

Midwifery

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Attendance at birth has been suggested to be essential in facilitating mother-child survival as the physiology of birth changed during human evolutionary history. "Midwife," an Anglo-Saxon term meaning "with woman," aptly describes the role that women have long assumed as birth attendants. The anthropology of midwifery is *the study of non-physician primary birth attendants within and across cultures*. The birth attendant is not always a specialist, nor do all cultures have specifically delineated roles for birth attendants. Thus our definition of the anthropology of midwifery is expansive enough to include a wide range of biomedical and non-biomedical, formal and informal birth attendants. Important elements of study in this field include the definition, education, practices, identities, and knowledge systems of midwives. Much anthropological research is directed toward the documentation and critique of ongoing international battles over the definition and social roles of midwives, especially as viable alternatives to the over-medicalization of birth.

There is a sharp distinction made in international literature and discourse between "professional midwives" and "traditional birth attendants" (TBAs). Health authorities tend to accept this distinction, while anthropologists tend to reject or contest it, examining the social roles of definitions as tools of power to determine insiders and outsiders. The international definition of a "midwife" was created by the International Confederation of Midwives and formally accepted by other international organizations, including WHO and the International Federation of Gynecologists and Obstetricians:

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised 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 practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

Those who meet this definition may be fully incorporated into health care systems; those who do not (the TBAs) may suffer multiple forms of discrimination. The World Health Organization since 1992 defines the TBA as "a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants," distinguishing trained TBAs as having "received a short course of training through the modern health care sector to upgrade her skills." WHO suggests that TBAs are stop-gap measures until more "qualified" personnel are available.

Midwifery in the Developing World

Non-governmental organizations, multilaterals, and bilaterals have invested heavily in professional midwife and TBA training for over forty years in their efforts to reduce maternal and perinatal mortality in the Third World. The anthropology of midwifery grew out of this trend, and reflects anthropologists' roles in analyzing TBA training programs for development organizations and the impact of new models on both quality of care and health outcomes. Women trained as official midwives are usually young and have borne no children themselves. They are educated in an urban environment, then sent out to serve in a rural village, where they wear the white coat and expect respect from the townspeople for their professional, educated status. They usually work in underfunded and understaffed government-built clinics, but for an extra sum of money will sometimes attend a homebirth if they are called. Workloads and stress levels in such clinics are high, often resulting in maltreatment of women and early "burnout" on the part of the midwife.

Even though governments have embarked on massive programs to bring birth into the clinics and hospitals, many rural women resist, choosing instead to birth at home with a community midwife (TBA). Community midwives are usually older women who have given birth several times and who have become midwives by being asked to attend the births of friends and relatives, slowly gaining first-hand experience of birth. Some of them undertake long apprenticeships, while others learn simply by attending births. From the local point of view, the biggest difference between community and professional midwives is that community midwives are recognized by their community as legitimate birth attendants, while the professionals are often seen as young and inexperienced women who have to prove their worth to the villagers before they can be trusted.

TBA training courses have been highly criticized for their pedagogy and ideology. The purpose of these courses has generally been to educate TBAs in how to identify risks that require transport and to improve their prenatal and maternity care. Designed by biomedical personnel, course content is often inappropriate to local circumstances and realities. Courses often assume access to material resources that are lacking locally, are taught in a style inappropriate to the literacy skills and learning styles of midwives, and fail to provide TBAs a respected and effective place within an integrated system of medicine. Many anthropologists have called for the replacement of such top-down systems with models of mutual accommodation. But the worldwide hegemony of Western biomedicine has made this an elusive goal. When professional midwives make a sincere effort to learn about and honor local customs and traditions, when they approach local people with an attitude of respect and demonstrate willingness to work with community midwives, mutual accommodation is achievable.

It is important not to romanticize or demonize professional or community midwives. Both work under discriminatory biomedical systems and both usually try to give skilled and considerate care and remain, in many parts of the world, the only viable option for millions of women. Anthropologists question the wisdom of dividing professional midwives and TBAs in a hierarchical way that allows government agencies and development planners to support one group while trying to exterminate the other, and suggest that a "real midwife" may be recognized either by her government or her community as such.

Midwifery in the Developed World

Changes in midwifery in the developing world are intimately linked to debates over midwifery in the developed world, where professional midwives provide care for the majority of pregnant women. Their education is generally university-based and often post-graduate, giving them skills in research and publication unavailable to midwives in the developing world. They practice in hospitals that are usually well-staffed, well-funded, and replete with medical technologies. Their major dilemmas are

ideological: they struggle both in thought and in practice with the tension between what they themselves call the “medical” and the “midwifery” models of care.

Obstetrical dominance over birthing represents not a neutral substitution of one care provider by another, but rather a fundamentally different and opposing philosophical approach to birthing care. In the US and Canada, obstetric control over birth was cemented in the early 1900s and midwives were nearly eliminated. Since then, midwives have been attempting to achieve their renaissance. American midwifery is split between nurse-midwives (trained first in nursing and then midwifery), who practice mostly in hospitals and who attend approximately 8% of American births, and direct-entry midwives (not additionally trained in nursing) who practice mostly out-of-hospital, attending around 1% of births. In Canada, midwifery was illegal until 1993, when it was legalized in Ontario through the work of a coalition of nurse- and direct-entry midwives, a process that has since continued in other Canadian provinces. The reclaiming and revitalization of midwifery in both countries has resulted from alliances between activist consumers, midwives, and others. European, Australian, New Zealand, and Japanese midwives are engaged in a process of self-examination, attempting to reclaim the autonomy they lost with the obstetrical takeover of birth in the 19th and 20th centuries.

Hundreds of professional midwives in the developed world regard traditional midwives in the developing world as their ideological “sisters” and are working to support and sustain the preservation of traditional midwifery and its future development. Such midwives combine elements of traditional and professional midwifery knowledge in their personal practices, dedicating their professional lives to being, and helping others to be, “with woman” during the processes of pregnancy, birth, and the postpartum period.

Further Readings and References

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