsequent years by American direct-entry midwives (see Endnote 1) as they underwent a complex process of professionalization. Throughout this process they have sought both to create standardized international certification criteria and to remain true to their counter-hegemonic practices and ideals (Davis-Floyd 1998a, 1998b, forthcoming a, forthcoming c). It was partly as an effort to understand these American midwives, the unusual Mexican *parteras* she was interviewing, and the global midwifery movement she was encountering at international conferences that Davis-Floyd, in dialogue with midwife Elizabeth Davis and midwife/anthropologist Janneli Miller,⁶ formulated the notion of an emergent postmodern midwifery — a notion aimed at capturing precisely those aspects of contemporary midwifery practice that fall outside the easy dichotomies of traditional ethno-obstetrics and modern biomedicine.

Doña Facunda’s self-conscious manipulation and implicit critique of the trappings of modern medicine, Doña Queta’s sensitive and transcultural response to the Blessingway Ceremony, Gladys Milton’s alliance with the professionalizing direct-entry midwives of Florida and their outspoken critique of the physicians and health officials who sought to eliminate them, are all examples of what Davis-Floyd thought of as postmodern midwifery. Previous anthropological ethnographies of traditional midwives have described them as unselfconscious participants in their local ethno-obstetric systems (Cosminsky 1977; Jordan 1993; Jeffrey and Jeffery 1993; Laderman 1983), as being involved in tension-filled and structurally subordinate relationships to biomedical practitioners (Susie 1988; Rozario 1998), and/or as having been phased out altogether by the advent of modern biomedicine (Fraser 1995). These descriptions seemed unable to capture the self-awareness and drive toward autonomy that Davis-Floyd was encountering in her research on American and Mexican midwives. She found that the international networking activities of the midwives she was following were inspired by a vision of “daughters of time” moving into the future through creative boundary crossings (Davis-Floyd, this volume). She formulated the notion of the postmodern midwife in order to encompass such movements and to capture the new conditions under which midwives are negotiating their identities, searching for appropriate roles, and seeking new rationales for their continued presence in the world.

Trying to encapsulate the characteristics of the midwives she was studying, Davis-Floyd came to see the postmodern midwife as one who takes a relativistic approach to various ways of knowing about birth and who can articulate ways of making discrepant systems complementary. Recognizing the limitations and strengths of both the biomedical system and her own system, the postmodern midwife moves fluidly between them in order to serve the women she attends. Lacking or actively rejecting a sense of her practice as structurally inferior to that of biomedicine, she is free to observe the benefits of traditional midwifery practices common in many cultures (e.g., massage, external version, eating and drinking during labor, birthing in upright positions, birthing at home, and uninterrupted contact between mother and baby). She compares these with what she sees in the hospital and with what she learns about scientific evidence (see Rooks 1997 for a compilation of this evidence); she concludes that biomedicine does not recognize the value of the midwifery approach; and she develops a sense of mission around preserving midwifery in the face of biomedical encroachment. In this way, she constitutes her alternative praxis as a form of critique. At the same time, she does not hesitate to appropriate the authoritative lexicon, the trappings, and the technologies of biomedicine when she finds them of either instrumental or symbolic value. She is a shape-shifter (she knows how to subvert the

medical system while appearing to comply with it), a bridge-builder (she makes alliances with biomedicine where possible), and a networker. When possible, she attends conferences and meetings, making connections with other midwives in other parts of the world, increasing her ability to translate between systems, and gaining consciousness of midwifery as a global movement. Through her interlinkages with other midwives around the world she works to create a global and increasingly shared culture of midwifery as well as to preserve, to carry forward, and to teach the best of her own cultural traditions around birth.

The articles in this theme issue reflect on this notion of the postmodern midwife. Describing the complexities encountered by the practitioners they have studied, some of the authors problematize Davis-Floyd's formulation, revealing it as an ideal type: it does serve analytically to capture the characteristics of many contemporary midwives, helping us to make useful comparisons between midwives across cultures and across socio-economic divides; however, it does not encompass the full range of complexity many other midwives must negotiate. These case studies from different parts of the world draw our attention to the real world processes that are generating the sorts of alliances, relativistic consciousness, implosions of disparate realms, and shape-shifting that might invite the label "postmodern." Yet they also show the dangers of using this term to define an epoch. Such singular definitional moves inevitably reintroduce modernist teleologies through the back door by misleadingly suggesting an inevitable historical movement through stages of "tradition," "modernity," and "postmodernity." If the notion of the postmodern midwife is looked at as a blueprint for the future — a future that some contemporary midwives are closer to than others — then it will have the unfortunate effect of perpetuating the idea that some midwives are, indeed, old-fashioned relics of a superseded era. If, however, the notion of the postmodern midwife is looked at as an ideal type, then it will refract, and thus enable us to comprehend and reflect upon, the multiple forms and conditions of contemporary midwifery practice.

Negotiating Relationships within Structures of Power

Around the world the pressures that, a priori, define biomedicine as structurally superior to traditional medicine, doctors as superior to midwives, and professional midwives as superior to folk midwives have not so much supplanted various ethno-obstetric systems with a set of universal "modern" practices (or resistances to them) as they have produced a multiplicity of practices of accommodation and negotiation. It is upon these tactics and practices that this volume focuses. The original invitation to authors to contemplate the notion of postmodern midwifery has led to many nuanced considerations. In the movement from proposing this notion to receiving ethnographic case studies, it became clear that any account of how midwives work between domains of knowledge must consider structures of power. Biomedicine exists not so much as a free-floating system of knowledge and techniques as a nationally and internationally authorized project — one that is often linked to state efforts of modernization and that, in actual clinical form, often does not live up to the plans behind it (for examples, see Lukere and Jolly 2001). A close-up focus on midwives and birthing practices inevitably opens out on the wider sweep of national and subnational health care institutions, reform projects, legislation, and international development initiatives. The Ontario legislature is present at home births (MacDonald, this volume); the World Health Organization walks through Ghanaian villages (Geurts, this volume). If we are to recognize that midwives are creative inventors of systems of accommodation, then we must first acknowledge that not all accommodations are of the same type, nor do they occur on a level playing field. Likewise, in order to describe how midwives play the system we must also provide an account of the role of the state (and other institutions) in designing and enforcing that system. In some cases, as Jenkins (this volume) shows for Costa Rica, the state can effectively close off the legal space in which midwives might operate, while, at this same time, failing to provide adequate access to other health care and thus making midwives indispensable to remote rural residents. What can be called "fluidity" and "boundary-crossing" may simply be strategies adopted by the marginalized in order to survive (cf.

Tsing 1993). In other cases, the services offered by midwives may be affected by what the state is unwilling or unable to do; midwives may be pressed to fill in the gaps in reproductive health services, ranging from contraception and abortion to postpartum care.

Midwives in locales around the world thus negotiate their roles in relation to diverse and very complex layers of institutions and interests. Midwives engaging in transnational networking often find themselves lobbying legislators or government officials for the right to exist, struggling to balance conflicting ideologies and knowledge systems, and arguing with each other about appropriate standards for education and practice. In many countries, developed and developing alike, the tensions between biomedical, traditional, and alternative/holistic knowledge systems permeate professional midwifery training and praxis and generate conflicts between midwifery educators, between educators and students, and among practicing midwives and those who regulate them.

The relationship between “professional” and “folk” midwives can also be a significant issue. The distinction between these “types” of midwives is itself a product of a long history of role negotiation (see Hsu, Davis-Floyd, this volume). In some places, professional midwives trained in government-approved two-year courses and sent to rural villages work hard to get to know the village women, to give them nurturant care, and to cooperate with the local village midwives (Chen 1977; Kroeger 1996; Kwast 1992). In others, such professional midwives adopt an attitude of arrogance and superiority; they treat the village women badly, slapping them, yelling at them, and giving inadequate care (Allen, forthcoming; Armstrong 1989; Byford 1999; GRMA 1990:49; Iskandar et al. 1996; Kargbo 1986; Schwartz 1981; Velimirovic and Velimirovic 1981). In countries like Guatemala, where there are no professional midwives, labor care often falls to nurses who sometimes act arrogantly and scold both midwives and mothers, in effect discouraging further referrals to the hospital (Hurtado 2001; Houston 2001; Cosminsky this volume). Some folk midwives, transformed into traditional birth attendants (TBAs) through short government-sponsored courses, are creatively adapting biomedicine to their native systems, occasionally with the help of professional midwives (see Daviss 1997; Graham 1999; Davis-Floyd 2001, this volume), while others find themselves phased out of existence or subsumed and marginalized (Whittaker 1999; Dieteker, forthcoming; Cartwright, forthcoming; Sieglin, forthcoming; Geurts, Jenkins, this volume).⁷

Denise Roth Allen’s (forthcoming) careful ethnography of birth in a Tanzanian village also illustrates the concatenation of global forces, national initiatives, and local realities that complicate the politics of contemporary childbirth. Her research highlights some of the unintended consequences associated with the implementation of the global Safe Motherhood Initiative. For example, based on international recommendations, the Tanzanian government’s policy regarding prenatal care includes the use of the prenatal card, or home-based maternal record. In theory, the prenatal card, which the pregnant woman keeps in her possession, is meant to serve as a mobile medical record that ensures consistent care during pregnancy and childbirth. But in the rural community where Allen conducted her fieldwork, health care personnel were so underpaid that they often sold drugs and supplies out the back door in order to make extra money. So when a local woman showed up for care, they often had little to offer her but a birthing table, where she would be expected to labor without food (and often without water) and with no family members present. In Allen’s observations of births in clinic and hospital settings, and in her interviews with women concerning their pregnancy-related experiences, she found that women were often mistreated by midwives, who frequently yelled at them when they complained or asked for help. Consequently many local women chose not to attend the clinic and would either decide to give birth at home or with a TBA who lived in a nearby village. The TBA would treat them with relative kindness and would not subject them to undue economic and emotional pressure. Because the TBA was structurally defined as “outside the system,” visits to her did not officially count as prenatal care and so could not be recorded on an official prenatal card. If a problem developed during labor and the woman needed a cesarean, she would not be admitted to the clinic without the requisite card documenting the requisite

number of prenatal visits. So the TBA had to deal with whatever arose and would be blamed if the mother or baby died. Thus a system that was intended to be supportive ended up being punitive -- for the mothers who did not get the care they needed, for the TBAs who were blamed for situations they could not fix, and for the midwives who were overworked and underpaid.

Davis-Floyd vividly recalls the 1999 Safe Motherhood (*Maternidad sin Riesgos*) conference in Mexico City, during which a United Nations International Children's Emergency Fund (UNICEF) official stated that it was the fault of the village *parteras* that women died in childbirth because they did not transport them when they should. Outraged, Doña Nieves, a *partera* from a small town in Oaxaca who was wearing her traditional *huipil*, grabbed the mike and firmly responded, "Don't tell me that I'm responsible for this! I've been practicing for 30 years and I *know* when to transport women to the hospital! But I have no way to get them there! If you want to reduce mortality in my community, don't blame me -- give me a car!" As Doña Nieves made clear, the problems the global Safe Motherhood Initiative seeks to address are real -- far too many women die in childbirth in many parts of the world -- but blaming TBAs only obscures the painful truth that the solutions generated by government and development planners are usually superficial and, therefore, ineffective. They do not address serious infrastructural problems like bad roads, lack of transport, or the poor care many women receive when they do make it to the hospital (see, for example, Davis-Floyd, forthcoming b).

To take another example, Morsy (1995) has shown that, in Egypt, maternal mortality is often medically induced: in some Egyptian hospitals, more than half of all maternal deaths result from infections that occur after a Cesarean section. In the rural areas, where maternal mortality rates are highest, sophisticated midwifery systems were systematically disrupted by the British colonial approach to medicine, which gave authority to men only. Having destroyed a viable women's health care network, medical men then blamed the remaining midwives for the disastrous outcomes experienced by women in these regions. The medicalization of maternal mortality in Egypt has meant that these deaths are attributed to toxemia, postpartum hemorrhage, and the like rather than to the politico-economic factors that keep women overworked and malnourished and, thus, susceptible to life-threatening complications. Blaming midwives enables development planners and government officials to pour millions of dollars of non-governmental organization (NGO) money into stop-gap measures (like hospitals and clinics) that further medicalization without addressing the root causes (e.g., socio-economic and infrastructural problems) of maternal mortality.

The case studies described above, like the ones gathered in this volume, make it clear that blanket classifications of -- or judgments about -- types of midwives make little sense outside the specificity of a given historical context. National health care systems, development programs, and the bureaucracies that administer the law do more than simply manage the scope of midwifery practice vis-à-vis biomedicine. These institutions actively perpetuate the categories through which local folk specialists are classified as "traditional" as opposed to "modern"; indeed, for far too long anthropology itself has worked within this same type of framework. The terms of engagement between knowledge systems are set up by classificatory systems and ground-level power struggles that tend to manifest themselves in the value-laden implications of the traditional/modern dichotomy. Critical reflection on modernist categories is essential to ethnographic studies of midwifery, as the studies in this volume from the developing world make clear (see Cosminsky, Geurts, Hsu, Jenkins, Davis-Floyd). Previous anthropological research on birthing has shown the heterogeneity in the roles of folk specialists who provide birth assistance worldwide; some, like those in Mexico (see Sesia 1997) and Guatemala (see Cosminsky 1977, 2001), are respected healers who provide important pre- and post-natal care, while others, like those in some parts of South Asia (see Jeffrey and Jeffrey 1993), are low-status birth attendants who simply perform the "polluting" tasks others refuse. Some perpetuate physiologically harmful traditions, like using dung to seal the umbilical stump or wiping the baby with dirty rags; others (or sometimes those same practitioners) perpetuate physiologically beneficial traditions like

breastfeeding and giving birth in upright positions. Some folk or traditional midwives operate from within relatively closed knowledge systems, while others, like Doña Facunda, expand their traditional systems to encompass a wide range of concepts and practices. Across this diversity of roles, knowledge bases, and status, unity cannot be found in an ethos of woman-centered care or in an efficacious practical wisdom. Ironically, what *does* unite this heterogeneous set of folk birth specialists is the fact that modern institutions classify all of them as TBAs.

The Ramifications of Definitions

Any effort to make sense of the complexities of contemporary midwifery must deal with the issue of definition. How does the concept of “midwife” translate across borders? The international definition of a midwife, endorsed by the WHO, UNICEF, the International Federation of Gynaecologists and Obstetricians (FIGO), and the International Confederation of Midwives (ICM) states:

A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. (World Health Organization 1996)

All midwives who have not graduated from such programs are not considered “midwives” but, rather, TBAs. Since there are a myriad number of local names for midwives in a myriad number of languages, the impact of this naming at local levels can be hard to assess (Cosminsky 1976, 1983; Pigg 1997). However, on the global scale, the ramifications of the distinction between midwives who meet the international definition and those who do not have been profound. Those who do meet it are incorporated into the health care system, usually below doctors and above nurses (see Matsuoka, Hsu, this volume); those who do not meet it suffer multiple forms of discrimination (see Geurts, Jenkins, this volume).

The blame cast on TBAs in Tanzania and many other developing countries has serious repercussions for them. Because in most places 30 years of TBA training programs have not resulted in any demonstrable drop in maternal mortality, UNICEF and other agencies are now withdrawing support for TBA training all over the Third World and increasing support for midwives who meet the WHO definition. As early as 1978, Brigitte Jordan demonstrated the cultural inappropriateness of the two-week TBA training programs initiated in Mexico’s Yucatan, showing that their content was entirely biomedical and took almost no account of local beliefs and practices (whether harmful or beneficial). An additional problem was that the technologies the courses taught were often too expensive for the midwives to obtain or were inappropriate to their cultural circumstances. Nevertheless, such training continued to be administered to traditional midwives all over Mexico as well as in many other countries. In spite of their limitations, these courses often did have the effect of integrating midwives to some extent into local health care structures as well as enabling them to sign birth certificates, to develop relationships with physicians, and (sometimes) to obtain access to family planning information and devices. Midwives themselves often valued this interface with the official health care system more than the information provided in the courses. The sudden withdrawal of funding for such programs, which at least provided traditional midwives with a set of official channels, leaves those who depended on them (and on the official registration certificate that they guaranteed) in limbo -- a phenomenon that is occurring in various countries as such programs are increasingly eliminated.

Taken together, the articles in this volume suggest that how concepts of midwifery are translated within the global arena is an important area of ethnographic investigation. The new International Alliance of Midwives (IAM) is one example of active, engaged efforts to establish a common bond among midwives.⁸ Part of this movement’s aim is to generate an alternative international definition of midwife, one that will encompass the local realities and complexities of those who are generically and somewhat

demeaningly referred to as TBAs and who are now, in many places, going to be officially left out of the game.⁹ Rather than seeing TBA training eliminated, many in this international movement would like to see it radically redesigned to address local realities and needs, to respectfully evaluate the systems of knowledge local midwives already use, and to stress on-site development of viable forms of “mutual accommodation” (Jordan 1993) between biomedicine and community styles of birth.¹⁰ Other forms of professionalization, whether through the training of nurse-midwives (see Hsu, this volume) or through self-initiated alliances among direct-entry midwives (see Davis-Floyd 1998, 2000), also build upon visions of midwifery as something much more than a merely local project. The awareness of some midwives that they are part of a specialist community that transcends international borders is an extremely important development. Which practitioners are most easily incorporated into these translocal networks and which are not? What are the bases for these new alliances? What new distinctions among midwives emerge as a result of these developments?

About This Volume

From an anthropological perspective, the eight articles in this special issue of *Medical Anthropology* investigate the shifting identities today’s midwives adopt in order to define their place and role. These articles are but a small sample of the range of midwifery ethnographies being produced in the subdiscipline known as the anthropology of reproduction. Our aim in bringing this work together is to encourage a comparative reading of the literature in terms of the issues raised -- a reading that is self-conscious in its regard for the differential interplay of local and global forces in changing midwifery practice.

The first four articles describe midwives in Japan, the Netherlands, Canada, and Mexico who most closely fit Davis-Floyd’s notion of the postmodern midwife. Japanese anthropologist Etsuko Matsuoka describes how the shift from agriculture to industrial production to the contemporary service and information economy has been mirrored by a shift from birth at home (attended by folk midwives) to hospital birth (attended by doctors and hospital midwives) to the emergence of a plethora of options regarding place and type of childbirth (attended by postmodern midwives). Ironically, these options include some elements associated with “traditional” birth, such as out-of-hospital birth and the use of upright positions. Matsuoka gives us important insight into the factors that motivated professional, hospital-trained midwives to abandon hospital practice, the most salient of these being the damage to mother and baby caused by the application of routine technological interventions to the process of parturition. Their personal evolution through hospital practice to attending births in birth centers and homes belies and contests modernist evolutionary notions that define the movement of birth from home to hospital as “medical progress.”

In the Netherlands home birth never disappeared. Linking the historical emphasis on home and family with the contemporary retention of autonomous midwifery and a 30 percent home birth rate, sociologist Raymond DeVries proposes reasons why, in striking contrast to comparable advanced industrialized nations, the Netherlands retained a strong emphasis on home birth. Many regard the Dutch midwifery system as one of the best in the world. DeVries provides an account of the conditions that made possible this combination of midwife-controlled birth and technocratic birth. However, he also shows that the same system that is touted by outsiders as being in the vanguard of the midwifery movement is regarded by some within the Netherlands as a vestige of the past. Nonetheless, the Dutch case remains one of the premier examples of how it is possible for a thriving midwifery tradition to exist within an effective biomedical health care system.

Canadian midwives, too, have found their practices affected by the hospital management of birth; however, in their case, the process has gone in reverse. In Canada, where midwifery was without legal status until the 1990s, the first generation of lay midwives practiced outside the hospital, attending births at home. After a long struggle, in 1993 midwifery was legalized in the Province of Ontario; other

provinces have since followed suit. Legalization meant full incorporation into the publicly funded health care system; following the Dutch model, Ontario midwives can now practice in all settings: hospitals, birth centers, and homes. Analyzing midwifery's move from the margins to the mainstream health care system, anthropologist Maggie MacDonald illustrates the resultant tensions between the midwives' move into the hospital system, which is accompanied by a greatly expanded use of technology, and their original mission to preserve the essence of midwifery as a critical, low-tech alternative to hospital-based "technocratic birth." Focusing on the role of the consumer, MacDonald argues that the complex negotiations between the clients of midwives and medical technology have been instrumental in re-shaping postmodern midwifery in Canada.

Davis-Floyd's article documents the emergence of a new kind of midwife in Mexico, the thoroughly postmodern *partera profesional*. She traces the transnational conjunctures that facilitated the creation of this new Mexican midwife, illustrating key aspects of her philosophy and praxis, and probing her ongoing articulations of identity. *Parteras profesionales*, women of diverse socio-cultural backgrounds, initially sought training from American direct-entry midwives in the independent out-of-hospital midwifery model and now are reformulating that model for Mexico. Through their own practices, through intensive liaison work with traditional midwives, and through organizing national midwifery conferences and meetings, they are creating midwifery as both incipient profession and nascent social movement. A recurrent theme in Davis-Floyd's article is the tension these women feel between their desire to preserve traditional midwifery and their desire to create a professional form of midwifery in Mexico. These goals alternately complement and conflict with one another, yet both are central to the *partera profesional's* ongoing efforts at identity articulation.

In contrast to Mexico's new professional midwife, professional nurse-midwives in St. Lucia are trained in the hierarchical and fragmented biomedical approach to birth. And yet midwifery, while part of the St. Lucian biomedical system, is multiply constructed through the dynamic play of "bush" practices (which people learn at home), biomedical practices (which are imported to the island), and local structures of authority and knowledge. Anthropologist Clarissa Hsu examines the form and content of midwifery education in St. Lucia, providing rich insights into the way practitioners of midwifery come to make sense of these multiple and often contradictory discourses. Hsu argues for an expansion of Davis-Floyd's notion of the postmodern midwife, stretching the term to include midwives whose shape-shifting and bridge-building are not always conscious, and who must struggle to find their path through a cultural universe characterized by competing ways of knowing about medicine and birth.

These competing ways of knowing also characterize the dynamics of a Guatemalan mother-daughter duo that Sheila Cosminsky has studied extensively across generations. Cosminsky's comparison of mother and daughter serves as an important illustration of the differences between the mother's earlier praxis and the modernizing influences to which the daughter (in particular) must respond as she copes with increased legal regulations and supervision by the biomedical system and the state. Exemplifying the strategies adopted by many midwives under the twin pressures of modernization and medicalization, the daughter negotiates with biomedicine: she accepts its structural and intellectual claims to superiority while strategically utilizing its greater cultural capital to enhance her own status and authority. At the same time, she joins her mother in the deliberate retention of many elements of traditional belief and practice, especially those that reinforce her own sense of identity as a full member of her cultural group. Cosminsky suggests that the sacred dimensions of their practices and knowledge are a means by which these midwives are able to maintain some authority outside the biomedical system. Through her spirituality, the daughter is empowered to continue to give culturally meaningful care even as she incorporates many biomedical elements (such as insisting that women lie down to give birth) into her practice.

In Ghana "modern" birth is now coming to mean hospital-based birth, while the government's move to

make home birth safer reflects not a conscious shift toward a positively valued home birth but, rather, a pragmatic acknowledgment of local realities. By focusing on a folk midwife who rejected attempts to stop her from practicing because she had not attended the government-sponsored TBA training course, Kathryn Geurts examines some of the local realities of being a midwife in Ghana. Geurts analyzes the complex factors that impel this midwife to encourage one woman to stay at home to birth while insisting on transporting another to hospital, and she describes this woman's ongoing enactment of community values -- values that stand in marked contrast to the individualistic Western values instantiated in medicalized birth. This midwife's pragmatic maneuvers forge links between two different systems of birth; however, they often do so "at the cost of fluidity and smoothness, forcing tensions, disjunctures, and rifts." In Ghana, Geurts argues, the "modernity" of the medical system lies in its insistence that the natural dimensions of childbirth be separated from its social dimensions — an impossible ideal which, through "habits of pragmatism," this particular midwife brings down to earth.

In Costa Rica, as Gwynne Jenkins shows, midwives survive in the interstices of the cosmopolitan biomedical model of care, providing interventions demanded by women (although demeaned by biomedicine) and creating a bridge by which poor, rural women can gain access to biomedical care. Jenkins describes the impact of international organizations like WHO on Costa Rican policy toward midwives: first, they train them with the idea that they can function as a stop-gap measure, and then they eliminate them as the biomedicalization process gains steam. In the face of such governmental efforts, traditional Costa Rican midwives demonstrate a growing awareness of their own importance as practitioners, clearly articulating the practical need both for their roles in ensuring the safety and well-being of the women in their communities and in criticizing the biomedical model of birth.

Discussions of midwifery practice and its relation to biomedicine are inevitably colored by the history of this debate in the West. Some midwives have been generating criticisms of the biomedical model of birth since its beginnings in Europe four centuries ago. During the 18th century, as physicians and male midwives increasingly introduced interventionist technologies like forceps into the birthplace, often applying them inappropriately and causing more harm than good (Donnison 1977; Wilson 1995), midwives in various European countries wrote treatises criticizing the over-use of such technologies (e.g., Stone 1737; Nihell 1760; see also Marland 1993; Murphy-Lawless 1998; Lay 2000). These midwives were fully autonomous practitioners under no regulatory obligation to work with or under physicians; they generated their critiques from the perspective of many years of independent experience and practice. In most European countries, these autonomous midwives were prevented from forming professional guilds and schools by laws that reserved such rights for men. By the time most contemporary European midwifery organizations were finally created in the 19th and 20th centuries, obstetricians were firmly in control of birth, and, in most European countries (with the exception of the Netherlands), midwives were subordinated to physicians within the stratified biomedical system. In other words, modernization, in childbirth as in many other bodily arenas, meant medicalization and a consequent loss of autonomy for midwives. This loss has generated an ongoing debate among contemporary midwives concerning their appropriate roles and identities (Barclay and Jones 1996; Kirkham and Perkins 1997; DeVries et al. 2001), and it has played a major role in generating the rise of the transnational midwifery renaissance, whose progenitors have identified regaining that lost autonomy as one of their major goals (Kitzinger 1991; Lecky-Thompson 1996; Flint 1995; *Midwifery Today* 1998). The articles by Matsuoka, DeVries, and MacDonald illustrate how some of these ongoing struggles for autonomy are being carried out by midwives in the industrialized North, even as folk midwives in the less affluent South (as Geurts shows for Ghana, Cosminsky for Guatemala, and Jenkins for Costa Rica) continue to lose their former autonomy. In Mexico, as Davis-Floyd illustrates, the *parteras profesionales* and the *parteras tradicionales* do practice autonomously, but both are highly marginal in relation to the national health care system and, thus, both are in danger of disappearing.

Indeed, the midwives whose ideas and practices are encapsulated in this volume represent possible responses to the full range of forms of biomedical practice and state-led regulation, from a Guatemalan midwife's relatively uncritical acceptance of biomedicine and the strategic appropriation of its authoritative status, to the dissenting critique of biomedical conventions and assumptions generated by a small set of midwives in Japan, to the burgeoning numbers of certified midwives in Canada. The Japanese midwives studied by Matsuoka passed through medicalization and came out on the other side, developing new identities as autonomous out-of-hospital practitioners. In contrast, the Canadian midwives studied by MacDonald started out as participants in a counter-hegemonic social movement (Davis 2001) and are now struggling with the tension between those original countercultural identities and the demands of professionalization. As they integrate more fully with biomedicine and incorporate its technologies in response to client preference and demand, these Canadian midwives increasingly question to what extent they can sustain their originally radical critique.

Some of the Mexican *parteras profesionales* studied by Davis-Floyd operate outside the medical system, as their Canadian counterparts used to do, while others, like the midwives of Ontario, have carved a niche within it. The mere existence of these self-consciously activist midwives in Mexico constitutes a critique of monological Mexican medicine and its high cesarean rates, but these midwives have a long struggle ahead to define their identities, legalize their practices, and generate a sustainable space within the emergent Mexican technocracy. To their intense dismay, this struggle must take place within the context of the escalating disappearance of the traditional midwives they seek to support -- a context within which their own survival is far from guaranteed. In Costa Rica, traditional midwives have already almost disappeared; those who remain must grapple with the tension between their own sense of mission regarding attending the women who seek them out and the fact that they can no longer legally offer midwifery care. The changing social meaning of midwifery leaves these women feeling increasingly devalued and disempowered not just by the state, but also -- and more important -- by the local women and families they serve. Who can they be, now that they have no place to stand? Like the Guatemalan and Ghanaian studies carried out by Cosminsky and Geurts, Jenkins's Costa Rican study highlights the extreme challenges faced by these "daughters of time" in so-called "developing" nations as they grapple with multiple trajectories, knowledge systems, and structures of power in an ever-changing world.

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Notes

¹ Labels such as "traditional," "folk," "professional," and so on are symbolically loaded and have long been problematized by anthropologists. In this Introduction, we use the terms "traditional" and "folk" interchangeably to identify indigenous midwives whose practices reflect and respect local knowledge and customs identified with specific folk or ethnic groups. As the articles in this volume amply demonstrate, both change and continuity are features of the practices of these midwives. Identifying midwives as "traditional" or "folk" does not imply that they are locked into static knowledge systems; rather, these articles show the various forms of dynamism and creativity that characterize "traditional midwifery."

"Granny" midwives are the black folk midwives who practiced historically in the American South; "professional" midwives are those who meet the international definition of a midwife, which we describe later on in this Introduction; "nurse-midwives" are professional midwives trained and jointly certified in nursing and midwifery; and "lay" midwives are the American midwives who generated what is often called the "midwifery renaissance" in the United States and Canada during the late 1960s, 1970s, and 1980s. By the 1990s, these midwives had professionalized; they dropped the term "lay" and began to refer to themselves as "direct-entry" midwives.

² *Midwifery Today* is both a magazine and an organization dedicated to the dissemination of information about midwives worldwide. The Midwifery Today staff hosts and/or co-sponsors midwifery conferences in the United States and in other countries around the world. For more information, see <www.midwiferytoday.com>.

³ Acevedo and Hurtado 1997; Allen, forthcoming; Barrington 1985; Benoit 1991; Benoit et al. 2001; Biggs 1983; Blanchet 1984; Boddy 1998; Bourgeault, Benoit, and Davis-Floyd, forthcoming; Brink 1982; Burtch 1994; Buss 1980; Butter and Kay 1990; Byford 1999; Campanella et al. 1993; Chalmers 1990; Cosminsky 1976, 1977, 1982a, 1982b, 1983, 2001; Chawla 1998, 1999, 2000; Davis-Floyd 1998a, 1998b, 2000, 2001, forthcoming a, forthcoming b, forthcoming c; Davis-Floyd and Davis 1997; Daviss 1997, 2001; DeVries, 1993, 1996; DeVries and Barroso 1997; DeVries et al. 2001; Dougherty 1978, 1982; Faust 1988; Fraser 1995, 1998; Fiedler 1997; Good Maust 2000; Good Maust, Guémez Piñeda, and Davis-Floyd forthcoming; Graham 1999; Huber and Sandstrom

2001; Hunt 1999; Hurtado 1984; Hurtado and Saenz de Tejada 2001; Jambai and MacCormack 1997; James-Chetalet 1989; Jeffery and Jeffery 1993; Jeffery, Jeffery and Lyon 1989; Jordan 1993; Justice 1986; Kaufert and O'Neill 1993; Kay 1982; Kay et al. 1988; Kolenda 1998; Lay 2000; Lay et al. 2000; Lefebvre 1994; Lefebvre and Voorhoeve 1998; Lukere and Jolly 2001; MacCormack 1979, 1984, 1988; MacDonald 1999; Macdonald and Bourgeault 2001; McClain 1975, 1981, 1989; Mellado 1989; Michaelson 1988; Mead and Newton 1978; Morsy 1995; Newman 1981; Paul 1975, 1978; Paul and Paul 1975; Peterson 1983; Pigg 1997; Romalis 1982; Rosario 1998; Rubel et al. 1971; Rushing 1988; Sakala 1988; Sargent 1982, 1985, 1989a, 1989b; Sargent and Bascope 1997; Sesia 1997; Schreiber and Philpott 1978; Sukkary 1981; Susie 1988; Szurek 1997; Trevathan 1987; Vincent-Priya 1991; Villatoro 1994; Whittaker 1999.

⁴ Copyright 1975 Mary Offermann.

⁵ The video *Daughters of Time* illustrates the history and practice of nurse-midwives, showing certified nurse-midwives (CNMs) attending a birth at home, in a clinic, and in a hospital. Produced and directed by Ginny Durrin, the video was filmed during 1979-1980 and was premiered in 1981 at the British Embassy in Washington, D.C. A copy can be obtained from the national office of the American College of Nurse-Midwives, 818 Connecticut Ave. Suite 900, Washington, DC, 20006 (1-202-728-9860) or from Durrin Productions Inc. (1-800-536-6843; durrinprod@aol.com).

⁶ Davis-Floyd especially wishes to thank Janneli Miller for her contributions to the formulation of this notion.

⁷ For example, Mary Kroeger, an American-trained nurse-midwife with broad international experience, worked closely in Central Java, Indonesia (where there is still a maternal mortality rate of 390/100,000 live births), with the *bidan di desa* -- government-trained professional midwives sent to live and work in rural villages -- and the *dukun bay*, or "traditional birth attendants." The idea of the Ministry of Health-sponsored program in which Kroeger took part was that the *bidan* were to move into three villages and eventually replace the *dukun*. Ironically, this replacement was to be accomplished through the development of a partnership between *bidan* and *dukun* at the village level. Aside from the obvious competition-for-business issue, Kroeger found that one of the biggest problems with fostering this partnership was the failure of the Ministry of Health safe motherhood program to officially recognize the *dukun* as a critical part of the health service, in spite of the data showing that they attend over 70 percent of home deliveries. The regular "Maternal Perinatal Audits" conducted quarterly in many districts in Java in order to uncover the causes of mortality (Kroeger 1996) exclude the *dukun*. Yet the audits show that the initial problem originates when the family and the *dukun* fail to arrange for referral in time to avert a tragedy. In "Unraveling the Mysteries of Maternal Death in West Java" (Iskandar et al. 1996), the authors show what Kroeger experienced: the *dukun* and family often avoid transport until it is too late because of their fears of high medical costs, of being treated badly by the midwives or doctors at the hospital, and of inadequate hospital care. The unfortunate young *bidan di desa* must account for the reasons for the death even though she may not have been directly involved in the care.

The Indonesian village midwife program has been the focus of much international study and foreign aide. In spite of its problems, Kroeger (personal communication, 2001) reports that in some areas of Indonesia the partnership between *bidan* and *dukun* is working. The following conditions seem to characterize such successful partnerships: (1) The *bidan* herself is likely to be originally from that village or area and familiar with the local practices; (2) she has shown willingness to take time to develop trust with the community and work within the village leadership structure and local customs; (3) she has developed a trusting relationship with the *dukun(s)* who attended births in that village long before she arrived; and (4) she has shown that, when an emergency develops during a birth, she can assist with the transfer and will act as advocate for the family at the district referral center (Kroeger 1996).

⁸ For more information about this movement, visit Midwifery Today's website <www.midwiferytoday.com> and click on "International."

⁹ For one example of this movement to generate an alternative international definition of midwifery, consider the following statement by the midwives of Puerto Rico:

Position of the Midwives of Puerto Rico on Their Identification (written by the Group of Midwives of Puerto Rico and translated into English by Robbie Davis-Floyd, Carol Díaz Ortiz, and Debbie Díaz Ortiz)

The midwives of Puerto Rico accept the international definition of a midwife to denominate the partera, comadrona, matrona or midwife; however, we consider it clearly limited to one concept. The midwife who has acquired her knowledge by attending birth in an academic program recognized by the government of the country where she is located does not deprecate and, on the contrary, considers as her equal, the

midwife who arises from other formal social paradigms accepted by the group of people who comprise her community. Traditional systems of learning have been transmitted through centuries, from woman to woman until the present. This is an historical reality of midwives that has persisted in diverse sectors of the world.

Therefore, we, the midwives of Puerto Rico, recognize as a *matrona*, *comadrona*, *partera* or midwife she who has learned the profession within a group of midwives, in systems of instruction transmitted from generation to generation, and is accepted as such in her community or group.

As well, the names midwife, *partera*, *comadrona* or *matrona* will be honored to have been historically identified with the persons who practice midwifery. We want to establish that when talking about the traditional midwife in the English language, she should be referred to as a "midwife," as this name corresponds to the realities of her practice. This should be the only name used in Puerto Rico to identify both the midwives who practice by tradition and those who are recognized by the World Health Organization.

The practicing midwives in Puerto Rico have decided to include this document in the Science and the Art of Attending Childbirth of the Special Documents of the Midwives of Puerto Rico, 21 January 2001.

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¹⁰ Various such models already exist (Graham 1998; Daviss 1997; see also Davis-Floyd, this volume, regarding the CASA project in Mexico).