

Daughter of Time: The Postmodern Midwife¹

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For past millennia, midwives have served women in childbirth. In premodern times, midwives were usually the only birth attendants. With the Industrial Revolution and the arrival of modernism, male physicians either replaced midwives or superceded them in the modernist medical hierarchy, leaving them with plenty of women to attend but with relatively little autonomy. As the new millennium dawns on a growing worldwide biomedical hegemony over birth, midwives, the daughters of time and tradition, find themselves negotiating their identities, searching for appropriate roles, and seeking new rationales for their continued existence.

“Modernity” is a narrow canal through which the vast majority of contemporary cultures have passed or are passing. It arrived in various parts of the world at different times; first in the industrializing countries of the North, and more slowly in the colonized and exploited countries of the South. So anthropologists consider “modernism” not to be a particular point in time but rather a univariate (single-pointed, single-minded, unvarying) orientation toward “progress,” defined in terms of Westernized forms of education, technologization, infrastructural development (highway, rail, water, and air systems etc.), factory production, economic growth, and the development of the global marketplace. This univariate orientation identifies a single point in a given area toward which development should be progressing: in economics, that single point is capitalism; in health care, it is Western biomedicine. Thus in modernizing societies traditional systems of healing, including midwifery, have become increasingly regarded by members of the growing middle and upper classes as “premodern vestiges” of a more backward time that must necessarily vanish as modernization/biomedicalization progresses.

[Box:]

Modernity’s progression toward univariate points

- In economics, capitalism
- In national development, the building of infrastructures: water, sewage, electricity, telephones, and transportation systems (water-, air-, rail-, and highways).
- In production, the elimination of the small in favor of the large: industrial agriculture and the factory production of goods
- In health care, biomedicine

[Box] Some of the costs of modernity

- The colonization of most of the world by a few Western capitalist and industrial countries
- The ongoing elimination of subsistence agriculture and indigenous cultures
- Massive worldwide pollution of the environment and its concomitant health costs to people and the planet
- The supervaluation of “the modern” and the devaluation of indigenous cultures and knowledge systems

Yet around the world, the univariate orientation of modernization is increasingly contested. Postmodern thinking widens the narrow canal of modernization beyond uncritical acceptance of modernization as good, noting the enormous environmental, social, and cultural damage modernization entails, and seeking to generate more polymorphous societies in which multiple knowledge and belief systems can coexist and complement each other. In postmodern societies and groups, conservation and preservation of the environment and of indigenous or traditional languages, cosmologies, health care, and economic systems take on particular urgency and importance, and such endeavors are sometimes considered to be more important than expanding the reach of industrialization, capitalism, and biomedicine.

These postmodern efforts at conservation are fueled both by global organizations and by myriad local grass-roots social movements. In the cultural arena of childbirth, for example, as some governments and development planners urge the elimination of traditional birthways, other international workers seek to conserve these. Thus many indigenous women who have tried out the government-funded hospitals and clinics subsequently reject them because of the impersonal care they receive there, and deliberately return to traditional midwives for out-of-hospital birth. In some regions, midwives trained in a modernist ideology of biomedical superiority act, in fact, superior, while other professional and traditional midwives are displaying a variety of creative and highly relativistic responses to biomedical encroachment and constraints.

My familiarity with midwives and midwifery systems in many countries leads me to see the midwife/TBA distinction not as a dichotomy but as a continuum, so I prefer the labels “professional midwives” (to indicate those who have had professional, accredited training) and “traditional midwives,” to indicate those who practice within the traditions of their communities, without professional degrees or culturally valued certifications

Informed Relativism: The Characteristics of the Postmodern Midwife

Around the world we are witnessing the emergence of a phenomenon that I call “postmodern midwifery” —a term aimed at capturing those aspects of contemporary midwifery practice that fall outside easy distinctions between traditional birthways, professional midwifery, and modern biomedicine. With this term, I am trying to highlight the qualities that emerge from the practice, the discourse, and the political engagement of a certain kind of contemporary midwife—one who often constructs a radical critique of unexamined conventions and univariate assumptions. Postmodern midwives as I define them are relativistic, articulate, organized, political, and highly conscious of both their cultural uniqueness and their global importance. By “postmodern midwife” I specifically do not mean midwives who accept without criticism either their own folk system or that of biomedicine, but rather midwives who fully understand these in a relative way, as different ways of knowing about birth, discrepant systems that often conflict but can be complementary.

Postmodern midwives are scientifically informed: they know the limitations and strengths of the biomedical system and of their own, and they can move fluidly between them. These midwives play with the paradigms, working to ensure that the uniquely woman-centered dimensions of midwifery are not subsumed by biomedicine. They are shape-shifters, knowing how to subvert the medical system while appearing to comply with it, bridge-builders, making alliances with biomedicine where possible, and networkers, attending conferences and meetings and making connections with other midwives in other parts of the world. Such networking increases their ability to translate between systems, and to gain consciousness of midwifery as a global movement. These transnational interlinkages among midwives work to create a global culture of midwifery as well as to preserve, carry forward, and teach to others the best of one’s own cultural traditions around birth.

Lacking or actively rejecting a sense of structural inferiority to biomedicine, the post-modern midwife is free to observe the benefits of traditional midwifery practices common in many cultures such as massage, external version, eating and drinking during labor, birthing in upright positions, birthing at home, and uninterrupted contact between mother and baby. A comparison with what takes place in the hospital and what can be learned from scientific evidence results in the conclusion that there is value in the midwifery approach that biomedicine does not recognize. The post-modern midwife then develops a sense of mission around preserving that approach in the face of biomedical encroachment, and an understanding that for a midwife, the professional is always political: midwives and their colleagues must have an organized political voice if they are to survive. So postmodern midwives work to build organizations in their communities, join national and international midwifery organizations, and work within them for policies and legislation that support midwives and the mothers they attend. It would be easy to conclude that only professional midwives, with their greater access to high technologies and international networking systems can achieve the informed relativism I am highlighting as the primary characteristic of the postmodern midwife. But traditional midwives in many countries are undergoing radical changes, to which an emergent postmodern consciousness sometimes characterizes their responses.

[Box:] Characteristics of the Postmodern Midwife

- An informed relativism that encompasses science, traditional midwifery knowledge, professional midwifery knowledge, and complementary or alternative practice systems
- Local, global, and historical awareness
- Cultural competence
- A sense of mission around preserving midwifery in the interests of women
- A sense of autonomy as practitioners
- Dedication to the midwifery model of care in its humanistic and transnational sense and to midwifery and women's health care as social movements
- Political engagement, including work with governmental authorities and participation in local, regional, national, and international organizations

The Traditional Midwife as Postmodern

Previous studies of traditional midwives have shown them to be unselfconscious participants in their local folk systems and/or in structurally subordinate relationship to modern biomedical practitioners or as phased out altogether by the advent of biomedicine. To me, these descriptions seemed inadequate to capture the self-awareness, relativistic perspective, political savviness, and drive toward autonomy I was encountering in my research on American and Mexican midwives (Davis-Floyd 1998a,b; 2000; 2001; 2003, 2004a). I formulated the notion of "the postmodern midwife" not only to encompass the informed relativism of various internationally oriented professional midwives, but also of increasing numbers of traditional midwives who are trying to re-negotiate their identities and to articulate new ways of practice and new rationales for their continued existence.

Anthropological research on birthing has shown the heterogeneity in the roles of folk specialists who provide birth assistance worldwide. Some are respected healers who provide both maternity and general health care. Others are low status birth attendants who simply perform the "polluting" tasks associated with birth, while decisions about how to manage labor rest with the family, as in some parts of South Asia. 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 birth in upright positions. Some folk or traditional midwives operate from within relatively closed knowledge systems (see Davis-Floyd 2004b), while others expand their traditional systems to encompass a wide range of concepts and practices from other systems. Where some traditional midwives are compassionate and woman-centered; others crossly order women to comply with their commands. For example, Jordan (1993) reported how midwives in the Yucatan sometimes stuffed a birthing woman's braid down her throat to make her gag so her pushing would be more effective, and Graham (1999) documented the occasional slap a traditional Ugandan midwife may administer to snap a woman out of self-pity during labor. Traditional midwives do not all share in "the midwifery model" of woman-centered care, and the only real unity that can be found among them is their international classification as "traditional birth attendants."

By contrast, the traditional midwives I am identifying as *postmodern* hold and adhere to "the midwifery model of care"—indeed, I developed the concept of *the postmodern midwife* as a way of bridging the definitional gap between TBAs and professional midwives who share the same essential characteristics, including humanism, a sense of autonomy, a high level of political engagement, and most especially, informed relativism.

Postmodern Traditional Midwives in Mexico: Negotiating Knowledge Systems

For example, imagine my surprise when I rounded a corner in a birth center owned by Doña Facunda, a *partera tradicional* (traditional midwife) in Morelos, Mexico, and encountered a flat marble delivery table, complete with metal stirrups. Laughing as I expressed my amazement, 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 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." In what I have since come to think of as the perfect postmodern midwifery moment, Doña Facunda added, "So this is what we mostly use the IV pole for!" as she grabbed the metal handles from which the IV bag would be suspended and used them to support herself in the birth position known as a "hanging squat."

Irony compounds irony in the postmodern midwifery world! Doña Facunda was fully aware that "the hanging squat" (which involves the woman squatting in front of a support person, who sustains her under the arms and sometimes by the knees) is not *per se* a traditional birthing position, most of which involve the woman squatting or kneeling alone or on a birthing stool or chair, often pulling on a pole or rope. Rather, the hanging squat had been named and displayed around the world by French physician and author Michel Odent. Facunda had attended one of his lectures a few years before. Her self-conscious transformation of the biomedical IV pole into a support mechanism for the hanging squat perfectly exemplifies what I mean by "postmodern midwifery": a traditional midwife appropriates a biomedical artifact (1) to implicitly critique its normative use in modernist medicine; (2) to reinforce her traditional birthing system (which has long utilized upright positions for birth); and (3) to expand it to include a birthing technique currently in vogue in the international birth activist and midwifery communities.

Such examples (I could cite many!) confound the over-determined association of "midwife" with "tradition." They confront us with novel combinations, ironies, and unexpected juxtapositions. They

highlight the fact that exchanges of knowledge and technology across locales increasingly muddle our attempts to find “authentic” cultural practices and value systems. Most of all, they underscore the inadequacy of the modernist tale of linear “progress” that has for so long been used to narrate the relationship of midwifery to the biomedical management of birth.

Traditional Birth Attendant (TBA) training courses and other forms of exposure to biomedicine have resulted in fundamental alterations in practice for many traditional midwives in Mexico. Across the country, it is now common for traditional midwives to give pitocin injections to hurry labor, insert IVs for hydration, and wear blue biomedical garb when attending births—practices that they themselves think of as “modern.” Combining such practices with the traditional *sobada* (massage), herbal treatments, and religious beliefs, Mexico’s contemporary traditional midwives practice at the intersection of various cultural domains. These trends have particularly influenced midwives who practice in urban areas, as my extensive interviews with Doña Facunda and her colleagues who live and practice in the city of Cuernavaca (in central Mexico) reveal. Most of these traditional midwives are in their forties or fifties, attended only elementary school, and became fully literate in their thirties. For at least a decade, they have been incorporated into the state health care system in Morelos through bi-monthly seminars on family planning and other topics. All of them went through a period of using allopathic interventions like oxytocin injections and experiencing complications as a result, so they have returned to the use of traditional herbs—in other words, they went through a process of modernization and have come out, as they themselves say, “on the other side.” Marina Rodriguez, who is both a nurse and a traditional midwife, explained the difference between the biomedical and traditional systems as follows: “Allopathy is powerful, but it does too much. Its interventions are too extreme. Our traditional herbs take longer to work, but their effects are much more subtle and more precise.”

Today traditional Mexican midwives like Marina routinely send women out for ultrasounds when they diagnose a breech or transverse presentation and offer their clients an eclectic potpourri of traditional and biomedical techniques. Into this mix they add multiple “New Age” or “alternative” modalities that they have studied (reflexology, homeopathy, iridology, Reiki, etc.). They all have birth centers attached to their houses, complete with autoclaves, sterile equipment, and two double beds, one for the birthing woman plus an extra one for family members. Some of them own Dopplers, and use them with delight to exhibit their technological expertise and to let the pregnant woman and family members hear the baby’s heartbeat. Their walls are covered with laminated diagrams of fetal positions and the female reproductive cycle, and with certificates from the dozens of continuing education courses they have taken at local universities on topics from anatomy to aromatherapy (even though many of them never attended high school). Their shelves are filled with homeopathic remedies and herbal oils and salves they have learned to make in such courses. A few of them have computers and email addresses. Dancing fluidly at the interface of biomedicine, holistic alternatives, and traditional birthways, these midwives are strategically negotiating the boundaries between knowledge systems and creatively producing a hybrid and increasingly well-articulated knowledge system of their own. These postmodern midwives of Cuernavaca elide and confound the usual distinctions between professional and traditional midwives: trained through traditional apprenticeships, they are presently engaged in a visible process of self-professionalization. Their efforts constitute a very conscious attempt to preserve home birth in the face of biomedical hegemony: practicing as they do in a city whose hospitals have cesarean rates of over 70%, they are very aware that they often constitute the only alternative to a cesarean.

Many traditional midwives still practice autonomously, except when they need to transport a client to the hospital (see Davis-Floyd 2003 for an analysis of “the trouble with transport”). Thus their major desire is not for autonomy, which they have, but for some form of governmental or professional recognition above and beyond the status of “TBA.” Aware that professional midwives have such recognition, and of the many benefits it confers, postmodern traditional midwives like Doña Facunda, Doña Irene, and Doña Nieves long for national certification and state licensure as the professionals

they feel themselves to be, in spite of their lack of governmentally accepted training. But their status as TBAs has kept them in limbo, blocking them from recognition as professionals.

I have personally met and spoken with traditional midwives from Guatemala and Brazil who also exemplify my profile of the postmodern midwife, so I know that the postmodernity of these Mexican midwives is not unique in the world. I suspect that their efforts to renegotiate their identities and restructure their practice to meet the demands of a changing world are mirrored by other postmodern traditional midwives in many countries, and therefore I suggest that much more ethnographic research on such postmodern traditional midwives should be conducted.

The Professional Midwife as Postmodern

Although the most recent trend at WHO and UNICEF is toward diminished support for traditional midwives coupled with increased support for professional midwives, recent anthropological ethnographies call into question the appropriateness of this approach. A distressing cross-cultural trend is showing up in the growing body of anthropological literature about midwifery and birth in the developing world. From Croatia to Tanzania to Papua New Guinea, anthropologists who observe professional midwives giving prenatal care and attending births increasingly note that, far from the midwifery ideal, professional midwives often treat women very badly during birth, ignoring their needs and requests, talking to them disrespectfully, ordering them around, and sometimes even yelling at them and slapping them. At the same time, and in direct correlation, the professional midwives are themselves often treated badly by the healthcare systems in which they work. They are almost always underpaid, are frequently mistreated by physicians who rank above them in the medical hierarchy, and generally work long hours under stressful conditions that often include inadequate facilities and equipment and too many women with too few midwives to care for them well. In short, many professional midwives are trapped in the biomedical healthcare system, a system that is failing to meet the needs of birthing women in developing countries.

Although unlike traditional midwives, professional midwives have the structural benefits conferred by government certification, access to certain technologies, and the status-conferring white coat, they still must struggle with the pressures imposed on them by the modernist and colonialist biomedical model, which defines biomedicine as structurally superior to traditional medicine, doctors as superior to midwives, and professional midwives as superior to traditional midwives. Where doctors are few and midwives predominate, professional midwives have opportunities to establish themselves as relatively autonomous practitioners and can make culturally and individually reasonable choices about how to interact with the local traditional midwives. Where doctors are many and professional midwives are clearly subordinate to them in medical hierarchies, they often find that their only route to biomedical status and respect involves rejection of, and often downright rudeness too, traditional midwives and their clients. Studies show that 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). But in others, professional midwives adopt an attitude of arrogance and superiority, and treat the village women disrespectfully (see for examples Allen 2002; Byford 1999; Iskandar et al. 1996), in effect discouraging further referrals to the hospital. It is a paradox of contemporary midwifery that while some professional midwives are working hard to help traditional midwives creatively adapt biomedicine to their native systems (see Daviss 1997; Graham 1999; Davis-Floyd 2000, 2001), other professional midwives and most physicians are working equally hard to further marginalize or fully eliminate their traditional predecessors (Whittaker 1999; Dietiker nd; Sieglin 2002; Geurts 2001, Jenkins 2001).

Postmodern professional midwives as I am defining them very consciously strive not to engage in such behaviors. When they interface with “TBAs,” they apply the same relativistic perspective to the

knowledge system of the TBA as they do to the knowledge system of biomedicine. In other words, they seek to identify and support efficacious aspects of the traditional birthing system, and, respectfully and sensitively, to change harmful practices. I could cite hundreds of examples of professional postmodern midwives. But for the sake of space and simplicity, I will confine myself to three studies recently published in a special issue of *Medical Anthropology* entitled *Daughters of Time: The Shifting Identities of Contemporary Midwives*, which I coedited (Davis-Floyd, Cosminsky, and Pigg 2001) on midwives in Mexico, Japan, and the Netherlands who fully exemplify my profile of the professional postmodern midwife. Here I will briefly summarize these descriptions.

Postmodern Professional Midwives in Mexico

My ethnographic research in Mexico (Davis-Floyd 2001, 2003) documents the emergence of an entirely new kind of midwife, the thoroughly postmodern *partera profesional*. These women of diverse sociocultural backgrounds initially sought training from American direct-entry midwives in the independent out-of-hospital midwifery model; since then they have been reformulating that model for Mexico. Through their own practices, intensive liaison work with traditional midwives, and organizing national midwifery conferences and meetings, they are creating midwifery as both an emerging profession and social movement in Mexico. Some of them operate outside the medical system while others are carving a niche within it. These 50 or so women face a long struggle 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 disappearance of Mexico's traditional midwives, who are vanishing at a rapid rate (in the 1970s, traditional midwives attended over 40% of Mexican births; today that figure is below 15% and the majority are over 65 years of age). Mexico's new professional midwives live in constant tension between their desire to preserve traditional midwifery and the need to create a sustainable form of professional midwifery. They cope with this tension by adding to their professional knowledge base many traditional birthing techniques (such as the use of herbs and of the *rebozo* (shawl) to shift the baby's position). And they help traditional midwives as best they can through foundations, joint conferences, skills-sharing workshops, and government advocacy.

This effort to respectfully combine professional and traditional knowledge systems is particularly visible at the CASA School for Professional Midwives in San Miguel de Allende, where students undergo a professional three-year training program that combines didactic classroom work, clinical work in the CASA hospital, and five three-week apprenticeships with traditional midwives in small and remote rural villages (Davis-Floyd 2001). These apprenticeships not only allow the professional students to incorporate traditional techniques into their practices, but also prevent them from developing the attitude of arrogance and superiority that many professional midwives around the world exhibit toward traditional midwives. Living in the homes of the traditional midwives, helping with their daily routines, and observing their forms of care instill an attitude of deep respect and admiration for these elder midwives in the younger professional midwifery students, and a strong desire to follow in their footsteps while making the path they traced viable in the postmodern technocracy.

Postmodern Professional Midwives in Japan

Japanese anthropologist Etsuko Matsuoka (2001) demonstrates how the shift in Japan from agriculture to industrial production to the contemporary service and information economy (which I call "the technocracy") has been mirrored by a shift from birth at home attended by traditional midwives, to hospital births attended primarily by professional midwives, to the emergence of new midwives who are beginning to offer Japanese female consumers a plethora of options for childbirth. In Japan's premodern period from the 1880s to the 1950s, licensed independent midwives exerted a strong

influence in society as they organized themselves on both local and national levels. Japan's modernization period took place after WWII from the 1950s to the 1970s as Japan experienced rapid economic growth. In those days professional midwives went into hospitals to produce babies just as workers went into factories to produce goods. But since the 1980s, with the advent of the natural childbirth movement, a new type of postmodern Japanese midwife has emerged.

The midwives who have been playing a prominent role in this natural childbirth movement are different from either of the two previous figures: they practice independently but cooperate with and learn from each other. Many of them have worked in hospitals for years but have passed in their thinking about birth beyond the limitations of the medical model and have “come out on the other side.” They pursue their own midwifery model of care and are developing new identities. Some have their own maternity homes or birth houses (known in the US as freestanding birth centers) and others work in hospitals trying to introduce a better way within a medical setting. They are mediators, crossing the boundaries between obstetric care and alternative care, home and hospital, modern and traditional, local and international, and thereby increasing options women. Ironically, these options include the re-incorporation of elements associated with “traditional” birth, such as out-of-hospital birth and the use of upright positions. The primary reason these Japanese midwives give for leaving hospital practice is the damage to mother and baby they observe to be caused by the application of routine technological interventions to the process of parturition. Their personal evolutions through hospital practice to attending births in birth centers and homes contradict modernist evolutionary notions that defined the movement of birth from home to hospital as “medical progress.”

Postmodern Professional Midwives in the Netherlands

While other modernizing nations moved birth to the hospital and brought midwives under the authority of physicians, an autonomous profession of midwifery and home based maternity care were preserved in the Netherlands, where around thirty percent of births still take place at home. Many regard the Dutch midwifery system as one of the best in the world. But sociologist Raymond DeVries (2001, 2004) shows that the same system touted by outsiders as a “postmodern vanguard” is regarded by some within the Netherlands as a “premodern vestige” from the past. As the world around them has changed, Dutch midwives have had to find new strategies to protect their profession and the right of Dutch women to choose their place of birth. DeVries examines the transformation of premodern midwifery into postmodern midwifery in the Netherlands. Noting that Dutch women were among the last in Europe to enter the workplace, DeVries links the historical Dutch emphasis on home and family to the contemporary retention of autonomous midwifery and home birth. He shows that as more and more Dutch women began to enter the workplace, home birth began a rapid decline. But by the early 1990s the Dutch midwives and mothers, newly aware that they were losing something precious, embarked on a campaign to create a postmodern social movement around preserving home birth. In this endeavor they found support in scientific evidence, to which the Dutch government paid close attention. Thus the Dutch case remains one of the premier examples of a thriving postmodern midwifery system that effectively incorporates autonomous midwifery care within the national health care system. The Dutch case demonstrates a primary value of postmodernism in health care: its relativistic approach allows each system to be judged on its own merits relative to the scientific evidence and to other systems, forestalling the univariate modernist view of biomedicine as superior.

Professional vs. Traditional Midwives: The Ramifications of Definition

Any effort to make sense of the complexities of contemporary midwifery must deal not only with biomedical and governmental power structures but also with the definitions such structures impose upon midwives and the ramifications of these definitions within and across national and cultural

borders. The international definition of a midwife requires graduations from a government-recognized educational program. Those who have not are not considered “midwives” (in English) but are labeled “TBAs” (traditional birth attendants). Since there are myriad local names for midwives in myriad languages (and many modes of birth assistance that occur but are not performed by named folk specialists), the impact of this naming at local levels can be hard to assess (Cosminsky 1977, 1983; Pigg 1997). But 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 are incorporated into the health care system (usually below doctors in the medical hierarchy and above nurses). Those who do not remain outside of it, and suffer multiple forms of discrimination as a result.

Many social scientists studying contemporary midwifery find the arbitrary distinction between TBAs and midwives to be highly problematic in terms of its cultural effects. From a social science perspective, a government-approved midwifery training does not necessarily produce a midwife—it may produce a “mini-doctor” instead. Thus social scientists tend to define a midwife not only in terms of their attendance at a birth but also in terms of their social and community roles. In other words, for most social scientists, a “midwife” can be a practitioner who meets the international definition and/or one who is recognized as such by their community.

In general, social scientists do not assume that the role or the practice of professional midwives according to the international definition is any more important to the welfare of women and children than the role of the practitioners officially classified as TBAs. Every social scientist who studies contemporary midwifery (including social scientists who are also midwives) is impressed by the ongoing contributions of TBAs and concerned by the colonialist and biomedical limitations of professional midwives. (Social scientists who study midwives also support midwifery in general, as we know midwives to be the most suited practitioners for all but high-risk maternity care.) Traditional midwives have already vanished or are vanishing at a rapid rate in many parts of the world. Yet those who remain, from the Indian *dai* to the Mexican *partera tradicional*, are providing vital services to the populations they serve, both rural and urban, and preserving knowledge systems that contain much that is of value and relevance in the postmodern world.

Defining traditional midwives as TBAs is a powerful statement that their knowledge does not count in the global system. And indeed in some cases their practices have been shown to be scientifically unsound, just as the practices of many professional midwives and many physicians have also been shown. The point is not to romanticize traditional midwives, but to approach them with the same informed relativism that postmodern professional midwives apply to biomedicine. A relativistic, postmodern perspective reveals that the same traditional midwife who uses cow dung on the umbilicus or tells a mother that her colostrum is bad for her baby can often skillfully and successfully attend births that would confound professional midwives accustomed to obstetrical backup. The same postmodern perspective reveals that professional midwives with years of government-approved training may withhold food and drink from laboring women and force them to deliver flat on their backs. Indeed, the surest marker that traditional midwives have had contact with professional midwives and government-sponsored trainings is that they suddenly begin to demand that their clients deliver in that most unscientific of positions. There is nothing postmodern about the willful eradication of traditional healing and birth systems, and everything postmodern about their preservation and their combination with science-based professional midwifery knowledge. This is a challenge faced by all postmodern midwives, whether professional, or traditional, or an elision of both.

As I hope I have made clear, postmodern professional midwives in my definition are culturally sensitive and competent, work respectfully and cooperatively with traditional midwives and, like the CASA students, include traditional practices in their repertoire. And postmodern traditional midwives gain exposure to both biomedical and professional midwifery information and techniques and selectively incorporate these into their practice, learning as they go. Thus the line between the

professional and the traditional midwife is becoming increasingly blurry. This fact affects the ongoing viability of the international definition of a midwife and the ultimate goal of all midwives—the welfare of mothers and babies.

Conclusion

Postmodern midwives, for all their value, often find themselves living in a constant state of stress, lobbying legislatures 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 developed and developing countries alike, the tensions between biomedical, traditional, and alternative 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 professional midwives of the industrialized North are accelerating their long struggle for autonomy even as traditional midwives in the less affluent countries of the South continue to lose the autonomy they formerly held. In short, today nothing is easy about being a midwife of any type. Yet motivated by a shared desire to offer viable long-term options to biomedical birth, these daughters of time and tradition continue their struggle, with varying degrees of success, but always with the necessary determination to make sure that midwives, with all their limitations and all their power, remain available to care for the mothers and babies of the contemporary world.

Endnotes

1. This article is a “thinkpiece” that stems from other publications that I have either authored or co-authored, in which I have only partially elaborated my notion of “the postmodern midwife,” which I develop fully here for the first time. These earlier publications include Davis-Floyd and Davis 1997; Davis-Floyd 2000, 2001, 2003; Davis-Floyd, Cosminsky, and Pigg 2001. The title for this article, “Daughters of Time,” originated in a song written in 1977 by American midwife Mary Offerman. The image expresses a hope that women today will be empowered to recuperate knowledges and skills maintained by women in the past, revitalize them for the present, and preserve them for the future. The phrase was further cemented in American midwifery lore in the early 1980s through a film about nurse-midwives called “Daughters of Time” (Durrin 1982) and through Barbara Katz Rothman’s (1998) article by that title.

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