Exploring Symbolic Exchanges in Childbirth:

Cultural Implications for Midwifery Education and Practice

Volume I

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Dawn Hillier
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Abstract

This thesis is concerned with the relationship between culture, policy and the curriculum in the context of their roles in the promotion of global, local socio-political ideals, illustrated through the lens of women’s and midwives’ experiences in Africa, America, Malaysia and England.

The concept of the new world order was first derived from a United Nations resolution (1974) that proclaimed a determination to work for, among other things, common interests, interdependence, and cooperation between nations to eliminate gaps between ‘developed and developing’ countries; to ensure accelerated economic and social development; to correct inequalities and redress existing injustices to ensure peace and justice for present and future generations. There is a premise that an international distribution of knowledge is an essential prerequisite for these far reaching objectives that draws midwifery education and its role in the preservation of maternal and child health into the framework of development.

The role and status of universities in the process of disseminating knowledge and in the exercise of economic power are, however, linked with the fact that modern science and technology are largely products of industrialised nations. Western scientific types of knowledge, however, is not only problematic to those at the outer
edges who feel the effects of globalisation slightly later, but is also problematical for women and midwives in the west under the conditions of postmodernity.

This poses a number of questions about what knowledge is distributed; its mode of delivery; its authority and power; the equality of distribution in a world where globalisation is like the ripples on a pond, ever weakening and changing as it spreads outward from the dominant western cultures to those on the periphery; and whether we can move beyond antidualogical models of curriculum where western hierarchical interests predominate. For as Freire (1972:150) stated, in antidualogical theory of action, cultural invasion (not only in the form of western models of curricula but also in the form of medico-scientific invasion of childbirth and midwifery) serves the ends of manipulation, which in turn serves the ends of conquest, and conquest serves the ends of domination and oppression. For Freire cultural synthesis serves the ends of liberation.

The curriculum maybe described as a selection from culture. If this is so, then the conclusion of this thesis is that midwifery curricula need to be designed in such a way as to develop a critical knowledge of childbirth within the cultural context. To achieve this it is necessary for midwives to be the ‘owners of their own learning’, so that they can be politically astute to engage in the transformation and humanisation of midwifery practice in the face of the reality of childbirth globally.
Preface

I threw a pebble into the pond and reflected on globalisation from the perspective of the modern world. I imagined the uniform expansion of modernity as it spread out in concentric circles from its point of origin in Europe and America.

This part of it was initially clear to me. As I watch, the energy from the pebble's momentum has been transferred to the waves in the pond as the water robs the pebble of its speed. The wave circles continue their journey outward through the pond against other forces caused by other events. Not only on the surface, but also throughout the pond's depths, waves of energy travel away from the pebble at a constant speed determined by their wavelengths within the medium of the pond water. This flow of energy does not push the water; rather, it draws the water in hegemonic fashion to manifest itself as peaks and troughs in the surface of the pond, migrating away from its point of origin. Then, gradually, these waves lose their form as they disperse and cross paths with other waves from other events, or collide with denser material like plants, animals, rocks and mud. These collisions result in friction, and the energy of the waves is transformed into an equivalent of released heat. I imagined that the heat would then dissipate throughout and beyond - like the ripples in the pond.

I imagined throwing another pebble into the pond. I watched the pond as the ripples began to fade.

1 Jarvis, 1997 provided me with the pebble in a pond metaphor to represent globalisation (in conversation).
I knew that eventually the surface would return to its original state, before the pebble and only the effects from the breeze would be seen. I wondered if the pebble would change the future of the pond in any lasting way, or if such an event would be so insignificant that it would leave no evidence that it ever happened. For those smaller or more vulnerable forms of life that live in the pond, such an event could have a dramatic impact, such as the impact of a global economic or environmental crisis on Africa. At the pebble's impact site, these life forms could be torn apart, with the organic material forming their structures scattered about. This might prompt other forms of life to move in and consume the leftover nutrients that would allow them to continue in their own struggle for life.

I imagined the dynamics could be more dramatic on a larger scale. Perhaps a marked change in behavioural patterns might occur immediately after the moment of impact, as daily activities of life become completely disrupted by the disturbance caused by the pebble. Possibly even the leading predators of the pond could suddenly take flight as their respective instincts would take control. For me the end of the Cold War and the fall of the Berlin Wall signalled such an event in the context of the reduction of real aid to developing countries. Likewise, lesser prey down the chain could follow suit, reacting in accordance with their own appropriate patterns of behaviour under these circumstances.
I threw another pebble into the pond. I watched the event unfold again. Then it was gone. I reflected upon the potency of change in the social and cultural context of life.

The activity of all of the life forms, along with the momentum of the pebble, I imagined, would act to disrupt the surrounding water's balance of pressure, creating turbulence in the wake of the change. The water would react to this disturbance by rushing to regain a natural state of equilibrium, as low and high-pressure areas would naturally seek out each other. Perhaps the disturbance causes some sediment to stir up from the bottom and constituent pond water chemicals to mix or separate, depending on the composition and conditions of the pond. Innumerable other reactions might well occur in response to the pebble, but soon after, things would settle back to what would be seen as normal for the pond. The energy of the ripples and turbulence would be assimilated into the greater mass of the pond. The biological and chemical dynamics resulting from the event would stabilise. The pebble would be lying in the mud at the bottom along with the other things that generally end up there. The entire event would be absorbed into the long history of the pond, forever sealed in time.

I threw another pebble into the pond. I watched the event unfold again in its entirety. Then it was gone. I reflected upon the symbolic exchanges in childbirth resulting from globalisation.

Logically, I thought, for such an event to exist, it must have a history; and therefore, it must have some beginning in time. If a line could be drawn at a point in time marking that beginning, then every subsequent thing that would happen during the event would have to be considered part of its history. If these happenings, which would be events

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themselves, could each be segregated and distinguished in time by lines marking absolute beginnings and endings, then some finite number of separately identified events would comprise the history of the greater event. It would take such an approach, I imagined, for the history of the event to be thoroughly analysed and understood. And in that it would be part of some greater experience, which would be part of an even greater event, and so on, understanding it thoroughly would be a necessary step in understanding the history of childbirth itself.

It occurred to me that without the use of these lines in time, it would be impossible to study a corresponding history, or evolution. Since beginnings and endings would be needed to capture whole events in time, lines in time would be needed to serve the purpose of marking those points. Thus, without beginnings and endings, no event could be adequately defined, and all observations would lose focus and relevance. The scope of the entire analysis, in consequence, would lose reference.

Thus, it would seem that in order to conduct a true scientific analysis of any event, lines in time would be clearly needed for the purpose of segregation. It occurred to me, however, that this realization would bring with it significant consequences.

I threw another stone into the pond. Again, I watched the event begin, evolve, and fade. I realised that it would be impossible to determine the absolute point at which an event would end. I reflected.

I imagined using lines to segregate an event in time. To completely segregate an event, however, I would have to capture the event in such a way that the entire event
would fall within the placement of the lines, but any line in time must interrupt the flow of time, and would therefore interrupt the happening of events. To establish what I might view as a beginning point for an event by placing a line somewhere in time, I would have to interrupt what might be viewed as an event leading to that beginning. Any event leading to, or otherwise causing, the beginning of another event, would have to be considered a connected part of that event, because of its significance to it. I soon realised that I would have to continue moving the lines to include every such connected events, until I could no longer recognize the original event I was attempting to capture. There would be no end to this broadening of this scope of analysis and my original intentions of segregating a specific event in time would be defeated.

It also occurred to me that time, as a continuum, would not allow true snapshots, or representations of absolute points in time. I knew that a real-world photograph or snapshot would be possible only because it represents some finite period of time. Such a period would be necessary to allow the light to make its representation, or for some kind of instant photographic measurement to be made. The result would be of a finite period of time merged together as a static representation. Points in time could not be represented because there would be nothing there to represent. So, a snapshot would create a quasi point in time, as an artificial representation of a real period in the continuum of time.

I threw another stone into the pond. I watched the event unfold again, with the visible activity concentrated near the stone's impact site. I reflected on the reach of globalisation.
I wondered if there could be any part of the pond not affected by the event, and if so, whether a line could be drawn to separate that part from the rest of the pond. In this way, space, like time, would have the quality of being a continuum. But this quality would also allow cohesive and continuous movement through space via what must be seen as flow. In any continuum, flow must be the rule. Therefore, flow must be the nature of all progress. This must be the case wherever dividing lines are not permitted such as in time, and in space.

I threw another stone into the pond. I watched the ripples grow and fade into the pond. I reflected.

It occurred to me that without these dividing lines, space would become one indivisible medium. I also knew, however, that scientific analysis would demand that space, an environment or an event must be studied as separated constituent systems isolated from their surroundings. Whatever one is studying, meaningful analysis would always require that theoretical lines be drawn to, if nothing else, focus the analysis on something and not everything.

I threw another stone into the pond. I imagined that the reactions below the surface would be varied as a result of a variety of different perspectives, each with a value structure dictating appropriate behaviour. I reflected.

Physical variety would allow perspectives, which would give rise to values, as a result of want. Specific wants would then generate behaviour, thus identifying roles. This must be true for all living things. In this way, all roles would be a function of values based on perspective in a varied universe.
I threw another stone into the pond. I imagined a systematic world below the surface. I reflected.

I knew that there would be a dynamic at work between perspective, values, and want:
Values would be a reflection of perspective generated from want in a varied universe. Values would be formulated as a result of variety, or the contrast between relative possibilities, as seen from a perspective. If there was only one possibility or potential from a given perspective, there could be no value distinctions. Such a world without values would be homogeneous and could only give rise to one perspective. Values require alternatives. Values require a range of possibilities and potential. Values also require the ability to distinguish and prefer. In this way, values become the manifestation of distinctions and preferences resulting from a particular perspective. This would seem to be intuitive.

My story starts in Africa. At the time it was not planned as a story but as my life and work changed, I found myself climbing out of the primordial soup in Africa and following the development trail to the most technologically advanced country in the world, America. It was like leaping from one ripple in a pool to another across a gulf that represented wealth and technology. That is not to say that everyone in America or Europe is wealthy nor does it mean that everyone in Africa is poor. But taken globally the power that those wealthy countries have to impose their ideals, values and beliefs is significantly greater than those countries that rely on financial help to maintain basic human life.
There is growing evidence that the consumption of the mass media throughout the world often provokes resistance, irony, selectivity, and, in general, agency. Examples of this can be seen in terrorists modelling themselves on Rambo-type figures (who have themselves generated a host of non-Western counterparts). Or in women reading romances and soap operas as part of their efforts to construct their lives. Muslim family gatherings listening to speeches by Islamic leaders on cassette tapes and domestic servants in South India taking packaged tours to Kashmir all exemplify the active way in which media are appropriated by people throughout the world. T-shirts, billboards, and graffiti as well as Rap music, street dancing, and slum housing all show that the images of the media are quickly moved into local repertoires of irony, anger, humour, and resistance. (Appadurai, 1996:7)

At the present time, as this thesis demonstrates, traditional birthing systems are undergoing tremendous change under the influence of Western medicine, while Western obstetrics itself has been under pressure to adjust to in light of changing views, status and competencies of women. For traditional systems the high prestige medical model overwhelmingly provides the standard template for change. However, some of the very obstetric practices that are currently being exported to developing countries by the medically oriented, technologically sophisticated nations have ironically taken on a controversial status at home. In the USA and UK, the appropriateness of the medical model for the entire conception of childbirth has been seriously challenged over the past few years and there now exists a wide range of alternatives. But the sense of superiority and moral requiredness that is built into, every functioning system usually keeps practitioners resistant to and often uninformed about alternative ways of birthing, since too much tampering with the "correct" way
will generally be regarded as unethical, exploitative, “bad practice” and potentially
dangerous.

This thesis examines the changing world of childbirth and midwifery practice and
education. It is written for all midwifery practitioners and others who are concerned
with women in childbirth. It is also written for educators, international midwifery
consultants and students. It questions current thinking about childbirth and highlights
the role that global changes have played in determining its outcome.

The thesis has two main purposes: to highlight and examine the role that globalisation
plays in changing childbirth practices and to try to understand more clearly the
connection globalisation and midwifery and traditional birth attendant curricula.

In structuring the thesis, I made a decision to place description of the research process
(appendix 2) in the appendices so as allow the story to flow. It became very clear
early on that I needed to explore culture in depth and so the base of the study had to
be ethnographic. The adoption of the human ecology model was important in terms of
assisting me to bring the microsystems of the individual, community, culture and
national, and macrosystems of the global economy, ecological factors, political and
the ramifications of mass media and the marketplace, together, although, in the end
data gathered using this model only features in an implicit rather than explicit way.
Against this background then, I choose to create an interpretative conceptual
framework and to include different research methods to achieve a somewhat complex
but rich data base from which to examine the issues of concern.
The thesis represents a commitment to an ethnographic perspective both in terms of the fieldwork and in the sense that a semi-comparative and inclusive perspective has helped ease me out of assumptions born of the parochial experience of modernity, postmodernity, globalisation and localisation in my own society through dissonance created by the experience of these phenomena within other social and national contexts. I fully acknowledge that in using my material to illustrate my interpretation and perspective, that I come close to the idea of ethnography as 'apt illustration', therefore, the material is used to exemplify, not confront.

My work is both empirically informed as of a qualitative science but also inextricably infused with moral and interpretive direction. A bias may be noted as emergent from my background in modern midwifery studies rather than social anthropology. I am more concerned to examine observed practice, while treating language more as a level of legitimation by informants than as privileged access to explanation. To assist me in this, I drew upon social support theory (Oakley, 1992), standpoint theory (Clough 1992, 1994; Collins, 1991; Harding, 1991), human ecology (Hawley, 1950), cultural theory (Douglas, 1997) and hermeneutics (Gadamer, 1976) theories to develop a conceptual framework for the study.

The starting point for this study was the question how should a midwifery curriculum be constructed? What content was relevant to midwifery education and practice? How should we teach midwifery and who should teach it?
In the beginning the question I was concerned with writing a midwifery curriculum for nurses who wished to become midwives. I was interested in providing them with a European dimension and having gained Jean Monet grant I spent some time with nurses and midwives from different countries in Europe, asking the question:

*How is midwifery education in Europe constructed?*

Three years later, as my work became increasingly international in scope, the question had been applied to more countries but had not fundamentally changed. I, on the other hand, had changed with increasingly global experiences of writing curricula nurses and midwives in countries. Moreover, the world had changed around me.

Today the key question is:

*Can a universal midwifery curriculum be designed that is relevant, meaningful, and liberating in the context of the global age; that would foster the international distribution of knowledge as an essential prerequisite for the elimination of gaps between ‘developed and developing’ countries; to correct inequalities and redress existing injustices to ensure health, and wellbeing for women in childbirth for present and future generations?*

Given Lawton’s (1974) definition of a curriculum being a selection from culture, further question, therefore, must be:
Can there ever be a universal midwifery curriculum that is constructed from something other than a policy driven selection from culture or move beyond hierarchical objectives model of curriculum or one that is based on medical ideology concerning content orientated to address childbirth dilemmas, or is the ripple effect going to continue to generate different curricula?

These questions, however, like the ripples on the pond, lead me to examine the global context and the life world of women in childbirth and ask the following embedded questions:

1. How do the processes of globalisation, modernization and development affect approaches to childbirth and impact on midwifery education and practice?

   • What are the defining characteristics of globalisation, modernization and development?

   • Does globalisation inevitably mean modernization?

   • Does globalisation inevitably lead to Westernization or Americanization?

   • Does globalisation only progress in one direction – centre to periphery – fast to slow world?

2. What are the symbolic exchanges that are impacting on women’s experience of childbirth?

   • How do women construct their lives in a rapidly changing social and cultural context?
• How do the changes impact on childbirth practices?

• Why do some people emphasise certain childbirth risks whilst others ignore them?

• What is the value of science in childbirth?

3. *Is the western concept of medically defined childbirth risk globalizing? If so, can we know what risks we face now or in the future?*

4. *Some universities are globalising and offering standardized curricula by distance and electronic means. But is it just another form of cultural imperialism?*

• *How should the midwife teacher think about her role and the curriculum for the future?*

• *How can midwifery education designed in the west and transmitted over the global network or in educational programmes delivered in the rest of the world meet the diverse needs of different countries and localities?*

As midwifery educators and consultants become increasingly global in their reach, we must now begin to appreciate the issues surrounding the globalisation of modernity, which has taken human beings in one direction, trading synthesis for analysis, sacrificing community for the individual and losing focus on the real issues concerning childbirth in the process (Maclean, 1999). It is within our means, however, to reclaim the power that we have yielded to the dominant institutions and re-create societies that nurture cultural and biological diversity-
thus opening vast new opportunities for social, intellectual, and spiritual advancement beyond our present imagination.

Chapter 1  An Introduction: Presents the background to the study and outlines the argument.

Chapter 2  Presents a conceptual framework for the thesis

Chapter 3  How do you hold a moonbeam in your hand? Defining Globalisation. Presents a definition of globalisation.

Chapter 4  Modernization, Risk Society and Development in the Context of Globalisation. Discusses spread of modernization, the advent of the risk society and development in the context of globalisation.

Preface  Symbolic Exchanges; Global Childbirth Dilemmas. Sets out the dilemmas created by globalisation of modernity by women in childbirth. Provides reference to childbirth rituals.

Chapter 5  Childbirth in Africa. Presents vignettes of the experience of women in childbirth and the women who attend them in Ghana and Malawi. Both countries are in a phase of development and can be found along the continuum of pre-modern to modern, but largely maintaining their traditional, pre-modern, albeit colonial influenced, cultures.

Chapter 6  Childbirth in Malaysia. The journey moves to the Malaysia where the context of childbirth and social situation of women is rapidly changing. Malaysia typifies a country in a transitional phase of development and women are forced to realign their concepts and beliefs about themselves, their role and childbirth as the country passes into modernity.

Chapter 7  American Women in Childbirth. We journey from a transitional culture to one that can be described as the most modern country in the world – the United States of America. Women in childbirth, however, are also experiencing change as the medical profession increasingly introduces more complex technology into the birthing context.

Chapter 8  Women in Childbirth in England. Birth technology is also a feature in British childbirth and in this chapter the experience of women in England is explored as they try to balance 'risk' with notions of 'safety'.
Chapter 9  Symbolic Exchanges in Childbirth: Reflections from the Case Studies. The key elements of the case studies are drawn together and reflected upon.

Chapter 10 Symbolic Exchanges in Childbirth: The Influence of Science and Medicine. Discusses the cultural implications of science and mathematics on childbirth; focuses on risk and notions of making motherhood safe.

Chapter 11 Cultural Implications for Midwifery Education and Practice Discusses the cultural implications of globalisation for the education of professional practitioners.

Chapter 12 The Midwifery Curriculum. Explores approaches to curriculum design and considers the relevance to changing childbirth and the global virtual classroom.

Final Conclusion and Recommendations Concludes and makes recommendations.

Appendix 1 Globalisation: Some Key Ideas

Appendix 2 The Research: Rationale and Processes. Approaches and research design are outlined.

Appendix 3 Research Methods are outlined.

Appendix 4 Describes the Amish Community

Appendix 5 Shows how Research Leadership rests in the hands of the Americans

Appendix 6 Goals and Objectives of Traditional Birth Attendant Training in Ghana

Appendix 7 Example of a Malaysian Midwifery Curriculum: Hierarchist Model

Appendix 8 Example of British Midwifery Curriculum: Egalitarian Model

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Chapter 1

Autobiographical Beginnings

This is certainly not the thesis I set out to write when I started my research in 1992, following personal experiences of working with nurse and midwife educators in the Netherlands and Germany and seeing the similarities in our stories of practice and teaching experiences. Nor was it the study I set out to undertake when I started fieldwork back in 1993 or indeed later when I continued fieldwork in Malaysia in 1994. I set out to study midwifery education in Europe. As I began to gather my data, the study very quickly became more global as my work became increasingly international in scope and experience.

But I must not run ahead of myself. Several years ago whilst working as a practitioner-researcher (Jarvis, 1999) in midwifery education, I was engaged in writing a new curriculum for midwives. This curriculum was being designed to allow neophytes into the profession of midwifery in the United Kingdom. At the same time, the qualification would be recognised through reciprocal arrangements across Europe. The syllabus and outcomes of the programme were already identified by the Statutory Body and laid down in rules and codes.

Consequently, the practice of writing a curriculum should have been straightforward since the outcomes define the nature and content of the programme. Taking the World Health Organisation's definition of a midwife as a starting point, I began to wonder, however, if a curriculum developed in the UK would truly prepare midwives to work in
Europe, or indeed anywhere else in the world. This question was really one about my own capabilities and knowledge base. Was I adequately knowledgeable to provide the appropriate preparation for potentially ‘global’ practitioners? What was the relevance of transferable knowledge in midwifery? Was there a commonality, as is suggested by the WHO definition of a midwife or the reciprocal arrangements for recognition of qualifications between different countries, cultures and locations?

If, however, midwives qualifying from this programme could work as midwives in Europe upon completion of this course, I considered it important that information and some experience of midwifery in mainland Europe was important for these students. I set about writing a module on Midwifery in Europe and was awarded a grant from the Jean Monnet fund. This enabled me to provide students with an opportunity to learn about European integration and to gain insight into the experience of childbirth and the practice of midwives in other European countries. Believing that genuine understanding of the field of study can only come about through practice and experience in the field, I spent time in a number of countries in Northern Europe (Holland, Denmark, Germany, and France). These albeit short, intensive visits allowed me to gain greater insight into the ways of birth among women in Northern Europe, and how midwives practised and were prepared for their role.

At the same time, I was increasingly concerned about the apparent lack of knowledge and understanding among midwives and students with whom I was working, regarding the impact of culture on women’s experience of childbirth, particularly women from different cultures around the world. I was working from the premise that since Britain is
a multi-cultural society, the students would, at some point in their careers, come across women from different cultural backgrounds. To address this, I set about writing a module on international and cultural perspectives in midwifery but soon found that published data in the UK was lacking in breadth, depth, spread and quantity. Taking the view that experience in the field was important to understanding, I applied for and received a travelling fellowship from the Sir Winston Churchill Trust to undertake exploration of childbirth and midwifery practice in Africa. Towards the end of 1991, I flew off in great anticipation to undertake a study of Safe Motherhood in Ghana and Malawi. My goal was to gather first hand experiences and data concerning the impact of global policies and principles on local activities and outcomes in both countries. In starting from the local and the national perspectives, I had achieved a different and sometimes disorientating view of childbirth and midwifery practice. This escalated when I later came to read the more generalised literature on economical development, structural adjustment and consumption in Africa.

Meanwhile, my employment began to change to incorporate international developments and teaching, particularly in Malaysia and the USA. Very rapidly, my post as Associate Dean (Academic) and later as Dean of School, with a remit for academic leadership and curricula design took me to Cyprus, The Netherlands, Belgium, Germany, Norway, Finland, USA, Moscow and the Philippines. As I participated in international workshops, teaching and research in Africa, USA and Malaysia, I began to see a pattern emerging of education being consistently viewed as a commodity to be packaged for global consumption with little apparent regard to where the information was being used, how it was being transmitted or indeed its relevance in other contexts. Indeed education
packages were being developed in the west with little real understanding on the part of the developer of the cultures in which the packages were to be used.

Following the formal commencement of my study, I began to read the literature and reflect upon my personal experiences in living and working with people in diverse settings around the world. I felt there was a gulf between books that concentrated upon consumption, modernity, postmodernity and globalisation, and my experience of these in Africa, Malaysia, USA and UK where I was working as a teacher practitioner-researcher. The question for me as an educator became how to secure mutual understanding and communication between cultures and cultural types (Douglas, 1997). As a 'global' educationalist, this became my chief concern in developing curricula and teaching to avoid new forms of imperialism and oppression.

Lawton (1973) stated that a curriculum is a selection from culture. If this is so, then from what culture should a midwifery curriculum be selected? Ultimately, in a world that is increasingly global, with increased migration and communication systems, all societies and cultures are becoming increasingly pluralistic. Moreover, the distance between cultures is diminishing as we experience what Gidden's (1991) terms time-space distanciation, or in Harvey's terms time-space compression (1989). At the same time, there appears to be an increasing number of 'cultures' and 'imagined communities' emerging with the growth of global diasporas, that are leading to globally-based localisation as well as increasing numbers of localities that are geographically based but not necessarily culturally determined. With increasing specialisation, as a feature of late
modernity and globalisation, leading to fragmentation, the ultimate question must be - can a curriculum be written?

Before this question can be answered though, I needed to understand the changing nature of the childbirth experience under the rapidly changing conditions of globalisation and to discover what the consequences these hold for women in childbirth. This was important for understanding the fundamental basis of the midwifery curriculum. Delving deeper into the context of childbirth, I attempted to uncover how the balances of power between competing discourses construct, negotiate and control, and in some instances impose, what is accepted as the cultural commonsense of birthing practice in specific environments.

Approximately 600,000 women die annually and unnecessarily (WHO, 1996). Ninety-nine percent of them die in developing countries where 85% of all births occur annually. Though this neglected catastrophe takes place in the developing world, the developed world is not without complicity. Many factors such as poor socio-economic status, lack of political will and oppressive conditioning of people, have contributed to the ‘silent carnage’ of childbearing women in developing countries. From field experiences in Africa and Malaysia one fundamental problem contributing to this anomaly stands out above all others. That is, many health professionals who teach and provide modern health care to those in the developing world work among but not with the people they serve. They work apart because they are not taught to understand traditional medical practice, customs, values and beliefs about health, health care and health problems. Curricula are devised that fail to meet the needs of local people and yet are sought as a
form of status. There also appears to be a belief that “midwifery core knowledge is the same internationally” (Verber, 1995). Educational programmes for international credentialing Verber claims, would include knowledge and clinical experience with antepartum, intrapartum, postpartum and newborn care; academic and clinical curriculum; philosophy (formal or informal); duration; outcome evaluations; written records with the required exit competencies as follows:

<table>
<thead>
<tr>
<th>Minimum number of deliveries and vaginal examinations;</th>
<th>electronic-fetal monitoring;</th>
</tr>
</thead>
<tbody>
<tr>
<td>physical assessment;</td>
<td>phlebotomy;</td>
</tr>
<tr>
<td>medications;</td>
<td>testing and microscope lab work;</td>
</tr>
<tr>
<td>artificial rupturing of membranes;</td>
<td>newborn assessment and resuscitation;</td>
</tr>
<tr>
<td>fetal scalp monitors and scalp blood testing;</td>
<td>family planning;</td>
</tr>
<tr>
<td>episiotomy; cutting and suturing;</td>
<td>well-woman health;</td>
</tr>
<tr>
<td>circumcision;</td>
<td>nutrition;</td>
</tr>
<tr>
<td></td>
<td>pre- and postnatal care;</td>
</tr>
<tr>
<td></td>
<td>community and patient teaching</td>
</tr>
</tbody>
</table>

Moreover, childbirth has been generally organised within a medical model, depending upon the degree of Westernization, Americanisation and capitalist productivity in the country. Against this backcloth, the World Bank, working in collaboration with the World Health Organisation and the International Confederation of Midwives have sought to address the issues of maternal and perinatal mortality. They believe that midwives could help to break the cycle of poverty and death and respond to the needs of women during the reproductive years. The problem is that midwives, who generally come from middle-class educated backgrounds, work mostly in hospitals, in towns, where other colleagues are available and often providing care of a nature that could be
delegated to other health workers. These relatively well educated and sophisticated, midwives are often out of touch with rural women and are rarely willing to work amongst them. Having been trained in well equipped hospitals with readily available medical staff, midwives are unable to function effectively in poorly equipped rural health units with little or no managerial or technical support.

Meanwhile the real issues remain unaddressed. These issues relate mainly to poverty leading to lack of educational opportunities, poor nutrition, inadequate transportation and road systems, inadequate communication systems, and insufficient services in developing countries. In addition, the imposition of Western style thinking about maternal mortality and the influence of language in directing that thinking is fundamentally changing the ways in which influential people in developing countries formulate strategies for maternity care. Much of the literature on human behaviour and perception has arisen in the West based on how individuals in the West react to certain situations - which is predominantly constructed as a result of Western philosophies, ideologies and capitalist experience. It is not a simple matter to translate psychology from one era to another let alone one culture to another. In developed countries, the influence of medical science remains evident even where there is a backlash against it.

If, as the ICM believe, the people who need to be mobilised for implementation of the new midwifery action, health information and education, are in most cases rural folk whose perceptions of illness, health, health care and health problems are based on local traditional concepts and minimally influenced by concepts of modern medicine, the educational process will be considerable without any real evidence that it will ultimately
make a difference to maternal mortality. In many communities and villages of developing countries, people rely on both modern and traditional health care systems for resolution of their health problems. However, the bulk of the knowledge that influences their thinking and behaviour in matters relating to health, health problems and health care come from local or traditional information. The people learn effortlessly as they grow up. This embodied knowledge is difficult to overcome, regardless of its value or otherwise and what emerges is a melding of both traditional and modern. Neither is held in pure opposition to each other resulting in the creation of a somewhat distorted configuration of the two. The cultural processes in globalisation can be described as analogous to the emergence of Creole languages. The assimilation of differing cultural beliefs and practices form a lexicon of language structures from different origins into localised vernacular and practices. This thesis shows that there is a rapidly emerging creolisation of childbirth.

The creolisation of pre-existing cultures happens because differently located groups with different histories, needs and experiences appropriate the opportunities and commodities offered by the global market in distinct ways, thus continuously producing cultural expressions and identities of their own. This leads, according to Hannerz (1996) to new fragmentation of earlier national cultures as cosmopolitan groups in the metropolitan areas start to identify more completely with global consumer and elite culture while local workers, traders and peasants turn to their new bricolage that most appropriately meets their needs. The resultant practices may ultimately be more detrimental to health than either of the original practices.
In order to identify gaps and establish acceptable areas for integration between modern and traditional knowledge and views of midwifery, it is necessary to understand women’s perceptions of fertility and to study their cultures’ views on the perpetuation of life. In some cultures children are valued for their role as the perpetuators of life and the family name. Implicit in the word family, in most societies, is the concept of offspring. In some cultures the individual is viewed as not fully mature, and in others as not spiritually or morally mature until their ability to reproduce has been proved. For these cultures, therefore, fertility and procreation are regarded as the most vital and integral part of marriage. Conception and childbearing become the ultimate need for admission into full adulthood.

In the West, we have been faced with major developments in obstetric technology in the last twenty years, with fetal monitoring, epidural analgesia, oxytocin augmentation, ultrasound, and hospital births becoming routine. In contrast, the move towards more 'natural' childbirth has been increasing in intensity. Some women are no longer content to be passive consumers in the childbirth process and in Western societies are requesting more involvement in the process of birth. Their demand for involvement is no longer based solely upon 'intuition' and emotion; instead it is based on research evidence demonstrating that less intervention is better than more (Beynon, 1988:280). Expectations and practices in childbirth are changing worldwide in response to a number of key factors. These include not only the advancements made in obstetric and medical technology, but also the global consequences of changes in socio-political, economic and environmental conditions.
Since the 1970s, an awareness of the global interconnectedness of social, economic, political and especially ecological problems has emerged. The ongoing process of globalisation is generally recognized. For many observers, it is synonymous with ‘Westernization’ or even ‘Americanization’, especially after the breakdown of the communist bloc. While the triumphant advance of market relations is seen as inevitable, critique is concentrated on the alleged cultural hegemony of the western world. MacDonald’s outlets in Beijing, Moscow and every other place of some importance become symbols for what is perceived and deplored as a global levelling to the least common denominator. Featherstone (1990) was concerned that globalisation should not be misunderstood as homogenization, for while cities and towns around the world are becoming similar to each other, every one of them is more diverse, various and complex than ever.

One implication for the imposition of western belief systems with its dominant cultural emphasis upon individualism is that increasing individualisation does not only imply the liberation of the individual from traditional social and cultural frames of reference. This process coincides with a growing dependence on abstract social institutions that strongly standardise the social conditions of personal life. People are more and more subjected to rules, regulations and facilities, which are anonymously and uniformly imposed by state-and market-institutions. Education legislation, infrastructural facilities, multinational chains or mass production and consumption, medical and social services, and so on, increasingly constitute the all encompassing frameworks, on which the apparently liberated individual is dependent for the organisation of his or her existence.
The Argument

Our inability to come to terms with childbirth systems failure stems from the fact that television reduces political discourse to sound bites and academia and medicine organises scientific and intellectual inquiry into narrowly specialized disciplines. As a result we become accustomed to dealing with complex issues, such as childbirth, in fragmented components. Yet in the complex world in which we live nearly every aspect of our lives is connected in some way with every other aspect. Consequently, if we limit ourselves to fragmented approaches to dealing with universal problems or natural physiological events such as birth, it is not surprising that our solutions prove inadequate. If human beings are to survive the predicaments we have created for ourselves, a capacity for whole-systems thought and action must be developed. Whole systems thought must include the environment, culture, politics, issues of power and control, institutions and so on.

Whole-systems thinking calls for a scepticism of simplistic solutions, a willingness to seek out connections between problems and events that conventional discourse ignores, and the courage to delve into subject matter that may lie outside our direct experience and expertise. (Korten, 1995:11)

In taking a whole-systems perspective, this thesis explores a broad terrain with many elements. To help the reader keep in mind how the individual arguments that are developed and documented throughout the thesis link together into a larger whole, the overall argument is summarised here. It must be borne in mind, however, that we are
all participants in an act of creation, and none of us can claim a monopoly on truth in our individual and collective search for understanding of these complex issues.

The point of departure of *Exploring the Symbolic Exchanges in Childbirth: Cultural Implications for Midwifery Education and Practice* is the evidence that we are experiencing accelerating social and environmental disintegration in nearly every country of the world—as revealed by increases in poverty, unemployment, inequality, violent crime, failing families, and environmental degradation. These problems stem in part from a massive increase in economic output over the past fifty years that has forced demands on the ecosystem beyond that which the planet is capable of sustaining. For Korten, the continued drive for economic growth as the organizing principle of public policy is accelerating the breakdown of the ecosystem's regenerative capacities. Moreover, the social fabric that sustains human community is under threat. At the same time, it is intensifying the competition for resources between rich and poor—a competition that the poor invariably lose (Korten, 1995:11).

Against this backcloth, women are struggling to give birth while large global organisations are spreading simplistic solutions based on economic equations and western medical ideologies. Western concepts regarding childbirth are being exchanged across the world with the result that simplistic solutions are being exported, perhaps without any real analysis of the issues. Consequently, medical ideology, using measurement and concepts of risk and probability is altering the ways in which childbirth is conducted in traditional societies, not always to their benefit. The problems within the medical systems in the west are being carried over into the
developing world. While in the more advanced societies, concepts of continuity and community are emerging as idealised approaches to birth derived from those very communities who are now being encouraged to abandon them.

Those who bear the costs of the system's dysfunctions have been stripped of decision-making power and are held in a state of confusion regarding the cause of their distress by corporate-dominated media that incessantly bombard them with interpretations of the resulting crisis based on the perceptions of the power holders. An active propaganda machinery controlled by the world's largest organisations including the World Bank, World Health Organisation and other Non-Governmental Organisations constantly propagate myths to justify the spread of the dominant western medical ideology and mask the extent to which the global transformation of human institutions at local and national levels, is a consequence of the sophisticated, well-funded, and intentional interventions of a small elite whose money enables them to live in a world of illusion apart from the rest of humanity.

The balances of power between competing discourses construct, negotiate and control, and in some instances impose, what is accepted as the cultural commonsense of birthing practice in specific environments. This in turn affects the way that the local culture and location of birthing fits with global perspectives and midwives personal beliefs about birth, women and midwifery practice. This is not a thesis about results, but about processes. The women who appear in these pages continue to act and react, shaping and being shaped by the transformation that characterises their world. In so doing, they manage to face inherent conflicts and contradictions and to devise compromises and
accommodations that permit them to develop new strategies. I have caught them at one moment in time but they continue to balance their lives in a world that continues to change.

The Questions

As elaborated in the preface (pages xiii – xv), this thesis addresses the following two key questions:

1. Can a universal midwifery curriculum be designed that is relevant, meaningful, and liberating in the context of the global age; that would foster the international distribution of knowledge as an essential prerequisite for the elimination of gaps between ‘developed and developing’ countries; to correct inequalities and redress existing injustices to ensure health, and wellbeing for women in childbirth for present and future generations?

Given Lawton’s (1974) definition of a curriculum as being a selection from culture, and influence of Bloom’s taxonomy of educational objectives (1966) a further question, therefore, must be:

2. Can there ever be a universal midwifery curriculum that is constructed from something other than a selection from culture or move beyond hierarchical objectives model of curriculum or one that is based on western ideals concerning content or is the ripple effect of globalisation and localisation going to continue to generate different curricula?
In the next chapter, I spend time building the conceptual framework that provides the theoretical underpinning for the research. After that, I seek to draw together theories on globalisation to provide a broad context against which to analyse the lives of women and midwives as they experience childbirth in their different countries and situations which are considered in the case study chapters. From my research and reading I will demonstrate how the global and local interact to impact on women in childbirth and how this all relates to the curriculum.
Chapter 2

Conceptual Framework

It became very clear early on that I needed to explore culture in depth and so the base of the study had to be ethnographic. The adoption of the human ecology model assisted me in bringing the Microsystems of the individual, community, culture and national, and Macrosystems of the global economy, ecological factors, political and the ramifications of mass media and the marketplace, together. Against this background then, I choose to create a reflexive conceptual framework and to include different research methods to achieve a somewhat complex but rich data base from which to examine the issues of concern.

In choosing a conceptual framework in which to locate this study there were a number of imperatives that needed to be considered. I needed a framework that would have the analytical power to recognise and work with the multiple positions women, childbirth and midwives occupy concerning the nature of knowledge and their concomitant practice, while still retaining a rigorous conceptualisation for distinguishing between 'knowledge' rather than mere opinion. Claims to knowledge needed to take account of the social situation and historical context. Such considerations problematise and raise questions concerning the exclusivity of knowledge as determined by scientific and positivistic principles as being beyond persons 'knowledge-as-truth', self-interest, place
and time. The framework provided conceptual space for acknowledging the 'truth' and clarity of vision of those who, by choice or necessity, are positioned outside the dominant group (Marx, 1970; Gramsci, 1971; Freire, 1972; Weber, 1976; Durkheim, 1982; Giddens, 1997). It is precisely because they are outside the mainstream, while still having their lives influenced by it, that they can see what has been left out. So midwives can not only see through the lens that shapes the medicalisation of birth and midwifery practice but they can also see the partial and distorted nature of the picture. As a concept, (positionality) globality is inclusive, and caters for the admittance of the view of non-dominant or marginalised groups as legitimate, in a way that fully acknowledges location as being significant in the construction of knowledge.

The framework had to be able to support the argument that truth-as-knowledge concerning childbirth and the practices surrounding it, are generally socially constructed and have historical precedents, but simultaneously acknowledge the notion that there are shared understandings, both between and across contexts. It involves considering all the conditions that both construct and deconstruct commonalities, both social and those located in the physical, being mindful that the physical is often socially constructed. This is a requirement for some form of objectivity (as much of the argument and research arise from positivist principles), and in standpoint theory this is specifically referred to as 'partial objectivity'. It is based in the concept of knowledge being situated and led to the use of storytelling and narratives (Miller, 1998:58-71) as a key methodological approach described in further detail in appendix 1. Whilst I am aware of the multi-layered knowledge that surrounds childbirth I am seeking in this research to privilege, where discernible, women’s and midwives’ personal narratives. Yet in
creating a space for women and midwives' to voice personal experiences and feelings, which they might find difficult to voice, I am aware that interpretation and representation of women's accounts also becomes an issue about how faithful to their accounts will I be able to remain. Consequently dilemmas in research design, the pervasive influence of gatekeepers, negotiating access, the self-silencing of participants and the researcher-participant relaitonship, had to be continually confronted throughout fieldwork. Listening to women's accounts and collecting their stories requires continual and systematic reflection so that the multi-layered voices can be distinguished and personal narratives privileged (Millier, 1998:70). It is through the process of listening to women and midwives voicing their experiences the complex and contradictory nature of childbirth is revealed.

In short, I needed some of the facility of post structuralism to argue that the way that birthing and midwifery are conceptualised and practised are socially constructed and variable across birth environments and time, but I also wanted to be able to argue against easy relativism, that any old claim to 'truth' and knowledge is as good as any other. Further, I wanted the framework to have the capacity to recognise shared understandings and experience that exist across contexts. Irrespective of the philosophy and beliefs concerning birth, women and midwives across the diverse spectrum of midwifery practice contexts also have common understanding that is beyond social situation and historical boundaries.

Often the physical body becomes the site of the situated knowledge. For example, few midwives would contest the common understandings about birth that midwives across
all contexts share such as the physical significance of a woman who is bleeding. This is not to argue that there is necessarily shared understanding of the social consequences such as the value of the woman's life, only that if the bleeding goes unchecked, the woman and the baby will die. Rigorous criteria for establishing claims to truth and knowledge, however, as opposed to opinion, that recognises the value laden nature of medical knowledge, also exposes much of the medical discourse concerning pregnancy and birth that is located in the physical body as being socially constructed (Rothman, 1990).

The conceptual framework had to be able to accommodate both of these facets. That is, those that are situated in common understanding of parameters of the physical while simultaneously contesting and often rejecting medicalised definitions of physical 'danger'. In practice, then definitions are often iatrogenically constructed yet are reconstructed as dangers inherent in the conditions of pregnancy and birth. The notion of partial objectivity potentially has this analytic power.

The framework, from an epistemological perspective, had to critically evaluate all these competing claims to 'truth'. That is, to critically evaluate 'the theory of knowledge such as who can be a knower, what can be known, what constitutes and validates knowledge and what the relationship is or should be between the knowing and being'' (Stanley and Wise in Stanley 1990:27). Such a framework would allow me to give what I believe is "a faithful account of a real world, one that can be partially shared" (Haraway, 1991:187), of childbirth and midwifery across various contexts. In so doing, I was also concerned with the ethical and political dimensions of how beliefs concerning
development impact on the lived experience of women in childbirth, midwifery practice, and midwifery education.

In choosing a conceptual framework, therefore, I explored five interpretive epistemologies that seemed to offer a unifying and appropriately rich basis from which to collect and analyse data, and upon which to base a theory.

*Interpretive Epistemologies*

1. *Standpoint theory*

The starting point for standpoint theory is experience. It focuses upon the local. It is multivocal, collaborative, naturalistically grounded in the world of lived experience and is organised by a critical interpretive theory. For this study, women's experience is taken as the point of departure (Clough, 1994:62) for interpretive work. From there, women's place in their own cultural setting is examined. The inherent danger in this, of course, is the problem of confusing "real" experience with its representation.

Standpoint theory argues that the view that is available is largely constructed from the position occupied. Marginalised groups see from a different perspective than the dominant group because while simultaneously having to function within the wider society where the parameters are established from the dominant perspective, they occupy other position(s) that lie outside this domain. It provides an insight from which
to call into question the epistemological foundation of the society of which they do not (fully) belong.

Oakley (1992) argued that it is precisely because of 'marginalisation', from the 'below' position, that people are able to see why and where the dominant position excludes their perspective. But one must take account of hegemony (see Habermas, 1978; Gramsci, 1971) and the need for a critical theory (Geuss, 1981) in order for people to "see" their situation. Groups, such as midwives who do not subscribe to medicalised birth, whose position and subsequent interests generally either lie outside, and/or who are at odds with the values and beliefs of the ideological and material forces of the dominant group in society, may be, to varying degrees, marginalised. This is important because when looking globally at government spending and policies relating to maternity care, women's and midwives considerations are seldom taken into account. However, the ability to see critically is not guaranteed by position.

A word of caution from Haraway (1991: 191), however, is timely here when she says that "to see from below is neither easily learned nor unproblematic, even if we naturally inhabit the great underground terrain of subjugated knowledge." Despite the historical, and generally current oppressive relationship between medicine and midwifery, being a midwife does not guarantee vision, insight or understanding of the way some approaches to midwifery practice and childbirth can disempower women, both mothers and midwives alike. This is particularly so if birth takes place in a highly medicalised context where 'truth' and knowledge is defined from scientific medical principles.
A conceptual framework based in standpoint theory has the in-built analytical mechanism to expose medicalised Western birthing practices as being the view from above, that is partial and distorted. This view is both the essence and the by-product of the interactions of the ideologies of technology, patriarchy and capitalism. Together they underpin the dominant western medical discourse (see Foucault, 1973) and they construct what is taken as the cultural common sense of birth.

This then is a study that calls into question the dominant scientific and medical construction of birth as representing the truth and the knowledge concerning birth and the midwifery practices surrounding birth that is being globalised. It is making the claim that the scientific medical approach represents only one of many views. Further, and significantly, in that it is constructed from its location in the dominant positivist paradigm, it can only see from that one perspective. In so doing this study is calling into question the notion that the dominant scientific and medical knowledge is 'value-free', and hence is challenging the basis of its claim to truth. The claim of value-free scientific truth is "the view from above" (Haraway, 1991) and it does not have access to understanding how birth looks from the perspective of those who are not committed to this view. Those midwives and women in birth who do not subscribe to the dominant view, either explicitly or implicitly, are marginalised in a system that gives priority, if not exclusivity, to a scientific and technological medical perspective. This is particularly a feature of:

1. The conflict between obstetrics and midwifery, masculine versus feminine voice, and mechanistic-instrumental versus humanistic knowledge all play roles in the
interpretation of data, and the way in which this may or may not be received as knowledge.

- mechanistic knowledge - the mastery of nature (Hamelink 1990) dominates the medicalisation of childbirth. It emerges from an ideology that values efficiency and rationality emphasising systematisation, control, and practical organisation (Wertz & Wertz, 1979).

2. Social Support theory

Oakley (1992) takes us further in the development of a conceptual framework and brings into focus the need to consider the women and the significance of the social and cultural support systems that come into play during childbearing (see also Miller, 1998:58-71). Certain hostility to the role of social factors in influencing patterns of health and illness is built into the development of modern medicine (Oakley 1992:40-41) exists. The relevance of social science is at the margins of medicine, as in the common confusion among doctors between social science, on the one hand, and social work on the other (Oakley, 1980; Stacey & Homans, 1978). Although the emergence of 'social medicine' in the 1950s in Britain, the USA and elsewhere seems at first sight to reverse this scepticism and confusion, the vitality of social medicine itself proved limited by the tunnel vision of the social embedded in it (Oakley, 1991a). As the study of social support and allied fields becomes more sophisticated, so more attention will be paid to the question of meaning (Oakley 1992:42).
In social support research it is important that researchers be sensitive not only to socially structured contexts that discriminate between the meaning of social support to individuals, but also the *individual* differences, and the importance of different life situations, circumstances and local contexts. Most importantly, in studying individual responses, we must also not be distracted from understanding the power of environmental and political influences on health.

Detailed in-depth inquires are required to illuminate the processes involved at the individual level in mediating relationships between health outcomes, on the one hand, and potential causal factors on the other. This brings into play the concepts of the *global* in harmony with the *local*. In social support research, one cannot help but consider the cultural dynamics of the community in which the childbearing woman and her family live and the 'membership' rituals of that community. These are the underpinning aspects of social support - it is more than the 'help' of a partner, or relative, it is the whole foundation of the cultural belief systems and the ritual processes that support it that create the social support conditions.

3. *Human Ecology*

The study of territorially based systems, according to Hawley, (1981) of which the urban community is a prime example, is known as human ecology. More abstractly, this designation refers to a concern with the processes and the form of human beings' adjustment to the environment. The community is a generalised form of that
adjustment. In the reasoning of human ecology, adjustment is accomplished, not by each individual's acting independently, but by means of a division of labour developed among a number of individuals. Adjustment is a collective achievement. The unit of observation, therefore, is a population; the adaptive organisation, that is, the division of labour with its various ramifications in social relationships, is the property of a population.

Environment on the other hand, embraces all of the external factors that impinge on the life chances of a definable population. It includes not only the physical and biotic elements of an occupied area but also the influences that emanate from other organised populations in the same and in other areas. In certain circumstances the latter acquires a more critical importance than the former.

The basic hypothesis of human ecology, then, is that, as a population develops an organisation, it increases the chances of survival in its environment. The emphasis is on organisation. In its ecological application, organisation is an inclusive concept. It refers to the entire system of interdependencies among the members of a population, which enables the latter to sustain itself as a unit. The parts of such a system - families, schools, hospitals, shops, and industries, for example, - cannot be self-sustaining; they can only survive in a network of supporting relationships. It does not, however, fully dispose of the question of how to define the boundaries of a system, especially in the light of globalization and the merging of boundaries. And yet, with increasing localisation and the formation of ever specialising localities, the boundaries are becoming more and more closely defined. Nonetheless, the identification of the
effective limits of organisational units is one of the persistent challenges in human ecology. It is sufficient at the moment to state that ecology is committed to dealing with the most inclusive unit manageable.

Thus the concerns selected for the second part of the study are of the order commonly characterised as macroscopic. This provides a balance with the microscopic view taken in the standpoint and social support theories. Human ecology seeks its explanations among variables that are structural properties, demographic attributes, and features of environment, including interactions with other systems (Hawley, 1981:10). The import of this theoretical position will become more understandable as one follows the exposition in succeeding chapters. Human ecology may well provide a bridge between the globalization theory which encapsulates modernity, postmodernity, capitalism, rural and urban discourses, with the experiences encountered within the case studies.

4. Cultural Theory

According to Milner (1994) pre-modern societies clearly exhibit behaviours we would describe as cultural but have no awareness of this since it is central to their everyday lives. It is only in the West where we have externalised and examined it that 'culture' has been created. Cultural has become a theoretical problem for us only because it is already socially problematic. It is because culture is not central to our lives, or at least to the institutionally received accounts of our lives, that culture becomes so 'theoretical' a concept. Cultural theory is not, then, simply a particular, specialist academic discourse, the guiding hand behind a particular set of empirical, substantive research problems. It
is also, and more interestingly, itself the repressed 'other' of a society the official rhetoric of which is provided almost entirely by what was once known as 'political economy' and what are now called the separate disciplines of economics and political science. Cultural theory is one of the central discontents of our civilisation with capitalism as the dominant form of organisation of modern cultural production.

In reading the literature on cultural theory, one finds the books refer to a number of different theories and include structuralism and post-structuralism, Marxism, feminism, postmodernism, culturalism, and utilitarianism as separate discourses within cultural theory.

Following Mary Douglas (1997), I have arrived at a description of culture as a social bond based upon the construction of common categories. For Douglas, culture is the "package of values" which arise out of the categories that organise interaction within a social group. Ritual and symbols transmit shared assumptions and perpetuate the cognitive and perceptual bias of the social world. Social cohesion and reproduction of the social order result from these processes of 'collective memory'.

Douglas sought to develop Durkheim's basic observation -- that social cohesion depends on individuals sharing categories of thought. But a cultural system is not a barred enclosure. According to Douglas (1966), pollution beliefs are essential to the maintenance of the 'package of values' which constitute culture. This provides a foundation for exploring how childbirth can be described as a form of pollution within both modern and traditional culture.
The Cultural Debate

Culture, for Douglas, is not an open-ended field of infinite possibilities because each culture is legitimated on a different logical base. Culture is constrained by a conceptual device that provides basic categories, an explicit pattern in which ideas and values are ordered. In this context culture has authority, since each person is persuaded to agree because of the agreement of others. The 'logical base', which constrains action and thought within a culture, is expressed through categories (for example, 'mother,' 'sister') which organise social action. Douglas (1997), however, does not see culture as impervious to change.

Douglas prefers to start with the assumption that "collective action is difficult." The collective action that culture implies arises out of a set of choices which "construct conceptual categories" seen as appropriate to the context of social interaction. But once a social group establishes its conceptual categories, debate then arises over how to achieve shared goals. According to Douglas, the object of the debate within a group is to legitimise the structure of their society. A culture, therefore, is a structured framework arising out of this debate which affirms some things while denying others. Culture is the arena of public debates about control.

Douglas' cultural theory begins with the claim that culture is a system of individuals holding one another mutually accountable. Belief that something is dangerous is used within the debate to constrain the behaviour of group members, for example, medical definitions of childbirth as dangerous. The idea of danger and pollution acts as a rhetorical resource within the cultural debate. The debate itself is about cultural
conformity and social reproduction. Such debates sway between pressures for emancipation from the old institutional constraints and pressures to sustain the institutions in which authority and solidarity reside. In the ongoing cultural debate danger acts as a politicised form of social coercion. Within the debate danger is cited when a valued institution is threatened. Witchcraft accusations are an example of pollution beliefs in action. They are a response to a perceived danger to the order of the universe and local allegiances.

Douglas (1966) uses the idea of pollution beliefs to explain how the social world is maintained. For her complex pollution beliefs preserve the social categories. These categories are communicated through the processes of collective memory. At stake in the cultural debate are the very categories of social life which collective memory reproduces. Pollution beliefs will prove useful in understanding how childbirth is received within institutions and how globalization of these ideas affects the classificatory powers of penetrated countries.

Douglas' cultural theory examines social cohesion through three claims about culture:

(1) cultures are precarious; they exist through time because each culture legitimates coercion to resist pressures to transform, "authority is always fragile and power always held precariously;"

(2) pollution, danger and risk beliefs are used as bargaining weapons within the endless normative debate, and different types of culture will select different kinds of dangers; and
(3) the normative debate, which arises at the founding of any culture or institution, can collapse. Since the object of the debate is to legitimise the form of society, the end of the debate brings with it the end of the social intercourse, which constitutes the social world. The precarious nature of culture, authority, and power; the politicised context of danger and risk perception (pollution beliefs); and the threat of cultural collapse I take from Douglas to describe the context in which childbirth takes place. All of these take shape according to the perceptual biases of any given culture.

**Pollution Beliefs and Definitional Control**

Douglas described pollution beliefs as emerging from the process of classifying and ordering experience. These beliefs operate around the underlying assumptions communicated through symbols within the social world. Pollution beliefs are a form of socially embedded authority. They maintain the underlying assumptions within a culture. Pollution beliefs enforce conformity to shared assumptions and categories by defining dangers and prescribing punishment.

Pollution beliefs, however, do more than simply enforce conformity, they also provide the critical service of protecting the weakest part of a culture's framework. Wherever there is ambiguity within the shared classifications and categories underlying behaviour pollution beliefs arise to protect and preserve these fragile aspects of a culture's life.

Pollution beliefs protect the implicit assumptions behind shared social experience. In so doing they serve to reproduce the social world. But the power of social cohesion implicit in pollution beliefs is not absolute. Pollution beliefs are effective
as a means of social reproduction only in so far as individuals are committed to the shared set of assumptions underlying society. The power to hold people to a code of behaviour is no more than the power of those people's respect for that code. This sets limits to the scope for manipulating a social situation by citing risks. When implicit assumptions are shared widely across the social world, pollution beliefs prove to be highly effective in ordering behaviour and maintaining universal categories that organise the social world. For Douglas (1966), pollution behaviour is ultimately defined as "the reaction to any event likely to confuse or contradict cherished classifications." Wherever social values and implicit assumptions are widely shared, pollution beliefs will be seen to operate.

Pollution beliefs hold people accountable to the classifications, which establish social order. When the social order is at stake pollution beliefs will arise to protect the credibility of authority, which is based on a particular ordering of the universe. For authority to maintain its legitimacy it must ensure that the classification of nature at the foundation of its credibility is not rejected within the social world. Pollution beliefs operate as rhetorical devices within the ongoing cultural debate over the shape and direction of the social order. Pollution beliefs will carry moral force only if the categories and classifications in question are widely shared.
Cultural Types

According to Douglas (1992-18) there are four distinctive ways of organising society. These four cultures, as she terms them, are each in conflict with the others. People tend to embody one of the cultures and play out a lifestyle that exemplifies that cultural type as exemplified in the following descriptions.

Individualistic lifestyle

Those subscribing to this cultural type tend to be characterised as 'Driving in the fast lane'. They tend to be entrepreneurial, competitive with wide flung, open networks of people. They enjoy high tech instruments and generally lead a risky lifestyle, insisting on the freedom to change commitments. Persons who subscribe to this cultural lifestyle are on the whole knowledgeable, enthusiastic and fashion conscious (even to the most fashionable way of giving birth). Individualist’s philosophy of life and cultural bias embraces politics, aesthetics, religion, morals, friendships, food and hygiene. The individualist cultural alignment is based on a way of life that is free to bid and bargain and needs nature and women to be robust to refute arguments of those who are against any action s/he has in mind.

Hierarchical Lifestyle

Persons subscribing to this cultural type are characterised as being formal; adhering to established traditions and established institutions. They insist on maintaining a defined network of family and friends (driving in the slow lane). For them nature is robust, but
only within limits. This is a version that justifies the hierarchist's control and planned projects. The hierarchist wants to manage the environment and institute regulations on the individualist's projects, therefore s/he needs nature and women to require structure.

*Enclavist or Egalitarian Lifestyle*

The enclavist is essentially egalitarian who are against formality, pomp and artifice. They reject authoritarian institutions, preferring simplicity, frankness, intimate friendships and spiritual values. Nature and women are fragile and pollution (either physical or spiritual) can be lethal. This position is entered in fundamental disagreement with the policies of the development entrepreneurs (individualist) and with the organising hierarchists, and with the fatalism of the isolate.

*Isolate lifestyle*

This refers to a lifestyle that is characterised as eclectic, withdrawn but unpredictable along with a refusal to be recruited to any cause. Friends do not impose upon the isolate, and she is not hassled by competition or burdened by obligatory gifts, nor irritated by tight arrangements or timetables. In this cultural type, nature and women are seen as unpredictable.

To understand the way in which our social experience affects how we think we need to recognise two distinct ways in which society may exert pressure on an individual, two distinct ways in which society may restrict his/her options. Douglas (1992:9) uses the
term 'grid' to refer to restrictions that arise from the system of social classification, for example, the distinction between lord and commoner or between man and woman. Grid in this sense is the set of rules, which govern individuals in their personal interactions. Strong or 'high' grid means strongly defined roles, which provide a script for individual interaction. Towards the weak end of this axis, the public signals of rank and status fade and ambiguity enters the relationships. Individuals no longer have the guidance of a script, but are valued as individuals and relate to each other as such. The constraints become correspondingly weaker, until they take only the generalised form of respect for each person as a unique individual.

Douglas uses the term 'group' to refer to the extent to which an individual’s interactions are confined within a specific group of people who form a sub-group within the larger community. Where the group is strong, there is a clear boundary between members and non-members, and though it may be possible for an individual to leave the group, that will have high costs in that membership of the group confers benefits (consider the case of Wendy Savage (1986) who risked alienating herself from the dominant obstetric group by advocating different approaches to childbirth). As a result, members of the group are able to exert considerable pressure on the individual to conform to its requirements. By contrast, where the group is weak, the individual is free to form relationships or negotiate exchanges with anyone, and the resulting network of interactions constitutes a myriad of overlapping groups, with sub-groups of individuals who interact only with themselves.
Cultural Theory and Myths of childbearing

Another piece of the jigsaw for the analysis of the study is to examine the conceptions surrounding birth. I need to consider the cultural dynamics of the ritualised processes of childbirth and so I turned to Douglas (1966) and Turner (1969). The concept of ritual is generally used to indicate stereotyped actions that remain faithful to an established pattern. Their invariability grants them their efficacy in different domains, ranging from promoting the restoration or creation of social solidarity, order, purity, health, or fertility, to effecting changes of status, to causing harm to someone. Moreover, it is precisely through this changeless nature rites play an important role in complementing the information provided by mythology in this investigation. Its link to mythology is so close that it can be said that rites are the enactment of myths.

Rites are commonly divided into two kinds: public and private. The first is concerned with social groups that are beyond the level of the individual, family or domestic units. The setting for these rituals are often villages, compounds, schools or hospitals, for example. The second is more to do with the individual or family. Rituals have several phases (see van Gennep, 1966; Turner, 1969), which alternate between liminal and structured periods. This means that apart from the symbols that surround rites one also examine their sequence. Moreover, since the actions take place in particular areas and among people who have some kind of relationship, spatial referents and social relationships also provide important information. Through them one can obtain, information about conceptions of space and time and about patterns of social interaction.
Building upon that base, I further expanded the concepts developed by Schwarz and Thompson (1990) surrounding the myths of nature. I found that these latter conceptions interlocked with Douglas's cultural types, as can be seen in figure 2.1.

![Figure 2.1: Myths of Childbearing](image)

1. Childbearing women's bodies are robust. This version justifies the individualist who will not brook her/his plans being blocked by warnings that pregnancy and birth may cause irreversible damage. Her/his cultural alignment to a way of life based on free choice and negotiation. S/he needs nature, i.e. women's bodies to be robust to refute the arguments of those who are against the actions s/he has in mind.

2. Childbearing women's bodies are unpredictable. There is no telling how events may turn out. This version justifies the non-alignment of the isolate. S/he uses it as her/his answer to attempts to recruit her/him to any cause. This lifestyle is characterised by a sense of fatalism.

3. Childbearing women's bodies are robust, but only within limits. This is a version that issues from the hierarchists' platform, their justification for instituting controls and planned projects. The hierarchist wants to manage the environment (pregnancy,
labour and birth). It is the version that justifies the anxiety of obstetricians and some midwives and women. To justify imposing regulations on the individualist's projects, s/he needs women to be not completely robust.

4 Childbearing women's bodies are vulnerable and pregnancy can be lethal as a result of societal and environmental risk. This position is entered in fundamental disagreement with the policies of the individualists and with organising hierarchists, and with the fatalism of the isolate. It justifies political activism on behalf of women to redress the balance of society and nature. This lifestyle focuses on activating the community to effect in the social conditions of the individual and the individual's role in contesting risk challenges.

5 Childbearing women are vulnerable to unknown dark forces – if unprotected they become victims of these forces and their baby may die. This position is used to justify ritual practices and may act to reinforce the 'healer's' position and power.

During fieldwork in Africa, Malaysia and the United States of America, I came across another cultural type. This was more related to the concerns of women, men and communities in respect of 'witchcraft' or the spiritual realms – something beyond our knowing or control in the concrete world. Those subscribing to this cultural type are characterised by ritualistic behaviour. In Africa and Malaysia, this cultural type was concerned with bad spirits, but in America and Britain, some obstetric and midwifery practice might be recognised as falling into this category.

There is no communication without symbols and no social existence without the framing of a social world through implicit assumptions contained within collective memory. All communication depends on the use of symbols. Symbols, to be intelligible, require the pre-existence of shared implicit meanings.
The symbols used in figure 2.1 represent both cultural types and discourses adopted by practitioners and women in childbirth. I have used them as a symbolic pointer within the case studies to illustrate the cultural type I believe had been adopted by different individuals and groups and to show how conflicts between the different cultural types and groups are difficult to resolve. For Douglas (1992), the cultural type stands in opposition to all the others and may have to remain so for the stability of the society. Individuals can be forced out of one group into another either by choice or by coercion but in the process undergo a period of liminality and appropriate ritual processes before being admitted to another group, even if it only a personal, symbolic ritual. Liminality refers to a point of transition between two definite positions. Hence its main characteristic is ambiguity. The rites of passage of this period coincides with the moment in which an individual (or I would argue a community or culture or country) passes from one status to another. These rites consist of initiation ceremonies, which according to van Gennep (1966) include the following stages: separation, transition, and integration. The ambiguous nature of the second phase is generally expressed in acts and symbols that convey an idea of chaos or of indefiniteness.

5. Hermeneutics

Hermeneutics seeks to reveal the fundamental conditions that underlie the phenomenon of understanding in all its modes, both scientific and non-scientific, and that constitute understanding as an event over which the interpreting subject does not ultimately preside. For philosophical hermeneutics, "the question is not what we do or what we should do, but what happens beyond our willing and doing." (Gadamer, 1960:xiv
quoted in Gadamer, 1976:xii). The universality of the hermeneutical question can only emerge, however, if we free ourselves from the methodologism that pervades modern thought and from its assumptions regarding the human condition.

The hermeneutic field of application comprises those situations where we encounter meanings that are not immediately understandable but require interpretive effort. It encompasses both the alien that we strive to understand and the familiar world that we believe we already understand, although one can become lost in a familiar place. The familiar landscapes of the interpreter’s world are seen as integral to the event of understanding as are the explicit procedures by which she assimilates the unfamiliar experience. These landscapes constitute the interpreter’s own immediate participation in traditions that are not themselves the object of understanding but the condition of its occurrence. This reflexive dimension of understanding is crucial to the present study since the aim of philosophical hermeneutics is to illuminate the human context within which scientific understanding occurs and to account for the necessity for repeated attempts at critical understanding.

For Gadamer, however, understanding is not reconstruction but mediation. We are all conveyors of the past into the present where even in the most careful attempts to grasp the past, understanding remains essentially a mediation or translation of past meaning into the present situation. Thus, Gadamer’s specific emphasis is concerned not with the application of method, but rather on the fundamental continuity of history as a medium encompassing every subjective act and the objects it captures. For Gadamer, understanding is genuinely productive rather than reproductive; it is an event, a moment
of history itself in which both interpreter and text are interdependent, an experience where past and present are mediated. In hermeneutics the researcher loses her privileged position and becomes instead part of a fluid and relative moment in the life of effective history, a moment that is productive and disclosive, and, like all others before it, will be overcome and fused with future landscapes. Understanding is the formation of a comprehensive landscape in which limited horizons of text; experience and interpreter are fused into a common view of the meaning. In the working of tradition such fusion occurs constantly where the old and the new grow together again and again without one or the other explicitly being removed (Gadamer, 1960:289).

The concept of understanding as a fusion of landscapes provides a more critical picture of what happens in every transmission of meaning. Gadamer shows us that the fusion of horizons, as he terms it, has more in common with a dialogue between two people or a game in which the players are absorbed, than it has with the traditional model of a methodologically controlled investigation of an object by a subject. Like all genuine dialogue, the hermeneutical conversation between researcher and the text involves equality and active reciprocity. It presupposes that both conversational partners are concerned with a common subject matter about which they converse.

Language mediates our relation to reality. The interdependence of word and idea demonstrates that languages are not merely means of representing a truth already known, but rather of discovering the previously unknown. For Humboldt (1963, quoted in Gadamer, 1976:xxx), the diversity of words is not one of sounds and signs, but a diversity of world perspectives. Gadamer, however, considers this relativistic conviction
to be a mistake fostered largely by the tendency of linguistic studies to concentrate on
the form or structure of language while overlooking the actual life of language as
speaking, that is, as a process of communication that is essentially dialogical. It is just
this unreflective life of language as communication - which one might call its disclosive
function - which is of interest to hermeneutics.

Language, in Gadamer's view, goes beyond the rules and structure of language. It is in
its ability to make oneself understood by others regarding the subject matter that
language finds its true meaning. The spoken word functions precisely by not being
thematic, but by concretising and disappearing into the subject matter they reveal to the
other person. In this way living language is unconscious of itself - the more it becomes a
living operation the less we are aware of it. Its real life consists in what is said in it,
which constitutes the common world, in which we live, and manifests itself in what is
said and what is heard. It is on this level that language emerges as the universal medium
of understanding. So to know a language is to be open to participation in a dialogue
with others that transforms and broadens the horizons from which we start. Language
unveils realities that then react upon language itself as it assimilates what is said.

Gadamer (1976) shows how language as conversation constantly presses against the
limits of established conventions and moves between the sedimented meanings and
usages that are at its base and the view that it strives to express. Understanding, then, is
essentially linguistic, but that is not to say that it is frozen into one static language in
such a fashion that translation from one language to another is impossible. The
constantly self-transcending character of language in its concrete use in conversation is
the foundation of the fluid landscapes of understanding. Understanding transcends the limits of any particular language, thus mediating between the familiar and the alien. It is porous and open to expansion and absorption of ever-new mediated content.

The universality and mediating power of language returns us to the metaphor of the game, for it is in the playful give-and-take of conversation that language has its disclosive function. It is not the possession of one partner or the other, but the medium of understanding that lies between them. In conversation, language becomes individualised, tailored to the situation and context of speaking where the selection of words are determined by their meanings and their power lies in the meaning it holds for the listener (Lipps, 1938:86, quoted in Gadamer, 1976: xxxii).

The playful character of language involves a process of natural concept formation that is greater than the employment of pre-given general meanings and rules for their combination. Rather, the meanings of words depend finally on the concrete circumstances in which they are spoken. The logic of language, at this level, is not simply the formal logic of Aristotle or that of the positivists, but the ‘hermeneutical’ logic of question and answer. General meanings are therefore, drawn into a constant process of concept formation in speaking. Consequently each word is surrounded by what Lipps refers to as the ‘circle of the unexpressed’, which has direct relevance of the meaning of language (Lipps, 1938:71, quoted in Gadamer, 1976: xxxiii). In every moment of dialogue, the speaker holds together what is said and addressed to the listener with the “infinity of the unsaid” (Gadamer, 1960:443-444 quoted in Gadamer,
1976: xxxii). It is this infinity of the unsaid and its relation to the whole of the being that is disclosed in what is said, into which the one who understands is drawn.

It is this whole of being that is mirrored and revealed in language, including the language of texts, that gives interpretation its continuing task. The infinity of the unsaid cannot be reduced simply to the present for every new interpretation brings with it a new “circle of the unexpressed”. What is exposed in language poses ever-new questions to its interpreters and gives new answers to those who are challenged by it. The research methods chosen for this study, therefore, reflect the need to explore the “circle of the unexpressed” through dialogue with both participants and texts.

Based on the philosophies of interpretive epistemology, I used narrative inquiry and the unique perspective it brings to qualitative research as the primary methodology of choice to explore women’s and midwives’ experiences in the case studies chapters (please see discussion of methodologies in appendix 1). Although the terms story and narrative are often used interchangeably, I will use story to refer to the tale as a whole and narrative as the created structure of a story. Stories include many elements, such as character and setting, narrative inquiry is particularly concerned with the plot, that is the temporal unfolding of events. Bruner (1991) described narrative as ‘how humans come to construct the social world and the things that transpire therein’ (p6). Thus, narratives appear in many settings beyond the literary, although analytic approaches used by literary scholars that attend to both structure and analysis of narrative, may prove useful in these settings. These activities highlight the dual nature of narrative: that they are created and interpreted by different people whilst at the same, the very act of creating a
narrative is also an interpretive exercise as a result of the discretionary selection of events, details, and explanations that go into the telling of the story (Poirier and Ayres (1997:552)

Narrative inquiry is thus characterised by the awareness that a story is often contested ground, as a reader may not interpret a story’s meaning in the same way as does its teller. According to Poirier and Ayres (1997:552), overreading occurs on this contested ground since no story can be narrated in its entirety and that no narrator or interpreter can be truly omniscient. Stories are created to fit an author’s purpose, pieced together by the author as a means to the narrative end – a story that appears to be a seamless garment. A similar selection process occurs in the stories we create of our lives.

Making sense of our lives is an ongoing project, so new events often are interpreted within our present understanding. Although adding new events to the evolving tale may alter our interpretation, these new events are just as likely to be interpreted to fit, unchallenged, the existing story. (Poirier and Ayres, 1997:550)

Narratives seeming directness, therefore, is actually indirect and multilayered. Stories are liable to misinterpretation or contradictions on the part of the teller. Because the narrative act is grounded in the struggle to understand one’s own world and grows out of experience, feelings and personal needs, it is constantly subject to change, reconsideration, or even whim. With one telling, a particular aspect of the story may be foregrounded rather than another in response to recent events and moods. As
inconsistency is part of the human nature, so too will the stories that we tell. Narrative inconsistencies point to areas of confusion, uncertainty, or conflicting emotions in the narrator. These alert the hearer of the story to pay particular attention since all may not be as simple as it seems.

Individual stories and narratives were important to the study so too were the collective and evolving stories of groups of women and midwives. I wished to explore their experiences using a 'culture as a symbolic system perspective' (Harper, 1987; Brown et al., 1989). Within the culture as symbolic systems perspective, the focus is on the interaction, on shared meanings, understandings and symbols. I was particularly interested in the social integration and communal nature of knowledge among groups of midwives. Hence focus group methodology was also adopted to understand how people acquired not only the system of understanding and values of both the local and the global community, but also the ability to make use of the understanding and values. A significant aspect of the fieldwork was 'being there' and listening. Being present when these interactions were taking place created a meaningful backdrop from which to interpret the world. The early hermeneutics were concerned with trying to understand the culture and meaning attributed by individuals and groups to their lives. This was a significant element in my research.

Before telling the various stories in the country case study chapters, however, I must draw attention to my own role in its telling. First, the various women, whose stories and narratives are italicised for ease of recognition, were not told to me in sequence as I have presented here. I have pieced together a chronology from the interviews, thus imposing an order on the events that the women themselves might not present. Second,
the questions I posed during both individual and focus group interviews may have elicited stories that the participants may not of otherwise told. Finally, the very information I selected and juxtaposed from the interviews became an interpretation in itself. Various strategies were used to guard against gross misrepresentation or the imposition of bias, but the impossibility of a purely objective recounting of another's story must always be acknowledged. As Poirier and Ayres (1997:552) state, 'in narrative inquiry the ultimately, unavailable, subjective nature of interpretation is foregrounded'. Interpretation, as they previously stated, is always qualified (Ayres and Poirier 1996).

Summary and conclusion

I set out to explore the differing perspectives that play a role in determining women and midwives’ experience of childbirth in the countries under study. Following an initial detour into the work of Jordan and her views on the challenges of undertaking research in a number of countries, I began to focus upon five theoretical perspectives that would provide an all encompassing, if rather complex model from which to examine the multi-context case studies.

In a sense, many of these theories overlap and so it would be possible to examine the case studies from any one theory, but in essence, there are key elements that are covered in one that is missing from the others. I selected, therefore, to use an eclectic interpretive framework (see figure 2.2) that would promote both reflexivity and integration of theories to underpin the investigation.
The integration of these theories has enabled me to capture the different aspects of women’s lives in five different countries. There are only women’s voices present in this thesis which sing out from the glimpses documented herein. This is the story of my interpretation of these glimpses of reality. I am creating the discourses because that is
the nature of the thesis. In these pages I describe the cultural manifestations of women's lives through listening to the discourses within them. These are cited here but were heard and seen in the field.

Having arrived at a conceptual framework for the research itself, I now turn to explore the contexts in which the research occurs. Firstly, I explore the definition of globalisation and localisation before looking at what these concepts mean at a macroscopic level.
Chapter 3

'How do you hold a moonbeam in your hand'1:

The Defining Characteristics of Globalisation

Globalisation, according to Robertson (1992:8) is a concept that refers both to the compression of the world and the intensification of consciousness of the world as a whole. The processes and actions, to which the concept globalisation now refers, he claims, have been proceeding, with some interruptions, for many centuries. Globalisation is intimately linked to modernity and modernisation, as well as postmodernity and postmodernisation.

For Albrow (1996:86) the term globalisation binds the syntax of the global and its derivations into a unifying set of meanings which are entwined in an unfolding story over time. It conveys a widespread sense of transformation and concrete structuration of the world (see Robertson, 1992:53). For Albrow, the tendency to establish blanket coverage should indicate how unlikely it is that globalisation will have a precise analytic set of reference points. He goes on to say that the social sciences have often responded to the demand for control of nature and society through the provision of clear concepts, precise data and testable propositions. But, he argues that clarity and precision is often context and time bound.

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1 Rogers & Hammerstein. "Maria"
For Robertson (1992:52) globalisation is a process but Albrow (1996:87) warns against claiming for 'globalisation' the quality of being a 'process' which explains the social transformation around. If we do, he says, we repeat the modernist errors and produce a dead modern theory for the Global Age. We should rely on more sober forms of conceptual analysis, which go back long before modernity in order to get our thinking straight. In the first place it will be useful to attend to a formal definition of globalisation.

Albrow's three definitions of globalisation (1996:88) provides a useful starting point:

<table>
<thead>
<tr>
<th>Globalisation</th>
<th>Making or being made global</th>
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<tr>
<td>1</td>
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<td>1</td>
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<td>1 a</td>
<td>In individual instances</td>
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<td>1 a i</td>
<td>by the active dissemination of practices, values, technology and other human products throughout the globe</td>
</tr>
<tr>
<td>1 a ii</td>
<td>when global practices and so on exercise an increasing influence over people's lives</td>
</tr>
<tr>
<td>1 a iii</td>
<td>when the globe serves as a focus for, or a premise in shaping human activities</td>
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<tr>
<td>1 a iv</td>
<td>in the incremental change occasioned by the interaction of any such instances</td>
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<tr>
<td>b</td>
<td>seen as the generality of such instances</td>
</tr>
<tr>
<td>c</td>
<td>such instances being viewed abstractly</td>
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<td>2</td>
<td>A process of making or being made global in any or all of the senses in (1)</td>
</tr>
<tr>
<td>3</td>
<td>The historical transformation constituted by the sum of particular forms and instances of (1)</td>
</tr>
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</table>

These constructions are nuanced to do justice both to the ambiguities and complexities bound up in the daily use of the term. They seek to grasp the essential features of
globalisation as expressed in an informed general usage and set them out in an ordered and coherent way. They are not ideal types nor do not affirm scientific validity of ideas.

For Albrow (1996), there are clear distinctions between three kinds of definitions with quite different functions:

- the first is analytical, attaching to specific facets of social life, which are replicated in innumerable different ways under contemporary conditions. It is capable of generalisation and being referred to as an abstraction.

- the second Albrow (1996:88) calls realist, and applies to the process notion in so far as it contains the sense that there is an underlying, subsisting sequence of change which forms the real basis of the variety of forms of globalisation.

- the third is concrete and historical, referring to a once-and-for-all transformation which takes place in a definite period of world history, as with, say, the Renaissance or the Industrial Revolution.

'Globalisation' is often used in all three ways, sometimes to refer to abstract conceptual elements, which enter into concrete social relations, sometimes to refer to a complex set of social changes, which have taken place over historical time. The former properly may be subject to social scientific treatment; the latter belongs to the language of contemporary history and political commentary.
Globalisation and its derivations (globality, globalism, etc.) are metaphors that capture a disparate range of phenomena and experiences. The global metaphor has an important significance for broadly indicating both the actual range of human activities across the world and at the same time a disregard for any divisions human beings might establish between themselves. "From that point of view the transcendence of nation-state boundaries is the most potent of the meanings of globalisation." (Albrow, 1996:91).

The recognition that the metaphorical nature of the term brings us closer to the root indeterminacy of the idea of globalisation. For 'finitude', 'completeness', 'transcendence' are clearly abstract and ideal points, never achieved in actuality. The lack of both a determinate end-point to globalisation and the impossibility of arriving at a complete enumeration of its impact have a consequence, which is equally important for analysis. It is not possible to indicate a single route when the goal is ill defined in both time and space. In practice then globalisation is always relative to some past state of affairs, say 19th century colonialism, or to a standard which aspires to something less than world relevance, say the regulations of the British Housing Association, or UK Midwives Rules. A European common currency clearly transcends national boundaries and it might be a step towards a world currency, which could appear to be the ultimate in globalisation, the transcendence of all national boundaries. But even as an idea is realised so alternative futures can be conceived - local money currencies, alternative media exchange, competing world currencies. Is a world with more than one world currency more or less globalised?
There is no inherent logic to globalisation, which suggests that a particular outcome will prevail. In addition to this indeterminacy there is a problem of ambiguity. It will always be open to question whether globalisation brings the possibility closer of anyone broadcasting to any part of the globe, or the possibility of everyone in the world receiving the same programme at any one moment of time. The debates surrounding homogenisation versus diversification or hybridisation reflect this ambiguity. They concern the issue of whether culture and all forms of social activity are becoming more standardized, which might be the logic of capitalism, or whether multiple cultural contacts lead to an ever increasing variety of new forms.

It is an ever-recurring debate. One attempt to resolve it is to use a semiotic argument on the nature of communication and to say that both are necessarily happening simultaneously but at different levels: for instance there is standardization of channels of communication, but diversification of contents. This effectively is the same kind of message Robertson (1994) provides when he stresses that globalisation also involves a kind of localisation. The global by virtue of its scope can be located anywhere. He has therefore advocated the merits of a term originating in Japanese marketing, 'glocalization', for the localisation of the global - the global mindset (Globalization) - in concert with the value of the relationship between countries and their people (Localization).

Globalization stands for the emergence of a world economy, a world polity, and perhaps a world culture, in short, for the emergence of a world society in the widest sense of the term (Giddens 1991). Localization stands for the rise of localized, culturally defined
identities, sometimes within, sometimes transcending, the boundaries of a state. While globalization represents ever-wider horizons of universalistic sociocultural networks until they encompass the whole world, localization stresses sociocultural specificity, in a limited space. For Kloos (1999) globalization and localization are not static conditions: both are processes - albeit unfinished - in a certain direction. As processes they seem to point in opposite directions and thus on first sight appear to be contradictory. This contradiction is tangibly present in the realms of politics and of language. In the realm of politics the national state is rapidly loosing its sovereignty in favour of transnational, continental, and even global regimes, while at the same time a number of sub-state minorities are demanding more autonomy and political independence.

Another is to argue from a perspectivist standpoint, as Gifford (1990: 129) did in his account of the paradoxes of quantity and scale, which arose out of the 1851 Great Exhibition at the Crystal Palace. The quantity and variety of exhibits was so great that the total effect was one of sameness.

Each of these arguments supplies insights and understanding but they do not remove the paradox. Indeed they are important precisely because they enable us to live with the realisation that ambiguity may be a necessary and inherent aspect when we reference some concepts. And this enables us equally to recognise the necessity to use metaphor for grasping some realities. The fault lies not in our imaginations but in the texture of the human condition that a metaphor may be the best way to convey its open-ended quality. This is particularly the case when we try to grasp transformation over time.
From Local to Global: From Division to Integration

For Friedman (1999: 7) globalisation is the international system that replaced the Cold War system. The Cold War system was defined by a single word – division and it was symbolised by a single object – a wall, the Berlin Wall. It was a divided world in which one could not go very far or very fast in this world without running into a wall.

The globalised world is also defined by a single word – integration and all the threats and opportunities in this globalized world flow from integration and it is symbolised not by a wall but by a virtual object – the World Wide Web, which unites everyone. Friedman considers that we no longer have a first world, second world or third world. There is just have a fast world and a slow world. The globalisation system, unlike the Cold War system, is not static, but a dynamic ongoing process that involves the inexorable integration of markets, nation-states, and technologies to a degree never seen before. This is happening in a way that is enabling individuals, corporations, and nation-states to reach around the world farther, faster, deeper, and cheaper than ever before. People are either in the fast world or in the slow world. Friedman equates globalisation to running in the hundred-metre dash run over and over and over again, and no matter how many times you win, you have to race again the next day. If you lose by one tenth of a second, it is as if you lose by two hours – the gap is so wide that it is also producing a powerful backlash from those brutalised or left behind by this new system.
For Freidman (1999) the driving idea behind globalisation is the spread of free-market capitalism to every country in the world under the belief that the more market forces rule and the more the economy is open to free trade and competition, the more efficient and flourishing the economy will be. Along with its own set of economic rules that revolve around opening, deregulating and privatising the economy, globalisation also has its own defining technologies: computerisation, miniaturization, digitisation, satellite communications, fibre optics and the Internet. These technologies help to create the defining perspective of globalisation. Moreover, these technologies act as symbols of the modern world.

The constraints of contextual, environmental and social factors upon the involvement of women in childbirth and midwives in research that could influence policy-making and service-delivery are challenged head-on by the technology of the internet (Hewitt, 2000). The internet is characterised by an uncompromisingly egalitarian and libertarian ethos, access is open to anyone with a personal computer and a telephone line, and censorship is virtually impossible. A user can be who she wants and say exactly what she chooses. The anonymity of the system allows people to escape from those aspects of reality that oppress them and to assume any identity or characteristic that they choose. Thus women can cast off the oppression of society and the workplace and become a cyberspace super-hero, and they can engage in combat from the complete security of the study or bedroom. On the internet we are all equal, a novel experience for many, and one that will become increasingly exploited as the cost of computer hardware is driven ever downward and cheap internet-only equipment (already on sale in the USA) becomes available.
Once a country makes the leap into the system of globalisation, its elites begin to internalise this perspective of integration, and always try to locate themselves in a global context.

Unlike the Cold War system, globalisation has its own dominant culture, which is why it tends to be homogenising. In previous eras this sort of cultural homogenization happened on a regional scale. Friedman (ibid.: 8) gives the examples of the Turkification of Central Asia, North Africa, Europe and the Middle East by the Ottomans or the Russification of Eastern and Central Europe and parts of Eurasia under the Soviets. Culturally speaking, in his view, globalisation is largely, though not entirely, the spread of Americanization.

Globalisation is also characterised by its own demographic pattern exemplified by the rapid acceleration of the movement of people from rural areas and agricultural lifestyles to urban areas and urban lifestyles that are more intimately associated with global consumerism trends in fashion, music, food, and entertainment.

Most importantly, globalisation has its own defining complex structure of power. The Cold War system was built exclusively around nation-states, and it was balanced at the centre by two superpowers: the United States and the Soviet Union. For Friedman (1999:11) the globalized system, by contrast, is built around three overlapping and interacting balances- the nation-state (i.e. the superpower), the multinational companies, or the supermarkets, and, in Friedman’s terms the relatively unrecognised, the super-empowered individual.
The first is the traditional balance between nation-states. In the globalized system, the United States of America is now the dominant *Superpower* and all other nations are subordinate to it to one degree or another. The balance of power between the United States and the other states is still important for the stability of this system. The second balance in the globalisation system is between nation-states and global markets. These global markets comprise investors moving money around the world by a click of a 'mouse'. Friedman refers to them as "the Electronic Herd". This herd gathers in key global financial centres, such as Wall Street, Hong Kong, London and Frankfurt, which he calls "the Supermarkets." The attitudes and actions of the Electronic Herd and the Supermarkets can have a significant impact on nation-states today, even to the point of triggering the downfall of governments.

The United States is the dominant player in maintaining the globalisation 'gameboard' (Friedman, 1999:12), but it is not alone in influencing the moves on that gameboard, sometimes pieces are moved around by the obvious hand of the superpower, and sometimes they are moved around by the invisible hands of the supermarkets.

The third balance in the globalisation system is the balance between individuals and nation-states. Since globalisation has eliminated many of the boundaries that restricted the movement and reach of people, and because it has simultaneously networked the world, it gives more power to individuals to influence both markets and nation-states than at any other time in history. Consequently, there are now not only a Superpower and Supermarkets, but also Super-empowered individuals able to act directly on the
world stage without the traditional mediation of governments, corporations or any other public or private institutions. For example, Jodie Williams who won the Nobel Peace Prize in 1997 for her contribution to the International Ban on Landmines achieved that ban not only without much government help, but also in the face of opposition from the Big Five major powers. Her secret weapon for organising 1,000 different human rights and arms control groups on six continents was simply "E-mail." (Friedman, 1999:13).

Nation-states, and the American superpower in particular, are still hugely important today, but so too now are Supermarkets and Super-empowered individuals. To understand the globalisation system, it is vital to “see it as a complex interaction between all three of these actors: states bumping up against states, states bumping up against Supermarkets, and Supermarkets and states bumping up against Super-empowered individuals” (Friedman, 1999:13).

Robertson (1992) and Giddens (1991) find that in general globalisation involves a relativization and destabilization of old identities, whether of nation-states, communities or individuals, or, like Hall (1992) or Cohen (1997), stress the creation of new hybrid entities, transnational phenomena like global diasporic communities. As the Organisation for Economic Co-operation and Development (OECD) studies (1993) have found, it is flexible transnational sourcing, production and marketing that mark the globalised firm.
For Albrow (1996), the analytical concept of globalisation is fraught with indeterminacy and ambiguity. In his terms there is no justification therefore for assuming that diasporic communities, just-in-time production and negotiated gender identity are necessarily linked in the same comprehensive and relentless process. They may well be related to different aspects of globalisation, which even run counter to each other. Those different senses of globalisation may relate to relatively independent processes such as technological development, concentration of capital, modernisation and rationalisation. The complexity of their linkages and the difficulty in determining the direction of causation between them are such that caution must be taken before they are interpreted as belonging to some underlying unidirectional process.

There is an alternative strategy for dealing with instances of globalisation and their mutually determining and determined factors. They can now be seen as part of a non-direction period of historical change, characterised by globality but with an open future. Globalisation, therefore, could be representative of a transitional period in history, rather than a single overall process of change. It characterises the beginning of the Global Age simply because the weight of reference to globality displaces modernity from a prior position in characterising the configuration, but it has no inherent direction or necessary end-point. In this respect it is unlike modernity. For me, globalisation is like a bus. Its passengers include modernity and modernisation, postmodernity and postmodernism, new forms of colonialisation and oppression, in addition to technological advances, cultural, political, economic and material exchanges.
The difference in emphasis is profound. Not only is globalisation not just a continuation of modernisation: it is not a lawlike process either. The contrast that is drawn here is as great as that between alternative explanations of the experience of, for example, pregnant women, either in terms of childbirth, or in terms of their altered place in social structure and culture. In the former case appeals are made to a scientific law-governed sequence of physiological change. In the latter case the concerns are with the aggregate effects, with individual responses to contingent changes in environment and milieu, and with the communication of these responses in social interaction. In these can be seen the configuration of a unique historical period (Albrow, 1996: 94).

If the term 'globalisation' is used to refer to the aggregate of historical changes over a determinate period of history, this is quite different from referring to some developmental logic. In this sense a phenomenon equivalent to the Renaissance, Reformation, Enlightenment or the Age of Imperialism is addressed. All those countless instances in which the global is taken into everyday life, where national economies merge with a global economy, where satellites provide news on the world worldwide, where protests erupt in one part of the world about conditions in another. Putting them all together and recognising the way in which the one reinforces the other, a transformation can be seen which is of our time and unique. It may not penetrate absolutely every aspect of social life, or every culture, but its scope and pervasiveness is sufficient for us to say that it both represents the specificity and dominates our experience of our time.
The concept of globalisation is an obvious object, claimed Waters (1995: 3) for ideological suspicion because, like modernisation, a predecessor and related concept, it appears to justify the spread of western culture and of capitalist society by suggesting that there are forces beyond human control that are transforming the world. This thesis makes no attempt to hide the fact that the current phase of globalisation as it impacts on women in childbirth, is precisely associated with these developments. Globalisation is the direct consequence of the expansion of European and American culture across the planet via settlement, colonization, and cultural imitation.

For Waters, the contemporary accelerated pace of globalisation is directly attributable to the explosion in signs and symbols. Human society is globalising to the extent that human relationships and institutions can be converted from experience to information, to the extent it is arranged in space around consumption of simulacra rather than the production of material goods, to the extent that value-commitments are badges of identity, to the extent that politics is the pursuit of lifestyle, and to the extent that organisational constraints and political surveillance are displaced in favour of reflexive self-examination. These and other cultural forces have become so overwhelming that they have breached the banks not only of national value-systems but also of industrial organisations and political-territorial arrangements. Globalisation does not imply, however, that every part of the world has become westernised and capitalist, rather,
those social arrangements in every sector must establish their position in relation to capitalist west.

According to Waters, (1995:7) globalisation can be traced through three arenas of social life that have come to be recognised as fundamental in many theoretical analyses (see appendix 1). These are:

1. **The economy**: social arrangements for the production, exchange, distribution and consumption of goods and tangible services.

2. **The polity**: social arrangements for the concentration and application of power, especially insofar as it involves the organized exchange of coercion and surveillance (military, police, etc.) as well as such institutionalised transactions of these practices as authority and diplomacy, that can establish control over populations and territories.

3. **Culture**: social arrangements for the production, exchange and expression of symbols that represent facts, affects, meanings, beliefs, preferences, tastes and values.

Waters takes these three arenas to be structurally independent, thus rejecting both the Parsonian position that culture determines the economy and polity and the Marxist position that the economy is constitutive of polity and culture. However, the argument does make the assumption that the relative effectivity of the arenas can vary across history and geography. A more effective set of arrangements in one arena can penetrate and modify arrangements in the others just as a more effective set of arrangements in
one country can penetrate and modify arrangements in another. The Soviet Union was a prime example of this. The highly organised Soviet State, an effective polity, controlled Russia and its adjacent territories and populations. Here the state organised culture, allowing only certain forms of artistic expression and religious commitment, and it also organised the economy in a command system of state factories, farms, banks, and shops. Here, Waters suggested, we could speak of the economy and culture being politicised.

These themes can now be linked to an argument about globalisation. Waters argues that the types of exchange that predominate establish the link between social organisation and territoriality in social relationships at any particular moment. Different types of exchanges in his view apply to each of the arenas indicated above. Respectively these are:

- **Material exchanges** including trade, tenancy, wage-labour, fee-for-service, and capital accumulation;
- **Political exchanges** of support, security, coercion, authority, force, surveillance, legitimacy and obedience;
- **Symbolic exchanges** by means of oral communication, publication, performance, teaching, oratory, ritual, display, entertainment, propaganda, advertisement, public demonstration, data accumulation and transfer (research), exhibition and spectacle.

For Waters (1995:9) each of these exchanges exhibit a particular relationship to space, respectively:
• **Material exchanges** tend to tie social relationships to localities: the production of exchangeable items involves local concentrations of labour, capital and raw materials; commodities are costly to transport which mitigates against long-distance trade unless there are significant cost advantages; wage-labour involves face-to-face supervision; service delivery is also most often face-to-face. Material exchanges are therefore rooted in localised markets, factories and shops. Specialist intermediaries (merchants, sailors, financiers, etc.) who stand outside the central relationship of the economy carry out long-distance trade.

• **Political exchanges** tend to tie relationships to extended territories. They are specifically directed towards controlling the population that occupies a territory and harnessing its resources in the direction of territorial integrity or expansion. Political exchanges therefore culminate in the establishment of territorial boundaries that are coterminous with nation-state-societies. The exchanges between these units, known as international relations (i.e. war and diplomacy), tend to confirm their territorial sovereignty.

• **Symbolic exchanges** liberate relationships from spatial referents. Symbols can be produced anywhere and at any time and there are relatively few resource constraints on their production and reproduction. Moreover they are easily transportable. Importantly, because they frequently seek to appeal to human fundamentals they can also claim universal significance.

In summary then, the theorem proposed by Waters (1995:9) that guides the argument of this thesis is that: *material exchanges localize; political exchanges internationalize; and symbolic exchanges globalize.* It follows that the globalisation of human society is
contingent on the extent to which cultural arrangements are effective relative to economic and political arrangements. Waters expects the economy and the polity to be globalized to the extent that they are culturalized, that is, to the extent that the exchanges that take place within them are accomplished symbolically. We would also expect that the degree of globalisation is greater in the cultural arena than either of the other two.

This a radical proposal because it stands in opposition to one of the most influential theories of global integration, Wallerstein’s (1974; 1980;1987;1989;1990) theory of capitalist world-system that takes its lead from Marx in suggesting that the driving force for global integration is capitalist expansion. Water’s view (1995: 10) is that the ability of purely material exchanges to move beyond a local nexus reached its limit at the end of the nineteenth century at which point they were transformed into political exchanges (e.g. state colonial expansionism, alliance systems, global war, superpower arrangements). A similar transformation of political into symbolic exchanges is occurring at the present historical moment.

**Cultural Globalisation**

Globalisation proceeds much more rapidly in contexts in which relationships are mediated through symbols and rituals. Economic globalisation is therefore most advanced in the financial markets that are mediated by monetary tokens and to the extent that production is dematerialised. Political globalisation has proceeded to the extent that there is an appreciation of common global values and problems rather than
commitments to material interests. However, material and power exchanges are rapidly becoming displaced by symbolic exchanges, that is, by relationships based on values, preferences and tastes rather than by material inequality and constraint. In the context of this argument, globalisation might be seen as an aspect of the progressive ‘culturalization’ of social life (Waters, 1995:124).

While it is clearly not the case that culture, as an arena differentiated from economics and politics, has ever been totally globalized it has shown a greater tendency towards globalisation than either of the other two arenas. This is particularly evident in the area of religion. For many centuries, the great universalising religions of the world, Buddhism, Christianity, Confucianism, Islam and Hinduism offered adherents an exclusivist and generalising set of values and allegiances that stood above both state and economy.

The Protestant Reformation (Skinner, 1978; Sheils, 1989; Arnold, 1994; Mashall, 1997) was critical in the development of globalizing trends in two important respects. First Christianity had always fudged the issue of the relationship between the powers of the state and church so that there had been a long series of jurisdictional conflicts between kings and the popes to whom they nominally owed spiritual allegiance. The Reformation resolved this dispute either by subordinating the church to the state, as in England, or by secularising the state, as in the USA and republican France. The state could now rely on the political legitimating and the stage was thus set for the emergence and enhancement of its powers which was itself the prerequisite for internationalisation.
Second, Protestantism raised universalism to a new level by asserting the possibility of a direct relationship between every individual and God by the mechanisms of prayer, conscience and faith. It was therefore asserted that all were equal in relation to God and that salvation did not depend on one’s inclusion within a religiously ordered political community. Religion, whether Protestant or reformed Catholic, that is associated with Western modernity is highly secularised and privatised (Merton, 1968). It specifies that the morals of state and economic action, for example, are governed not by general and public principles but by the consciences of their individual practitioners. Thus were the foundations of individualism laid

With the ascent of a formal ‘rational-science’ approach to childbirth with modernisation and the inevitable extension of the industrial model into hospital based maternity services, informal aspects of childbirth have become devalued and suppressed (see for example Oakley, 1992; Davis-Floyd, 1996). The occupational culture of midwifery in the modern world has been derived from women's and midwives’ experiences of the on-going tension between the ‘rational’ and ‘non-rational’, between the ‘scientific’ and the ‘emotional’. The culture of midwifery has been highly significant in the negotiated process that has underpinned the contemporary organisation of the childbirth process. It has also helped to sustain important continuities and rituals. Some of the data from hospital-based midwives indicates a desire to maintain the specialness of childbirth as a highly significant social and emotional process, even within a formally organised, bureaucratic system of maternity care childbirth. The question is can this be sustained given the increasingly instrumental approach to childbirth as currently experienced in hospitals around the world?
A globalized culture is chaotic rather than orderly - it is integrated and connected so that the meanings of its components are 'relativized' to one another but it is not unified or centralised. The absolute globalization of culture would involve the creation of a common but hyperdifferentiated field of value, taste, and style opportunities, accessible by each individual without constraint for purposes either of self-expression or consumption.

Time-space distanciation is necessary for the disembedding or 'lifting out' of social relations from local contexts of interaction and their restructuring across time and space (Giddens, 1990:21). There are two types of disembedding mechanisms:

- Symbolic tokens (McLuhan)
- Expert systems

Symbolic tokens, according to Giddens, are for the most part concerned with money tokens. Such tokens have enabled the extension of reach across national and local boundaries. While expert systems represent the repositories of technical knowledge that can be deployed across a wide range of actual contexts. Expert systems provide guarantees about what to expect across all of these contexts and ultimately lead to standardization and routinization of activity. Both imply an attitude of trust. That is people have to have confidence in the value of money and technology and the accuracy of expertise that is provided by absent others. Modernity, therefore, implies a high level of trust alongside high risk.
The fact that modern people trust their societies and their lives to be guided by impersonal flows of money and expertise does not necessarily mean that they leave all decision making to others. Modern people engage in monitoring activities because they are aware of risk. People do constantly observe, inquire about and consider the value of money and the validity of expertise. Modern society is therefore, for Giddens (1990) reflexive in character. Social activity is constantly informed by flows of information and analysis that subject it to continuous revision and thereby constitute and reproduce it. “Knowing what to do” in society even in such resolutely traditional contexts as kinship and childbirth, almost always involves acquiring knowledge about how it is done from books, television programmes or experts in the specialist field, rather than relying on experience of self and others or the authoritarian knowledge of elders.

The particular difficulties faced by modern people are that this knowledge is constantly and rapidly changing so that living in a modern society appears to be uncontrolled or chaotic. Lash and Urry’s (1994) application of time-space distanciation and reflexivity while influenced by Giddens (1990) arrives at a different conclusion. Under organised capitalism in the twentieth century, flows of money, large corporations and states tightly controlled commodities and means of production and labour in time and space. Disorganised capitalism involved an expansion of these flows in the international arena and an increase in their velocity. Speed and the reduction of time invade culture and it becomes in their terms, postmodern. This postmodern world is focused on instant consumption and flexibility in the application of labour. This is the experience of midwives working in mainstream American birthing systems and British midwives.
working in the National Health Service and increasingly by midwives working in large
city and town hospitals in Africa and Malaysia. This serves to explain the ways in
which midwives work in organised systems of childbirth. However, objects are not the
only items that become highly mobile in a postmodern world. Individual persons also
become mobile by means of migration, instrumental travel and tourism. And as objects
and people become more mobile they progressively dematerialise and are produced as
symbols (signs).

For Lash and Urry, there are two sorts of signs possible.

- Cognitive signs - symbols that represent information; and
- Aesthetic signs - symbols that represent consumption.

Childbirth falls into both categories in my view, both in terms of symbolic knowledge
transference of information, whether scientific, medical or cultural, and in terms of what
people can and do consume. Consumption for Douglas (1997) requires a cultural
alignment and acts at the level of values, beliefs, and feelings. Cognitive signs act at the
level of instrumental decision-making based on available information but underpinned
by cultural values and alignment. The relationship to Douglas' (1997) cultural types in
terms of consumption of childbirth practices will be discussed in chapter 9.

The proliferation of signs promotes two kinds of reflexivity:
• It promotes a pattern of what Lash and Urry (1994) refer to as ‘reflexive accumulation’, the individualised self-monitoring of production and of expertise and an accompanying increasing and widespread tendency to question authority and expertise.

• It promotes an aesthetic or expressive reflexivity in which individuals constantly reference self-presentation in relation to a normalised set of possible meanings given in the increasing flow of symbols. People monitor their own images and deliberately alter them.

In Conclusion

Considering all the various explanations and definitions offered by a multiplicity of authors, globalisation, for me, is a metaphor that encapsulates a variety of different elements, processes and actions. It is an unfolding story over time that illustrates the seeming compression of the world by seeking the transcendence of national boundaries and the intensification of consciousness of the world as a whole. It conveys a widespread sense of transformation of the world by expanding the frontiers of relevance beyond the narrow time and spatial boundaries of modernity, thus reintroducing grand narrative that brings history into the present

Globalisation, therefore, is making or the experience of being made global in individual instances by the active dissemination of practices, values, technology and other human products throughout the globe; when global practices and so on exercise an increasing influence over people's lives; when the globe serves as a focus for, or a premise in shaping human activities; in the incremental change occasioned by the interaction of
any such instances. Globalisation is seen both as the generality and abstraction of such instances. In practice then, globalisation is always relative. There is no inherent logic to globalisation, which suggests that a particular outcome will prevail. Globalisation is, therefore, ultimately indeterminate and ambiguous.

Taken together, the theories of globalisation represent a new sociology of globalisation that has emerged over the past two decades. In summary, it proposes that:

- Globalisation is at least contemporary with modernisation and therefore has been proceeding for the past three centuries. It involves processes of economic systemization, international relations and an emerging global culture. The process has accelerated through time and is currently in a highly rapid phase of its development.

- Globalisation increases the inclusiveness and the unification of human society by involving the systematic interrelationship of all individual social ties. No relationship can remain isolated or bounded in a fully globalized context. Each is linked to the others and is systematically affected by them especially in a territorial sense where geographical boundaries are unsustainable in the face of globalisation.

- Globalisation involves a phenomenology of contraction – time-space compression - in which the world appears to be shrinking.

- The phenomenology of globalisation is reflexive (Giddens, 1991). People orientate themselves to the world as a whole – multinational companies explore global markets, countercultures move from an ‘alternative community’ to a ‘social movement’ and governments attempt to maintain a level of human rights and will
often intervene to maintain world order (take the more recent conflicts in Kosovo
(UNCHR, 1999; United Nations, 2000)

- Globalisation involves a collapse of the differentiation between public and private
spaces, work and home and system and lifeworld. The separation was largely
accomplished by boundaries in time and space but because globalisation annihilates
time and space the distinctions can no longer apply. Each person in any relationship
is simultaneously an individual and a member of human society.

- Globalisation involves a Janus-faced mix of risk and trust (Giddens, 1991). He
argues that in previous eras people trusted the immediate, the knowable, the present
and the material. To go beyond these was to run the risk of injury or exploitation.
Under globalisation individuals extend trust to unknown persons, to impersonal
forces and norms (the 'market', or 'human rights') and to patterns of symbolic
exchange that appear to be beyond the control of any concrete individual or group of
individuals. In so doing they place themselves in the hands of their fellow human
beings. Consequently, the commitment of all the participants is necessary for the
wellbeing of each individual member.

For Albrow (1996:95-96) we have moved from the Modern Age to the Global Age. He
believes that we have not realised the profundity of this break as yet. For that to happen,
he claims, we need to look crucially at the narrative habits behind which modernity has
sought to conceal the demise of the Modern Age. But are we, as yet, ready to deny the
real experiences of modernity that we encounter daily? In order to be ready to discard
the idea of the passing of the Modern Age we need to first explore what is meant by
modern, modernity, modernisation and all its derivatives, which will be considered in
the next chapter.
Chapter 4

The Nature of Modernity: Society, Development and Risk

Economic restructuring and its relation to social policy are among the most important and controversial issues of our times. Changing economic conditions and a revolution in economic policy approaches has shattered the broad consensus reached in the post-war period concerning the objectives and approaches of social policy. The increasing interdependence of national economies - as well as increasing social and cultural global linkages - means that economic fluctuations and their social impacts now reverberate on a global level. Growing poverty and insecurity are linked to social conflict, extremism, violence, crime, child labour and other social problems. Because the source of these problems involves a global dimension, their solutions cannot be found only on the local level: local and national action must be complemented by action taken at the global level.

Engagement in modernisation and industrialization effects permanent changes on a country and its people. For traditional societies, life was and is, determined by natural forces in combination with forces of spiritual necessities. People functioned, and continue to function, in accordance with natural laws of seasons, sunrise and sunset, low tide and high tide. Their lives mostly revolve around locally determined material exchanges of goods and services. Religion and traditional belief systems prescribed the
course of everyday-life. The invention of a temporal structure of societal life came about because of the necessity for religious services according to Christian faith (Zerubavel, 1981, 1985).

**Industrialisation and Modernisation: The Consequences**

For many, the Industrial Revolution was a transition from a difficult and tedious way of life, to a leisurely, more productive society. The revolution encouraged innovation ranging from the discovery of electricity to the vaccinations for yellow fever. Despite the negative effects of industrialization, certain inventions have revolutionised the course of history yielding a wealth of benefits. With the creation of the automobile, x-ray, electricity and medicinal vaccinations; life was made easier for most people. But, as the technology improved, wealth and power gained from the factory owner's larger profits widened the gap between the upper and lower classes. In addition to the societal effects, environmental concerns also question the benefits of this economic period of enlightenment.

Just as the early Europeans had the desire to look westward, and fulfil a need to discover new worlds; the great minds of the 1800's explored imaginative new ways to devise a transformation of time. The factory owners of the 1800s needed to find faster and easier ways for their workers to accomplish tasks by maximizing their time. Disease, sanitary conditions, injury, death and labour conditions were only a few concerns that these new innovations generated. Not only were work place conditions poor, so too were the sanitary conditions of streets, factories, and homes. Death tolls rose considerably as the scientists began to rush to find solutions.
Although the role of innovation was to make life simpler, many negative repercussions over shadowed the positive qualities. Increasing problems of pollution, over crowding, water pollution, deforestation, ozone level depletion, and natural resource consumption and population growth continue to worry environmentalists.

During the 1800s, health became a matter of scientific curiosity and the medical profession established itself as the experts in and arbiters of life and death. Eventually dissociating themselves from lay concepts of health (Williams, 1983; Calnan, 1987; Pavis, S., et al, 1996) related to the living conditions and ways of life people in the context of natural rhythms, and the control of the church, medical men created a separate monopoly of knowledge and practice which increasingly competed against the spiritual fatalism of Christian religion by introducing principles of rational pragmatism (Foucault 1994a, 1994b). This led to the development of a philosophy which dominates our thinking today (Scully, 1981; Arney, 1982; Ehrenreich and English, 1973; Donnison, 1977; Treicher, 1990; Tew, 1990; Garcia, et al, 1990; Leap and Hunter, 1993; Goer, 1995; Marland, and Rafferty, 1997; Oakley, 2000).

This conceptual and instrumental development occurred simultaneously with the development of industrialized societies. While mass production became the preferred mode of the capitalist economy, the medical profession gained control over bacteria and subsequently, communicable diseases, which had previously evolved as epidemics in densely populated areas generated by industrialization. In general, industrialization was and is not possible without sophisticated medical surveillance and monitoring systems being able to detect anomalies in their earliest stages and treat them with biochemical
substances. The reasons for the successful control of communicable diseases, however, was not solely the result of medical inventions and treatment (see Dugan & Dugan, 2000:18-19).

Durkheim (1984 [1895]) argued that the general direction of change in society was characterised by the process of structural differentiation. In the mid twentieth century, structural-functionalist sociologists expanded and modified Durkheim's argument to encompass the globalising effects of differentiation. The argument is as follows: industrialisation involves the primary differentiation of capitalisation and collective production from domestic production and reproduction. To the extent that a society can make this separation its material wealth and therefore its political success relative to other societies increase. Once the option of industrialisation is available political and economic leaders will therefore tend to choose and pursue it. Industrialisation, therefore, spreads from its seedbed, like ripples on a pond, out into societal contexts in which it is not indigenous and the world becomes more industrialised.

Industrialisation, however, carries with it more general societal ramifications. It induces the pattern of differentiation to other areas of social life as these increasingly become functionally articulated with the industrial core (hospitals, for example, or childbirth). Families specialise in consumption, schools teach differentiated skills to the labour force, specialised units of government provide economic infrastructure, the mass media sell appropriate symbolic representations of the world, churches promulgate supporting values, and so on.
These structural changes induce value shifts in the direction of individualisation, universalism, secularity and rationalisation. This general complex of transformations is 'modernisation.' As industrialisation spreads across the globe, it carries modernisation with it, transforming societies in a unitary direction. Imitating societies may even adopt modern institutions before effectively industrialising.

Levy (1966) effectively reduced modernisation to industrialisation by defining it in the following way: 'A society will be considered more or less modernized to the extent that its members use inanimate sources of power and/or use tools to multiply the effects of their efforts' (1966:11). Such is the case in childbirth in the United States of America and the United Kingdom. Increasingly this is evolving as the situation in major urban centres in Malaysia, Ghana and Malawi. Levy also lists the major societal-structural characteristics of a relatively modern society (1966:38-79). Many of these bear a close resemblance to Parson's (1964) evolutionary universals:

- The units of society, its collectivities and roles are highly specialized with respect to the type of activity, which they perform; this means that individuals can specialize in the skills, which they use in role performance.
- The units of society have a relatively low level of self-sufficiency – they must rely on other units to provide resources which they do not themselves produce.
- Value-orientations are highly universalistic – they tend to stress what a person can do that is relevant to the situation rather than what they are;
- An increasing centralization of decision-making is set up by the need to coordinate and control diverse, specialized activities;
• A large proportion of human relationships are characterized by rationality, universalism, functional specificity and emotional avoidance;

• A large proportion of the exchanges between specialized units takes place by means of generalized media (e.g. money) and within market contexts;

• The multilineal, conjugal family is established which covers a maximum of two generations, disemphasizes unilineal descent, and focuses on the spouse relationship as the foundational bond.

Modernisation in these terms is no longer the impersonal functional imperative of adaptive upgrading (Parsons, 1964) but rather a materialistic motivation at the level of the individual agent. In societies that modernized early: ‘no society has members completely unable to comprehend or sense advantages in some applications of power from inanimate sources and tools’ (Levy, 1966:25-6). Latecomers are highly vulnerable to the ‘universal social solvent’ of modernisation. Likewise, once a traditional society is in contact with a modernized society, at least some of its members will want to change it in order to improve their material situation, more or less out of envy of the ‘inordinate material productivity’ of modern societies (Levy, 1966:125-6). The most imitated society becomes easy to specify.

The United States is the most extreme example of modernisation (Levy, 1966:36). Levy was able to show that latecomer modernisation is essentially reflexive and that this reflexivity establishes a systematic pattern of inter-relationships between societies. For Levy, members of every society are faced with two questions, each of which presupposes that every society will indeed modernise. The first is concerned with
whether development of non-modernized societies can be achieved in a stable fashion. The second is whether highly modernized societies can maintain their high rate of modernisation and a stable condition.

**Social Consequences of Adjustment and Restructuring**

It is generally assumed that the development of a society depends on the improvement of the socio-economic conditions, i.e. on economic growth and the improvement of existing, and the invention of new, technologies to rationalise production processes and services. Research and development play a key role in driving the economic sectors of industrialized societies. The production of knowledge and skills to develop, implement and control technologies lies at the heart of these societies. While traditional societies are based on agriculture, developed societies (Giddens 1991) are based on technology and the exploitation of traditional societies, which provide them with resources of food, raw materials and inexpensive labour.

Development refers to two different processes that happen simultaneously: the improvement of socio-economic living conditions in industrialized countries and the political, economic, technological and military control of development in traditional societies (Escobar 1995). The development of industrialized countries is based on lower levels of development in other parts of the world. According to classic economics, development has always been linked to economic growth, and subsequently it has been linked to competition rather than to cooperation.
The coherence of effects that the development discourse achieved is the key to its success as a hegemonic form of representation: the construction of the poor and underdeveloped as universal, preconstituted subjects, based on the privilege of the representers; the exercise of power over the Third World made possible by this discursive homogenization (which entails the erasure of complexity and diversity of Third World peoples, so that a squatter in Mexico City, a Nepalese peasant, and a Tuareg nomad become equivalent to each other as poor and underdeveloped); and the colonization and domination of the natural and human ecologies and economies of the Third World.

Development assumes a teleology to the extent that it proposes that the "natives" will sooner or later be reformed; at the same time, however, it reproduces endlessly the separation between reformers and those to be reformed by keeping alive the premise of the Third World as different and inferior, as having a limited humanity in relation to the accomplished European. (Escobar, 1995: 53-54)

For Mebmet (1995:2-3), mainstream economics produced flawed theories of economic development for the Third World. These flawed theories imported from the West lacked fit, resulting in distorted and biased Third World development. He argued that Western theorists have stubbornly ignored the basic flaws in their theories, hiding these behind idealised constructions of perfect competition or rational (i.e. Western) behaviour. Overall, mainstream economists have failed to realise that underdevelopment may be causally linked to:
• monopoly profits, externalities, transaction costs and other 'market failures', and above all,
• hidden subjective values embedded in these theories themselves.

Escobar (1995) comments on the effects of this kind of development:

Development was - and continues to be for the most part - a top-down, ethnocentric, and technocratic approach, which treated people and cultures as abstract concepts, statistical figures to be moved up and down in the charts of "progress". Development was conceived not as a cultural process (culture was a residual variable, to disappear with the advance of modernisation) but instead as a system of more or less universally applicable technical interventions intended to deliver some "badly needed" goods to a "target" population. It comes as no surprise that development became a force so destructive to Third World countries, ironically in the name of people's interest. (p 44)

The social and economic consequences of free-market reforms have been dramatic. In general, the primary incomes of the poor have decreased, the number of people living in poverty has increased, and social income and access to public services has also decreased. Targeted interventions meant to protect the poor and vulnerable groups from the worst aspects of adjustment failed to reach all of the poor, and seldom reached most of the poor according to a United Nations Research Institute for Social Development Seminar (Vivian, 1995).
"[In Africa] the major beneficiaries of adjustment have tended to be small groups of individuals with access to foreign exchange ... We are witnessing peculiar types of social polarization and fragmentation, both of which are detrimental to the social and political order upon which independence was built." (Bangura\(^2\), quoted in Vivian, 1995)

Furthermore, a range of other social impacts is associated with free-market reform. The UNRISD Report (Vivian, 1995) stated that there has been a "desocialization" of social actors, as people from community to national levels direct their attention to coping with growing economic hardship in their individual contexts. Inter and intra group conflict has increased as previous social bonds have been disrupted and social tensions have intensified.

In many cases, the impact of restructuring on women is especially pronounced, as the household provides the primary safety net for those economically displaced by restructuring. Women's reproductive work has thus intensified just as they are increasingly joining the labour force themselves. Moser\(^3\) reported that:

"[In the World Bank research on the coping strategies of the urban poor] we found four critical areas of results. First, in the area of employment the dramatic

\(^2\) Yusuf Bangura, is a Project Co-ordinator, UNRISD, Geneva, Switzerland
\(^3\) Caroline Moser is a Senior Urban Social Policy Specialist, Urban Development Division, World Bank, Washington, D.C., USA.
story is of the increased number of women who are economically active. In other words, the coping strategy in all these cities was to send women out to work.

Second, the increased casualization of work is significant. The informal sector is very much a residual sector, especially for women, and thus unpacking what is going on in the informal sector in particular contexts becomes very critical. Third, the relation between home ownership and vulnerability was found to be important. Home ownership provides a cushion against extreme poverty. Fourth, when looking at the question of where the safety nets are, it was found that the households are themselves safety nets. Households are shock absorbers in the short term - they absorb new members during crisis periods. The extent to which this can be an advantage depends on whether the new members go out to work." (Moser, quoted in Vivian, 1995)

In the specific case of structural adjustment programmes, designed to comply with the policy directives of donors and international financial institutions, debate has raged over the causal relationship between mean restructuring and deepening social problems. It has been argued that the latter cannot be attributed to adjustment policies, and that social problems might have been worse had adjustment measures not been undertaken. Vivian (1995) claims that it is not really necessary to address this unanswerable counterfactual question. Adjustment measures were ostensibly meant to address problems of poverty and inequality - to permit renewed economic growth and
development. In fact, the World Bank has said that its work must be judged by the extent to which poverty has been alleviated. Thus, if poverty has increased, adjustment can be said to have failed.

The psychosocial and ecological costs of full-blown industrialized societies are harder to calculate. In terms of individual and collective morbidity and mortality, we are confronted with diseases and suffering hardly known to people in developing countries. While communicable diseases still plague them, developed societies have developed a new panorama of non-communicable diseases such as cancer, cardiovascular diseases, allergies, etc. All together, the global health situation is of major concern, for as the World Health Organization (1999) reported, both developed and developing countries, share serious environmental health problems affecting:

- hundreds of millions of people who suffer from respiratory and other diseases caused or exacerbated by biological and chemical agents, including tobacco smoke, in the air, both indoors and outdoors;
- hundreds of millions who are exposed to unnecessary chemical and physical hazards in their home, workplace, or wider environment (including 500,000 who die and tens of millions more who are injured in road accidents each year).
- Health also depends on whether people can obtain food, water, and shelter. Over 100 million people lack the income or land to meet such basic needs. Hundreds of millions suffer from undernutrition. (WHO, 1992:xiii)
In addition to health problems, developing countries face a number of social, economic, cultural and political difficulties. Most of these can hardly be dealt with in short-term development programmes. Among others, they include:

- health care system,
- educational system,
- unemployment and under-employment,
- inter- and intracountry migration,
- rapid urbanization,
- public and private transport,
- adequate housing,
- water and sanitation facilities,
- solid waste disposal
- energy supply,
- food supply,
- population growth,
- environmental pollution.

The economic situation of most developing countries is somewhat unbalanced; the national budget is low, often due to difficulties in collecting taxes, lack of governmental revenues, and rising foreign debt repayments; falling prices for almost all raw materials offered by these countries; and low average income per capita (Brown and Jolly, 1999). On the other hand, energy costs have gone up during the past decades so that industrialization is improving only slowly in many countries. This situation is exacerbated by the lack of vocational training among many people. The lack of an infrastructure needed to improve economic growth prevents foreign investors from coming into the country. Finally, many countries are confronted with unstable political and social conditions.

Risk and Society

In this thesis, three distinct forms of risk are identified. Risks that are related to purity, danger and pollution in Mary Douglas’ (1966) terms which are essentially locally based and bound up in concepts of spirituality, magic and nature. Risks associated with local
social, technological and environmental dangers (Douglas and Wildavsky 1982). These can be grouped as follows at the level of public policy:

1. Foreign affairs: the risk of foreign attack or encroachment; war; loss of influence, prestige, and power
2. Crime: internal collapse; failure of law and order; violence and abuse; white collar crime.
3. Pollution: abuse of technology and industry; fears for the environment
4. Economic failure: loss of prosperity – low paid workers, unemployment; poverty and its impact on housing, water supply, waste disposal, transport, education, etc.
5. Health: disease; accidents, etc.

For Beck (1992), risk is related to the global exposure of people to risks generated by contemporary industrialised society, such as nuclear wastes. During the modernisation phase, people had willingly accepted medical and ecological side effects in return for an increase in material welfare, however in...

... the welfare states of the West a double process is taking place now. On the one hand, the struggle for one’s ‘daily bread’ has lost its urgency as a cardinal problem overshadowing everything else, compared to material subsistence in the first half of this century, and to a Third World menaced by hunger. For many people problems of ‘overweight’ take the place of hunger.... Parallel to that, the knowledge is spreading, that the sources of wealth are ‘polluted’ by growing ‘hazardous side effects’. (Beck, 1992:20)
These side effects constitute risks and the distribution of these risks is becoming the central feature of global society. It is not that the hazards themselves that are necessarily new but the way in which they are socially constituted are. Consequently, an important defining feature of risk is its social reflexivity. The risks of which Beck speaks are primarily generated by industrialization, and include threats from toxins, pollutants, radioactivity, and nuclear waste, which may ultimately cause irreversible and invisible damage to the environment.

The contemporary experience of risk is bound to the concept of reflexive modernisation and is both scientifically and politically reflexive. Society is intentionally recast as an attempt to reduce risk but cannot deal with 'the threatening force of modernisation and its globalisation of doubt' (Beck, 1992:21) because contemporary risks are qualitatively different from the hazards and dangers experienced in previous periods of history.

The risks and hazards of today thus differ in an essential way from the superficially similar ones in the Middle Ages through the global nature of their threat (people, animals and plants) and through their modern causes. They are risks of modernisation. They are a wholesale product of industrialization, and are systematically intensified, as it becomes global.

(Beck, 1992:21)

Risk, for Beck (1992), globalizes because it universalizes and equalizes. It affects every member of the world population regardless of location and class position. Moreover it respects no borders. I would argue, however, that in global risk does not equalise since
wealthy developed industrial countries are in a position to transport their risks, that is their pollutants such as toxic waste to less developed countries. In this way wealthy countries can play down their own risks while increasing others who are less likely to be able to find a solution to the hazards. Beck further argues that the only possible solutions to risk, therefore, are supranational solutions such as strategic arms reduction, international agreements on emission reduction or the proliferation of nuclear weapons.

Social institutions not only tend to standardise ways of life and life-style options on a national scale. They are involved in an ever-intensifying process of globalisation. In individualised societies like America or the United Kingdom, autonomy is always dependent on and restricted by the kind of institutions that give shape to the conditions of social life. On the other hand, this state of affairs makes clear that people have common interests in the quality of the institutions that they so heavily depend on. Exactly because of the penetrative effects of schools, universities, hospitals, social services, and industrial companies on the individual life chances of each of us, everyone has a vested interest in the quality of the goods and services that such institutions deliver. Therefore, the ‘high-tech’ that is practised by these institutions should be the subject of public decision-making.

Even more important is the awareness that local events and personal actions have become heavily dependent on developments and decisions that have their origin in other parts of the world. At the same time decisions and choices that we make here-and-now have a serious impact on the life chances of people living far away - in space and time. For example, each and everyone's adherence to uphold the standards of production and
consumption of Western societies, not only reinforces the unequal distribution of material welfare and life chances between the rich and poor countries of the world. It also contributes to the continuing exploitation of natural resources that endangers the life and future of coming generations.

Of course, these kinds of global interdependence may be and are ignored on a massive scale in everyday life, but it is no longer possible to deny their existence. That is why, I believe that we cannot escape from our inherent responsibility for the destiny of other people while acting and choosing in local contexts and on behalf of our personal concerns - even if we don’t know these ‘others’ personally.

The globalisation of modern institutions coincides with a globalisation of the self-referential reflexivity that gives rise to social transformations that are at the heart of the risk society. The self-referentiality of dominant economic, political, scientific and technological institutions creates more risks for the survival and life chances of the human species, than these institutions are able to solve. These risks are no longer restricted to specific places or particular social categories; they are universal, as a result of the globalisation of the logic of self-referentiality.

People were always insecure, but now they are being threatened on a global scale from the risks of pollution and the poisoning of food and water, and the impact of desertification, soil erosion and deforestation that ultimately threaten our health. People’s insecurity is also increasingly bound up in the risks of becoming unemployed, and of being deprived of social and physical security. This is the outcome of a
worldwide dominance of social institutions that lessen the daily experiences and ethical questions that exceed the limits of their internal criteria and logic. Needs, desires and imaginations that 'escape' their logic are excluded, become objects of discipline, or are suppressed. They are seldom allowed to cause public debates about unforeseen consequences, nor about the ethical dilemmas of modern institutional ways to handle nature (including childbirth), to produce economic growth, or to control the victims of social and economical deprivation.

In the next section I will discuss the implications of the concepts of public health risk and issues of trust.

*Public health: Public trust*

The let's all go jogging, stop smoking and eat brown bread type of health promotion campaigns have failed to reduce the health inequalities experienced by people subjected to modern-day poverty. Individualising the problem and the solution only damages the moral and spiritual health of the nation.

Modern day poverty is a worse killer than smoking - and it is also passive. That is why people in my community (i.e. Glasgow -EW) are convinced that as much passion must be applied to stubbing out poverty as is being applied to stubbing out smoking. We need homes that are fit to live in and incomes or benefits that prevent us from having to choose between heating and eating (McCormack 1994: 10).
Cathy McCormack argued that health promotion should be concerned with living conditions because her own living conditions were not on an acceptable level for health. She argued that health promotion campaigns aimed at the individual do not make sense in the absence of adequate living conditions for human beings.

Health as defined by the World Health Organization (WHO) comprises physical, mental and social well being, and as an expression of trust in the present and in the future. Health is both a universal and a specific indicator for people's experience of the quality of their environment and the embedded quality of social relations they share.

Wellbeing cannot be thought of without referring to trust. If people cannot have trust in themselves, they feel insecure. If they cannot have trust in the sustainability of the environment, they lose perspective on their lives and the lives of our children and future generations. If they cannot have trust in the government, they feel alienated and excluded from the decision-making regarding their future. Trust is a key category for understanding the construction of societies (Layder, 1997). Without trust, societies would tend to be a conglomeration of individuals, more or less ordered to certain interest groups, pursuing their particular interests in competing against each other for the control of resources.

The societal development of industrialized countries, in my view, with which Cosio-Zavala and Gastineau (1997) would sympathise, has led to an almost total elimination of traditional values and belief-systems and the roles and functions of their respective institutions. Economic and technological development has simultaneously replaced
traditional social systems. Traditions seem to have lost their meanings and functions for societal systems based on the individualization of social relations in all social sectors and areas. Traditional systems of rationality appear to have been replaced with the rationality of technology. Traditional systems of inter-generational families have, by and large, been replaced with the two-generation family, although a growing proportion of the population lives alone or in single parent families. Modern societies, therefore, have become post-traditional societies in the sense that they have broken with traditions to a large extent.

Self-realization and self-sufficiency have now become an overall ideal of human life in modern societies and are the core criteria of success (Romanyshyn & Whalen 1987). Human potential has to be developed to the fullest extent by each individual. In developed societies there is no escape from good advice about how human potential can be achieved (see Horton, 1971). People are subjected to institutions and agencies, which provide an overload of information and advice, resulting frequently in contradictory concepts and measures for improving individual lives. Advice is provided for the selection of the 'right' schools and universities, the purchase of the 'right' clothes, the use of the 'right' language and communication skills, the 'right' foods to eat, the selection of politically correct television channels to watch, the right trust funds to invest in and how to build ecologically sound homes, where to give birth, and so on. Whatever people do, there is someone "out there" telling them how to do it correctly, often supported by some kind of statistical evidence.
Quite apart from governmental bureaucracies regulating public and private life in terms of law and order, developed societies have developed private and public organizations and agencies to design individual life itself. This has led to the development of a considerable industry dealing with every aspect of modern day life mostly covered up by labels such as "Do-it-yourself" or "Self-help". These labels are euphemisms because the professional advisers or consultants do not really intend people to improve their faculties and skills. Self-help does not mean self-determination, and it certainly does not mean self-organization or even empowerment of individuals and groups. What the consulting industry is aiming at is gaining control over individuals and the potential risks they bear for society in terms of development, creativity, solidarity, and empowerment through community organization. The focus is on self and not on help (Romanyshyn & Whalen 1987). It is the self as a discrete unit that is targeted, not the self as a social human being in relation to other human beings.

The consulting industry does not deal with communities or social groups but with numbers of discrete units sometimes packaged to target audiences if the issue needs to be transmitted in a relatively short period of time. The relationship between consultant and client is not always characterized by commitment, but by commerce. As soon as people have accepted the advice, i.e. as soon as the advice has become the individual’s property by making it part of her life, the responsibilities regarding the effects of acting accordingly are hers. Once the individual starts to jog, the heart failure is hers. It takes time for the consulting industry to discover whether its advice is sound. Until then, because more and more frequently unequivocal research cannot be delivered, the risks have to be borne by the individual.
Giving advice is an integral part of social relationships because it is an expression of the commitment felt to significant others. The difference between this type of advice and the advice provided by the consulting industry lies in the quality of the relationships between them as illustrated in figure 4.1 below for example.

**Figure 4.1 Quality of Relationships in Health Care**

**Social Relationships:**
- are generally characterized by a strong personal responsibility for individual action
- are characterized by trust
- have a long-term perspective
- are necessary to build communities and societies through cohesive action
- are based in the context of everyday life

**Client relationships are:**
- characterized by the interests of the consultants to lead people on *their* paths of life
- characterized by efficiency
- short-term and outcome oriented
- designed to fix "problems"
- grounded in artificial settings of professional expertise.

*(after Romanyshyn & Whalen 1987)*

In traditional societies, societal and social processes on the whole are worked through the whole community. In developed societies, these processes are designed by functionaries and experts and are implemented subsequently according to target audiences and target areas. Developed societies have individualized human life by disembedding the individual from her reference groups and treating her as a discrete unit in relation to her social functions (Giddens, 1991). Developed societies have sought to organise and impose controls on individual activities but despite the prevalence of a consulting industry, individuals have been and will be unpredictable in their response to such control mechanisms. This is particularly true with regard to all social areas such as
education, health, intimate relationships, entertainment, recreational activities or the entire leisure sector.

Developed societies have undergone major changes in terms of economic policies, technological development, international relations, globalisation, and environmental degradation. While considerable wealth has amassed at home, poverty and hunger have increased abroad in so-called developing countries. While excelling in developing and implementing more and more sophisticated technologies at home, almost primitive conditions maintained by extreme poverty prevail in "developing countries". For as Beck (1999) states, simply by being able to control resources\textsuperscript{4}, that is global funds, one country is able to control another.

When internal changes in modern societies are investigated, the rapid processes of destruction of traditional values, beliefs, roles and responsibilities, education, families, and so on, are almost simultaneous with processes of construction of new ways of dealing with the effects of societal changes on a human level. New values and new rituals are superseding old are replacing old values and rituals. For Illich (1976), key among these is the medicalization of life.

\textit{Medicalization}

Modern societies interpret social issues as social \textit{problems} that need to be dealt with by professionally trained experts. In order to assign experts to "problem-solving", the

\textsuperscript{4} The United States of America, for example, is highly influential in determining who gets financial aid via the World Bank in line with their foreign policy.
"problems" have to be formulated in terms of the experts' knowledge base. For example, social issues like values, family life, education, public health or nutrition are translated into categories of sociology, psychology, social work and medicine. The public discourse about these issues is translated into an expert's discourse addressing the public. In effect, the public discourse is replaced by an expert's discourse taking place in public. The public is reduced to interest groups claiming to represent the public or at least considerable segments of the public.

For Wenzel, (1997) expressions of everyday life are interpreted in the light of analytical categories of social and medical sciences. Everyday life itself loses its pragmatic, frequently trivial character and becomes a highly sophisticated issue that needs scientific input to be understood and changed. Human expressions of love, passion, anger, anxiety, enjoyment or lust are decontextualised and robbed of their continuity with other life processes by reducing them into frozen categories of psycho-, medico- and socio-analysis. These analytical categories are used as representations for complex and often complicated psychological, sociological and cultural processes. For example, the term depression is assigned to a variety of decontextualised behaviours thereby leading to the epidemiological statement that depression is prevalent in developed societies. When defining certain behaviour as depressive, the behaviour is identified accordingly without needing to question whether the definition is reasonable or valid in the first place.

The conceptual circle stabilises the social system as well as the role of experts - and in the end, it tends to make individual and collective behaviour consistent with the
categories rather than constructing categories to become consistent with behaviour. However, this is typical of any process of scientification: the objects of concern are shaped according to categories in order to make them fit with the theories the categories are based upon. As far as health-related issues are concerned, this process is one of medicalization of everyday life, for as Conrad states:

> With medicalization, medical definitions and treatments are offered for previous social problems or natural events; with healthicization, behavioural and social definitions are advanced for previously biomedically defined events (e.g. heart disease). Medicalization proposes biomedical causes and interventions; healthicization proposes lifestyle and behavioural causes and interventions. One turns the moral into the medical, the other turns health into the moral (Conrad 1992: 223).

Following the medicalization of social issues, the solution to the defined problem lies in experts' knowledge and skills of problem solving as regards individual and collective behaviour. Again, it is assumed that experts know how to solve social problems because they are trained professionally to understand human thoughts and behaviour and to be able to change human thoughts and behaviour according to set objectives.

In order to legitimise the role of experts in the process of problem-definition and problem solving, the problems themselves have to be translated into judicial terms. The law is a strong control agent of individual and collective behaviour in as much as it is perceived as the general behavioural and cognitive guideline of the societal framework.
of public and private life. The extension of these concepts into childbirth is clearly seen not only in the American legal context, but also increasingly in the British legal systems as will be shown in the case studies.

In conclusion

The globalisation process today is also marked by the accelerated pace at which informational and cultural exchanges take place, and by the scale and complexity of these exchanges (on the latter, see Appadurai, 1990:6). Facilitated by the new technologies, it is the sheer speed, extent and volume of these exchanges that have engaged popular imagination. Cheater (1993:3-4) lists an impressive array of such technologies from electronic mail to the satellite dish, and although these are clearly not accessible to all, they have obviously been directly or indirectly responsible for exposing many different sorts of people to new influences. Such technologies are able to uncouple culture from its territorial base so that, detached and unanchored, it travels through the airwaves to all those with the means to receive it. The accelerating effects of electronic communication and rapid transportation that can whisk people from one location to another create a structural effect that McLuhan (1964:185) called 'implosion'. By this he meant the bringing together in one place all the aspects of experience where one can simultaneously sense and touch events and objects that are great distances apart. The centre-margin structure of industrial civilization disappears in the face of global synchronized and instantaneous experience. In what has become an evocative and iconic formulation, McLuhan asserted that "This is the new world of the global village" (1964:93). But global space is not in any way similar to a tribal village.
Whatever the ultimate outcome might be - greater homogeneity or heterogeneity of culture - and this is hotly disputed, the contemporary phase of globalisation has thus resulted in more people than ever before becoming involved with more than one culture (cf. Featherstone 1990:8). It is perhaps this, which above all else captures the sense in which the term is used here.

There are a number of key symbolic exchanges to arise out of this chapter that have significance for women in childbirth. These present themselves as potential risks in today's societies around the world to a greater or lesser degree and act differentially upon women. The major areas identified for the purposes of this study are:

- The changing nature of culture, the global and local responses of women who live in urban and rural areas impinge on their experience of childbirth. Moreover, issues of communication, language, mobility, access to transportation and health services, quite apart from the influence of media in altering cultural perceptions and expectations of birth, play a significant role in determining the context in which birth takes place.

- One of the most significant universalising effects of modernity is the conception of time. The mechanical clock disrupted recursive and seasonal conceptions of time and replaced them by a durational conception where time is measured in precise divisions. Measured, universal time became an organising principle for a modern world divorced from the immediacy of human experience.
• New technologies and shifts in the institutional organization and ideologies- (i.e. economic, political, legal, and medical ) leads to increasing specialization that seems to be an inevitable outcome of the technological age which sparks increasing specialization under the assumption that this is part and parcel of progress. However, specialization has consequences for individuals and the societies in relation to women in childbirth and the education of those practitioners who care for them. Nevertheless, a key driver in organisational change is the development of new information technologies. Computers and communication networks allow us to move, store, and process information faster, more cheaply, and over greater distances than ever before. These new technologies have already led to the creation of new industries, to the accumulation of new wealth, to changes in almost all kinds of organisations and increasing specialization in work, research and education.

• The powerful hegemonizing forces at work through globalisation as a consequence of the expansion of European and North Atlantic culture that means that those countries and Japan play an hegemonic role in the development of non-national transnational practices that do not originate from all parts of the world equally. Consequently, there has been a growth of ‘global governance’, so that it is increasingly difficult to think of nation-state as the appropriate power-container of important economic and social relationships As a result, nation-states are adapting to the new pressures by changing their functions. Specifically, it is now apparent that contemporary nation-states are now too small for the big problems of
contemporary social life and too big for the small problems, thus increasing their need for international collaboration.

- The local and the global intersect in different ways in different places, and there is great spatial variability in the robustness of the local conditions, which permit growth. We are increasingly seeing alienation between 'skyscraper' and 'shanty economies', the resultant problems and risks of poverty become a major socio-political and environmental concern for women in childbirth.

- The role of women in relation to the risk, with special emphasis on the state of the environment and development is now recognised in some areas but still does not feature as the prime focus of many programmes for the major governmental or non-governmental aid agencies. It is an issue that is highly important, not only for the environment and development, but also for the health and well being of women themselves. In developing countries, many women's relationship with the environment is vital to their daily lives, for example, the provision of water, fuel, food and other basic needs. These women do not only bear the brunt of environmental degradation, but also play a crucial role in environmental management. Women everywhere are influencing the environmental debate in a numbers of ways - as consumers, as educators, as campaigners and communicators.

- There are some clearly observable countertendencies to globalisation. Whatever the future of the nation--state, there is no doubt that nationalism and religious
fundamentalism as both a force and ideology are on the increase despite globalisation.

This chapter has provided a contextual underpinning for the study and while it is at this point in a conventional thesis that a chapter on research methodologies would follow, I have chosen instead to place the methodological issues and problems in appendix 1 so that they do not get in the way of the unfolding story.

Having begun to reveal the some of the fundamental problems in constructing a universal midwifery curriculum that is relevant, meaningful, and liberating and would lead to the elimination of gaps between ‘developed and developing’, in the following chapters I attempt to bring women’s lives more sharply into focus in the context of globalisation and localisation.

Lawton (1974) defines the curriculum as being a selection from culture so in order to take the thesis further and unravel further issues, we now turn to an examination childbirth culture in five different countries. What will become apparent in the following four chapters, are the dilemmas facing women in childbirth as they engage in the symbolic exchanges under the influence globalisation and localisation. The chapters address the following questions:

How do these processes of globalisation, modernisation, industrialization and development affect approaches to childbirth and impact on midwifery education and practice?

How are women constructing their lives in a rapidly changing social and cultural environment?

How do these changes impact on childbirth practices?

How do birth practitioners construct their work?
David-Floyd (1992:60) identified eight major conceptual and procedural dilemmas with which natural birth process confronts American society. She chose to emphasize the label 'dilemmas' (in the sense of “a problem seemingly incapable of a satisfactory solution” (Webster’s, 1979:317), instead of “oppositions” or “anomalies”. She presented these dilemmas in “how-to” terms in order to emphasize that they are conceptual problems whose successful resolution depends on concrete, operational, “how-to-proceed” plans for action in the face of a potentially paralysing paradox. I have modified the dilemmas to extend it beyond the American context into the global context. These dilemmas were summarised as follows:

1. Modern and modernising societies are increasingly conceptually grounded in the technocratic model of reality under the influence of globalisation and thus have a vested interest in maintaining the conceptual validity of that model. Yet the natural process of birth appears to contest the technocratic model because the birth process confronts modernised people with vivid evidence that babies come from women and nature, not from technology and culture.
This dilemma for modern societies can be stated as follows: how to make the 
natural process of birth appear to conform, instead of refute, the technocratic 
model?

In developing its belief system, every culture must make the basic conceptual move of 
separating itself from the natural world that spawned it, of deciding and then delineating 
where one ends and the other begins. The description of the Aowin culture in Ghana in 
chapter five provides a graphic illustration of this separation. Yet because it is only 
through nature that new members can enter culture, childbirth calls into question any 
conceptual boundaries a culture tries to establish between itself and nature. Such a 
visible and constant reminder that we can never really separate ourselves from the 
natural world presents an especially serious challenge to modern cultures, for it 
threatens to undermine the promise of ultimate transcendence inherent in the 
technocratic model.

In the African context there appear to be two models at play - the model associated with 
tradition and magic and the other with the desire to transcend into a culture that 
emulates the technological cultures of modern societies. Both models - magic and 
technocratic - attempt to control nature and separate culture from the natural world for 
the same reason - because it presents a dilemma. A common cultural response to this 
type of conceptual threat is to wall it off from the mainstream of social life by creating 
categories of 'taboo' which are often reflected in actual social spaces specifically 
constructed to contain the conceptual danger (Douglas, 1966). An example here from 
fieldwork is the creation of birthing centres special areas in hospitals and birthing huts
in villages for the purpose of birthing. In Malaysia, America and the United Kingdom, birth mainly takes place in hospitals where the danger can be contained. In urban centres in Africa, women give birth in hospitals and in the villages, they give birth either in their own homes, or in specially created birthing huts.

A further widespread cultural technique is the careful and consistent performance of rituals designed to shape the inconsistent phenomenon into apparent compliance with society’s belief system (Vogt, 1976). Cultures took advantage of these techniques in their struggle to cope with the conceptual threat presented by natural birth. Childbirth has been tabooed and removed from everyday life by walling it off in hospitals. These institutions were specifically created to isolate most of the boundary-threatening reminders of human subordination to nature presented to society by the human body, including disease and death, as well as childbirth (Kearle, 1989; Miner, 1975 cited in Davis-Floyd, 1992:63). Finally, childbirth’s potential for conceptual upset has been defused by processing it through rituals specifically designed to eliminate the inconsistency between the birth process and both traditional and technocratic belief systems by making birth appear to conform, instead of challenge, those belief systems.

Modern cultures have a strong need to feel that they are in control of nature and their own future, and yet the birth process, on which the future of their society (still) depends, in many fundamental ways cannot be predicted or controlled.

So the dilemma becomes, how to create a sense of cultural control over birth, a natural process resistant to such control?
Hidden beneath the stubborn insistence on the mechanistic nature of childbirth, the truth of its ‘natural unpredictability and spiritual unknowability’ (Davis-Floyd, 1992:63). Because ritual mediates between understanding and acceptance and chaos by appearing to restructure reality, people in all cultures have chosen it as the most effective means of surmounting their fear of the mystery and unpredictability of the natural and cosmic universe. To accurately perform a series of rituals is to feel oneself following a trail of breadcrumbs through the forest, once on the path, the trail will inevitably carry one all the way through the perceived danger to a safe and predictable end. In the same way obstetrical rituals serve doctors, nurses and midwives. For as Davis-Floyd (ibid.: 64) pointed out, these routines psychologically enable medical personnel to attend births. Without their routines, childbirth attendants ‘would feel powerless in front of the power of nature, conceptually adrift in a category-less sea of uncontrollable and uninterpretable experience’. Like Davis-Floyd, I was often told by obstetricians in America, England and Malaysia, that they could not and would not attend home births for fear of not knowing what to do without their artefacts and security of the hospital routines around them. With their routines, however, doctors and midwives are empowered, physically and psychologically, to define and categorise the events of labour and birth that confront them, and to act confidently in terms of those definitions to impose cultural order on elemental nature, as is indicated in the following quote from Williams:

*Except for cutting the umbilical cord, the episiotomy is the most common operation in obstetric. The reasons for its popularity among obstetricians are clear. It
substitutes a straight, neat surgical incision for the ragged laceration that otherwise frequently results. It is easier to repair and heals better than a tear. It spares the fetal head the necessity of serving as a battering ram against perineal obstruction....[which] may cause intracranial injury. Episiotomy shortens the second stage of labor. (Pritchard and MacDonald, 1980:430)

Thus the obstetrician imposes surgical order on nature’s chaos. According to Enkin et al (1989:231), there is little evidence to support these postulated benefits of liberal use of episiotomy but obstetricians own belief in birth’s inherent danger made essential the development of rituals they could rely on to give them the daring to face daily the challenge nature presents. In consequence, the performance of obstetrical rituals had to take on the predictable pattern of a mechanical process. From the admission routines to ‘prep’ the woman in labour to the episiotomy, these procedures serve for birth attendants as the mechanisms that would mechanically activate and inevitably carry the birth process right through the perceived danger to a safe and predictable end.

Many birthing women who must individually face the same unknowns seek the same kind of psychological reassurance. Regardless of whether these women are traumatised or empowered by obstetrical rituals, these rituals usually provide at least a sense of certainty and security to women that their babies will be born, and that neither they nor their babies will die. Through ritual women are also shown that a natural process perceived as terrifying and uncontrollable can be controlled and rendered conceptually safe when its course is mechanistically channelled into predictable pathways.
3. Childbirth constitutes one of the most profoundly transformative and uniquely individual experiences of a woman’s life. Across cultures, people seek ways to generalise such experiences by turning them into cultural rites of passage to make it clear that the transformation is effected, not by nature, but by the culture itself. Moreover, the transformative period is used to inculcate the individual with basic cultural beliefs and values through ritual.

*So the dilemma is, how to generalise an individual transformation - that is, how to turn the natural birth experience, which left unshaped by ritual, would remain a purely individual transformation, into a cultural rite of passage?*

The naturally transformative childbirth process presents a conceptual dilemma that is faced by all cultures at various phases in the human life cycle: how to generalise an individual transformation. Generalisation is necessary to ensure conformity with the official social belief system given that undirected individual transformative experiences might challenge the dominant belief system. This dilemma is resolved in most societies by channelling individual transformation through established cultural conduits - the generalised process known as a *rite of passage* (Davis-Floyd, 1992:64).

Obstetrical procedures, through which modern birth is channelled, carry and communicate cultural meaning far beyond their ostensibly instrumental ends. Thus, they not only transform individual childbirth transitions into cultural rites of passage, but also resolve another potentially troublesome dilemma peculiar to a society that insists on appearing as rational, scientific, and non-ritualistic as possible. That is, how to make
birth into a rite of passage that transforms the initiates through inculcating them with core social values and beliefs, without *looking* ritualistic.

Unusually extensive elaboration of ritual is most likely to occur when the ideological system enacted by a series of rituals is not explicit. It is precisely because ideology is fragmentary and scanty that more persuasion and intensive communication of information is required (Moore and Myerhoff 1977:11). Unlike religious doctrines that are explicitly spelled out, the technocratic core value system of the culture, despite pervading modernised life experience in countless ways, are below the level of consciousness for most people. The enormous variety of most explicit religious, philosophical and ethnic core value and belief systems in America, for example, necessitates special efforts on the part of the representatives of society-at-large to preserve and to perpetuate its dominant core value system. Accordingly, the largest social institutions founded on the principles of that system, that comes into contact with the lives of the vast majority of American citizens, become primary socializing agents for the inculcation of mainstream America beliefs and values into young citizens. This begins with their birth in hospitals and continues throughout their lives as they encounter various societal institutions such as schools, hospitals, and religious, recreational and social agencies.

Moreover, most pregnant women, undergoing quite powerful and psychologically potent physiological and cognitive transformations, feel a very real need for social acknowledgement and cultural alignment to give meaning and order to this chaotic bewildering experience. It is precisely these needs, of course, which officially
conducted rituals are specifically designed to meet. In spite of the distinctiveness of each birth and each birthing woman, standardized obstetrical procedures provide this structure, which is the ultimately transformational process, the reassuring appearance of sameness and conformity to the socially dominant reality (Davis-Floyd, 1992:66).

4. **Rites of passage** involve a period of liminality (Turner, 1979) in which the initiate is considered dangerous to society, because the person is inhabiting a transitional realm between social categories deemed officially not to exist. The fact that it does exist threatens the culture's entire category system. Yet this danger, if properly handled, could be culturally revitalising, as it carries the alluring possibility of cultural change. Although too much contact with this danger can be culturally disruptive, some is essential for combating the constant dangers of anarchism which threaten to undermine those societies who fail to venture into the unknown.

*So the problem becomes, how to “fence in” the dangers associated with the liminal period in birth, while at the same time allowing controlled access to their revitalising power?*

Most initiatory rites of passage presents a fundamental paradox to the cultures that design them that lies in their official recognition and the publishing of officially non-existent transitional stages of being. The category systems of most cultures allow individuals to be either “here” or “there”, but not in-between. The very existence of in-between calls into question the absoluteness of “here” and “there” (Douglas, 1966). A
well-documented feature of ritual is that those in the liminal phase must be conceptually, as well as physically, isolated from the rest of society (Chapel and Coon, 1942; Turner, 1969), since their existence poses a threat to the entire category system of that society. Yet it is also well documented that this very threat can be of tremendous benefit to society, for in the process of the symbolic inversion of a culture’s category system, and thus of the culture itself. This brings us to the fourth conceptual dilemma presented to American society by birth: how to “fence in” the dangers associated with the liminal period in birth, while at the same time allowing controlled access to their revitalising power.

Roger Abrahams (1973) pointed out that a tremendous amount of energy is generated in the profound symbolic inversion of a culture’s deepest beliefs that is characteristic of the liminal period in initiation rites. He stated that although this energy may remain unfocused for the initiates, who often or not know exactly what is happening to them, it is focused and thus usable by the elders conducting the rite. Therefore, Abrahams suggested, initiatory rites of passage may be carried out as much for the benefit of these elders as for the initiates (1973:12). Jordan (1983:50) illustrates the symbolic process through which the focusing of the energy generated by the birth process away from the mother and toward the medical personnel, who attend her, takes place. This interactional pattern of focusing creative energy of birth onto the doctor works to revitalise and perpetuate the medical system in its present form, and thus American core value system is perpetuated as well. Many women attempt to reclaim this revitalising birth energy through subsequent, self-empowering births in the hospital and at home.
Babies are natural beings, born essentially culture-less. Yet people universally seem to insist that being culture-full is what makes people human.

*How to enculture the newborn?*

Birth is not a rite of passage for the newborn unless specific cultural actions are taken to make it so. Before the mechanistic model of the universe had diminished religious hegemony in the west, the symbolic inculturation of new members into society was mainly accomplished by baptism. In Ghanaian and other African societies inculturation is achieved through various ceremonies such as the naming ceremony among the Ashanti in Ghana. Babies in America, Britain and other industrialised nations are nowadays 'baptised' by examinations by the official representative of the society – the doctor. In the United Kingdom, midwives first perform this examination at birth, but it is often re-enacted by a doctor later. Weighing, testing reflexes are all rituals within a technocratic process that extends even to the alteration of physiology through the administration of vitamin K by injection, and in America, the administration of antibiotic eye drops. Medical procedures replace religious ones and whereas most cultures traditionally seem content to use their baptismal rites as a process of humanising the child, modernised processes, as Davis-Floyd (1992:68) states, in our arrogance or fear, use the entire set of birth rituals to re-create babies as cultural products.

Most human cultures are strongly patriarchal, American, African, Malaysian and British culture included. Yet childbirth, which men depend upon for their own and
their children’s existence, is a purely female event. Consequently, childbirth poses ‘a major conceptual threat to male dominance, as male dependence upon females for birth would seem to demand that women be honoured and worshipped as the goddesses of their society’s perpetuation’ (Davis-Floyd, 19992:61).

The dilemma therefore is how to make childbirth, a powerfully female phenomenon, appear to sanction patriarchy?

Ritual cleansing of women has been a feature of childbirth purification since ‘Churching’ of women following childbirth was conducted during Renaissance times in Europe (Reynolds, 1983). Childbirth was considered impure and the newborn was unable to go to heaven until baptised by a male priest. Thus the female phenomenon of birth was channelled into sanctioning patriarchy. The conceptual tension inherent in the paradox of childbirth as a female phenomenon evaporates in the face of hospital rituals. These procedures not only re-create birth as a mechanical process by which the baby is produced, it also makes the mostly male ‘manager’s of that process appear to be the producers. Thus patriarchy continues to be sanctioned by childbirth.

7 The technology and the institutions in which people place their faith for the perpetuation of culture are inherently asexual and impersonal. The process of childbirth, upon which the perpetuation of the culture depends, is inherently sexual and intimate. Consequently, its intimacy and sexuality constitute yet another arena in which birth threatens to undermine the conceptual hegemony of the technocratic model.
How do those responsible for the cultural management of birth devise culturally appropriate ways to remove the sexuality from the sexual process of childbirth?

Davis-Floyd (1992:69) suggested that if babies are to be technologically as opposed to naturally produced, and if their production sanctions patriarchy rather than equality, then sexuality is going to become an anomaly in relation to birth. Female sexuality has long been a problematic issue for westernised cultures (see for example, Freud, 1938). Sexuality today remains a potent conceptual threat to the creative powers of technology, and female sexuality remains the chief reminder of that threat. Modern societies have developed no more effective response to this conceptual dilemma than obstetrical rituals. Kitzinger (1972) and Newton (1973; 1977) stressed that birth is a normal female sexual function – a function that technocratic societies find threatening and labels as ‘defective’ and ‘taboo’. Hospital rituals are very effective at masking the intense sexuality of birth, so much so that women today are unaware of the sexual nature of childbirth.

The exclusion of the labouring woman’s partner in times when she is having intimate procedures, ensuring the partner stands at the head of the bed, rather than watching the happenings at the other end until the labouring woman is fully shrouded in sterile towels has the effect of desexualising birth. Moreover, intimate contact between the couple is strongly discouraged during labour and yet there is some evidence that nipple and clitoral stimulation are effective in strengthening uterine contractions (Field, 1985). Rather than encourage such activities, hospitals instead administer chemical stimulants.
Another example of desexualisation of birth is the routine performance of episiotomy. Some midwives and TBAs instead use perineal massage with warm oil, which is probably considered too overtly a sexual procedure for most obstetricians.

Modern and modernising societies remain strongly patriarchal, and yet are paying increasing lip service to the ideal of equality. Since growing numbers of women espouse this ideal, modern cultures will not survive in their present form unless these women can also be made to internalise the basic tenets of the technocratic model of reality.

This dilemma is one of the most intriguing: how to get women, in a culture that purports to hold gender equality as an ideal, to accept a belief system that inherently denigrates them? (Davis-Floyd, 1991:61)

This final conceptual dilemma, which confronts modern or modernising societies constitutes a potential cultural bombshell in Davis-Floyd's (1992:71) view. British and American culture have for some time attempted to address the knotty problem of gender inequality. The espoused ideal is one of equality and yet official societal systems and their representatives remain stubbornly patriarchal. For me, as for Davis-Floyd, the decoding of the symbolic messages buried in the scientific disguise of hospital routines leads to a chilling reminder of the twin political threats presented to women by the technocratic model of reality. This model deprives women of their innate uniqueness and power as birth-givers whilst perpetuating the cultural belief in women's innate physiological inferiority. Yet, because of the potential for egalitarianism inherent in
technology, this model does contain certain conceptual advantages for women which, in the early part of the last century, proved alluring enough for many women themselves to actively work for the cultural adoption of this model of birth. Today the technocratic model offers women freedom from biological constraints that many increasingly desire.

The birth process in American culture is and always has been a matrix of gender differentiation. In the 1800s, when most women gave birth at home, motherhood was the central defining feature of womanhood, and women's appropriate domain was the home. Early feminists eagerly sought technological hospital birth, in the hope that is would constitute a positive step toward true equality of the sexes through removing the cultural stereotypes of women as weak and dependent slaves to nature. (Davis-Floyd, 1992:71).

In America, for example, many early feminists went to great lengths to achieve anaesthetised births (Wertz and Wertz, 1989:150-154) that ultimately lead to women being strapped down to delivery beds. Instead of leading to equality, in its unmitigated classification of the female body as an inherently defective machine, the technocratic model reflects and perpetuates the profound cultural belief in the innate inferiority of women. Thus modern society is faced with the dilemma of how to persuade women to accept a belief system based on the body-as-machine metaphor, given that the system entails the principle of the male as the physically and intellectually superior member of the species.
Some of the dilemmas are universal problems presented by the childbirth process to all societies. From fieldwork and research in Africa, Malaysia, America and Britain, it appears that for those societies, the dilemmas presented by childbirth are fundamentally the same. There are, however, varying degrees of concentration dependent upon the degree to which western ideologies and practices have penetrated, particularly in the context of the urban-rural divide. Each dilemma contains within it a fundamental paradox, an opposition that must be culturally reconciled lest the anomaly of its existence undermine the fragile conceptual framework in the terms in which society understands itself in relation to the world. Thus any society's ability to perpetuate its belief system depends greatly upon offering its members a variety of ways to mediate those conceptual oppositions that constantly threaten to tear it apart. As Davis-Floyd (1992:62) pointed out, the cultural responsibility for mediating these eight dilemmas in which birth and modern or modernising cultures are fundamentally opposed lies with the obstetric profession. The response of the science of obstetrics to this cultural challenge has been:

- to work out carefully a strong and consistent philosophical rationale for the management of birth which interprets birth specifically and exclusively in terms of the technocratic model;

- to develop a set of ritual procedures that could be uniformly applied to the natural process of human reproduction in order to transform it conceptually into a cultural process of human production, similar to the production of any other technocratic artefact.
Implicit in the dilemmas is the curriculum issues that we will come back to in chapters 11 and 12. The following four chapters will attempt to demonstrate exactly how this socialisation is taking place in Africa, Malaysia, America and England (appendix 1 contains details of field work undertaken in each country) through rituals of modern obstetrics operating under the full force of the belief and value system transmitted under the conditions of globalisation and will begin to raise questions about the curriculum which will be drawn out explicitly at the end.

Each case study chapter presents only a glimpse on reality taking a different part of the pond at roughly the same time. In this I present only a personal perspective and in a sense it is impossible to paint a whole picture and is not intended to be representative. The glimpse, however, gives and impression of the balancing act of women and midwives under the conditions of globalisation and localisation.
Chapter 5

Childbirth in Africa

Characterising African Rural and Urban Society

In Africa, village society still forms the context in which many present-day urbanised people were born, and where some will retire and die. Until recently, the polarisation between town and village dominated African anthropology. It is crucial to realise that in the twentieth century, even with reference to rural settings, we are not so much dealing with 'real' communities, but with rural people's increasingly problematic model of the village community. For van Binsbergen (1999) the village has become a virtual village. Throughout the twentieth century, rural populations in Africa have struggled, through numerous forms of organisational, ideological and productive innovation combining local practices with outside appropriations, to reconstruct a new sense of community in an attempt to revitalise, complement or replace the collapsing village community in its viable nineteenth century form.

If the construction of community in the rural context has been problematic, the village yet represents one of the few models of viable community among Africans today, including urbanised people (van Binsbergen, 1999). In dialogue with urban dwellers in Ghana and Malawi, the village personifies the cultural ideals of community, sharing, collectivity, history, continuity, boundaries, identity formation, family, trusts, cultural alignment and spirituality. Figure 5.1 illustrates in graphic form the contrast between
traditional societies and modern societies, as perceived by participants during dialogue and is reinforced in the description of the emerging differences between the herbalist and spirit medium in figure 5.2. Modern societies are perceived to individualistic in nature where ties between individuals are loose and people are expected to care for themselves (see also Hofstede, 1991:261). By contrast traditional societies were perceived to be concerned with collective and integrated communities producing strong cohesive groups that protect individuals throughout their lifetimes. I would argue that for development workers as for indigenous people, the weakest point of any relationship
is at its interface with potentially conflicting worldviews that can either cause cultural collision in which the worldviews clash and create disorienting dilemmas or there is a symbolic exchange worldviews leading perhaps to a creolisation of cultural practices.

When central reproductive institutions of the old village order, including rituals of kinship, are already under great pressure from new and external alternatives in the rural environment, one would hardly expect them to survive in urban contexts (van Binsbergen, 1999). Urban life is obviously structured, economically and in terms of social organisation, in ways that would render all symbolic and ritual reference to rural-based culture, obsolete. Why would people pursue apparently rural forms when socially, politically and economically their lives as urbanised people are effectively divorced from the village? Staging a rural kinship ritual in town would be held to restore or perpetuate a cultural orientation which has its focus in the distant village not in the intangible ideal model of community, but the actual rural residential group on the ground.

The enactment of rural rituals in urban settings is concerned with the construction of meaningful social locality out of the fragmentation of social life as experienced in urban settings in Africa and Malaysia and beyond that with the social construction of female personhood. This involves the active propagation of a specific ethnic identity among urban migrants, which serves to conceptualise an urban-rural community of interests, assigns specific roles to villagers and urbanised people in that context (the townsmen would often feature as ethnic brokers vis-à-vis the outside world). In this way they effectively re-define the old localised and homogeneous village community into a de-
localised ethnic field spanning both rural and urban structures, confronting ethnic strangers and organising those of the same ethnic identity for new tasks outside the village. In this ethnic context, the urban staging of 'traditional' rural ritual would be explained as the self-evident display of ethnically distinctive symbolic production. If urbanised people stage rural kinship rituals in town it is not because they have no choice. Since rural relationships are largely reproduced through rural ritual, urbanised people stage rural-derived ritual (often with rural personnel coming in to town for the occasion) in order to ensure their continued benefit from rural resources: access to land, shelter, healing, historical political and ritual office.

What I saw in Africa was neither a rejection of the old nor the complete adaptation to the modern but an amalgam of both, creating something very different from either traditional or modern - creolisation.

This chapter examines the symbolic exchanges (Waters, 1995) that women and midwives have experienced in the last few decades by means of narratives collected from women. The women whose stories form the basis of this chapter were all living in the Western and Eastern Africa in 1991 when I was carrying out my research into Safe Motherhood Initiatives. Many changes have affected Ghanaian and Malawian women's lives over the past few decades - political insurrection, violence, poverty, etc. As the chapter unfolds some of the changes are revealed as the following questions are addressed:
The questions

How is childbirth being reconstructed in Ghana and Malawi?
What are the symbolic exchanges that are creating the ‘space’ for these changes to occur?
How do these exchanges impact on?
- women
- birth attendants
- professional midwives?

The chapter foregrounds the stories of women to illustrate their experiences as they go about their daily lives. In short, I seek to demonstrate that childbirth is being culturally transformed in Africa through the process of symbolic exchanges of childbirth rituals, into a medically-dominated initiatory rite of passage through which birthing women are taught about the superiority, the necessity, and the ‘essential’ nature of the relationship between science, technology, patriarchy, and institutions. I will show how this socialisation into modern society’s collective core value system is accomplished partly through obstetrical procedures and partly through western educational ideologies. The rituals of hospital birth are not only exhibited in hospital facilities but are being replicated in every village where government trained Traditional Birth Attendants (TBAs) practise – notions of sterility, dorsal position for delivery, examination, recorded and timed births and so on are being embedded. I have presented illustrations of how these procedures work to map the technocratic model of reality which underlies modern societies core value systems onto the birthing women’s perceptions of her childbirth experience, with the goal of achieving complete conceptual fusion between this technocratic model and belief system of birthing women.
Abena: Ghana

Whilst visiting a small village outside Tamale in Ghana, I was present at a birth conducted in what I interpreted to be a traditional style. The village women sat around the hut where the woman was giving birth. They sat and told stories of their own births and the history of the birthing woman. They spoke of her birth, how the midwife had helped her into the world. They spoke of how the girl had grown and of her place within the village community. These women conveyed a message of continuity across time but contained within the confines of one place – the village. They plotted the passage of time and the changes they had seen over the years. First they explained about the advent of the training of the TBA. The village elders had selected Akua to be trained. It was considered a great honour and there was much excitement. Then came the building of the birthing hut. All the villagers took part in creating a place for birth. Where the women could go to have their babies away from the family home – in peace and quiet. They told of the gathering of the women at these times to make the traditional (ritual) porridge to feed to the labouring woman to give her energy. They described a community of women that provided not only physical support through their presence but emotional and spiritual support through their united protection from harmful agents. The creation of a birthing space. From time to time the women would sing, clap and dance perhaps to convey their unity through the ritual enactment of warding off harmful spirits.
Huddled in a corner of the hut Abena lay on the floor, or rather on a piece of thin cloth that was once brightly coloured. No cushion or comfort as we would know it. No pillow for her head and no mattress for her back. She lay curled into a small ball on her left side. Her pregnant and contracting uterus protruding from her thin frame. No sound came from her. No sound came from Akua, the midwife either. She was seated in the corner of the dark hot hut, waiting. Suddenly Abena gave a low whimper and she hauled herself into a sitting and then squatting position. Akua crept over to her and gently supported the Abena’s back as she bore down. No words, no commands, no yelling. The expulsive contraction was handled in a quiet and dignified fashion. Once it was over, Abena lay down on the ground again to rest until she was required to continue the process of giving birth. Her body was well practised in the art of birthing. She had had four children before. Another contraction gripped Abena and she lumbered up into her squatting position again. This time, the Akua crouched in front of her, waiting. The head appeared gradually, slowly making its progress into the world. How did the midwife know that it was time? No words had been spoken by either of them. It was almost mystical. A kind of unseen language passed between the woman and the midwife. It was as if Abena’s body had communicated its readiness to the midwife and she needed no verbal information to guide her in what was happening to her at that precise moment in time. A soft whoosh and the baby’s body was born into the steady and confident hands of the midwife. And still there was no sound. The baby did not cry, not because there was a problem, but because it was a gentle birth. The baby was breathing and at once handed to his mother (Ghana, October 1991).
The Reconstruction of Childbirth in Africa

In global health development, the term Traditional Birth Attendant (TBA) is used to refer to the diverse kinds of people who assist women in childbirth. The term TBA is a one commonly used in health development discourse. The abbreviation TBA stands for a complex process of translation from which it is produced and not simply for more cumbersome generic term. TBA is an especially interesting term because it refers not to development's internal world, as do abbreviations or acronyms for agency names, but to features of the societies that development aims to change (Pigg, 1995). This abbreviation substitutes for other words in the languages of specific cultures. It is not a matter of simple abbreviation of terms in English; they foreshorten the space separating a local cultural world in which people call on certain healing specialists and an international world of health service management.

The language used by the global development authorities for talking about various indigenous healers, including midwives, has, it is argued, practical consequences. Pigg (1995) who considered that development institutions act as the locus of authoritative knowledge while devaluing other, local forms of knowledge would support my argument. Paradoxically, this devaluation of local practices occurs even as development programmes explicitly seek to work with local practitioners. Programmes for training TBAs in Ghana and Malawi offer the basis of a case study that shows how development systematically dismantles different sociocultural realities whilst taking them into account.
Training programmes are based on a particular way of translating local African frameworks for understanding and managing birth into a generic model of birth assistance. Such translations are always problematic because the categories, values, and practices at work in one cultural context never map perfectly onto those of another. Health development initiatives that aim to spread scientific medicine and health knowledge in places where other idioms of care and healing exist face the issue of translation in their practices. Training for indigenous healers and birth attendants has been encouraged by the World Health Organisation since the mid-1970s with the launching of the Safe Motherhood Initiative, as one means of achieving this goal. These training programmes seek to enhance, rather than replace them with other medical practices, by improving health service delivery through cooperation with existing indigenous systems. In the course of their implementation, however, many such programmes flounder on the ideals of "enhancement" and "cooperation." In the first place, as fieldwork revealed, it is not easy to identify whom to train, or to communicate often unfamiliar medical principles to trainees, or to introduce new practices into existing routines. Nor is it clear how indigenous practices are to be respected when the explicit goal of these programmes is to alter them as is clearly illuminated in Mama Yawa's story overleaf.
The lesson that day began with a repetition of the main points they had covered the previous week. Sister stood in the centre of the clinic delivery room, which had been converted into a cramped lecture hall. The bed had been pushed into the middle and served as a stage on which various parts of the delivery were mimed. Sister smiled importantly round at her audience, asking for a volunteer.

One woman got up readily and, amidst murmurs of encouragement, pretended to heat some water into which she dropped some pieces of cotton. She then spread out two empty plastic sacks in front of a cardboard box that represented the labouring mother's torso. Repeating, in word and gesture, the previous lecture, she carefully wiped - from top to bottom, one side at a time, with some little pieces of cloth - round a hole cut into the side of the box, through which the baby represented by a brown nylon stocking knotted and sewn into a baby shape was delivered, followed by a sizeable length of plaited rope representing the umbilical cord.

"On no account should any medicine be put on the cord" she intoned, pretending to tie the boiled cotton threads round it.

Mama Yawa didn't need to watch. She knew the sequence by heart; had even practised it in real life just the previous night. The difference was that the woman she delivered had squatted on the floor in the traditional way and was not conveniently displayed on a waist-high clinic bed; her torso was tilted half-vertical, half-reclining - not spread-eagled on its back the way the box on the bed was. Mama Yawa had had to kneel on the cold beaten mud and bend right over to catch the first glimpse of the baby's emerging head. And then there was the mixture she had put on the cord - in direct contradiction to the clinic's teaching.
The women applauded as the first volunteer lowered a cotton sanitary towel over the gaping hole, to mark the end of her demonstration. Sister stood up again, smiling her approval, then, turning away from Mama Yawa's corner of the room, she asked if there were any questions.

Mama Yawa hesitated, intimidated by the way the nurse had so pointedly averted her body. But she caught the eye of the other nurse - who occasionally brought her own children to Mama Yawa for treatment. That nurse nodded encouragingly and Mama Yawa put up her hand.

"Yes, Mama Yawa, what is it this time?" Sister sighed, like a harassed parent addressing an irritating child. Mama Yawa asked her question. She was worried about the cord, she said. In her many years of practice - and she tried to stress the length of her experience - she had come to recognize several abnormalities of the umbilical cord, each of which could make a baby dangerously ill if it were not treated promptly by the application of some preventative potion. Everyone knew - and here she looked round at the circle of women who were listening attentively and nodding - that a baby was very susceptible to diseases carried by bad air. Bad air could enter the child by many routes, but the cord navel was one of the most vulnerable points. If they were forbidden to put anything on the cord, or give the child any medicine when it was born, how could they stop the bad air entering and the baby falling ill?

What exactly were these abnormalities of the umbilicus? Sister wanted to know, indicating by a raised eyebrow that she did not really take Mama Yawa seriously. Undeterred, Mama Yawa went on to describe in great detail certain subtle changes in skin colour and texture and in the outline of veins and arteries. She had studied these painstakingly over the years in an attempt to account for subsequent ills suffered by the children in her care. She was convinced that there was a pattern. But she failed to convince Sister, however, who stood and smiled indulgently. "All the symptoms you describe are perfectly normal," she pronounced kindly and dismissively. "There's no need to treat them at all." Mama Yawa kept standing for a while, wanting to continue
the discussion, but Sister ignored her and went on to repeat her warnings about cord hygiene and eventually Mama Yawa sat down again.

The conflict raged in Mama Yawa's mind between the demands of her traditional understanding as a spirit medium and the newer demands of a changing culture and the demands of her TBA training in particular (Malawi, November 1991).

Such is the experience of many TBAs I interviewed in Ghana and Malawi. Stories told by midwives in Malaysia also confirmed this dilemma for the TBA as was seen in the story about Azizah, where the TBA, Mek Limah was loath to undertake her traditional role in the presence of the professional midwife. These conflicts were not confined to untrained midwives either. I also found that such conflicts were experienced by professionally trained nurse-midwives in all the case study countries where they had acquired knowledge through considerable experience that did not match the official lessons they were taught in class.

At issue in training programmes is how different knowledge systems are brought together. Brigitte Jordan ([1978] 1993) observed that training programmes for traditional midwives presented cosmopolitan obstetrics as authoritative. They rendered indigenous knowledge illegitimate and indigenous ways of knowing invisible. The lesson most effectively learned by midwives and nurses was how to present themselves to the official health care system and how to legitimate themselves by using its language.

Instead of working with indigenous knowledge and ways of knowing, the training I observed attempted to override existing knowledge and practices. Trainers worked from
the implicit assumption that the midwives knowledge was wrong or inferior to the medical knowledge being presented. Jordan, drawing on her experiences concluded that by not recognising indigenous knowledge, "cosmopolitan obstetrics becomes cosmopolitical obstetrics, that is, a system that enforces a particular distribution of power across cultural and social divisions" (Jordan, 1993:196).

Pigg (1995) looked more deeply into the ways this power asymmetry was produced. Despite a widespread appreciation of the need to take indigenous knowledge into account, training programmes continued to serve the "cosmopolitical" function of establishing medical obstetrics as authoritative. Jordan's insightful analysis showed how this occurred in the classroom where midwives were trained. Pigg considered that indigenous knowledge was rendered invisible long before trainers met midwives. Training programmes, whether in Ghana, Malawi, Malaysia, or elsewhere, are embedded in a wider discourse of health development, socioeconomic politics and global imperatives that systematically produces the authoritative relationship to local cultures.

There are three issues of translation that arise in training programmes for TBAs. First, there is the problem of identifying who should be recipients of training. For example, in Ghana it became apparent that despite the diverse range of practitioners including private midwives, TBAs, and government midwives, women in childbirth were seeking alternative sources of assistance. One private midwife reported that she believed that women were going to the spiritualist church for delivery. It became clear that there was
a group of people who had not been identified for TBA training but who were practising.

Second, there is the problem of modifying medical messages to local contexts. Third, and least apparent to development professionals themselves and virtually unexamined in applied development writing according to Pigg (1995), is the problem of translating a medical model that views physical processes as separated from social contexts to other conceptualizations of well-being and illness. This is illustrated further in the following section describing the changing culture among the Aowin people of Southwest Ghana as described by Victoria, (1991).

The Aowins are a matrilineal people whose political and social organization closely resembles that of the neighbouring Asante (Busia, 1954; Fortes, 1950; Rattray, 1923). They have a hierarchical political structure in which judicial and ritual authority rests in the office of the paramount chief who carries out his official duties with the help of the other members of his court, the Queen Mother, the village chiefs, the court and the spirit mediums. The female mediums are responsible for mediating between the Aowins and the spirit world and it was their official duty to maintain the well being of the town. (Victoria, Ghana, 1991)

In times of crisis, for example during epidemics, drought or heavy rains, the mediums perform the communal ritual, known as the momome in which they sweep the streets of the town and outline its borders in white clay. They define the boundaries between the town and the forest and in this way express the polarity between the social universe and the world of mystical power. A harmonious relationship between men and the spirits depends on the maintenance of these boundaries. The mediums also enforce certain practices such as the use of space in town, the observance of sacred days and ritual prohibitions that form the pattern of everyday life.

In addition to their official role, the mediums also act as individual practitioners and are asked for their diagnosis and treatment of illness and affliction. In this capacity the mediums are in competition with the male herbalists who have their own distinct view of
illness. Among the most common complaint they hear are those related to childbearing and infertility.

Nowadays all the spirit mediums are women and the herbalists are men, although until about 15 years ago men, too, acted as mediums and the role of the head medium was always held by a man (see Ebin, 1982: 142). This change follows a pattern seen in other roles as well. Men generally receive an education that qualifies them for better jobs. They can, therefore, abandon some of their former positions in favour of those that bring them greater income and prestige. Older women, who are generally illiterate, have access to a comparatively narrower range of occupations but they can now begin to move into the positions abandoned by men. It appears also that the restrictions imposed on the medium's personal life, as well as their official responsibilities, has less appeal for men than previously.

Men do act as healers, however, and claim to have access to mystical power, but with the important difference that they do not act as mediums of the spirits. In contrast to the roles of mediums, herbalists can practise their profession as it suits them. They are not under the authority of the chief and are not obliged, as mediums are, to use their mystical powers to protect the community. In other words, the spirit medium is concerned mainly for community healing whilst the herbalist, adopting a modernist approach is solely concerned with specialisation, individualisation, and technical skills. It is interesting to note, however, that for many herbalists, both rationality and magic coexist.

The spirit mediums, in their interpretation of misfortune, emphasise harmonious social relationships. The tension and hostility between two individuals can threaten the well being of the entire community. Often the mediums will act as informal adjudicators and will intervene to give their opinions in cases of dispute. For a woman who is experiencing reproductive complications, her social relationships are a central issue in the diagnosis of her complaint. (Just as women in Malaysia, as identified in the story about Azizah, the woman must reconcile her relationships with her kin and neighbours as well as her husband). The medium organises the reconciliation and calls upon them
to attend this final stage of the woman's treatment. After the purification has been performed and the woman is dressed in white they all share in a ceremonial meal.

The medium's treatment is directed towards maintaining the fabric of social life (see Ebin, 1982:153). In her view of the world, good health depends on good behaviour. She attempts to regulate the quality of life within the town, she urges good social relations and cohesive kin ties and upholds a certain order in community life which is manifested in the use of space and in maintaining the boundaries between states of purity and pollution.

Unlike the mediums, herbalists are not part of the political hierarchy and are not under the jurisdiction of a superior. While the mediums emphasise the conservative values associated with political authority and the traditional standards of behaviour, herbalists make use of their western education and exposure to western ways. Some are well educated by local standards and speak English. On the whole, these men form a prosperous group: some are cocoa farmers, mechanics. School teachers and craftsmen. For all these men western thought has played some part in their healing techniques and they augment their traditional remedies with the terms and concepts they have learned from school science books.

The herbalist spends his time leaning the properties of leaves and the appropriate remedies for specific afflictions. Even after the apprenticeship has ended he continues to learn new remedies. The herbalists trade such knowledge with each other and sometimes travel great distances, to Upper Volta and the Ivory Coast, to acquire new and, they hope, more powerful healing remedies and charms with magical powers. The acquisition of this sort of knowledge is essential to attracting new clients and forms a basis of a herbalist's prestige. They energetically collect new formulas and recipes that are quickly discarded in favour of new and more sensational cures.

As outlined in the figure 5.2 overleaf, we begin to see the symbolic exchanges being made by the herbalists who are appropriating into their everyday lives and practise
elements of modernity. This manifests itself in pseudo-scientific approaches and specialization, in obsolescence of knowledge and of forming 'expert' communities with those who are likewise specialized. Mobility is also important as they move around the country collecting recipes and sharing knowledge. The women encountered during fieldwork were much less mobile. It would be a short step to picture these herbalists in a western setting, attending conferences and reading the latest journals. Additionally, there is a sense of professionalisation emerging from this description. Furthermore, we being to see the 'body as machine' metaphor creep into their practises as follows.

Figure 5.2 Symbolic Exchanges Amongst Herbalists

The Herbalist

In his treatment of illness the herbalist relies on the knowledge he has acquired. His techniques are based on the patient's physical symptoms. While the medium immediately looks for an explanation of affliction in the woman's social relationships, the herbalist offers an explanation based on an anatomical model of the processes necessary for conception. Some of the herbalists use their interest in lorry engines to explain the dynamics of human physiology. They compare the human body to a lorry engine with its intermeshed gears and power-charged batteries (Ebin, 1982:145). The treatment of the herbalist is directed to the patient's complaint. He is not interested in her personal relationships, either with the community or with the spirit world. Her behaviour does not affect her state of health and to this healer she does not have to explain her conduct. The herbalist's focus on the physical aspects of her affliction represents a departure from the world-view of the medium. Here then we see the separation of the body from the social being as in western medicine.

To the herbalist, with his emphasis on learning and models of the workings of the body, childbearing is not part of an overall worldview. To him it is a different sort of problem, one, which can be seen as a discrete and isolated occurrence, and not one that reflects the core of human relationship with the social and mystical worlds.

The Spirit Medium

For the mediums, infertility, for example, is not seen merely as an individual malady but it becomes the focal point from which to view the client's relationship with the social and spiritual universe. Disorders of childbirth or infertility reflects a disturbance in the community; it is an index of the quality of social relations between men and the gods and are highly threatening to the community; they are a violation of the order that separates the social universe from the spirit world. The medium's treatment revolves around the transformation of the opposed concepts of dangerous and safe, heat and cool, polluted and pure. These themes are conceptualised during the treatment in the use of space between the forest and the town and in the use of red and white. As a healer, the medium is concerned not with the individual client but with the well being of the community as a whole. In her view of the world, every member of the society is a catalyst to which others are vulnerable. She treats the infertile woman and at the same time protects the community from the harm she may bring. The medium seeks to control and regulate childbearing. Sexuality and childbearing are brought within the domain of culture and are integrated into an overall view of the social universe.
This account illustrates for me the diverging experiences of midwives and medical men. On a crude level one could equate the experience of the spirit mediums and the herbalists with the historical and continuing diverging experiences, world views and practices of midwives and doctors all over the world.

A major force for symbolic exchange seems to be the Westernization of thought and the subsequent implications for practise. The education and language of the herbalists seems to be implicated in their separation from their cultural worldview and practices. From my fieldwork there is clear evidence of an increasing Westernization of traditional TBA and childbirth practices, but using a set of images that may have been true fifteen years ago, but has since changed in most industrialised countries in the North. The diffusion of innovation that accounts for the new practices being introduced for TBAs and herbalists alike, seem also to not only appropriate the new but incorporate the old ways. This incorporation of new ideas into traditional beliefs appears to lead to an entirely new form of practice. This was clearly the case for the herbalists who incorporated their new learning into traditional beliefs about the body and conception but juxtaposing these with the new models of the body as machine, and the new concepts of individualism (see Keddie, 1980 for discussion on ideology of individualism).
Madam Nancy is a fifty year old TBA in Gondanu, a small village near Hohoe. She had been in practice for 14 years and her grandmother was a TBA. Nancy is the only TBA in the area with a population of 4000 people to serve. Nancy is now training her eldest daughter. She had formerly delivered women in their homes but since her training, the villages have built her a birthing hut.

(Nancy's story was translated by Victoria, Ghana, 1991)

I visited Nancy on a day when several women were in labour. A young woman of about twenty was pacing the room. Nancy just sat quietly watching her. She told me that she could assess the stage of labour from the way the woman was breathing and moving. Later Nancy told me that she did perform vaginal examinations to assess progress in labour. When the woman was about to deliver, Nancy took her into the birthing room and encouraged her to lay on her back on the platform built especially for the purpose of delivery.

Following delivery, Nancy completed her register of births and gave the mother a mini birth certificate which she could then take along with the baby weighing card, to the official registrar of births and deaths. After delivery, the newly delivered mother would stay with Nancy for 24 hours.

I asked Nancy about any complications she may have encountered. She informed me that she recently referred a woman with a transverse lie for caesarean section and that in the same week she detected a ruptured uterus on vaginal examination. The latter woman presented late in the first stage of labour and Nancy referred her directly to hospital.
The use of herbs was fundamental to Nancy's practise, although she would not divulge which herbs she used. This information was jealously guarded and only passed on from mother to daughter. She did tell me that she generally used herbs for perineal softening, retained placenta, post-partum haemorrhage, and cord care.

Nancy's level of knowledge and experience was indeed impressive from a modern perspective. It was significant that she had abandoned traditional positions for birth currently becoming increasingly popular in Britain, in favour of an approach research had shown to be detrimental to the health of mother and baby. Moreover, she had exchanged traditional practices for western symbolic rituals such as vaginal examinations, and record keeping, which is mainly concerned with the concept of surveillance and control.

**Modern Rituals and Childbirth Practices**

**Ritual Confusion**

Flora was a midwife, who had trained in the UK, before returning to Ghana to be posted to one of the two major teaching hospitals. She worked in a large urban centre in England more than 20 years previously and had learned a great deal about pregnancy and labour care during her training. The hospital had a team of doctors and comparatively well equipped delivery wards.

Yaa was a young woman who had moved from the rural area to live and work in the city. (Ghana, 1991)

The contrast in the next story is sharp in relation to the story of Yaa and her midwife, Flora

Yaa was admitted to the hospital after waiting for several days under a tree outside. She was determined to give birth in hospital. The delivery room was very crowded. Several women were in labour and two of them were giving birth as Yaa was wheeled in. There was no spare bed so she was left on the trolley. Later as I was 'doing the rounds' with the obstetric team and I saw Yaa in one corner of the large room, a midwife was about to deliver her baby. The midwife was shrouded in green theatre gowns, gloves on her hands and a hat a mask almost
totally concealed her face. She was mumbling something to Yaa. She grunted in response and began to push—otherwise she was silent. The baby’s head appeared. This happened in full sight of everyone present. There was no apparent concept of privacy. Moreover, neither I nor the doctors and other visitors were gowned in theatre attire as we wandered through the delivery suite.

Childbirth in the hospital context had truly become a public spectacle. Yaa was laying on her back with no pillows for support. The emergence of the baby was witnessed by all present. The following day, on visiting Yaa, she expressed her pleasure in having had her baby the modern way. Only peasants squat and only peasants had their babies at home. During a discussion with Flora about the delivery, she expressed satisfaction that the woman had survived.

One of the key features of modern birth practices observed during fieldwork in Ghana and Malawi was the growing acceptance and desire for hospital birth where there was increasing standardization of practices and confirmed during focus group meetings of senior midwives (1991). For example, on entering the hospital, birthing women were separated from their attendants; their clothes removed and ritual vaginal examinations among other measurements of her bodily functions were performed. In no cases in hospital births did I see women supported by either their husbands or female friends or relatives. The labour wards were much too busy and there was, at that time, still a belief that childbirth was women’s business, except among the more ‘modern’ middle-class wealthy families who could afford private maternity care.

As the moment of birth approached there was an intensification of activities performed on the woman. In two hospitals I observed women labouring in the antenatal ward and once ready to deliver was transferred to a delivery room. The midwife or doctor
routinely placed women on their backs to allow greater access; sometimes the woman was placed in the lithotomy position, covered with sterile towels and washed down with antiseptics. After the birth the baby was handed to the mother. Meanwhile she was given an injection to make her uterus contract and then her placenta was routinely extracted. If an episiotomy had been performed, it was sutured and finally the woman and her baby were cleaned up and transferred to a hospital bed and cot.

All of these activities have ritual purposes in modern society and for the object of brevity; I will only focus on two rituals for discussion. The first ritual concerns the removal of the woman's own clothes with a hospital gown. This ritual effectively communicates the message that she is no longer autonomous, but dependent on the institution. The gown indicates the woman's liminal status (Turner, 1969:95).

Liminal entities, such as neophytes in initiation or puberty rites, may be represented as possessing nothing. They may...wear only a strip of clothing, or even go naked, to demonstrate that as liminal beings they have no status, property, insignia, secular clothing indicating rank or role...Their behaviour is normally passive or humble; they must obey their instructors implicitly, and accept arbitrary punishment without complaint. It is as though they are being reduced or ground down to a uniform condition to be fashioned anew. (Turner, 1969:95)

The gown begins a powerful process of the symbolic inversion of the most private region of the woman's body to the most public. Its openness (at the back) intensifies the message of the woman's loss of autonomy for not only does it expose intimate body
parts to institutional handling and control, it also prevents her from simply walking around. The gown labels the woman as belonging to the institutions (Goffman, 1961). This ritual also intensifies the strange-making process and the further breakdown of the initiate’s category system.

In Africa hospital gowns are comparatively rare items since the institution may not have the finances to provide all women with gowns. The women observed in hospital settings tended to wear their own cloths wrapped around them. These however were precarious since beneath them the women were naked and the doctors would frequently simply draw the cloth up or open without asking permission, to examine the women. The absence of seeking consent reinforced the message that the women belonged to the institutions and could be intimately touched and controlled at any time. The women observed were indeed passive and accepting of any procedure performed upon them. They had been reduced to a uniform, almost invisible entity to be recreated in the medical image.

In the case of pain relief, there seems to be a fundamental assumption in western culture that pain is bad. As a microcosm of society’s culture, in the condensed world of childbirth western cultural values stand out in sharp relief, the medical fraternity constantly seeks to demonstrate the negative value of pain. Pain reminds us of our basic human weaknesses, like childbirth, it reminds us of our relationship to and dependence on nature. Since modern medicine operates from the basis of the body as machine metaphor, and machines do not feel pain, it is hardly surprising that medical practitioners feel uncomfortable with women in childbirth experiencing pain, which
presents a challenge to the technocratic model. Birth without pain removes half of that
threat bringing us closer to the long-term goal of technological transcendence.
Analgesia administered to women intensifies the message that their bodies are machines
by adding a clear statement, in the case of epidurals, that their bodies as machines can
operate without them. This message would not have been possible without our cultural
notion of the separation of the mind and body — a basic tenet of the scientific-
technocratic model. This is a model that is being globalised. In developing countries,
however, as previously stated, such a model may well have long-term consequences for
women who may receive and accept the model but are unable to afford this type of care
or the drugs may well be unavailable in the hospital. In some countries the only
medication available for pain relief is aspirin, which is clearly inadequate.

Extending Medical Care - Risk Concept and Life-Saving Skills Training

The policy in both Malawi and Ghana was for all nurses to undertake midwifery
training, and the majority of midwives practising in both countries were enrolled
(second level) nurse-midwives. They practise in hospitals, health centres, health posts
and mobile units. They do not undertake any care in the home. Midwifery practice in
hospitals was very similar to that of the UK some thirty years ago. The challenges
facing African women and midwives, however, were not the same as those for women
and midwives in the UK. High levels of maternal deaths due to poor health as a result
of poverty and indigenous diseases created complications that required midwives to
have skills far beyond those needed by British or American midwives.
During fieldwork in Ghana, I spent some time with midwives undergoing a two-week training programme in Korforidua where they spent a minimal time in the classroom and the rest of the time on the maternity unit. The two-week experience was on a continuous twenty-four hour basis. Participants slept on the ward, sometimes on the floor if there were insufficient beds, to maximise their clinical experience and to avoid missing cases. Following completion of the programme, the midwives received their own life-saving skills pack which included a vacuum extractor, suturing kit, patella hammer, local anaesthetic and documentation.

Dora had been asleep when the call came. A woman had just delivered and she was bleeding profusely. Could she come to the labour ward quickly? Earlier that day Dora had sat in the classroom with the other eleven participants, listening to the tutor talk about and demonstrate how to conduct a bi-manual compression to staunch haemorrhage.

On arrival in the labour ward, I saw Dora being instructed by the doctor who was supervising her in performing a bi-manual compression. He proceeded to explain the process to me in detail. Once the bleeding was under control, Dora was able to express her feelings about the experience. This had been the first time she had performed what she considered a ‘doctor’s’ job. It was exhilarating and frightening at the same time. She was terrified of doing something wrong that might result in the woman dying but at the same time felt she was doing something valuable to save her life. These were not skills she learned during her training in the UK. Midwives in England were not permitted to undertake such ‘medical’ procedures but, as Dora explained, these were the very practices midwives in developing countries need if they were going to make a difference to women’s lives. “There are very few doctors here. Midwives have to do the doctor’s work or the women will die.” Despite the lack of qualified doctors in general...
and obstetricians in particular, there was considerable medical opposition to the life-saving skills programme. (Dora, November 1991).

Conclusion

The key symbolic exchanges observed in Ghana and Malawi that have implications for a universal midwifery curriculum were centrally concerned with:

- Collective versus Individual: Imagined communities?
- Technological ideology - as a metaphor for practice in the absence of technology
- New rituals for old
- Measurement – positivism
- Surveillance and control
- Specialisation

In this chapter I have applied an eclectic model derived from sociology to women in childbirth which interprets this process as a rite of passage. In so doing, I have sought to illuminate the underlying cultural significance of symbolic exchanges in childbirth, concerned mainly with the globalisation of symbols and signs of modernity, and its uses. I have argued that childbirth is a rite of passage of tremendous cognitive significance for women across the globe; that messages conveyed by the rituals of hospital birth both reflect and reinforce the core values of modern societies originating in the West (that is American and Europe). The messages conveyed by antenatal care and the rituals of hospital birth both reflect and reinforce the core values of modern society (principally American). These rituals transform women in childbirth in ways
that reflect their orientation to those core values and to the technocratic belief system that underlies them.

In Africa, these things are not entirely overt but what are being transmitted are the symbols and signs of this belief system although the actual physical tools are lacking. These messages are conveyed in conversations, in shared ideologies, in imagined communities. These symbols are promoted by such agencies as the World Bank and WHO, IMF and so on. They are conveyed in the imperatives placed on governments to conform to global ‘standards’ of health care. The models for standard care being that which are exemplified in American medical facilities. But Africa cannot aspire to that level of care so all they are left with are the ideologies and not the wherewithal to make a difference in their system. But the application of time and measurement, of rules and policies that control birth does not cost money. So we are left with a high technology ideology without the high technology equipment. The Emperor’s new clothes.

In short I have sought to demonstrate that childbirth has been culturally transformed globally through the process of globalisation, into a medically-dominated initiatory rite of passage through which birthing women are taught about the superiority, the necessity, and the ‘essential’ nature of the relationship between science, technology, patriarchy, and institutions. I have shown how this socialisation into modern society’s collective core value system is accomplished through obstetrical procedures. The rituals of hospital birth are not only exhibited in hospital facilities but are being replicated in every village where government trained TBAs practice – notions of sterility, dorsal position for delivery, examination, recorded and timed births. I have
presented illustrations of how these procedures work to map the technocratic model of reality which underlies modern societies core value systems onto the birthing women’s perceptions of her childbirth experience, with the goal of achieving complete conceptual fusion between this technocratic model and belief system of birthing women. In consequence, one has to ask if we have lost the concept of rite de passage in modern societies since birth is no longer a social but individual event.

In the next chapter we travel to a country in the process of rapid modernisation under the influence of globalisation – Malaysia. There we will explore the experiences of women who live in a society that is undergoing rapid urbanization, has both poverty and wealth, high technology, developing financial, communication and transport systems whilst at the same time suffers from many of the problems of developing countries.
Chapter 6

Childbirth in Malaysia

Aminah was a young woman who had moved to the city to find work. She was also keen to see and experience a way of life very different from her own in the village. Alice, Kuala Lumpur, assisted (me September 1994)

I took a job in Kuala Lumpur, leaving my kampong and poorly paid local jobs for a better salary in the capital city of Malaysia. Although better paid by comparison, the money I earned working in the Texas Instruments factory was still very low and I had to share my sleeping quarters with three other young women. I worked on rotating shift in the factory. The conditions were harsh and my family was concerned for my health. I already had a health problem that I had consulted both traditional healers and western medical practitioners about (without resolution).

My mother hoped to buy some land for growing vegetables and perhaps rubber tapping to encouraging her daughters to work with her. But I, although hating my job, chose to continue working there in the hope of winning the firm's lottery with a prize of a free trip to the United States. I do return home for celebrations [life-cycle events] or for an Islamic occasion, taking a break from work to visit my family and friends [reaffirming ties with family and the traditions of our community]. (Aminah, September 1994).

This brief glimpse of the lives of two women in Malaysia gives a sense of the profound changes occurring in their lives but also of the continuing importance of age-old patterns of behaviour and belief. What this single snapshot can only hint at is the way
in which both the important transformations and the persistence of traditions are linked to the growing incorporation of Malaysian society into the international capitalist economy.

Malaysia, like many countries in the developing world, has been undergoing a process of intensive capitalist development. This entails the extension of capitalist property relationships in both agrarian and industrial sectors, a growing incorporation of people into international division of wage-labour, and increasing dependency on a cash economy in a competitive world market. While these changes are encouraged and supported by Malaysian government policies, the new economic forces and their penetration into the local context are largely controlled by and under the direction of multinational corporations and financial institutions (Lim, 1982; McAllister, 1987; 1988-93; Ong, 1983, 1987; Jomo, Kwame Sundaram, 1988; Scott, 1989).

Such processes induce a fundamental transformation, often rapid and abrupt, of traditional societies and cultures. In Malaysia, this affects even those sectors of the Malay ethnic groups left untouched by the earlier period of European colonialism. The current transformations most seriously affect women and thus are revealed through the changes in their lives.

**Persistence and change**

Neither capitalist development as it is occurring in Malaysia today, nor its effect on women, is a simple unilineal process. Instead, along with the growth of a wage-and-
market economy and the new social relations and cultural conceptions this induces, there is also the persistence of traditional economic and social forms and accompanying value systems and worldviews. For some parts of Malaysia, such as the Negeri Sembilan, this means particularly the continuation of matrilineal and Islamic traditions. In spite of extensive economic and social restructuring, such traditions are not being simply replaced by new forms of organization and belief; nor are they mere 'vestiges' of a previous stage of social evolution about to disappear, (McAllister, 1992:90). Rather, both matriline and Islam persist as vital and evolving components of people's lives and, as such, continually develop new points of accommodation and conflict with each other as well as with the increasingly dominant capitalist system. Village women creatively adapt both economic and social practices to their new circumstances and then use these renewed traditions to meet changing needs. McAllister (1992:108) suggested that the revival and elaboration of communal practices provide these women and their families with a support system that buffers them from some of the more exploitative features of the wage-and-market economy into which they are increasingly drawn. At the same time, such matrilineal forms can become undermined and distorted by their encounter with capitalist relations and values, with particular results for women's roles and gender relations. It is these contradictory dynamics of the current transformation in political economy that we must grasp to understand the choices of women in Malaysia.

McAllister (1992:109) drew three conclusions from her study of the Negeri Sembilan women that she considered must be taken into account in any general model of developing world change. First was the fact that the co-existence of various aspects of
the matrilineal and capitalist systems was not a static or stable situation. Rather what she saw was an active interpretation and reworking of these different forms in a process that involved both accommodation and conflict. Rather than just being maintained, aspects of the matrilineal system were frequently revived, elaborated, and extended to new situations. This also applied to the management of childbirth. Through this process, however, such 'renewed traditions' can become more fundamentally transformed, sometimes experiencing a weakening or reformulation of core meanings or principles. The rise of religious movements, especially the fundamentalist Islamic revival in Malaysia must also be taken into account. The global Islamic revival not only transformed traditional Malay Islam, it affected the surviving matrilineal systems as well. The complex dialectical nature of these multiple interactions and their implications for the overall picture of social transformation must be grasped within any analysis of the contextual relationships in Malaysia that influence the experience of women in childbirth.

Second, McAllister (1992:109) urged us to recognise that this process of uneven and combined development affects different sectors of the population in different ways. Noor Bee's story, for example, illustrates the impact of capitalist development, globalisation and modernity on women's lives alongside their continued involvement in traditional birthing practices as a buffer against new forms of exploitation and stress. Women play a significant role in the perpetuation and elaboration of these traditional forms and that the survival of aspects of the matrilineal (including birthing) system had particular benefits for their lives.
Azizah sat among a group of expectant mothers patiently waiting for her number to be called. She had never missed a single appointment. She looked a picture of health.

"I'm amazed at the rate my baby grows" she once said cheerfully, "My mother-in-law is even more excited than I am. It's going to be her first grandchild". She was radiant and beaming with pride. Azizah's husband worked as a clerk in a school nearby and often took time off to accompany her to the clinic. Like most first time expectant parents, they were keen participants of the health education sessions held regularly at the clinic.

This health centre which Azizah was attending was in a remote district in one of the east coast states of Peninsula Malaysia where I once worked some fourteen years ago. Like all other government health centres, it offered a range of services including domiciliary midwifery services. The longest serving officer at that centre was Fatimah the midwife who had been at the centre for more than twelve years. She was a familiar figure among the villagers. When I was first posted to this place, it was Fatimah who oriented me to this village community and introduced me to the formal and informal leaders.

Traditions die hard in this village and physical changes and modernisation appeared to have little influence on traditional values and practices. These traditional practices were evident especially in childbirth, postdelivery, confinements and childrearing practices. Not all beliefs and practices were detrimental to health though. In fact, there were those which enhance and promote health.

Late one night, I was called to help Fatimah who was attending to a case of home delivery. The patient was Azizah and she had already been in labour for some time when
I was called in, for it appeared that Fatimah had not been successful in trying to convince the family to get Azizah to hospital. I envisaged a difficult task ahead of me. I could not believe that the patient she was dealing with was Azizah for she and Hashim, her husband, had always been very co-operative.

There were already a number of people in the house when I arrived, both men and women, some of whom I was familiar with like the headman, the traditional birth attendant (TBA) Mek Limah and Azizah's mother in law. From a distance I could smell the burning of incense and the smell of traditional Malay lineament used for massaging. Azizah was lying on a mattress on the floor in a corner of the hall with Fatimah and the TBA attending her. Her family, especially her mother in law was adamant about using traditional methods and it was apparent that she did not want hospital treatment though modern treatment in the home was acceptable.

During the course of my interactions I realised that the deep rooted fear was actually the fear of surgical interventions. Azizah's labour had been prolonged and she was still at home. I felt a deep sense of remorse seeing her suffer excruciating pain and being denied the treatment, which was easily available. She appeared relieved to see me. After a quick and thorough assessment I called for the ambulance in readiness, although I knew that it would take time to convince her people to give consent.

The presence of pressure from the elders had caused Hashim to become rather passive. I resented that Azizah's husband did not make an effort to intervene in this crucial decision which concerned the safety of his wife and child. Caught in this situation, I realised how I had underestimated the strength of influence extended families had.

The greatest hurdle was actually the presence of a prominent 'bomoh', a traditional healer, who was called by the family for consultation and to carry out traditional treatment for many others had failed. Religious and magical systems excluding modern medical concepts of disease had placed traditional healers on the first line of intervention. I knew that everybody present were deeply concerned about Azizah's safety and that they were doing their best to remove 'barriers' that were causing the
delay in the delivery. It was a matter of perception and belief and I endeavoured to alleviate this ignorance.

Soon all drawers were opened, doors kept ajar and they went to the extent of unstitching ends of pillows that were available in the house. As time went on everyone especially the women folk were in a sort of frenzy. Azizah was asked to repent to her husband for her past 'wrong doings' and he was made to walk over her abdomen back and forth many times and a host of other things which seemed quite impertinent to me!

I desperately wanted to help this lady whose prolonged sufferings were unnecessary. I thought this was more than a health issue, it was a human issue and a woman's rights issue! Where else could I get help? I had to explore all avenues. The influential people were already there and I had to talk to them.

When the ambulance arrived, I had wished I was in control of the situation. Explaining to the ambulance team that Azizah was not ready to go was another issue. "We have to give Azizah a chance to deliver by herself", her mother in law said firmly. "We are all here to help her."

Slowly I began to see light at the other end of the tunnel. In the course of the event, they appreciated our anxiety and sincere desire to offer the best service available. They became more attentive to our explanations and asked a lot of questions expecting positive answers. Gradually they accepted that being given traditional and medical treatment together Azizah would be provided with the best of care. When it was time to wheel Azizah into the ambulance everyone lent a hand and we worked at top speed.

Azizah underwent a caesarean section and her baby boy was asphyxiated at birth but was well after resuscitation. A month later she was back at the health centre this time with the baby in her arms. Seeing both mother and child well and healthy, gave me a sense of satisfaction and pride (Malaysia, November 1993).
There are a number of key points that can be drawn from this story. Noor Bee herself identifies a number of salient issues, namely the complexities experienced by midwives in cultural situation, especially where they have to face the full blown cultural influences of the village community. For as she says, "modernisation appeared to have little influence on traditional values and practices" in village life in Malaysia. She came to understand her deficiencies in her understanding of culture and concludes that she should not have taken Azizah and her husband's ability to control their own birth experiences for granted, finally realising how deeply rooted traditional beliefs were and how this affected their behaviour. From another perspective, Noor Bee also came into conflict with her peers because of the delay in transferring Azizah to hospital. Noor Bee's clearly experienced horizontal violence (Spring and Stern, 1998) towards her because she failed to comply with hospital routines.

Pryia (1992:67) found that whatever the religious beliefs of traditional midwives in Malaysia, the incantations they used and the spiritual help they sought often came from a much wider or older spiritual tradition. In Malaysia, however, those of a more fundamental Islamic persuasion condemned the Malay Muslim traditional midwives for such practices. This appears to be the case here.

Noor Bee goes onto say that "To us outside the culture, their behaviour and ways of dealing with the difficult labour had appeared strange and wrong but to the insiders it is what they have learnt through the ages as being normal and appropriate way of dealing with the problem." Furthermore, she highlights that the different ways of tackling the situation were due to differences in beliefs and theories. The midwives’ beliefs were
based on current medical knowledge that made the assumption that prolonged labour is
dangerous for mother and baby. This knowledge created a sense of urgency to get the
labouring woman to hospital - as the only right and proper place to deal with this
emergency. Azizah's kin viewed the problem as a result of supernatural forces or
sorcery. In this scenario, their actions were suitable. The dichotomies encountered by
midwives are considerable and the introduction of new ideas from outside the culture
proves every bit as disorientating for traditional midwives.

At the same time, the distortion of such traditional practices that often results from their
interaction with the emerging capitalist, global medical systems had a special effect on
gender roles and relationships, in this case the undermining of pre-existing situations of
relative gender equality. This occurred even though traditional ideology of gender
relations may have remained in force (see McAllister 1989b).

Finally, McAllister suggested that models of the developing world change must take
account of the power relations involved in this "balancing act" of old and new. She
observed (1992:110) that Negeri Sembilan women often used their continued
involvement in matrilineal practices as a form of resistance against absorption into the
wage and market system. Abu-Lughod (1990) in an analysis of fieldwork based on
Bedouin women suggested that changing forms of resistance should alert us to changing
forms of power. She also warned against romanticising resistance, which often appears
very creative and resilient, without noting the creation of new dimensions of power to
which it is a response. Both of these points are well taken. For McAllister, the Negeri
Sembilan women were not engaging in new forms of resistance, those being employed
by the women were of long standing economic and cultural practices of daily life that were being converted into vehicles of resistance. In other words, what people were doing was not so new, but why they were doing it was. The different aspects of traditional culture survived primarily as ways of providing protection from or resistance to the developing capitalist system.

This transition occurred because of the imposition of new forms of power held by employers, the state, health care workers and international financial institutions, to name just a few (Abu-Lughod's, 1990). What was equally important, was whether such a transition would result in new divisions of power among the Malaysian people themselves - e.g. on the basis of gender or class. One could argue that given some of the distortions occurring in traditional practices, this might seem likely. On the other hand, everyday resistance continued through the acts of matrilineal practices that may presage another outcome, one in which the basic principles and practices helped shape the more conscious struggle for self-determination that is developing in Malaysia and throughout much of the developing world today. It is this larger 'balancing act' between the further undermining of traditional egalitarian forms or the use of such forms as effective resistance against new inequities brought about by globalisation- that represents the most important power struggle in contemporary Malaysian society. Its progress and outcome will fundamentally affect the lives of women and of their communities.
The Impact of Modernity on Women in Childbirth

Women from traditional societies are usually vague about when birth is likely to take place. In modern societies doctors are very concerned to pinpoint the expected date of delivery from which all interventions proceed thereafter if the pregnancy ends early or later than predicted. In contrast women in traditional societies have a more relaxed approach to this. They usually knew within a month or so as to when the baby might arrive and trusted to their own internal knowledge and experience of the pregnancy as to when birth would take place. In their own minds they made no distinction between the means used to ensure a successful pregnancy and those they took to ensure an easy birth, although inevitably some of the things they did focused more on birth than on pregnancy.

In modern societies the length of labour also has an expected period of time for each stage. When speaking with traditional midwives about how they assisted women in labour, it soon became apparent that what I meant by labour, being brought up in the western ideology of labour, was rather different to their interpretation of labour. I thought of labour as occurring in three stages: the first stage when the cervix opens, the second stage, when the baby is expelled and the third stage when the placenta is delivered. The separation of labour into the stages is an attempt to impose an order on it that in the minds of traditional midwives and the communities they serve, does not exist. The traditional midwives interviewed took a much more concrete view of labour. They concern themselves primarily with the delivery of the baby. The rest of labour seemed to merge imperceptibly into ordinary life and was considered far more
idiosyncratic, particularly in terms of the extent to which a woman might ask for help at this time.

The traditional midwives believed that women experienced labour in as many different ways as there were women. They found it difficult to talk in generalities, instead, as Priya (1992:64) discovered they chose to speak about individual cases and concrete situations. They told stories of different women and their families to illustrate their point; that each woman was different and whilst there were general principles, the important factor for them was to respond to the needs of the labouring woman. This at times might mean they might not follow their own general principles. For them labour and birth is a time of maximum vulnerability. The type of help a woman may need was not only in relation to what was happening in her body, but how she was experiencing it and the supernatural forces that may be hindering or helping the process. The expertise of these traditional midwives lay in their ability to gather all their knowledge and skills at all levels in response to the woman's individual needs.

In many places around the world there are special ceremonies undertaken around the time of birth to ensure a safe and easy delivery. To give birth, a woman must allow her body to open and to release the child. In the west, preparations for this usually include various physical exercises whereas in traditional societies women prepare by symbolically clearing the way, a process that is often described as sympathetic magic. They avoid all thoughts and actions which have anything to do with becoming stuck or closing up in case this is transferred to their body and the child becomes stuck or their body refuses to open easily to give birth.
A very common action of this type, which was described to me, was the behaviour of pregnant women in connection with entrances and exists to houses. Malay pregnant women avoid sitting in the doorway of their house or on the steps leading up to it in case this should cause a blockage and the child finds it difficult to be born. They are also careful to go out of the house by the same door that they entered.

To enable her body to be open easily the pregnant woman should not do anything to place herself in a situation, which implies a closing up, or the marking of an obstruction. In many places the wearing of belts or neckerchiefs is discouraged to prevent knots in the umbilical cord. In Sarawak, pregnant women avoid tying things together with rattan. If this is a job that has to be done then a non-pregnant woman is asked to start the job which the pregnant woman then finishes so that possible negative consequences are neutralised.

In traditional societies, it is generally believed that women who work hard are more likely to have an easy delivery; this is not only because it keeps them physically active but because it keeps them, and therefore their baby, ‘loose’ so that it will be born more easily. Birth preparation in the west is much more physically based, with various breathing exercises forming a large part of what is taught in antenatal classes. The roots of modern birth preparation stem from the work and writings of Grantley Dick Read whose first book on the subject was published in 1944.
The traditional midwives I spoke with did not expect to have many difficulties as, in their experience, most women gave birth without problems. They were, however, confident that they would be able to deal with any complications that might arise, especially when they had the assistance of their guiding spirit to whom they could turn to for more powerful help. If the labour is prolonged various methods are used to entice the baby out of the womb. The midwife may instruct the husband to step over his wife’s supine body three times to graphically show which gender is superior. The woman may have been unfaithful and or strayed from her prescribed feminine role by not being passive and submissive enough. By acting out the different gender roles in this way, order and harmony is restored and the baby can be born.

In Sarawak, if labour is prolonged, two medicine men are called to perform a special ritual. One goes inside the house and the other stays outside. The one inside places a loop of cloth around the labouring woman while the one outside place a loop of cloth around his own waist with a stone in it. This is followed by a long incantation sung by the man outside. The man inside uses his psychic powers to force the baby downwards and as the child descends, the tightly tied cloth is moved downwards to prevent the baby moving back up. The one inside shouts to his companion who moves the stone downward in mimicry of the baby. This proceeds until the child is either born or until everyone becomes convinced of the fruitlessness of his or her efforts.

If these normal methods fail then the midwife calls on a more powerful person to divine what the problem is and what further measures should be taken. A bomoh
would be called to whisper to the spirits, especially the good ones, to help banish evil spirits.

Domiciliary deliveries were always the responsibility of traditional midwives (bidan kampung) but since Independence and the resulting political shift, educated young women were trained as auxiliary midwives and sent to serve in rural communities. It soon became clear that these young, educated women were coming across some strong resistance from the established traditional midwife who naturally felt threatened both in terms of livelihood as well as social status. Colson (1969) observed that the trained midwife in the village she studied never attended a birth independent of the traditional midwife but that the traditional midwife attended many births without the government midwife. In the year 1970 traditional midwives were continuing to resist any attempt to replace them with trained midwives.

Chen (1975) noted that during childbirth, the traditional midwife, if she was the midwife of choice, attended the delivery alone as she was perceived by the family to be willing and capable of attending to all the needs of the mother during childbirth. Conversely, she noted that the villagers considered that the trained midwife only performed three of the fourteen traditional duties expected of the bidan kampung and that consequently, 80 percent of mothers had to employ a traditional midwife if she expected the remaining eleven traditional duties to be performed.

Although the trained and traditional midwives would conduct themselves with decorum, as required by Malay culture, they were covertly suspicious and resentful of each other,
the two treating each other as rivals rather than allies with a common objective. To the trained midwife the bidan kampung should have been subordinate since she had little training and her techniques were sullied by supernatural hocus-pocus. Further the trained midwife knew that half of the mothers attending clinic would be ‘stolen’ by the traditional midwife for delivery. On the other hand, to the traditional midwife, the government midwife’s air of superiority was insulting since she had no claims to the vast wealth of traditional knowledge about birth and life that distinguished the traditional midwife from ordinary women. Moreover, the trained midwives were always younger and thus less experienced.

Nowadays, the greater majority of women now deliver in hospital under the care of doctors. To counter this trend and to incorporate the traditional midwife into the health team, new roles were developed for each so that the midwife and bidan would be able to co-operate and support each other. The trained midwife, who had received at least twenty-four months of training, was supported by nursing supervisors, doctors and the hospitals, were responsible for the actual delivery of the mother, cutting the cord and the care of the newborn. She was also able to detect and refer high-risk cases and complications to the more qualified supervisors and doctors.

Members of a focus group of senior midwives (Kuala Lumpur, Malaysia, 1994) reported that “trained midwives do not receive instruction in the traditional duties expected by the communities they served as part of their midwifery training.” The absence of local traditional birthing practices is evident in the government defined midwifery curriculum (appendix 6). The traditional midwife would be expected, for
example, to provide advice and instructions concerning the antenatal taboos and
behavioural avoidances that the family had to observe in order to ensure a safe delivery
and a normal infant. She would be responsible for supervising the performance of
precautionary measures during labour; to ritually bathe the mother; to supervise the
ritual disposal of the placenta; to wash soiled linen; to provide advice and instruction
concerning dietary taboos after childbirth; to supervise the 'roasting' of the body and
abdomen and to provide 'heating medicines'. The traditional midwife would also be
expected to perform the traditional postpartum massage of the mother's body. (Alice,
focus group discussion, 1994)

Government trained midwives would not only lack the training and knowledge in these
matters but also are rarely inclined to provide many of these services. Neither does the
trained midwife have sufficient time to stay with the family to cook and to wash for the
whole household (Connie, focus groups discussion, 1994). The traditional midwife, on
the other hand, is the person obviously best suited to carry out most of these traditional
duties. She also supports breast-feeding and she can give advice on family planning
(Ong, focus group discussion 1994). She would, in an emergency and in the absence of
the trained midwife, deliver a mother and cut the cord (May, focus group discussion,
1994). The traditional midwife would also be given appropriate training to prevent
harmful practices being conducted. (Mahani, focus group discussion, 1994)

Chen (1975) reported that in their readjusted roles the midwives complemented each
other. At the first sign of labour the bidan kampung would be summoned, and upon her
arrival would begin to carry out all the precautionary measures traditionally expected of
Once the second stage of labour begins, she sends for the trained midwife who then conducts the delivery, cuts the cord and bathes the baby. Throughout labour, the traditional midwife sits opposite the trained midwife and from time to time would mutter a prayer or a charm and reassured the labouring woman.

Interestingly, when I was in Malaysia in 1994, the two-year training of midwives was coming to an end because it was considered that they had insufficient knowledge to perform effectively. The new policy was to ensure that all midwives had a nursing qualification before undertaking a midwifery programme.

Meanwhile, district services were decentralised and hospitals up-graded for diagnostic and management support of childbearing women. Antenatal screening has been refined and a national confidential inquiry of maternal deaths introduced. District teams were trained in solving and management and health professionals have been re-trained to improve skills. TBAs have also been re-trained as partners- referring pregnant women but also providing emotional support to the woman and family. Skilled professionals conducted increased numbers of deliveries and alternative birth centres have been introduced in rural and urban areas. Alongside these improvements, functional referral and emergency transport systems were implemented with the result that maternal mortality fell from 300/100,000 in 1960s to 40/100,000 live births in 1997. Attendance of a skilled provider at birth rose from 57 percent in 1980 to 95 percent in 1996 (Litsios, 1997). But what does this mean for women?
Lying in a crowded corridor, the woman clung to the rails of her trolley and screamed in pain. People were walking by on all sides but none came to her aid. My translator, Angelee, told me that she was saying that the baby was coming. But no one took any notice. I placed my hand on her arm to offer some comfort and asked Angelee why the woman was in the busy thoroughfare. "There are no delivery beds available and she is a third class patient in any case. Privacy is not an option for her." The mother was alone. There was no room for family attendants. Eventually someone came to assist the woman and called the doctors and nurses who were swarming about in their theatre gowns, wearing masks and gloves among the general chaos of the corridor with other people wondering all around. Not even screens were available as the woman began to deliver her baby in the middle of the corridor. This was the best the hospital could do in the circumstances. One hundred percent hospital confinement was insisted upon and doctors delivered the babies. In a city that was populated by nearly two million, health service provision was stretched to the limits.

As the baby slid out of his mother, he was limp, blue and covered with a green slime. He was not breathing. The nurse grabbed him and rushed off to find help to resuscitate him. In the panic, no one told the mother what was happening and she screamed in terror. The doctor was called to another patient and the woman was left alone. The placenta had not yet been delivered.

On the next floor in the private patient's wing, a woman was labouring in a comfortable room with all the technical equipment available in case of an emergency. She had her husband with her. Clearly middle-class, the woman had requested the presence of two of her female relatives, which was granted. A nurse was also present throughout. As the baby began to make her appearance into the world, the doctor was called to conduct the delivery. He had been called away from the woman in the corridor (Anglee, September 1994).
The sharp contrasts between the women's experiences illustrate the differing perspectives of health care in Malaysia. From the professional viewpoint, it is firmly believed that women should be admitted to hospital for their confinement to prevent death and yet the experience for many women is perhaps less than satisfactory. Nurse-midwives and doctors interviewed were convinced that the safest place for birth was the hospital under the care of an obstetrician.

In a telephone interview with a renowned author and social anthropologist (Priya, 1998), she concluded that modern and traditional ideas and approaches to birth seem so very different that it is very difficult to find points of contact between traditional and western practices. The woman in the west expects to receive medical care during her pregnancy and labour and the vast majority go to hospital to give birth. This would probably be unimportant if pregnancy and birth were viewed as normal processes but the woman's experience from antenatal care onwards would be one of seeking and finding problems and maybe being told that she is part of a high risk group and thereby more likely to develop complications. She will either explicitly or implicitly be expected to defer to the doctor's ideas as to what is most appropriate for her and the responsibility for finding and dealing with problems will be the doctor's rather than hers.

With almost 95 percent hospital deliveries (as reported by the Supervisor of Midwives, Ministry of Health, 1997), Malaysia has gone a long way down the road of
incorporating western medical ideas into the everyday experience of women, although it might not be as quite so straightforward as might at first be supposed.

Malaysia is 30 years behind the times -- they are conforming to things that are not done now in the UK -- but they think they are modern but it is vital look at the local situation when adopting Western medicine. In the rural areas of Malaysia, like India, there are no real motorable roads. Getting a woman to hospital when in trouble is a problem -- the only means of transport is by ox cart which is very slow and women usually give birth in the cart before they reach hospital. This is very embarrassing consequently women tend to go to hospital before labour starts. Of course there is only hospital based medicine - hospitals are in the towns - not in the villages.

Women are being regimented in a way that women were regimented 30 years ago in the UK - but more exaggerated...worse in many ways...staff are overworked - impersonal. Women are not allowed to have their families with them during labour which is against their traditions....this creates a conflict and it is not surprising that women end up with caesarean sections. .....there are six women labouring and giving birth in a room - this is not a private space. The labours are very managed - they love to put up drips with drugs to get them going - to hurry labour along. Care is based on doing the technical stuff properly not on caring for women. (Patricia, August 1997)

My interpretation of this comment was that Patricia was making an assumption - intimation - that because of the conflict women experienced between their own culture and traditions and those of the imposed culture and rituals, creates a situation in which labour is more complex, dangerous and complicated. That is the consequences of a cultural clash for women that may result in a more dangerous labour, and may be increasing rather than decreasing morbidity.
In Kuala Lumpur I went to a public hospital for a Rhesus test for my last baby. Given that this was exotic and unusual - the Malaysians don’t have a Rhesus problem - I was to see the British doctor. Whilst at the hospital, I saw these women lining the corridors, alone - no family around them. A friend of mine is married to an obstetrician who works in the Chinese hospital in KL - she is very pro natural childbirth, etc. and he has set up a birthing room but no-one uses it - except perhaps some foreign women. If I was going to give birth in hospital that is where I would have had my baby. But the Chinese did not want this. They pay more for anaesthesia than for acupuncture, which is available in the birthing room. More and more Chinese women are requesting caesarean sections (C/S), and my friend’s husband says he turns down more than two per month. He will not perform C/S unless there is a reason but he knows his colleagues do - a C/S cost around $2000 - doctors make more money by doing them than vaginal birth.

It seems that when medicine is taken into another country it gets corrupted according to the local situation - ideas are taken and distorted - this half way place creates conflict. Another example is that mothers are more likely to give their babies processed foods rather than the locally available foods. It seems ridiculous to me that they will give dried bananas from a packet when they can get fresh bananas from the market practically free. There is something very strange about the way in which Western knowledge and actions are adapted in the local setting.

Take the ideas about the body and the way it works...the Chinese have a thing about hot and cold foods......pregnancy is considered a hot state therefore women will not take vitamins during pregnancy because they are also hot. There is a superimposition of Western ideas onto traditional ideas that can cause real problems. Some of the beliefs generated then can be really bad for mother and baby. How new ideas from other cultures and situations are interpreted is really important. Take the village health workers - they are taught to weigh pregnant women, take their BPs and test urine but they don’t look at the results nor do they interpret them or realise the implications. In
the village in Malaysia all the pregnant women were weighed but there was something wrong with the scales since all the women weighed the same - not only from one visit to the next, but as each other. The village worker weighed them religiously but failed to recognise the implications of what was happening. It takes on an element of magic - of ritual - if we do this then the baby will be all right.

When a doctor visited a village health centre, he examined a woman and found that the baby was in a transverse lie. When he pointed this out and asked how long this had been the case - the village health worker said yes, she had noticed but had said nothing - assuming the baby would turn. This was nearing the due date. Yes the baby might well turn but should the woman go into labour - and the lie remained transverse - then no-one would know anything about it because the health worker failed to see the significance. She had ritually examined the woman but did not connect that to the importance of taking action. Just doing the examination in her eyes and maybe that of the woman was enough to ensure that everything would be all right. ...There is an element of that in the West too.....women assume that just by having all the tests the baby will be all right.

In another incident a further aspect of modern ritual was highlighted.....when women are pregnant they are given an injection......they go to a government clinic....but when I asked what this injection was for they could not tell me other than to say that it made them strong. It took me ages to find out what this injection was...tetanus....but the myth had been built up that this was good -and yes it was....but not for the reasons they believed it to be. The women would only have the injection on the 3rd, 5th or 7th month because those are considered the luckier months of pregnancy...........this overlay of western medicine and traditional beliefs is very interesting. The injection had been worked into a ritual process - to guarantee a good birth and healthy baby. (Patricia, August 1997)

In traditional societies, pregnancy and birth are normal processes central to the life and identity of a woman. In the main a pregnant woman receives advice and care from
female relatives and friends and has access to the help of a more experienced traditional midwife or other traditional specialist should she need it. She protects herself not only from physical harm with various rituals but also spiritually by harnessing positive forces to protect her and her baby. The woman is in control of the process and through this control she has a measure of security that is bolstered by centuries of tradition. In these modern times, women's lives, even in rural areas, are changing but they may be unwilling to entirely give up their traditions and health services are beginning to take account of this.

**Conclusion**

The brief vignettes from the lives of a few women in this chapter attempts to provide a sense of the profound changes occurring in Malaysia but also of the continuing importance of age-old patterns of behaviour and belief. What these snapshots can only hint at is the way in which both the important transformations and the persistence of traditions are linked to the growing incorporation of Malaysian society into the international capitalist economy and global cultural reforms.

The key issues for women are associated with those reforms and risks that have emerged as a result of globalisation. These include rapid urbanization and industrialization which have been instrumental in increasing levels of environmental pollution and present serious threats to the health and wellbeing of the population in general and women in particular. An unstable economy also seriously undermines
health and wellbeing leaving the country’s poor to suffer the consequences of sudden depreciation of the currency.

Women in Malaysia face not only all the problems of women in developing countries such as Ghana and Malawi, but they also face the problems of rapidly modernising world and so straddle the traditional and the modern which may not be a very comfortable place to be.

If the changes engendered by globalisation are like ripples on a pond, then writing a universal midwifery curriculum would be difficult when different countries are receiving ripples at different times and in different forces. The ripples of modernisation are coming most strongly from countries that have destroyed their own traditions and may ultimately destroy indigenous traditions in penetrated countries. Because modernisation has always been viewed as ‘good’ from the western standpoint and we are, in reality, as American foreign policy exemplifies, attempting to recreate the conditions and practices in the western world to craft a mirror image of ourselves.

In the next chapter we travel to the ultimate in modernity - the United States of America. There we will explore the experiences of women who live in a society that has wealth, high technology, excellent transport systems and the most modern health care facilities in the world and yet find the reduction of maternal mortality a continuing challenge.
Chapter 7

American Women in Childbirth

I make five arguments in this chapter: American midwives, doctors and women view women’s bodies as unpredictable within the context of the dominant ‘body as machine’ ideology that leads to a belief that childbirth is only normal in retrospect; therefore most women experience childbirth as a process that is fundamentally risky; this leads to a high degree of instrumentalism in childbirth; and that the power of the American hegemony is such that these notions are being transmitted globally and have an impact upon how women experience birth in penetrated countries.

According to Davis-Floyd (1992:44) the rituals of initiatory rights of passage convey symbolic messages that speak of a culture’s most deeply held values and beliefs. Many of American society’s most deeply held beliefs and values derive from the model of reality they inherited from the Scientific and Industrial Revolution in Europe. The machine became the underlying metaphor for the organization of the human universe during the seventeenth century with the rapid commercial expansion of Western society (Merchant, 1983). Descartes, Bacon and Hobbes, among others, developed and widely disseminated a philosophy that assumed the universe was mechanistic, following predictable laws rather than the previously held view of the universe as being a living organism infused with a female ‘world-soul’. Those who were enlightened enough to free themselves from the limited medieval superstitions of the past could discover the universe through science and, moreover, could manipulate it through technology. These
ideas fitted so well with the view that humans had the right to dominate nature that by the end of the seventeenth century science and technology became the philosophical cornerstones on which rested the belief system of Western society.

Within the framework of these philosophies, nature, society and the human body became interchangeable, atomised parts that could legitimately be repaired or manipulated by external rather than inherent forces (Merchant, 1983:193).

The universal acceptance of the mechanical model in the Western world in the seventeenth century was accompanied by the fragmentation of the system of organised religion which had previously unified the conceptual framework of European society. As the mechanical model itself became the conceptual determinant "unifying cosmos, society and self" (Merchant, 1983:192), the primary responsibility for the human body passed from religion to the emerging medical profession. This developing science had taken the mechanical model as its philosophical foundation, better equipping it to take on the challenging conceptual task of transforming the organic human body into a machine - a transformation crucial to the development of Western society (Davis-Floyd, 1992:45).

The development of a rational conceptual universe Davis-Floyd saw as an essential step in the formation and continuation of any society. Social cohesion and continuity were enhanced when a society’s founding metaphors for cosmos, culture and individual self were consistent with each other. That is, like an onion, each layer is a scaled-down version of the other. Such consistency requires the body - the basic conduit of human
beings, and therefore social existence - officially reflects society’s vision of itself. If a society chooses to see itself and the universe as mechanistic, it will, therefore, need to see as equally mechanistic the human bodies that comprise it. The problem here, of course, is that bodies are not machines, hence the human body represented a great conceptual challenge to the mechanical model. It became the cultural mission and the vested interest of Western medicine to prove the ultimate truth and viability of this model by making the body appear to be as mechanistic as possible. For Davis-Floyd, medicine’s eventual success in this mission played a major part in the permeation of the machine metaphor into every aspect of American life and determined how women constructed their lives.

Erikson (1977:258) believed that whatever one may come to consider a truly American trait could be shown to have its equally opposite characteristic, although this could also be true for all ‘national identities’. The process of American identity formation appeared to support individual identity development provided that person preserved an element of deliberate tentativeness of autonomous choice. Erikson argued that the individual must be convinced that the next step was a personal choice. Thus functioning Americans, as heirs to a history of extreme contrasts and abrupt changes, base their final identity on some tentative combination of dynamic polarities such as migratory and sedentary, individualistic and standardised, competitive and co-operative, piety and freethinking, rigidity and vacillation, responsibility and cynicism, and so on.

While extreme manifestations of one or the other of these poles can be seen in regional, occupational, and character types, Erikson’s (1977:259) analysis revealed that this
extremeness contained an inner defence against implied, deeply feared, or secretly hoped for, opposite extremes.

To leave choices open, Americans, on the whole, live with two sets of ‘truths’: A set of religiously pronounced political principles of a highly puritan quality, and a set of shifting metaphors which indicate what, at a given time, one may get away with on the basis of little more than a hunch, a mood, or an idea. Thus, the same person may have been exposed in succession or alternatively to sudden decisions expressing the metaphors for example, ‘Let’s get the baby out of there’ and again, ‘Let’s give the woman a chance’. Both of these conforming to different myths of childbearing. The former would be an example of the myth that women’s bodies are unpredictable and that birth must be controlled. The latter referring to the myth that labour and childbirth were normal events in women’s lifecycle and that their bodies are robust.

Birth metaphors can be sufficiently convincing to those involved to justify their actions whether within or outside the law regardless of any pretence at logic or principle. These metaphors pervade public opinion in courts, in corner stores, and through television, films and the daily newspapers. This was borne out during fieldwork and data collection. Individuals and organisations appeared to swing between taking risks and avoiding risks, as expressed in the desire to try new things whilst fearing the consequences of failure. For practitioners in medicine and professional midwifery this may result in conservatism and defensive practice. The following story illustrates this point:
The labor/delivery/recovery room set ups in the hospitals in my area are now the standard birth facility in Houston except for large charity hospitals. Women are told they can use the Jacuzzi, shower, ambulate, eat, drink, etc. As a breast feeding counsellor and midwife (home birth) I will tell you that I have met many women who feel disillusioned in that they could not use those facilities because their water broke, they were too far along, they were not far enough along, in labor, etc. I have gone to hospital-based “Lamaze” (re. doctor obedience classes) classes and was even told that women with an epidural can walk and use the Jacuzzi and not have an IV or shave or episiotomy, etc. The “Lamaze” classes provided by the hospitals have merely become a tool of the hospital to indoctrinate couples into hospital routines! As for the women I HAVE NEVER MET ANY woman who has been able to meet the hospital’s criteria for any of the extras other than maybe a ‘free’ car seat for the baby. (Camellia, June 1995)

**The American Way of Birth: Dominant Medical Paradigm**

The medical fraternity had another responsibility apart from maintaining the consistency of the dominant belief system, that is, the inculcation of individual members of society with the basic tenets of this belief system. Davis-Floyd (1992:46) considered that it was no cultural accident that doctors themselves must undergo an eight year long initiatory rite of passage, “a process of socialisation so lengthy and thorough that at its end they will become not only physicians but the representatives of American society. For our medical system encapsulates the core value system our society has based on its technocratic model of life and thus is well-qualified to pass this system on.” (Davis-Floyd, 1992:46). The generally accepted and approved American biomedical ‘cures’ are based on science, effected by technology, and carried out in
institutions founded on principles of patriarchy and the supremacy of the institution over the individual.

The key point for Glennon (1997:34) was that definitions of reality were not innocent, isolated entities that had little interplay with the empirical world. A dialectical model existed wherein ideas derived from the social and material base, in turn acted back upon that material base. This cognitive habit of thinking in either-or categories was part of the change in consciousness that allowed for the introduction of sacred versus profane, private versus public debate concerning modernity (Nelson, 1993). The shape of the social world affects ways of thinking about that world. In turn, people’s conceptions become part of that social world insofar as they act toward things in terms of how they think about them. This is the connection between social perceptions and the way people actually behave. This can be illustrated in the thinking and behaviour towards women’s social roles, especially in regard to childbirth. This dominant view, however, may not be universal. A number of alternative groups adhere to different ideological and religious views of the world. The Amish society is an example of such a alternative approach, discussed later in this chapter.

**Birth Territory: Where Women Birth**

Childbirth in America, like many other human accomplishments, is in many ways a product of its technology. The artefacts of parturition, the utilitarian and ritual objects, instruments, and equipment necessary for a culturally proper management of labour and delivery constitute a significant part of America’s birthing system. Methodologically,
artefacts possess a quality that recommends them as vehicles for gaining access to a specific way of doing birth: in contrast to such intangibles as conceptualisations or expectations or attitudes, artefacts are visible and can be manipulated and thus directly available for the practitioner’s utilisation and the investigator’s observations, for the asking of questions about them, for listening to talk regarding them, and sometimes, even, for gaining firsthand experience in using them. The collection of physical objects considered here includes not only “obstetric tools” but all items recognised by participants as appropriate to doing birth. Thus, talisman to ward off evil spirits is as important an object as the birthing stool or delivery attendant as the utensil with which the umbilical cord is cut.

Birthing systems overwhelmingly prescribe an appropriate place for giving birth. Jordan (1993:67) considered that there were generally two kinds of environments: birth location may be relatively specialised, or within the woman’s normal sphere. In either case, the choice of location has significant consequences in the resources it makes available and in the kinds of social interaction it produces.

The practice of moving the woman to a delivery room during labour and transferring her to a special delivery table is not followed in the majority of hospitals in Europe, although in the UK there are still some hospitals that adopt this system. While for many professional practitioners, this may seem a trivial concession to hospital efficiency, it may in fact, have far-reaching consequences. Jordan (1993:68) observed in practice and in reports of women, the often rushed and hectic transfer to a trolley, the dramatic wheeling down the corridor with intravenous tubes dangling, and the always awkward
and often painful transfer from the trolley to the delivery table, often transforms a marginally tolerable situation into a scene of frightful panic. Because of the woman’s intense concentration and often desperate attempts to maintain control over her contractions at this time, the extent of distress created by these transfer is not visible to medical personnel. In the American hospital where Jordan videotaped, she had been impressed by the consistently angry remarks volunteered by women weeks later when their viewed their transfer to the delivery table. To quote one of Jordan’s research subjects

"That was the most terrible part of the whole thing. I couldn’t say anything because I was afraid I’d fall apart and I knew I had to get on that table to have that baby. But Jesus, why did they have to do that to me?" (quoted in Jordan, 1993:68)

From my own discussion with women who had had childbirth experiences in high technology settings, they often reported some years later an intense anger over being made to move at such a critical point in their labour. One woman said:

It was as if I was on a conveyer belt being moved along the assembly line in a factory. I had completed one section or rather one section had been completed, it had little to do with me as a person, it was the nurse’s success - not mine - that I had reached this point. I could then be moved on to the next operator - the doctor - for the next part of the production process. It was humiliating and embarrassing. The white hospital gown open for all to see, the big socks they made me wear. It was so undignified. Shifting from the trolley to the narrow delivery bed. I didn’t
think I would fit. Also the gap between the trolley and the bed seemed to be huge - I thought I would fall between them. It was terrifying. How could they expect me to be able to move about from one bed to another when I was trying to have a baby. It was awful. (Clare, 1995)

Movement from the accustomed environment may have significant negative impacts upon women's physiological and behavioural responses. Besides transfer to a different location, crowding, fear, excessive noise, and newborn separation have been shown to produce negative reactions in women (see Odent, 1984).

American obstetric wards have traditionally been designed with a view to organisational efficiency and central availability of the resources of medical technology. From women's point of view, obstetric wards of most large American hospitals have a universally clinical atmosphere, the kind of environment that, if it was familiar at all, was familiar as a place of illness and suffering, a place for patients. Furthermore, the only appropriate place for the labouring woman was the patient's place - the bed. It is noteworthy that standard hospital procedure gets the woman to her bed as quickly as possible and works to assure that she stays there.

Typically, following admission, an intravenous infusion was started and often an electronic fetal monitor attached. Either one of these procedures results in immobilising the woman on her hospital bed. Walking around during labour, encouraged as physiologically and psychologically beneficial in Europe, had been considered unsafe in America. Although the rhetoric of mobility in labour has been incorporated into most American hospitals, it was often rendered physically difficult, if not impossible by the intravenous fluid tubes and monitor leads. Consequently, women were not only
confined to the labour room and hospital bed, they were prevented from seeing what was happening around them to make sense of the noises they heard. People walking by in the hallway, trolleys being pushed, the clanging of instruments, strange faces coming into their field of vision from time to time, voices, screams, baby cries - against the background of their own increasing discomfort, all these contribute to a sense of disorientation, anxiety, and fear of what was to come. As long as women hold in common with other participants a medical view of the proper conduct of birth, it might be expected that the hospital setting would provide a sense of security, reassurance and trust for the parturient woman. From discussion and observations that trust is sometimes betrayed. Jordan (1993: 68) observed, however, that this was not the case to any significant degree.

According to Clare, (research participant, 1995) most obstetric wards were designed without facilities for non-patients. Thus, there was, not only conceptually but also physically, no place for non-specialist participants who might act as the woman’s companion, although the situation has been modified in recent years in many American hospitals. *It has become increasingly common for the labouring woman to be accompanied by the baby’s father, a relative or a friend* (Clare, Nurse-Midwives Focus Group, October 1995).

*Most power-defining encounters take place on the doctor’s territory where he can control the local resources and the power to use them at his discretion* (Mary (Nurse-Midwives Focus Group, October 1995). Apart from this more obvious influence of territory control, there were more subtle interactional consequences, such as issues, for
example, as who is guest and who is host, influence participants perceptions of what they are able to do, and thereby affect the tone of the interactions.

In the 1990s, when so many American women were educated for childbirth and gave birth consciously, with little pain (as a result of the extremely common use (80%) of epidural anaesthesia –Mary, Nurse-Midwives Focus Group, October 1995) physicians increased their accountability to the awake and aware patient for proper procedure, explanation, and justification. But the language of the explanation like the territory in which they gave it, were still theirs to manipulate and the patient’s to struggle to understand.

One of the most significant consequences of any system’s choice of birth location is that this choice assigns responsibility for the course of labour and credit for its outcome. In American hospital deliveries, responsibility and credit were clearly the physician’s. This became visible in the handshakes and “Thankyou” and “Good work” compliments to the doctor by someone qualified to judge, that is another doctor, or perhaps the nurse. Typically, nobody thanked the woman. In the common view, she had been delivered, (passive role) rather than given birth, (active role). In the home setting, by contrast, the initiative remains in many ways with the woman and her family. The birth is their choice, their problem, their task and will finally be their achievement.
Childbirth in the marketplace: 'Packaging' Childbirth and Emergence of the Birth Centre Concept

The birth centre phenomenon was a concept that was developed in response to a demand from educated, well informed women who began to reject the routine application of technology and the depersonalised care provided in hospitals during labour and birth. They looked for doctors or midwives to attend them at home where they would feel free to move about, take nourishment and be within the closeness of their family while they laboured and gave birth. At that time there were almost no professionals willing to attend births at home in most parts of the United States.

Following closely on the heels of the birth centre development came the in-hospital alternative birth centre in direct competition. One can only assume that considerable funds were directed towards attracting women back into hospitals to give birth. In regard to the territory issue, hospital birthing rooms were not much more of an improvement over the labour and delivery room. The woman still gave birth in an unfamiliar environment attended by unfamiliar people, a guest on someone else's territory with few rights and fewer resources. While more flexibility was allowed in such things as position in labour, real decision-making power remained with medical personnel. In important ways, the woman still did not own the birth. One could characterise the introduction of birthing stools as a token demedicalisation and a fairly superficial response to public demands for change. What was important, however, was that women responded very favourably to birthing rooms. They described the security they derived from the nearness of medical resources as an important factor in their
positive experiences. We see, then, that for these women the most salient evaluation criterion remained the medical definition of what constituted safety, which alerts us to the fact that the definition of birth remained fundamentally unchanged.

The topic of hospitals renaming regular labor and delivery areas birth centers, dressing them up with nicer furniture, etc., and thus misleading the public (and statistic gatherers) is a subject near and dear to me. I am a nurse in an in-hospital birth center which was created almost 10 years ago as a “real” alternative to the existing L & D. Without going into a lot of detail, I thought you might be interested in the fact that within the past two years our hospital has updated the L&D (definitely needed!), and advertised themselves as a Birthing Center (rather similarly named to our unit - The Birth Place) and thus they compete now with themselves!!! Worse yet, many of the care providers who have delivered with us very happily for 9 years are telling parents that there really isn’t any difference because in both places you deliver in the same room, and can have early discharge if you want. Somehow they miss the major difference in philosophy—we treat birth as a normal, physiologic activity with the family paramount; it is still seen as a patient-related medical activity in the hospital, even in low risk situations (Linda, 1995).

As in Rebecca’s birth, following, the thin veneer overlaying environmental change masquerades as profound change in childbirth philosophy and practice, hides the artefacts of conventional American birth traditions. From a childbirth ecology perspective birth location must be treated as an integral part of birthing systems. Apart from displaying to various degrees the local conceptualisation of the event, the nature and spatial arrangements of the birth territory shape interactions between participants and thereby the locally characteristic support system available to women. Underlying
these interactions and experiential consequences, we find that assignment of responsibility and credit for birth remain with the dominant medical fraternity.

The Technical Construction of Childbirth through Ritual Processes

In the latter day context developing on from the mechanical model, Glennon (1979:23) saw American society as essentially a technocratic society. Technocracy implies a social order in which all things are accommodated to the needs of science and technology - and their by-product, bureaucracy. Such a society finds itself more and more bureaucratised and run according to the dictates of scientism. In a technocratic society a cult of experts gains influential advocates, and ever larger areas of life are drawn into its scope. Child rearing, lovemaking, sexuality, face and body language, ways of arguing and similar 'human' concerns are handed over to the experts for diagnosis and prescription.

In a technocratic society selfhood becomes divided into instrumental and expressive selves and social life is split into public and private spheres. It presupposes polar opposites that are incompatible. The technocratic society reasons that 'business is business' or 'that's politics'. In so doing, it grants license to rampant self-interest in the public arena. Under this scheme of things, it makes sense that business and pleasure do not mix. Yet the truth of that statement springs not from any essential opposition between business and pleasure. Business (instrumental) and pleasure (expressive) simply do not mix in this particular historical creation called technocracy. Glennon (1979:22) pointed out that in some cultures no division between work and play existed,
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Childbirth and child rearing, among other things of the same ilk, reflect the acceptance of instrumental assumptions in everyday life. The following observations were made during fieldwork in an urban hospital.

This rather extended account has been included to illustrate a number of issues: firstly the pervasive instrumentalism underlying the attempt to provide a home-like experience; secondly to show how thin the veneer of home-like environment is; thirdly to demonstrate the pressure upon the nurse-midwife to regress to the dominant conservative model of birth, regardless of her personal convictions and fourthly, how difficult it is to be both an insider-outsider researcher at the same time and abstain from intervening.

At the hospital, I entered the cozy, brightly coloured entrance hall with its pretty pictures depicting the surrounding countryside during the various seasons. Three women in white dresses and white caps were standing behind the large, chest-high desk in the centre of the room, chatting to each other.

The delivery suite looked even friendlier. Subtle terracotta walls and rust-coloured carpeting eliminated any preconceived ideas about sterile hospital surroundings. In the waiting room, there was a fish tank and large plants to aid relaxation. There was even music playing. I began to look forward to the birth. Surely if the hospital administration had gone to this much trouble to make birth as home-like as possible, then women would be sure to have good experiences.

I met the nurse-midwife at the door of the private labouring room. She took me to the lockers to change into a pair of anonymous blue scrub pants and V-necked shirt. She
also provided me with a hat and slippers. The father was similarly garbed, before we went into the delivery room. The alarm bells started ringing. Were they still stuck on this purity-danger-pollution myth? I thought back to the white dresses and white caps worn by the nurses in the foyer and my heart sank.

"She's at seven," the duty nurse-midwife told me, as we walked back to Rebecca's room, "but when they ruptured her membranes, the water was green, very green, meconium, you know. I'm surprised they're willing to have an observer with that kind of problem."

As we approached the room, I could hear the hollow pounding of a baby's heart - it sounded as if it were beating inside a metal tunnel, but it sounded fine to me. The fetal heart monitor, a metal box standing on four metal legs, stood directly to the right as we walked into the room. It was attached to the infant by way of red and green wires that ran along the mound of the mother's abdomen and disappeared into her vagina.

The nurse-midwife turned first to the machine and, picking up the long strip of paper that poured from it, examined the graphed lines that ran its length. Absently she asked the mother how she was doing, absently she acknowledged the small sigh and a humble, "Okay," and then, finally having satisfied herself with the paper, she turned her attention to us. She introduced me, smiled at the father, and said something about things being just fine. He looked at me, winked to let me know that he had everything under control in here, and resumed watching the basketball game. For a moment, his wife tried to find me with her eyes, but gave up. The nurse-midwife adjusted the band around Rebecca's abdomen measuring her contractions. Like most of the other monitoring tools, it inhibited Rebecca's movement. This frequently had the effect of slowing labour.

The nurse-midwife patted Rebecca on the arm, saying "The doctor will be here shortly," and then left. I sat quietly in the corner of the room.
Rebecca looked slightly confused, then turned to her husband. “Am I having a contraction” she asked. He leaned over her and looked at the machine. “Why, yes, you are, dear. Now then, let’s push.

His wife screwed up her face and grunted. She clearly didn’t feel the contractions because of the regional anesthetic she’d had. The only way she could tell that her body was proceeding with its labor was by way of the machine. Her urge to push was so numbed that she had to fake it - “just imagine you’re making your bowels move dear, “ The nurse-midwife re-entered the room and told Rebecca to forget it. She stopped instantly and resumed her fuzzy stare into space. Her husband pecked her on the forehead and lifted his eyes back up to the television.

The doctor arrived. He stepped towards the delivery bed, put one foot on the rail and stared at the screen on the monitor. He didn’t look at, greet or touch Rebecca. “Let’s get her ready” he said pleasantly, walking out.

The nurse-midwife began to reveal the hidden equipment. As if by magic the room transformed into a space age technical laboratory. Machines and trolleys of every description emerged out of their hiding places in artfully disguised cupboards. On the far wall panel of stainless steel was uncovered to reveal electric receptors, metal clips that held stainless steel instruments, and ropes of rubbery black cord hanging from hooks, black cords that swooped down to the floor and coiled loosely around the base of flat-faced lamps that were brought forward to cast light on the delivery table. It, too, was unmasked. It changed position to allow Rebecca to lie flat on her back for delivery.
The doctor, and the onlookers slipped on caps, slippers, gowns, and masks. The doctor and nurse-midwife donned glove and goggles. The attending nurse-midwife became a doughy clump of blue while the husband took on the shape of a blue monolith standing near his wife's head.

Rebecca's body, drugged and heavy, was rolled awkwardly into the delivery position. Her legs were slipped into huge canvass socks that tied at the knees, and then they were lifted into the leg stirrups and bound with belts and buckles, twice on the foot and twice on the thigh. Once she felt a push breaking through the anaesthesia, and then she was asked to pant her way through it so that they could get her bound up. The nurse-midwife spread a drape over each leg and then the doctor stepped forward and placed the last drape over her body. It covered her to the neck. From his viewpoint, all he could see was the vagina and the anus. The lamps in the room flashed on. The room made its final transformation into an operating theatre. We had moved from 'home-like' conditions to high tech all in the space of minutes, so thin was the veneer.

Rebecca was secured in the lithotomy position.

The doctor picked up a syringe and with his back to Rebecca, he flushed the point of the needle, squirted some of the fluid in an arc in the air. Without warning he reached into her vagina and twice drove the needle deep into her perineum.

Rebecca's husband hadn't said anything since the doctor came into the delivery room. Rebecca, the tip of her nose barely visible above the mountain of drapes, said.

Purity and danger - who is this ritual for? Creating an illusion of theatre - drama with the doctor as the main character - the culture hero charging in to save the baby from a carrier that has failed in its task.
nothing. The baby’s head was moving gradually out of the birth canal.

The doctor hadn’t spoken to her or touched her except to put the needle into her. Now he picked up a pair of scissors and cut from the birth canal toward Rebecca’s flank, through five muscle groups and an inch and a half to two inches into her. It was a textbook medio-lateral episiotomy to open up the birth canal up. The vagina was wide open and the bay’s head rested on the vaginal tissue in a dark pool of blood.

The doctor stood back and reached at arm’s length in the general direction of the baby’s head. He slipped his fingers under the baby’s chin and pulled it out. “There” he said dramatically, “that’s what caused the trouble. This baby was trying to push with his arm out in front of his head. He’s fine now.”

The doctor handed the baby to the nurse-midwife, who carried him to a small metal table in the corner of the room. A heat lamp went on and the baby kicked slowly; he was uncovered and exposed for the first time in his life. The delivery lights came on. “He’s cold,” the doctor said. “I’d like to warm him up under the heat lamp.” The nurse put a plastic suction tube down the boy’s throat, a machine hummed, extracting mucus. Without talking to him, she trimmed his cord, wiped his face, and weighed him. His mother had not seen him yet except at a distance; she hadn’t touched him.

The doctor delivered the placenta, settled down on his stool, flashed his needle in the lights, and began stitching. He stitched muscle for fifteen minutes. When he finished stitching he pulled his gloves off, walked to the baby, and gripping the boy’s chin between his thumb and index finger, said, “You’re quite a boy.” He went over to the father, shook his hand, told him he’d examine the baby in the nursery, and walked out.

No-one appeared to consider Rebecca in all of this—her feelings—her needs—emotional, spiritual or otherwise. The underlying assumption being that all that mattered was a live baby suitably rescued and cared for.

The nurse-midwife started undraping Rebecca who was shaking and complaining of being cold. Her husband said, “Yes, dear, you’re supposed to be.” The nurse said nothing, and continued unbuckling the straps that held Rebecca in her stirrups and untying the giant canvas

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socks. Finally, the nurse-midwife said, "As soon as I've finished here, we'll let you hold your baby for a minute," and finally, she got a light flannel blanket and put it over Rebecca's body.

The nurse left the husband and wife in the centre of the now echoing delivery room and took the baby down the hall into the nursery. When I left at 1.30 am, the baby was on a metal table under bright lights and heat lamps. A woman in the nursery was measuring him. As she left the delivery room, the nurse-midwife said, "Mother can see baby in the morning after doctor makes rounds."

**Ritual Processes at Work**

There are several points at which ritual processes are enacted and myths of childbirth (see figure 7.1) are played out within this story, for the purpose of brevity, I will address only three ritual processes drawn from the work of Robbie Davis-Floyd (1992) and personal observation and analysis:

1. **Electronic Fetal Monitoring (EFM).** Obstetricians and other supporters of electronic fetal monitors attribute the fall in perinatal death rate to their use. Others point out that there may well be other factors that contributed to the fall in death rate during the 1970s, including the increase in contraceptive use and the reduction in

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5 The pattern of the fetal heartbeat during labour often reflects the baby's condition. During contractions, the normal pattern is for the fetal heart rate to slow, returning to its previous pace as the contraction ends. The heart rate must be monitored during labor, because certain fluctuations in this pattern, such as precipitous drops in the heart rate at the end of a contraction, can constitute a true life or death situation requiring immediate emergency delivery of the baby. Before the invention of the electronic fetal monitor in the 1950s, nurses and doctors periodically monitored the baby's heartbeat themselves by placing a stethoscope on the mother's abdomen. Electronic monitors, attached to the mother by large belts strapped around her abdomen, continuously print out a record of both the fetal heartbeat and the strength, duration, and frequency of the uterine contractions, so that deviations from normal patterns can be identified. Part of what makes the use of the electronic fetal monitor so questionable is that acceptable degrees of variation in the fetal heart rate have never been firmly established. Not uncommonly, even extreme fluctuations result in perfectly normal babies born without technological intervention.
Figure 7.1 Myths of Childbirth: Obstetric Myths and Research Realities in Rebecca’s Story

**Epidural**
- **Reality:** Reported maternal complications of epidural analgesia include: hypotension, increased use of operative delivery, neurological complications, bladder dysfunction and even maternal death. The fetus may even suffer complications as a result of maternal effects and drug toxicity.
  - Simkin & Dickerson, 1989

**Myth:** Natural childbirth makes as much sense as natural dentistry, and epidurals are the Cadillac of anaesthesia.

**Myth:** An IV is necessary in labour because eating and drinking are dangerous — you never know when general anaesthetic might be required.
  - Reality: Eating and drinking are generally safe, healthy and natural practice for healthy, unmedicated women.
  - McKay & Mahan, 1988:331-221

**Fasting & intravenous fluids**

**Episiotomy**
- **Reality:** Like any surgical procedure, episiotomy carries a number of risks: excessive blood loss, haematoma formation, and infection. There is no evidence that routine episiotomy reduces the risk of severe perineal trauma, improves perineal healing, prevents fetal trauma or reduces the risk of urinary stress incontinence.
  - Sleep, Roberts, & Chalmers, 1989

**Myth:** A nice clean cut is better than a jagged tear.

**Myth:** Electronic fetal monitoring allows us to rescue babies from death or brain damage.
  - Reality: Twenty-five years after electronic fetal monitoring became part of intrapartum care, it is yet to be proved of value in predicting or preventing neurological morbidity.
  - Rosen & Dickinson, 1993:745-751
unwanted pregnancies, improved maternal health and increased intervals between births (Brackbill et al, 1984:10 cited in Davis-Floyd, 1992:107). Along with EFM came an increase in caesarean sections. The real reasons for increased caesarean section rates amongst electronically monitored labours may well be obstetrician's impatience and nervousness. Studies have failed to demonstrate benefits of routine EFM meanwhile doctors cite malpractice as a reason to persist, but since the plaintiff's can and do portray the most trivial findings as ominous, the monitor recordings may be more harmful than helpful. EFM appears to increase the risk of operative delivery without the justification of improved outcome. (Smith, Ruffin & Green, 1993:1471-1481) Even in the high-risk case of prematurity, no benefits result from using electronic fetal monitors instead of periodic manual auscultation (Shy et al. 1990:588-593).

In Rebecca and her husband's response to the electronic fetal monitor, we can observe the successful conceptual synthesis between Rebecca's and her partner's perceptions of her birth experience and the technocratic model. So completely had this model been "mapped on" to Rebecca's birth that both she and her husband began to feel that the machine itself was in control of her labour, indeed, even having the baby, whereas she was reduced to a mere onlooker.

**Ritual Purposes**

According to Davis-Floyd (1992:108) 'a common feature of rites of passage across cultures is the ritual adornment of the initiates with the visible physical trappings of their transformation'. In traditional societies the most deeply held values and beliefs of the society, are represented by such adornments as "relics of deities, heroes, or ancestors...sacred drums or other musical instruments" (Turner 1979:239). For Davis-
Floyd, this perspective provides an insight into the symbolic significance of the "EFM," a machine that has itself become a symbol of high technology hospital birth. The electronic monitor, once attached, becomes the focal point of the labour, as nurses, midwives, doctors, husbands, and even the labouring woman herself become both visually and conceptually fixed on the machine, which in turn shapes their perceptions and interpretations of the birth process—as in Rebecca’s story above.

The information produced by the electronic monitor is considered more authoritative than the information produced by the people involved generally and certainly more authoritative than the woman’s knowing, in particular. Jordan and Irwin (1989:13 cited in Davis-Floyd, 1992: 108) define "authoritative knowledge" as "legitimate, consequential, official, worthy of discussion, and useful for justifying actions by people engaged in accomplishing a certain task or objective". In early medical practice, doctors were completely dependent on their patient's description of his or her condition and on their own senses of touch and observation for knowledge about a complaint. With the invention of medical tests and procedures, medical practitioners became increasingly removed from the need to physically interact with their patients. ‘The recent shift in birth from a focus on the woman herself to a focus on diagnosis by machine parallels the same move in medicine, and both reflects and perpetuates the higher cultural valuation of objective knowledge over subjective experience (Davis-Floyd, 1992:108). This reliance on machines promises that the question of who knows what is really happening, and moreover what is best for the woman and her baby, will be resolved in favour of those who have access to the more valued technologically obtained information.
2. *Vaginal Examination*

Within the technocratic model the vaginal examination is an important procedure that is carried out at regular intervals since the woman is only allocated a set amount of hours in which to complete her delivery as defined by standard hospital policy. It is conducted by both nurses and doctors who insert gloved fingers into the labouring woman's vagina to ascertain the extent of cervical dilation measured in centimetres, how far it has effaced (thinned out), and whether or not the membranes are intact. Moreover the internal examination is used to insert the internal monitor and to measure fetal descent during second stage. If the woman’s labour is not progressing according to the standard tool of progress measurement, interventions must be instituted.

Cervical examinations are often quite painful especially when performed during the height of a contraction, as is often the case because more information can thus be obtained. The attending nurse or obstetrician normally performs these examinations. In teaching hospitals, however, any doctor in need of practice is likely to perform an examination sometimes without introduction or seeking permission. Each examination performed increases the woman’s risk of infection, especially if her membranes have been ruptured. At each examination the woman’s natural rhythm of labour is interrupted with the risk of increasing her anxiety and tension, as well as from the psychological stress that is often produced if the woman is told that she is not progressing well.
Ritual Purposes

For Davis-Floyd (1992:112) any strategies the woman may have developed for coping with her labour in her own way will be disrupted by the frequent performance of vaginal examinations. Such examinations act as quality control mechanisms and are thus a necessary part of the industrial model of birth that attempts to reduce production time. These frequent production control checks are necessitated by the standardization of modern birth, not by the physiological needs of the birthing woman and her child. In no other culture have such invasive, disruptive, and painful procedures been performed with such frequency and regularity as in the American hospital (Davis-Floyd, 1991:112), although in Britain such practices are rapidly being adopted. These frequent cervical examinations act to convince the labouring woman about the significance of time, about the suspected defectiveness of her own body, and about her lack of status and power relative to the hospital staff (the institution's representatives) and the institution (society's representative).

Painful cervical examinations also function as part of the ritual process in creating impersonal hazing of the initiate to ensure the complete breakdown of her category system so that she will be as psychologically open to the reception of the messages imparted by her birth experience as possible. These examinations powerfully intensify the process of symbolic inversion begun earlier. Imagine the messages conveyed to the woman by a series of strangers invading her body with their fingers through her vagina and deep into her cervix. For as Davis-Floyd states, this must approach the extreme opposition of a woman's usual ideas of an appropriate relationship between herself and society--an extreme that will ultimately be reached on the delivery table with the lithotomy position.
3. Lithotomy Position

The majority of hospitals and obstetricians in America still insist on placing the woman about to deliver her baby in the lithotomy position. The woman lies with her legs in stirrups and her buttocks close to the lower edge of the table. She is thus in an ideal position for the attendant to deal with any complications, which may arise (Oxorn and Foote 1975:110 cited in Davis-Floyd, 1992:121). This position, in other words, is the easiest for performing obstetric interventions, including maintaining sterility, monitoring fetal heart rate, administering anaesthetics, and performing and repairing episiotomies (McKay and Mahan 1984:111). From this position the baby is born heading upwards towards the obstetrician. The supine position, however, is possibly the worst conceivable position for labour and delivery for both the woman and baby.6

Ritual Purposes

For Davis-Floyd (1992:123) the lithotomy position completes the process of symbolic inversion that was set in motion since the woman was first put into the hospital gown on admission. Her normal bodily patterns of relating to the world have now been quite

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6 There are a number of problems generated by the lithotomy position, namely: it focuses most of the woman's body weight squarely on her tailbone, forcing it forward and thereby narrowing the pelvic outlet, which both increases the length of labour and makes delivery more difficult (Balaskas and Balaskas 1983:8); it compresses major blood vessels, interfering with circulation and decreasing blood pressure, which in turn lowers oxygen supply to the fetus (for example, several studies have reported that in the majority of women delivering in the lithotomy position, there was a 91% decrease in fetal transcutaneous oxygen saturation (Humphrey et al. 1973, 1974; Johnstone et al. 1987; Kurz et al. 1982); contractions tend to be weaker, less frequent, and more irregular in this position, and pushing is harder to do because increased force is needed to work against gravity (Hugo 1977), making forceps extraction more likely and increasing the potential for physical injury to the baby; placing the legs wide apart in stirrups can result in venous thrombosis or nerve compression from the pressure of the leg supports, while increasing both the need for episiotomy and the likelihood of tears because of excessive stretching of the perineal tissue and tension on the pelvic floor (McKay and Mahan 1984).
literally up-ended: her buttocks on the edge of the delivery table, her legs widespread, and her vagina completely exposed. 'As the ultimate symbolic inversion, it is ritually appropriate that this position is reserved for the peak transformational moments of this initiation experience: the birth itself' (Davis-Floyd, 1992:123). The official representative of society, its institutions, and its core values of science, technology, and patriarchy stand not at the woman's head nor at her side, but at her bottom, where the baby's head is beginning to emerge.

This, for Davis-Floyd, represents a total inversion, appropriate from a societal perspective, as the technocratic model promises that women can give birth with their cultural heads instead of their natural 'bottoms'. The cultural value is placed on the baby, who is emerging at the "top" toward the obstetrician and indeed emerging upwards against gravity – struggling against and symbolically conquering nature.

Conceptually speaking, the downfall of the initiate's category system is now complete. The lithotomy position expresses and reinforces the woman's now total openness to the new messages. One of those messages speaks so eloquently to her of her powerlessness and of the power of society at the supreme moment of her own individual transformation.

Obstetrics practices and hospital childbirth policies deconstruct birth, then invert and reconstruct it as a technocratic process through hospital ritual procedures. Unlike most transformations effected by ritual, however, birth is not dependent upon the performance of ritual to make it happen. The woman is transported into a naturally
liminal space that carries its own affectivity, through the physiological process of labour itself. Obstetric procedures and hospital policies take advantage of that affectivity to transmit the core values of American society to birthing women. The birth process will not be deemed successful from society's perspective unless the woman is properly socialised during the experience, transformed as much by the rituals as by the physiology of birth. Despite the power of these covert symbolic messages, the technocratic model of birth is overtly predicated on science. As Davis-Floyd (1992:124) reminds us, when there is a discrepancy between scientific fact and actual practice, as with the lithotomy position, that model must either be abandoned. This may well be the case among practitioners and women in some parts of the USA and in other countries of the modern world, or expanded to accommodate the most compelling scientific evidence that challenge its standard operating procedures, for example, the development of new technology that accommodates the changes in practice.

This transformative process is neither inherently negative or inherently positive since every society has a need to socialise its members into the social norms. Relying on surveillance and sanctions to make them conform would be impractical. It is more practical for societies to socialise their members internally, by making them want to conform to societal needs. Every culture has developed rituals to ensure just that. Women, however, are not automatons, and the extent to which this type of ritual succeeds will be discussed in chapter 9. Despite the power of obstetricians and the dominant medical model, there is a resurgence of interest in midwifery in the United States as a counter-balance to the medical supremacy.
Alternative Constructions of Childbirth: The Midwifery Model

By contrast, the midwifery model (Gibson, 1999; Schlenzka, 1999; Idarius, 1999) the United States aims to empower women by assisting them to actively engage with the challenges of pregnancy and birth. Traditionally, midwives view pregnancy and birth as healthy, normal everyday events, albeit ones that require supervision and care. In the midwifery model, the childbearing woman has the central role and the midwife watches over her, serves her, provides information and support, ultimately facilitating the birth process itself. Decision making is collaborative and any intervention needed often begins with what the woman can do for herself. Often women in America study midwifery in hopes of becoming closer to other women; not just as friends, but with the goal of establishing support systems and creating community. The evolutionary social aspect of midwifery was that it motivates women to extend the responsibility they take in birthing to one another, breaking out of isolated nuclear families into networks of interdependent mothers and children, identifying and sharing their resources. Thus midwifery can be linked to social innovations such as the provision of childcare facilities in the workplace, and generally a more tolerant attitude towards women who try to interface family life with their career.

Certainly the midwife appears to be an advocate of choice. Midwives in America vigorously defend the right of parents to choose their place of birth, as they fight for their own right to practise in a variety of settings. Hospital privileges are often denied midwives in the U.S. and home birth is still controversial, although statistics have
repeatedly shown home delivery to be as safe or safer than hospital birth (Mehl, 1977; Sullivan & Beeman, 1983; Duran, 1992).

My home delivery statistics were striking. I rarely did episiotomies. At first, I thought it might be a accidental— that I'd had a run of women with favourable birthing bodies. In those first months of doing home deliveries, Lette and I watched women, eight centimetres dilated, making coffee for us while cooking a family meal, bending and cleaning, making the bed, and stepping into the bathroom for a quick shower. We were used to American women in hospitals, eight centimetres dilated, who believed they needed help to sip water. (Mary,, 1995).

The majority of women wanting midwifery care choose to give birth at home. Typical reasons include greater comfort and less intervention. Despite the resurgence of midwifery, midwives themselves are constantly under duress from the dominant medical system as the following extract illustrates.

The actual work done with these women seemed to counter the contamination and warped values that the prevailing systems often reflected. I have worked in University settings, small county hospitals, large county hospitals, private BO (MD) practices, and one midwifery practice. All used the hospital as the birthing setting. All situations competed with physician’s caseloads.

Frequently I have had faculty appointments at large universities and have taught residents, medical students, midwifery student, nursing students, etc. The teaching role as a midwife is a balancing act between the client-midwife relationship and the learner’s needs. At times I justified teaching as a process of “humanizing” birth in the
larger picture. Lately, it is a sense that I have to do it or lose my job, despite the fact that the physicians I am teaching are the ones who will go into practice and decrease my numbers, causing my layoff. Competition is healthy if the playing field is level. It is not for midwives, and more recently, specialists.

I went into midwifery twenty years ago. It was a passion to care for women and families in the birth process. I wanted my work to be integrated into my life. I wanted a community where I could be part of the web. Watch the babies grow. Nurture my own homestead. Raise my own family. Participate in community events. A slow and thoughtful life, I hoped.

It seemed there was a crossroads when I chose the route into midwifery those many years ago. I opted to be a CNM because I didn’t want to work underground which was the tone at that time. I enjoyed school. I had the freedom to study on the east coast which was cross-country move at that time. I hoped to be part of the process of change which would allow more women to be midwives in their home communities. I always supported the home as an appropriate birth setting. I do not relate to a nursing identity and never worked as a nurse. I helped set up birth centres in the seventies. I wanted a “real” salary and benefits. It became increasingly clear that salary and benefits are a luxury if you want to practice out of the hospital or not to be on call the majority of your life. Now, midwifery seems polarized, when I felt we used to be sisters. I am at the end of my ability to compromise with the mainstream medical/midwifery scene (Petra, 1995).

Alternative Constructions of Women’s Lives and Childbirth: The Amish Society

In Lycoming County, I was privileged to meet with an Amish midwife, Mary, who invited me into her home and conveyed many birth stories from her years of practice as a lay midwife. Mary showed me a quilt that was embroidered by the mothers she had delivered. The first patch was made by the first delivery she conducted and had the
name of the mother, father and child embroidered on it. Several generations later, Mary could point to the history of birth in that family, to all the siblings and relations that she had helped to birth over the years. It was a history of not only her life but that of the community she served. Such traditions are an important feature of the Amish community.

Mary belonged to the Old Order Amish (see appendix 3) who are among the most conservative descendants of the 16th-century Anabaptists. They are usually distinguished from the Amish Mennonites, Beachy Amish and the New Order Amish by their strict adherence to the use of horses on the farm and as a source of transportation, their refusal to allow electricity or telephones in their homes, and their more traditional standard of dress, including the use of hooks-and-eyes fasteners on some articles of clothing.

In the last century the Old Order Amish population grew very rapidly. In 1900 there were approximately 3,700 Amish in North America. By 1990 the estimated figure had increased to 127,800 (adult membership approximately 56,200). According to Erickson (1979) and her colleagues, the Amish were among the fastest-growing populations in the world at that time. They prohibit the use of contraception and have low infant mortality rates. The average Amish woman expects to have at least seven live births. Childbirth in Amish society is unheralded and taken as an everyday event as can be seen from the rather lengthy story that follows. The full text is provided here to act in juxtaposition to the story of Rebecca’s birth. The purpose of this will become clear in chapter 9 as I reflect on the case studies and attempt to draw some conclusions.
Yesterday I delivered Ruth and Jacob’s baby. Ruth had a bunch of things yet to do before she had her fifth baby, and she was especially determined to get into a quick bath. She had her husband running here and there, looking for various unspecified items. I think she was just keeping him occupied as usual. I asked her if she felt like pushing yet and she said no, she didn’t, and besides she needed to have a bath. She’d been working in the field bundling up sheaves of corn right up until I arrived and her feet were dirty.

I’d set out my things in the bedroom, and sat down to read a magazine article about growing herbs. Ruth’s husband, Jacob, brought in some things I needed, and just before he sat down, Ruth called from the bathtub, “Ask Rachel if she wants any tea, Jacob.” I didn’t, so he sat down to read the weekly newspaper that serves Old Order Amish communities. There wasn’t a sound in the house except for the ticking of Ruth’s clock.

She came out of the bathroom about ready to push. “Come on, Jacob,” she said, “let’s go have this baby.”

Ruth and Jacob’s bedroom was too warm, and Jacob opened a couple of windows just an inch or two. It began to rain outside the window, the wind gusted, the white-dotted-Swiss curtains billowed slightly at the window, and the smell of wet earth filled the bedroom. There are always deliveries - count on it - on nights with thunder and lightning. Something about the barometric pressure. We got Ruth settled on her bed, arranged her pillows, and her husband lit a bedside lamp. For a while, I massaged her feet and legs; her husband dusted his hands with talcum and rubbed his palms into the small of her back.
“Okay, Ruth. Let’s get you up on your knees. We need to give those bones the best chance to spread for the baby’s head.” Ruth sat with her bottom resting on her heels. I worked the perineum with my fingers, helping it stretch. “That’s good. I can see the baby’s head now.” The baby came bounding down the birth canal. It turned, slid under the pubic bone, and then its head began to bulge. The perineum thinned. I put my fingers on the cap of the baby’s head to keep it from coming too quickly, to give the perineum a chance to stretch. I asked Ruth to pant, which slowed the baby’s coming. The baby’s head rotated, showing its slant of forehead, then more and more. The perineum slipped over the brow of the face. “There now, there, Ruth, there’s your baby’s head.”

Jacob couldn’t stand it anymore, he had to have a better look. He dropped his wife’s hand for a minute and came over to look over my shoulder to see the head. “One more push for the body”, I said. Ruth, not losing any momentum, surged one more time, and the baby was out. It started crying right away.

“It’s a boy”, I said, putting the baby on the bed next to Ruth and covering him with a receiving blanket while I cleaned fluids out of his nose and mouth with a syringe. Ruth stayed on her knees, a small amount of blood pooling about her, then giving its standard warning with a narrow rush of fresh blood - the placenta followed. Ruth said little. She had one arm free and, drawing the baby toward her, she cuddled him at her side. Jacob said, “This will make Grandam’s seventy eighth grandchild - that is, if somebody hasn’t beat us to it.”

Jacob cut the cord, we wrapped the baby a little better. I passed the baby to Jacob to carry about - “leave his head a little lower than the rest of his body so that he won’t choke on any mucus” - while I washed Ruth. She was shaking from having used up all her energy, so I covered her up with piles of family quilts and got her some apple juice.

Ruth and Jacob’s baby would be called Caleb. I washed him, amusing Ruth with my conversation as I did, weighed him, and then put him back on the bed to check him. Telling him who he resembled who the grandparents were, I dressed him and wrapped
him in a receiving blanket. I put him under the crook of his mother's arm and he started nursing.

I left Ruth and Jacob's house after the baby had started nursing at the breast. I said, "keep the baby warm and to help him get gradually accustomed to the outside world. Let him sleep next to you. Don't worry, you won't roll over on him - you'll know he's there."

In many communities the Amish have acculturated into the dominant culture to some extent. They have borrowed technology as well as ideas from their non-Amish neighbours. Examples of the former included the increase in the use of diesel or gasoline engines to provide power for machinery. Indoor plumbing, gas stoves, and refrigerators were found in more and more Amish homes. In some Amish homes secular as well as non-Amish religious print materials were found. Ideas which were not part of their culture are making their way into the Amish community. The following story exemplifies some of these changes.

Jennifer on Amish birthing (1995)
Jennifer is a nurse-midwife working among the Amish. I live in Indiana, which is a state where direct entry midwifery is a class D felony. I don't know anything about the stats. Because we are illegal, it is very hard to get good stats.

The Amish are regarded as quaint, picturesque, or with nostalgia, (the good old days), but they are mostly just women having babies, lots of babies. I had to learn practical things when working with the Amish. Lighting at night, no telephone if another client needs to talk to me, warming the house quickly, etc. The births, the babies, the sounds, the emotions, the beauty...it is all universal. "My" Amish clients eat a lot of junk food, highly processed foods, and home grown foods full of pesticides. They wear polyester, use pampers, have a high percentage of hospital births, a high caesarean section rate, (also a VERY HIGH hysterectomy rate) and don't breastfeed very long. Most of my work with them is trying to get them to have more prenatal care, better diets, to work less, especially postpartum
(which is a losing battle), and to breastfeed longer, which besides being good for the baby, will help delay the return of menses, and consequently next baby. They are interested in that! I probably do one or two Amish births a month, 3-5 a month total, but not all of those are primary care. I work with two other midwives and attend births with them also, as much as I can. (Jennifer, 1995)

While acculturation is occurring, there was no evidence that Amish culture is on the verge of disappearing. In discussion during fieldwork, the Amish I encountered clearly understood the boundary between their culture and the non-Amish world. Where change was deemed to be necessary, as in the case of providing Mary with a telephone in her home, and, in some instances unavoidable, it was made cautiously and with a great deal of discussion.

Concluding Comment

As has frequently been noted in respect of knowledge in technological cultures, the latent meanings implicit in bio-medicine lie in the very assertion that it is free from the influence of symbol and value. This is what a series of writers have referred to as the ‘de politicising’ role of modern science (Barthes, 1973:142ff; Habermas, 1971:114; Marcuse, 1972:130) which is fundamentally conservative because it supports the status quo. While it is clearly naive to assert that medicine can be seen as the mere product of utilitarian social interest, its symbolic forms, like those of all human knowledge, express particular resolutions of more deep-seated paradoxes, and a world-view consonant with definite social interests.
I have attempted to demonstrate that childbirth in America is a process that emerges from a society that is based upon technocratic assumptions and a core value of individualism. Part of that process involves an increasing refinement of the use of technology in birth, but at the same time an expanded exposure of more women to instrumental childbirth in the drive to reduce mortality as an indicator of the countries well being.

I have made five arguments in this chapter: American midwives, doctors and women view women’s bodies as unpredictable within the context of the dominant ‘body as machine’ ideology that leads to a belief that childbirth is only normal in retrospect; therefore most women experience childbirth as a process that is fundamentally risky; this leads to a high degree of instrumentalism in childbirth. The power of the American hegemony is such that these notions are being transmitted globally and have impacted upon how women experience birth in penetrated countries.

I acknowledge that these arguments are neither profound or novel. However they are significant, and an awareness of them can help midwives deal with some of the myriad complexities that are involved in childbirth both within their own culture and in others for to quote one of the respondents:

*Sometimes a birth means so much more to a woman than anyone can know. It is not about having a cosy environment. If birth is examined deeply it can be seen that it is more than just a means to an end. A healthy mother and baby is, of course, the bottom line, but sometimes there are many other factors involved. In cases where anomalies not compatible with life are present some families will choose to birth at home. The risk is acknowledged but death and difficulty are emotional issues that*
touch the core of existence and sometimes those involved need to be in a place where they can deal with it in their own way. A hospital environment with its rules and routines often overlook the inner needs that go beyond the nice wallpaper and rocking chair. The needs are for support, emotional and physical, for quiet and the chance to take their time. For a couple facing the inevitable death of their baby being at home may mean having the chance to let their baby die in their arms as opposed to an isolate filled with wires and tubes. To be surrounded by people they know and trust. The kind of fast food prenatal care given to most women does not allow that kind of relationship to develop. While some improvement is being made in some areas of America, the dominant paradigm still prevails. (Samantha, 1999)

American society is a much more complex and geographically and culturally diverse country than I have described here. I was unable to explore all the different racial and cultural groups. Clearly issues of race, poverty and access to maternity care across the United States are important and have implications for childbirth and preparation of midwives, the research population in Pennsylvania, however, was largely Germanic in origin and relatively wealthy. The most significant contrast that I could draw was between the Amish and other women in the county that enabled me to examine childbirth and midwifery education from different standpoints. One interesting question I was unable to address was why it was that the Amish were protected so that they could pursue their religious and cultural practices including childbirth when the African American's were not. African American lay midwives were outlawed and were unable to practice their traditional birthing practices.
Chapter 8

Women in Childbirth in England

Britain is a highly urbanised country where the greater majority of women give birth in obstetric facilities, whether they are having normal or complicated births. The very nature of these facilities fosters a temptation to treat all births routinely with the same high level of intervention required by those women who experience complications. This can have a wide range of negative effects, some of them with serious consequences. These range from the sheer cost of time, training and equipment demanded by many of the methods used, to the fact that many women may be deterred from seeking the care they need because they are concerned about the high level of intervention. Moreover, women and their babies can be harmed by unnecessary practices. Staff in maternity units can be rendered dysfunctional if their capacity to care for women with complications is swamped by the sheer volume of normal births that present themselves. In their turn, those normal births are frequently managed with standardised procedures that can only be justified in the care of women with childbirth complications.

Childbirth in the United Kingdom is very similar to that in the United States of America with a few notable exceptions. The first is that midwives operate freely and within the law in the United Kingdom. The second difference is that maternity services in the UK are concerned to provide women with choice, continuity and control in childbirth. These
themes were to become a central force in the Changing Childbirth report (Department of Health, 1993). At least the rhetoric was one of choice, continuity and control – the reality was and is frequently very different. In many other respects childbirth in the United Kingdom is the same: technologically determined, scientifically driven and medically dominated. The experiences of women and midwives point out the seemingly paradoxical nature of discontent with maternity services in the UK given the continued fall in perinatal mortality. There are persistent calls from women, pressure groups and midwives for a balance between considerations for the safety and the social aspects of childbirth. In the context of most health care systems in the industrialised the world, this is a radical perspective that recognises that childbirth is much more than a medical event.

Women in the United Kingdom do not need to be under the care of an obstetrician during their pregnancy or childbirth. Instead they could opt for midwifery care or indeed, none at all. Despite the apparent greater freedom of choice women have in the UK, there remains dissatisfaction among both women and midwives, which beg the following questions:

How is childbirth being reconstructed in England?
What are the symbolic exchanges that are creating the ‘space’ for changes to occur?
How do these exchanges impact on women and midwives?
Two Approaches to Childbirth:

Childbirth in the UK is changing, but in two opposite directions. One is toward woman-centred, holistic care provided by midwives, and the other is toward increasingly high technology obstetric management. Most childbirth in England now takes place in hospitals. The increasing medicalisation of childbirth is one aspect of social change, and its effect is carried on throughout the continuum. In an attempt to mediate across the divide midwives, women and obstetricians have more or less adopted a risk approach to childbirth. If a woman is deemed to be low-risk then her care falls within the domain of the midwife and her choices are more extensive - her place of birth, labour carer, position and so on. If a woman is deemed to be high-risk, then her care is more restricted and falls within the domain and control of the obstetrician. Risk assessment is based on probability - probability demands calculation. Because of the unpredictability of pregnancy and childbirth, the probability of something happening must, by default, be high - consequently all pregnancy and childbirth is risky.
Risk Approach in Maternity Care: Comparing the Risks of Childbearing for Women in Different Circumstances

Childbearing can be one of the most special events in a woman’s life. It can also be one of the most dangerous. (WHO 1987)

The improvement in perinatal mortality rate in the United Kingdom that followed improvement in maternal health status unfortunately coincided with increasing obstetric management. It was then 'all too easy’ to attribute the declining perinatal mortality rate to the benefits of obstetric management. The "risk approach" to maternity care has dominated decisions about birth, its place, its type and the caregiver for decades (Enkin 1994). The problem with many such systems is that they have resulted in a disproportionately high number of women being categorised as "at risk", with a concomitant risk of receiving a high level of intervention in childbirth since most

...obstetricians...have become convinced that the natural process of birth is fraught with dangers, which their increasingly sophisticated technological interventions are increasingly capable of minimizing. Amazingly, they have managed, without producing any valid supporting evidence, to persuade the majority of people, medical and lay, that they are right. (Tew, 1986: 659)
Relatively few people now believe that for healthy women, giving birth is a normal physiological process, which obstetrics cannot improve, though it can harm or that only in rare cases do obstetric interventions unquestionably help.

Obstetricians have used risk assessment to identify women who may have major medical difficulties during pregnancy or delivery. Typically, they label as "high-risk" those women who become pregnant under 15 or over 40 years of age, who already have more than five children or a recent newborn, or who have health problems such as diabetes, heart disease, or hypertension. These assessments are used to encourage non-pregnant women in high-risk categories to practice effective contraception and to monitor pregnant women for special treatment and referral if necessary.

For Rooney (1992) the effectiveness of a risk scoring system is measured by its ability to discriminate between women at high and low risk, that is by its sensitivity, specificity, positive and negative predictive value. Exact figures about the discriminatory performance of these risk scoring systems, however, are difficult to obtain, although such estimations are made (Van Alten et al 1989, De Groot et al 1993). For example, defining obstetric risk by demographic factors such as parity and maternal height has a low specificity and therefore results in many uncomplicated deliveries being labelled as high risk. The specificity of complications in the obstetric history or in the present pregnancy may be much higher. The problem with this analysis however, is that consideration of other factors such as social, environmental and health factors are seldom is included. Surveillance during birth cannot make up for a history of poor health, malnutrition and environmental hazards. Surveillance only leads to intervention
after the fact and this is often of little value to the present pregnancy or birth. It is less than useful in terms of prevention. Neither can high quality antenatal care and risk assessment substitute for adequate surveillance of mother and fetus during labour (WHO, 1999).

Obstetric risk assessment is a continuing procedure throughout pregnancy and labour because it is viewed that at any moment complications may become apparent and may induce the decision to refer the woman to a higher level of care. This is based on a view of childbirth in which the woman’s body is unpredictable, under duress, and requiring structure as shown in figure 8.1 below. Within this categorisation, the midwife functions within the dominant medical domain and her roles are of observing the conventions and maintaining the status quo of the medical paradigm (see figure 8.2). The language used is that of the medicine. Women are seen as patients, birth is spoken of in terms of confinement, and women are expected to be passive. Medicine lays claim to authoritative knowledge and women’s ways of knowing and knowledge of their bodies are regarded as inferior. Ultimately, women lose their identities and control as a result of the institutions ritual processes as described in Rebecca’s story in chapter 6.

*Figure 8.1 Myths of Childbearing*

1. Pregnant women are robust
2. Pregnant women are unpredictable
3. Pregnant women need structure
4. Pregnant women are under duress
5. Pregnant women are vulnerable to dark outside forces

See chapter 2 following figure 2.1 for more details
The prevalence of the concept of obstetric risk drives us towards a deficit model of maternal and child health, which leads to an ever increasing expenditure on technological development and further medicalisation. The risk concept in this case has severe limitations and yet, it continues to be used. The simplistic quantitative concept leads to reductionist approaches and focuses upon false risk factors, for example, grand multiparity that is a risk only in situations of poverty (Bergstrom, 1996).

The risk model is most ardently argued in the heated debates surrounding birth location. Many obstetrician and paediatricians argue that hospital is the safest place for a woman to be delivered of her baby (see for example, Young & Drife, 1992; Campbell and Macfarlane, 1994; Northern Region Perinatal Collaborative Survey 1996; Davies et al, 1996; Chamberlain et al, 1997; Drife, 1999; Young & Hey, 2000).

Reconsidering Relative Risks

Childbearing may well be physically risky, but it is also a highly emotional events imbued with pleasure and joy, anxiety and pain. The motives for having (or not having) a child at a given time are changeable, contextual, and often contradictory. Having a child is a social event of great significance to immediate families, extended kin groups, communities, and other social networks. Do we really know how women in different circumstances weigh these alternatives?
As a basis for making decisions about health care, the application of formalised risk assessment is too narrow. Moreover, applying group risks to predict individual outcomes can be misleading. We need to listen more closely to how women in different circumstances assess the costs and benefits of alternative childbearing options, because when we recommend that a woman use obstetric care, we are asking her to take risks that we cannot predict. These include not only physical risks, but also social and emotional risks that directly concern her in a multitude of ways unknown to the obstetrician or midwife, who inhabits a very different social world.

Why did childbirth have to change? —One woman’s experience.

Becky was a young woman who had found herself in a hospital in 1999 where the policies and procedures of the institution were far more important than her needs and desires. Whilst the midwives were being kindly and relatively friendly, they were distant and, to Becky’s viewpoint, uncaring. In many ways Becky could be deemed fortunate since she at least had the attention of one key midwife throughout her labour. For many women this was not the case and they might be attended by a number of midwives throughout the duration of their labour and deliveries as well as other medical personnel.
Myths of Childbirth

Women's bodies are unpredictable

Pregnant women need structure

Risk Averse

Conventional midwifery
Practice by Conventional Midwife (Nurse-Midwife)

Words, Beliefs and Actions

Based on 'Body-as-Machine' metaphor

Medically defined Obstetric Risk Model of Childbirth

Pregnant women need structure

Hierarchist

Pregnant women are vulnerable to 'dark outside forces' - woman's own body as enemy

Ritualist

Aligned with medical ideology

Characterised by strict control over time (clock-watching), measurement (electronic monitoring), standardization and routinization of practices (partogram), specialisation

Abstraction - recording only what is important to medical team not what is important to woman

Sees woman as patient. Speaks of home/hospital confinement. Birth seen as pathological in prospect. Women are required to be passive – inferior. Women lose their identity – i.e. through hospital rituals
I was home alone because Mum had gone to work – she’s works in a nursing home on night duty and the baby’s father was out of the picture – he’d run off months ago. I’d had the pains for a few days but they had gotten worse so I rang a friend for advice. I couldn’t ring the midwife again I’m sure she was fed up of me. Anyway we’d decided that I should go to the hospital. I called a cab and arrived in the admission room door around 2am. I rang the bell as the nurse in the clinic had told me to do and the midwife opened the door and invited me in. She took my card and took me round to the admission room. The sister came round from the labour ward to see what was happening – she put her hand on my tummy and told the midwife to carry on with the admission – “have you had your bowels opened today?” she asked – what a question to ask – I was embarrassed and didn’t answer straight away – then shook my head. “Give her an enema then, we don’t want you making a mess when the baby is born do we?” What did she mean – make a mess? Anyway I had the enema then had to have a bath. I had only had a shower before I came out and I told the midwife but she insisted that I have another wash. I then had to dress in this awful white hospital gown which was open at the back – everyone could see my bottom. Why did I have to wear that? I told the midwife that I had brought my own nightie. “It’ll only get dirty so you might as well use ours,” she said. When I was ready, the midwife made me get on the table and started to prod my tummy. Then she put this big belt around my middle and put a cold round thing on some clips on the belt (the transducer) she didn’t tell me what she was doing. Then there was this loud thudding noise coming from the machine by the bed. “That sound fine” the midwife said and left the room. That must be the baby’s heart, I thought.
The midwife came back and looked at the strip of paper coming out of the machine. "I'm going to examine you now", she said. She pulled the sheet away from my legs - I was naked. She took a pack off the shelf, washed her hands and then put on some gloves. She then told me to open my legs and put my heels together. She then put her fingers inside me. Well it hurt a lot - especially since I was having a contraction at the time - it brought tears to my eyes. "What is the matter?" the midwife asked. She was trying to be kind but she didn't stop her examination. Without telling me what she was doing, the midwife took a long pointed stick and put it into me and I felt a pop and then warm fluid running down onto the bed. (The midwife had ruptured Becky's amniotic membranes.) A few minutes later the contractions became much stronger and more painful. I was very distressed and the midwife called the doctor. "She needs and epidural" she said. The doctor rang the anaesthetist who finally came about an hour later. "I'm just going to put a needle in your arm and then give you a small injection in your back —you won't feel anything after that." I hadn't asked for an epidural and they didn't tell me what effect it might have. I didn't say anything —I thought, they must know what they are doing.

Later, the contractions seemed to go off, although I couldn't tell anymore so I had to have something to speed them up again. By now it was about 11am and I had been left alone in the labour ward for hours - with the midwife just popping in from time to time to look at the machine or take my blood pressure. I asked if anyone had rung my mum - they hadn't of course. They didn't seem to care really.

Midwives in the United Kingdom proudly announce that they are 'with woman'. Midwives are 'with woman' when inductions are performed; do they question the reason? Midwives are 'with woman' when unnecessary vaginal examinations are carried out; when early amniotomies are performed to stimulate stronger contractions. Midwives are 'with woman' when fetal monitoring immobilises women into physical inactivity and psychological passivity; when systemic analgesics are used inappropriately; when women are coached in second stage to "push, push, don't waste
the push"; and so on. Do midwives who are 'with woman' seek to restore to the woman the authority for her own body - authority that has been eroded over generations? Or do they stand by passively as the labouring woman progressively loses confidence in her ability to birth, then nod their heads sympathetically when she says she needs an epidural?

Becky had been defined as high risk in this context because she was seventeen, unmarried, and did not appear to be well educated – an assumption based perhaps on the fact that she failed to answer questions quickly and that she cried when examined. The power differential in this case was clearly in the favour of the midwife and doctors who attended Becky. She had little say in determining the course of her own labour. Many would argue that the pain of childbirth only becomes intolerable when a woman is in hospital, removed from her own environment and where her ability to exert control over the events diminishes (Symonds & Hunt 1996:94). Arney (1982) argued that pain relief is itself a way of exercising control over women. Moreover, an epidural renders a woman not only powerless but also immobile in more ways than one (as discussed in chapter 6). The pain of humiliation is as great for some women as the pain of childbirth and indeed, may well exacerbate it. This in turn renders the woman dependent upon the midwives and medical staff. The culture of dependency ensures that the doctor who is the expert makes the really important decisions. So Becky's birth becomes pathological, an illness requiring diagnosis and medical intervention to ensure a safe outcome. As Illich (1976) stated 'Diagnosis always intensifies stress, defines incapacity, imposes inactivity, and focuses apprehension on non-recovery, on uncertainty, and on one's
dependence on future medical findings, all of which accounts to a loss of autonomy or self-definition'.

Midwives and women under cover

In 1976 two student midwives shared their frustration and disappointment with the increasing medicalisation and intervention in maternity care and began meeting regularly for mutual support and study. Others joined them and in 1978 the group named themselves the Radical Midwives.

Why "Radical"?

In the mid 1970s, the large number of pregnant women in UK had labour induced by artificial rupture of membranes (ARM)\(^7\) around the date they were "due". These initials were used when the group needed a name, and so the Association of Radical Midwives was born, using the dictionary definition of "radical", (roots, origins, basics, etc.) which aptly described the basic midwifery skills they hoped to revive.

By the early 1980s, childbirth was already beginning to change. Both women and midwives influenced by reading literature and from experiences of birth in different contexts in different countries began to practice alternative approaches to childbirth that

\(^7\) ARM has been pro-active on many issues, which threaten midwifery and good maternity care, campaigning and lobbying in support of an enhanced service within the NHS for childbearing women as well as a strong professional identity for midwives. The Association has earned the respect of Government departments and other bodies on midwifery issues, and is now consulted at all stages of enquiries in the field. One of our members was appointed adviser to the House of Commons Health Committee during the wide ranging enquiry into maternity services in the UK which reported in 1992 (The "Winterton Report"). Many ARM members are elected or appointed to the UK professional regulatory bodies, as well as to the Council of the Royal College of Midwives, which is the largest professional organisation for midwives in the world.
challenged the dominant medical model. These women and practitioners aligned themselves with a cultural type that viewed women's bodies as robust and birth as a natural, everyday occurrence. They adopted a social model of childbirth (see figure 8.3) that enhanced the social aspects of childbirth as well as ensuring the safety aspects were addressed. Birth was defined as physiological. The woman was seen as the active and powerful central player in the birth event. The language is one of the social rather than medical world. In this model women maintain their identity and their control.

**Figure 8.3 Social Model of Childbirth**

![Figure 8.3 Social Model of Childbirth](image)

- **Myths of Childbirth**
  - 1. Pregnant women are robust
  - 2. Pregnant women are unpredictable

- **Crusader Midwife**
  - See women as equals. Speaks in terms of home/hospital *birth.* Birth is seen as physiological, normal in prospect. Women maintain their identities, i.e. wear own clothes, in control

- **Individualist**
  - Based on *Body-as-natural-organism* metaphor
  - Characterised by freedom of choice, negotiation, continuity of carer, natural rhythms. Support, encouragement

- **Isolate**
  - Pregnant women are under duress in risk society - risks are from high technology and medical instrumentalism

- **Choco-Warriors (Egalitarians)**
  - Choco-Warriors (Egalitarians)
Kate was a woman in her mid-thirties who was having her first baby. She had read extensively and was a member of the National Childbirth Trust. She was committed to having an active birth after hearing Janet Balakas speak at a conference.

Kate’s husband was fully supportive that this labour should be drug free and as active as possible with Kate walking around the room unencumbered by technology. An alternative model of childbirth

It must have looked a strange sight. Here, amongst some of the world’s most advanced obstetric technology Kate was giving birth on the floor.

Kate was not from some foreign land, she just an English woman who had read about and wanted an active birth\(^8\). She had arrived at the hospital in advanced labour and while the midwife was reviewing her antenatal records, Kate had quietly left her bed and began squatting on the floor. As she squatted, her waters broke. The midwife hurriedly placed some “sterile” sheet under her and joined her in a squatting position. Within minutes, a healthy baby girl slipped gently into the hands of the midwife. I was that midwife and this was more than fifteen years ago long before Changing Childbirth. (Birth report 1985).

The anomalous image of a squatting woman giving birth surrounded by the gleaming, modern equipment in a labour ward is a fitting metaphor for the problematic relationship some midwives have with technology. The question is can midwifery, with its low technology, non-intervention tradition, find a place in an environment where competence is equated with the use of the latest, high technology procedures? In deciding how to respond to the new technologies of birth, midwives face a dilemma: if they adopt the instruments of modern medicine, they risk sacrificing their distinctive tradition; if they cling to their tradition, they risk marginalisation as old-fashioned, bizarre, or perhaps, even dangerous practitioners. The dilemma of ‘midwives among the

\(^8\) An Active Birth is nothing new, it is simply a convenient way of describing a normal labour and birth and the way that a woman behaves when she is following her own instincts and the physiological logic of her body. It is a way of saying that she herself is in control of her body, rather than the passive recipient of an ‘actively managed’ birth on the part of her attendants (Balakas, 1991)
machines,' is also, in fact, a problem for women in childbirth in the United Kingdom as elsewhere. As the world around them changes, women and midwives must adapt, they must 'recreate' themselves.

_The beginnings of change_

Left in the hands of medical practitioners and their strong government lobby, costs of maternity services escalated because of the assumptions made that more obstetric care and intervention would mean less death and morbidity. This was and continues to be aided and abetted by the media and the legal system. As British society becomes increasingly litigious, any hope for less medical intervention and its consequent high expenditure and more social amelioration of health hazards will decline. Nevertheless, growing concerns regarding the costs of maternity care in the 1980s spawned a number of studies (Romalis, 1981, Annandale, 1989; Mugford, 1990, Clark, Mugford, & Paterson, 1991, Mugford, 1993) which were beginning to show that centralisation of maternity units was not based on good evidence about the cost-effectiveness of the policy. Furthermore, research found that the outcome for women in terms of satisfaction and infant and maternal morbidity appeared to be no worse in midwife run schemes than obstetric schemes and might even be improved (Flint et al 1989). Reviews, of the evidence on place of birth suggested that planned home birth for women with low obstetric risk had similar (Campbell & Macfarlane, 1987) or even better outcomes (Tew, 1985; 1990) than those of a woman equally at low risk, giving birth in hospital.
The ARM Vision - Proposals for the Future of the Maternity Services

In 1986 after two years intensive research the ARM published a document which was called "The Vision - Proposals for the Future of the Maternity Services". This report has been used as a basis for many innovatory changes in maternity care throughout the UK. The philosophy of the document, and of the Association, is that every pregnant woman should be cared for by a small number of professionals, giving her the opportunity to get to know and trust her attendants, and raising the standard of her care by the continuity thus provided. The influence of "The Vision" can be seen in the report "Changing Childbirth" which was produced in 1993 by the Expert Maternity Group set up by the UK Government, and accepted as Government policy for maternity care.

The Re-Creation of Childbirth in the United Kingdom

In addition to concerns regarding the escalating costs of obstetric care, there were growing doubts about the contribution of obstetric scientific medicine and the high technology, which accompanies it. A report from the WHO (1986) highlighted the adverse impact of increasing medicalisation of childbirth on perinatal and maternal morbidity. Furthermore, the first systematic meta-analysis of research in the fields of reproductive medicine and maternity care was published in 1989 (Chalmers et al, 1989), providing evidence that for many interventions there was no proven benefit and others caused harm. This was occurring at a time when the 'cultural critique' of medicine, informed by the writings of McKeown (1976) and Illich (1977) and feminist attacks on medicine's role in sustaining patriarchy (Ehrenreich and English, 1973)
challenged the legitimacy of the medical profession's authority. This coincided with the neo-liberal view concerned with restricting consumer choice (Green, 1988). It has been, however, the consumer organisations such as the National Childbirth Trust, the Community Health Councils, Maternity Alliance, Association for Improvements in Maternity Services (AIMS) that played a key role in the debate surrounding childbirth.

All this created a climate where it was valid for politicians, the media and the public to question the effectiveness and efficiency of medical care, particularly in the area of childbirth (Sandell 1996:202). The debates were also occurring within a context of a government that sought to challenge what it saw as unacceptable professional power (Department of Health & Social Services 1983). Moreover, the Government of the day proposed to shift acute services to the community (Department of Health 1989a) and emphasise the rhetoric of consumer choice (Department of Health 1989b, 1991, 1992; Levitt et al, 1999). These arguments can be seen in the key themes of Changing Childbirth.

The 'Changing Childbirth' (1993) Report of the Expert Maternity Group of the Department of Health was designed to stimulate significant change in the provision of maternity services in the United Kingdom. This report related to the fact that now the woman, not the care-provider, or the 'condition', is the focus of care. One of the many highly significant statements of this report was:

The Select Committee concluded that a 'medical model of care' should no longer drive the service and that women should be given unbiased information and an
opportunity for choice in the type of maternity care they receive, including the option, previously largely denied to them, of having their babies at home, or in small maternity units.

Following this report the Government published a special charter for pregnant women and new mothers that explained their rights and the standards of service they could expect to receive during pregnancy, the baby's birth and postnatal care. Among other things, the Patient's Charter and Maternity Services covers:

- The woman's choice about who will be responsible for looking after her; where she has her baby; the type of care she wishes to receive, for example whether she wishes to have her care led by a midwife, GP or consultant Obstetrician;
- what information she can expect to have to help her reach decisions about her care including information such as appropriate tests before the baby is born (ante-natal tests);
- the care of her baby.

These rights and standards are part of the Government's policy in "Changing Childbirth" that established key indicators of success as can be seen in figure 8.4 overleaf.
Within five years:

1. All women should be entitled to carry their own notes.
2. Every woman should know one midwife who ensures continuity of her midwifery care—
   the named midwife.
3. At least 30 per cent of women should have the midwife as the lead professional.
4. Every woman should know the person who cares for her during her delivery.
5. At least 75 per cent of women should know the person who cares for them during their
   delivery.
6. Midwives should have direct access to some beds in all maternity units.
7. At least 30 per cent of women delivered in a maternity unit should be admitted under the
   management of the midwife.
8. The total number of antenatal visits for women with uncomplicated pregnancies should
   have been reviewed in the light of the available evidence and the RCOG guidelines.
9. All women should have access to information about the services available in their locality.

The Changing Experience of Women

I was kneeling on the floor in the labour ward. It was the most comfortable position to relieve my backache. The midwife entered the room and immediately got down beside me. “Would you like to deliver in this position?” she asked. “If you do then I will organise a clean field on which to delivery your baby”. I had not thought of doing that – I told the midwife that I was happy to hop up onto the bed if that was more convenient for her. “No”, she said, she was happy to deliver me in any position I chose. I was quite surprised that the midwife asked if I wanted to deliver on the floor. I had had a baby not two years previously in this very
hospital and that was not the attitude then. At that time I had to conform to the hospital policy and deliver on my back — well half-reclining on the bed. I wondered what had changed. Of course, I was having my first child then and I supposed that had made a difference. I was better prepared this time — having been through it before and so was more confident in myself and knew what I wanted. Perhaps that confidence made a difference to the staff. Anyway, the midwife stayed with me throughout the labour, some five hours, popping in and out but never away too long. I felt comfortable with her and the birth was comparatively easy. Emily, my daughter was born with me kneeling on the floor. After it was all over, I suddenly realised that I had not needed any pain relief — I felt wonderful — awake and alert unlike the last time! (Beverly, 1997)

Beverly appears to have had a satisfying experience and was indeed happy with the outcome of the birth. Perhaps it would be interesting to assess why she had such a response for if we go back to Becky’s story, one can see a significant difference in approach. Clearly, Beverly was an articulate, well-educated middle-class woman. Beverly was indeed fortunate to have a midwife who could devote sufficient time to her to ensure she had a satisfying and safe birth. For many women and midwives this may not be the case with the growing crisis in midwifery as a result of staff shortages.

Before we all congratulate ourselves on how bad doctors are and how midwives can save the childbearing world, let's be honest about the state of the profession. We consider ourselves the guardians of normal childbirth but that is becoming less of a fact, with the numbers of midwives as sole carer dropping all the time. The reality is that, on the whole, midwives are exhausted and fed up. The constant struggle of working on labour wards staffed by four midwives at a time coping with shifts that usually have at least two epidurals and then the inevitable caesarean section, water births, premature labours, terminations, high-
dependency care of eclampsia, etc, etc., are taking their toll. Many midwives now have more skills than junior doctors and are expected to undertake all these tasks as well as being with women. (Schan, 1998)

Symbolic exchanges: Recreating midwifery

The sources of change in the context of childbirth and midwifery practice are varied. The need for midwifery 're-creation' is often the result of change coming from within the profession itself. As the health industry develops new technology and new techniques, midwives among other practitioners must adapt, changing practices and discarding old theories, making room for the latest professional information. Change in technology, however, is only one source of change originating within or outside midwifery. Decisions regarding the organisation of midwifery also bring about change. As midwifery develops new educational programmes, creates new areas of specialization, or reallocates tasks among other occupational groups, the profession reformulates itself. These same processes can also set in motion a course of action that results in unintended, sometimes negative, consequences for childbearing women and midwives as the following comment from one frustrated midwife shows.

In my unit we have reduced the use of Pethidine down to about 3% of women, but it is very difficult to persuade women and midwives that alternatives such as massage and support will work when it is impossible to provide one-to-one care. Community midwives fare no better - 24 hours on call at a time - which can involve a full day of visits and clinics and in our area up to two or three times in
the night to home births or helping on labour ward. This is a service run on goodwill and loyalty. (Schan, 1998)

Societal and cultural changes are important sources of professional re-creation. Included among the many influences exerted on medicine by society, for example, are changes in the local, national and global economy that may drive the reorganization of health care financing. Changes in the political environment, and demographic shifts such as baby booms, ageing populations, and increased urbanization all present challenges to the way institutions and individual practitioners organise themselves. Health care systems must also adjust to shifts in cultural concerns regarding gender, family, work, science, and religion. For example, the way health care changed in response to new cultural conceptions of gender: the gender balance in medical occupations has been altered, there is a new concern with the treatment of women as patients, and medical research has been re-focused to include women.

All health care professions are influenced by such changes, but not all are equally free to recreate themselves. Some, more than others, must work in an environment where their 'social capital' (Fukuyama, 1996; Kawachi, Kennedy and Lochner, 1997; Anderson, 1998; McConkey and Lawler, 2000; Schuller, and Bamford, 2000; Lowndes, 2000; Portes, 2000) is limited. Social capital is created by the players and in slowly changing societies, tends to perpetuate what already exists. In rapidly changing societies, social capital is reforming, and perhaps, it could be argued, is being lost in the *materialism of science. In this context culture is not static.
A profession's history and consequent cultural authority, however, determine the freedom it has to shape its place in the medical marketplace. Professions with greater prestige, greater income, and greater power are freer to influence political, organizational, and cultural processes. Professions like nursing, established as an adjunct to the profession of physicians, find their position controlled by those with more 'social capital.' Professions closely connected to a tradition, like midwifery and homeopathy, find their ability to adjust and recreate themselves limited by that tradition (see for example Greenwood, 1993). In the following pages, the ways in which midwifery is attempting to recreate itself is examined. First the factors that influence, enhance and impede the midwives' task of recreating themselves, are examined. Next the strategies of re-creation used by midwives on both organizational and individual levels are explored using data from fieldwork in England to highlight the socially situated nature of professional re-creation

*Strategies of re-creation*

The changed cultural attitudes of the 1960s and the economic realities of the 1980s and 1990s allowed midwives to maintain a foothold in modern medical systems. But the future of the profession remains unclear. To the extent that it promises to manage risk and to reduce pain, the machinery of modern obstetrics has wide appeal. Midwives face the difficult task of finding a way of recreating midwifery that preserves the distinctiveness of the profession while remaining up-to-date in obstetric techniques.
The strategies used by midwives to respond to this unmanageable situation fall into two categories:

1. **organisational strategies**: efforts undertaken by, or on behalf of, midwife organisations to preserve a place for the midwifery profession in the medical marketplace, and,

2. **individual strategies**, efforts undertaken by individual midwives to establish and protect the distinct practice of midwifery. These strategies of re-creation, be they organisational or individual, are influenced by the social context, a fact that is apparent in the contrast between the situations of midwives in the United Kingdom, the United States, Ghana, Malawi and Malaysia.

*The 'assimilationist' strategy of re-creation*

The 'assimilationist' strategy of re-creation chosen by some midwives threatened to extinguish the separate tradition of midwifery. In effect, midwives were exchanging their own tradition for the tradition of medicine or nursing. Societal and cultural change in the form of the feminist movement and a new and vigorous questioning of technology gave midwives the opportunity to emphasise their distinct tradition, to recreate themselves as separate from medicine.

In the light of this new cultural atmosphere midwives attempted to renew their identity as a 'low-tech, high-touch,' women-centred occupation. The very image that weakened the profession earlier in the century, now gave them a niche in the medical marketplace.
Midwives found further support for their profession extending their appeal beyond new cultural ideas about women and technology to economic concerns of policy makers and health care administrators. But this has backfired as the following midwife's comments highlight.

Almost seven years have passed since the publication of “Changing Childbirth”. And the question must be asked - are midwives better off? Are women better off? Many would say "No. Changing Childbirth was the great hope for turning the tide back to midwifery-led care and empowerment for all, but the reality is rising Caesarean section and epidural rates and decreasing numbers of babies being delivered by midwives (ENB, 1997). There seems to be pockets of excellence reported all over the country, yet a normal delivery, i.e. a birth without any intervention, becomes increasingly unusual. Midwives have begun to congratulate each other for "getting a normal delivery"! (Schan, 1998)

If we are honest, maternity services on the whole are in disarray - underfunded and overstretched, being held together by tired and demoralised midwives who feel dispensable and undervalued. The knowledge and skills of midwives are recognised within our profession, but are barely acknowledged by the people with real power - the obstetric hierarchy and the media. These are the people that women listen to and are influenced by. How can we change a whole generation which now consider technological birth to be the norm and are grateful when the doctors step in to "save" them? Elective caesarean sections and epidurals are
sold to women as the ultimate informed choice for the feminist, yet I consider having the birth of your baby controlled by machines and conducted by an unknown man (or woman) in an operating theatre the epitome of disempowerment. (Schan, 1998)

Increasing there is an emphasis given to a more holistic problem solving approach (Feuerstein, 1993; Pansini-Murrell, 1996; Thomas, et al, 1998; Thomas & Cooke, 1999) to midwifery practice and education based on a systematic assessment of biological, psychological and social needs. This has lead to the need to understand pregnancy and birth from these various perspectives which in turn means that midwives needed to draw from the behavioural and social sciences those concepts and theories pertinent to the care they seek to deliver. Yet, we are probably failing in achieving the stated goals. Ultimately, the approach midwives take to childbirth is determined by their cultural alignment, both in terms of their own socio-cultural, ethnic or religious group and in terms of their beliefs and values concerning childbirth and midwifery practice (see figures 8.2 and 8.3). For some it is a matter of survival, others rebel and either leave the profession or crusade against what they see as the ‘immorality’ of medical practice. Still others simply assimilate to the local cultural environment.

For midwives working in the community setting, their cultural alignment may be determined by the culture, in which they live and work. It is only in the context of the hospital where midwives are separated from the social context of childbirth, that midwives may develop a ‘midwifery culture’.
In the United Kingdom, fieldwork revealed the general dichotomy held by midwives about the fragility-robustness of pregnant women. Many argued that pregnancy was normal and natural, but midwives had to watch and examine women to ensure that pregnancy stayed that way, thus revealing an underlying fear that pregnancy is not normal or robust, that women need structure and are unpredictable. Some activists in the United Kingdom would argue that pregnant women are under duress. In Douglas’s (1997) terms this would be taken to mean that childbearing women’s bodies are fragile and pregnancy can be lethal. Such a view would justify the fears and anxieties of obstetrician’s and midwives. Indeed, women have been socialised into this view in the western world. However, I would argue that for some, the view of duress would be in terms of the risk posed by modern society to women in childbirth. I have given the title checo-warriors (childbirth ecology warriors) to illustrate the political activists attempt to challenge and change modern technological concepts of childbirth.

Another view of duress was found among midwives. They viewed women as being under duress if they had social problems, consequently, whilst women may not ‘need’ doctors, they certainly needed midwives who would guide them through their pregnancies, giving advice and identifying abnormalities as they arise. The predominant cultural type that emerged among the research participants was that of the hierarchist - women need structure, to justify midwives’ own controls and planned projects. For many women, they were quite content to fall into the structural category during pregnancy although they might adopt a different cultural type in other areas of their lives.
Even pregnant midwives still conform to the hierarchist cultural type, despite their own knowledge base, they look to the institutions to offer structure and control which may ultimately mean that they believe that women's bodies in pregnancy are unpredictable but instead of becoming isolated they cling ever more strongly to the hierarchical model for security. Obstetricians on the other hand fell mainly into the category where women's bodies are viewed as fragile and pregnancy viewed as dangerous to justify their own anxieties and fears. From this stance such mechanisms as automatic induction of labour should the pregnancy become prolonged, routine electronic fetal monitoring despite the evidence of its low value, and starvation during labour in case the woman may need a general anaesthetic brings a feeling of security for obstetricians, regardless of research evidence to the contrary. All women are treated in exactly the same way so that the doctors can be assured that their controls have been implemented.

Focus group discussion with experienced midwives

Most of them had children in their late teens and twenties. Most had studied midwifery in the 70s. They claimed to have been influenced by teachers such as Lamaze, Leboyer, Kitzinger, and more recently Odent, Wagner, Flint, Leap and many others.

The midwives were each committed to effecting change in their profession and de-medicalising pregnancy and childbirth. One was a leader in the home-birth movement; she was confident after many years of independent practice. Another had worked in Africa and so had experienced a different approach to maternity care. Another worked in a country hospital. Four midwives were part of a group midwifery practice attached to a local private hospital under the 'protection' of a group of obstetricians. Some had been leaders in the profession and were in private practice. A couple were managers of maternity units, seeking to implement new models of midwifery care into the system.

Haven't we all experienced the intrusion of ultrasound and other forms of prenatal testing into pregnancy? 'Quickening', (the time when a woman first feels the movements of her baby), is no longer an important date to remember. The black and white flickering screen of the ultrasound shows not only movement but also a heartbeat, and that is often prior to quickening. The woman can take home pictures, even videos, far more concrete than that small fluttering feeling (Jane 1998)
I've participated in continuous fetal monitoring, when the woman was no longer the focus of attention. The piece of paper rolling out of the machine and the sounds picked up by the transducer were what everyone, including the woman herself, paid attention to. Women used to be able to walk about, ignoring outside interference - these patterns of behaviour, which helped the progress of labour, are now over-taken by the fascination with technology (Beth, 1998).

Drugs and epidurals also block the woman's natural pain relieving agents - her production of endorphins. It was no wonder that we have seen rising rates of operative childbirth. By the time the decision is made to take the baby by forceps or caesarean section, the woman is thanking the good doctor for rescuing her and her baby from their dreadful state. Technology has replaced touch. Machinery has minimised the value of a woman's role in this essentially female experience (Mary, 1998).

I can understand why midwives are looking for something better, whether they work in hospitals or in the community. I find it difficult to understand why more midwives don't question the system, don't feel dissatisfied with the excessive imposition of medical technology into the birthing processes of well women (Clare, 1998).

The midwives in this study displayed a perspective adhering to one of four cultural types - that women's bodies are robust (see figure 8.1 page 220 and chapter 2 page 37). The question must be asked - what makes these midwives different from other more conventional midwives?

In the United Kingdom the battle lines remain drawn between those who support 100% hospital, medically controlled delivery and those who support home birth as a safe option for low risk women. The battle was never simply between midwives and medical
men it was much more complex than that. The battle is between differing and opposing cultural types.

If we take Mary Douglas' (1997:22) theory of myths of persons, with a little ingenuity we can turn this cultural analysis around so as to apply it to childbirth. In the contest about childbirth, the threat of infinite regress is blocked by reference to the nature of the childbearing woman's body. The choices relate to regulation and control.

Whoever wants to claim that pregnant women's bodies are robust enough to give birth without intervention is using that argument to defend the entrepreneur's claim to conduct birth as she feels is appropriate – without constraints. We would expect that claim to be reversed in the case of the person on whom that obstetrician or midwife or indeed, a woman, wishes to put constraints. The individualist/entrepreneur practitioner or pregnant woman will claim that women's bodies are robust so long as they are not put under stifling controls; women's bodies need to be free and will suffer damage if controlled.

The isolate, with no reason for sustaining any particular view of childbirth, maintains an uninvolved eclecticism. Meanwhile, the hierarchist, whose way of life is to organise and be organised, and whose justification is that women's bodies can only be safe if they are regulated, will argue that it is the nature of women to thrive in organisations. Structure is a necessary support for childbirth.
Egalitarians disagree with all of those positions because of a commitment to an egalitarian social order will have the same argument for the nature of the pregnant woman – the same corrupt, unequal structure that have caused pollution to the environment will also contaminate childbearing women and the child. Childbearing women’s bodies are seen as vulnerable and pregnancy can be lethal as a result of societal and environmental risk. This position is entered in fundamental disagreement with the policies of the individualists and with organising hierarchists, and with the fatalism of the isolate. It justifies political activism on behalf of women to redress the balance of society and nature. This lifestyle focuses on activating the community to effect change in the social conditions of the individual and the individual’s role in contesting risk challenges.

To take the analogy further, from my studies I have identified another cultural type – perhaps not strictly of the same order as those identified by Douglas (1995), but relevant to the case in hand, that is - the ritualist. In this permutation, ritualists fear not following rules and rituals regardless of evidence put before them, for fear of unleashing unforeseen dark and mysterious forces. Most modern midwives would not admit to belonging to such a group, but the evidence from the narratives and observations is indicative of their cultural alignment, even if their discourse was different.

The source of foundation myths of nature also produce foundational models of persons and models of childbirth, justifying or rejecting claims of authority from other persons (Douglas, 1995:22). If these five cultural types of childbirth are sound they deliver the practitioner and pregnant woman from the reproach of superficial fashion-proneness in
childbirth choices. It is a cultural competition that causes the underlying coherence of childbirth consumption choices. Cultural competition is a matter of conscience. Looking for coherence from the point of view of individual psychology will never reveal the conscientious woman, midwife or obstetrician defending a cultural outpost. Psychology has no idea of what they might be protesting against. But according to cultural theory, when they choose a method of childbirth they choose a flag to wave and they know whom they are waving it against. Childbirth is a public show, to encourage fainthearted followers the woman, midwife or obstetrician may want to stay loyal and deliver in hospital or break out and have the baby at home - either way - the place of birth is a sign - a symbol of cultural alignment. The choices are acts of defiance, intimidation and persuasion. Having a baby at home is wielding a weapon - the home is a badge of allegiance; just as modern technology in the form of the electronic fetal monitor is a badge of allegiance. Choosing the tools and approaches to birth is declaring dogma. Childbirth demands constant attention. Pressed hard by enemy forces, it calls for constant vigilance, subtlety and resource.
In Conclusion

In this chapter I have attempted to address the questions –

How is childbirth being reconstructed in England?
What are the symbolic exchanges that are creating the ‘space’ for changes to occur?
How do these exchanges impact on women and midwives?

There are persistent calls from women, pressure groups and midwives for a balance between considerations for the safety and the social aspects of childbirth. Women in the United Kingdom do not need to be under the care of an obstetrician during their pregnancy or childbirth. Despite the apparent greater freedom of choice women have in the UK, there remains dissatisfaction among both women and midwives.

Over the past two decades, childbirth began to change but in two diametrically opposed directions. One is toward woman-centred, holistic care provided by midwives, and the other is toward increasingly high technology obstetric management. In an attempt to mediate across the divide midwives, women and obstetricians have more or less adopted a risk approach to childbirth. Obstetricians have used risk assessment to identify women who may have major medical difficulties during pregnancy or delivery.

Meanwhile, reviews of the evidence on place of birth suggested that planned home birth for women with low obstetric risk had similar or even better outcomes than those of a woman equally at low risk, giving birth in hospital. Over time articulate middle-class women and midwives influenced by reading literature and from experiences of birth in different contexts in different countries began to influence childbirth practice
began to engage in alternative approaches to childbirth that challenged the dominant medical model. As the world around them increasingly changed, women and midwives attempted to 'recreate' themselves.

The purpose of this chapter is to attempt to draw together the threads of women's experiences of childbirth in the case studies chapters and explore the complexities, contradictions and consequences of globalisation for women in childbirth and those who attend them. This analysis, drawing upon some of the concerns and strategies of feminist cultural studies, seeks to illuminate how linguistic processes intersect with social structures, professional authority, economic resources, and political activism to produce gendered representations of social life and specifically of childbirth and women's health. Its ultimate aim is to propose a more complex theoretical understanding of how definitions of childbirth come to be constructed, codified, and mobilized. This in turn seems an essential prerequisite for developing more intelligent childbearing policies and practices globally.

The next chapter draws together the threads of women's and midwives' experiences of childbirth in all the case studies chapters and explores the complexities, contradictions and consequences of symbolic exchanges for women in childbirth and those who attend them.
Chapter 9

Symbolic Exchanges in Childbirth: Reflections from the Case Studies

The forces of modernity have taken childbirth away from the realm of social life and placed it into the professional health arena. (Jarvis, 2000 in conversation)

My personal journey of the past several years has brought me into contact with people of widely diverse backgrounds in countries as different as Ghana, America, Russia, the Netherlands, Norway, Finland, Cyprus, Malaysia, Malawi, the Philippines and of course, the United Kingdom. Everywhere I travelled I found an almost universal sense among people that the institutions on which they depend are failing them. Many are increasingly fearful of a future that seems to offer declining prospects for themselves and their children. In the UK as well as elsewhere, that fear is creating a growing sense of political frustration and alienation that is finding current expression in lowering engagement in political activities such as voting and the rejection of political rhetoric and inducements. Yet the issues go far deeper than a simple rejection of government.

It is often the people living ordinary lives far removed from the corridors of power who have the clearest perception of what is really happening. Yet they are often reluctant to speak openly of what they believe in their hearts to be true. It is too frightening and too
different from what those with more impressive credentials and access to the media are saying. Their suppressed insights may leave them feeling isolated and helpless (Korten, 1995).

The purpose of this chapter is to attempt to draw together the threads of women’s experiences of childbirth in the case studies chapters and explore the complexities, contradictions and consequences of globalisation for women in childbirth and those who attend them. This analysis, drawing upon some of the concerns and strategies of feminist cultural studies, seeks to illuminate how linguistic processes intersect with social structures, professional authority, economic resources, and political activism to produce gendered representations of social life and specifically of childbirth and women’s health. Its ultimate aim is to propose a more complex theoretical understanding of how definitions of childbirth come to be constructed, codified, and mobilized. This in turn seems an essential prerequisite for developing more intelligent childbirth policies and practices globally.

**Separation and individualisation**

Our definitions of reality are not innocent, isolated entities that have little interplay with the empirical world. The dialectical model wherein ideas are derived from the social and material base, and ideas act back upon that material base, is appropriate here. The shape of the social world affects ways of thinking about that world. As people, we continually create our social world and are being created by it. Dichotomised sex roles, as an example, have been internalised as real by people all over the world, regardless of
whether they exist 'really'. Whether sociology texts, psychotherapists, advice-to-the-lovelorn columnists, television characters, pastoral counselling, jokes, relatives and friends, or who or whatever perpetuates the socially constructed roles, they exist and affect all of us, constructing and controlling behaviour.

The technocratic society splits selfhood into instrumental and expressive self; it divides social life into public and private spheres. It presupposes polar opposites. Modern life is characterised by the dominance of the instrumental ethos. The dualism that characterises modern society is less a situation of separate but equal spheres than a matter of hierarchy, with the instrumental, public realms engulfing the expressive private ones.

Both America and Britain can be described as technocratic societies. Technocracy for Glennon (1979:23) legitimates the notion that science should serve productivity and bureaucratic administration by concentrating on the prediction and control of human behaviour. Moreover, technocracy implies the pervasive influence of instrumental orientations. Private and public spheres alike are approached technologically. Childbirth and child rearing guidebooks, among other things of the same kind, reflect the acceptance of instrumental assumptions in our everyday lives. The management of childbirth is a particular and important example of how pervasive the instrumental assumptions have become in modern and modernising societies to the extent that even the pain of childbirth has to be controlled as illustrated in the following field note.
Sitting in a dark corner of the hut, the TBA listened and watched the labouring women quietly. The woman was lying on her side on a cloth placed on a raised platform of mud. Every so often she would curl herself into a ball and wait out the contraction, pushing intermittently. From what Victoria had explained Ghanaian women did not make a noise or cry out in labour. I assumed it was for fear of attracting evil spirits who would do the mother and baby harm although this was never clearly expressed by my guide. I interpreted her lack of confirmation or denial, wishing as, perhaps, to distance herself from such notions. Victoria regarded herself as a very modern woman, well educated and middle class. To know of such things would be to admit to a more primitive understanding than she was willing to divulge to a western woman.

The labouring woman was clearly in some pain. She had been labouring on and off all day and was tired. Victoria was becoming anxious. And suggested to the woman that she should conserve her energy and not push until we saw the baby’s head. She instructed the woman to open her mouth and breathe through her contractions. After a while the woman lumbered to her feet and squatted to deliver the baby. Victoria wanted her to lay flat on her back as she was taught and as the TBAs were instructed but the woman ignored her. Presently the baby was born – received gently by the hands of the still silent TBA.

I wondered about Victoria’s interference. She was concerned for the woman and wished to relieve her pain and felt her actions were justified in the circumstances. I wonder whether the fear of pain so redolent in western culture and clearly absorbed by Victoria during her British training, motivated her actions. In my observations and from Victoria’s own stories, it appears that being stoical in the face of pain is part of the achievement of womanhood through childbirth. In a country that does not easily have access to pain relieving agents, a fear of the pain of childbirth may well result in unforeseen effects. During a conference in Manila earlier last year, one midwife
reported that she was concerned that TBAs and midwives were not giving women pain relief in labour. When questioned about the type of pain relief available, she informed me that it was aspirin. In the more affluent western world aspirin would not be considered a suitable agent for pain relief. Women in America and Britain receive large quantities of much stronger substances and increasingly they are requesting epidural analgesia.

Within traditional cultures, the practices and beliefs surrounding pregnancy, childbirth, and early childhood development are passed on from one generation to another. When societies are more or less isolated from one another and outside influences are limited, what one generation passes on is similar to the way the next generation conducts their lives and actions, for example, in childbirth, and there is a relative stability of values, practices, and beliefs. TBAs are trained by their elders to facilitate the birth process, and to assure both the well being of the mother and the infant. They also provide the new mother and family with support during the infant's early life. There is a sense of continuity across time.

In many of the stories shared by women in Africa and Malaysia and even among women and midwives in Britain, I sensed a yearning for the world left behind (Laslett, 1999), a world that represented certainty, of knowing absolutely what the world was about. Now the world was viewed as being uncertain, strange. Many of the research participants expressed a feeling of being a ‘stranger in a familiar place’, of being alienated from their past, their culture, beliefs and understandings of the world around them. One respondent explained that she felt disorientated and confused and being
constantly anxious as a practitioner (Jo, Focus Group, England, 1997). The midwives in
the focus group questioned the effect on their practice, 'I wonder whether this
uncertainty makes our practice more dangerous rather than less' (Caroline, 1997). This
feeling of uncertainty was evident in all the case study countries.

While some cultures have remained relatively isolated and intact, there are other
cultures, which have been more vulnerable to change. This vulnerability is the result of
increased exposure to other ideas, sometimes through formal education, and
increasingly through mass media. For some societies the introduction of different ideas
has resulted in a relatively easy incorporation of the new, with maintenance of the
traditional. For others, the juxtaposition of the traditional and the new, along with
economic changes which have threatened people's survival, has left cultures
disorganised and peoples at a loss in terms of their values and beliefs. In the jargon of
present-day psychology, these cultures could be classified as 'dysfunctional'. They are
no longer able perhaps to provide the next generation with the grounding, stability, and
vision that was found within traditional belief systems.

In the struggle for identity and in the desire to be "modern", some have completely cast
off their traditions, or think they have. Yet the modern does not always work for them.
As a result, people are seeking to identify and recapture traditional values. There is an
increasing awareness that much of what existed within traditional cultures was positive
and supportive of growth and development, for the individual and for the society.
Likewise there were practices that today we recognize as harmful to a person's health
and well being. It is this search to define and understand the traditional in relation to
what is known today that is the basis of current research and programmes in many parts of the world.

Childbirth practices are embedded in a culture and determine, to a large extent, the behaviours and expectations surrounding a child's birth and infancy. While childbirth practices may be different across cultures, there are basic needs that all women have and predictable patterns of progression during labour that is universal. From the stories shared with me, it became very apparent that what women in childbirth claim to be important was a supportive and nurturing environment quite apart from adequate nutrition, health, and care following birth. The lack of these support may have a significant effect on later health (see Oakley, 1992). Not only are there consequences for the woman's physical wellbeing; in addition, these variables interact with and have an impact on the woman's social and emotional wellbeing. While these factors are influenced by the economic and political context within which the woman lives, they are mediated through childbirth practices and beliefs.

In African, Malaysian, American and British societies the family, however defined, is the primary unit given responsibility for raising children. Within the cultures in this research, the community also had clear role to play whether to support women during childbirth as in Africa or to provide birthing systems. In pursuit of this task the family and community implement specific childbirth practices which they see as:

- Ensuring the survival and health of the child
• Ensuring the survival of the social group by assuring that women assimilate, embody and transmit appropriate social and cultural values through the process of childbirth.

To meet their goals, women in the case study countries adopted a set of practices, based on beliefs and values, from those made available to them through their culture. While women relied heavily on childbirth beliefs, which were a part of the culture as the basis for their birth, there was considerable individual variation in practice, depending on the cultural group (Douglas & Wildavsky, 1983) to which the woman ascribed. The psychological characteristics of the woman, her previous experiences, and the conditions under which she was experiencing birth were all important factors in determining the outcome of birth. The role of other members of the society in childbirth differs depending on the specific cultural group, with community members playing a significant role in some settings and a more distant role in others.

It is not possible to define childbirth practices simply in relation to the ways in which the family and community function. The broader context that surrounds the family and community must also be taken into account. In societies with limited exposure to outside influences, the context is relatively constant, and as a result, childbirth practices remain more or less the same across generations. In societies in a state of rapid flux, such as Malaysia, there are dramatic changes from one generation to the next in the context within which childbirth occurs. In countries such as Ghana and Malawi, the rapid flux and resultant changes happen more significantly in urban than in rural areas. Hospital births are much more common in urban centres, for example. Whilst the
majority of births still occur where the largest population reside, in the villages attended by traditional midwives. These lead to differences in the type of care that is provided to women. From data collected during fieldwork, I would conclude that the main areas where the context impacts upon childbirth practices and beliefs are as follows.

**The Context**

Understanding the context helps provide an understanding both of the ways in which childbirth practices have developed and the ways in which they are evolving. The context is composed of many things and includes:

- the physical environment—the climate, geography of the area that determines the need for shelter from the heat or cold, and the relative ease of raising food crops to sustain the family; mobility. This is important for all the case study countries but for developing countries, poverty exacerbates any problems that might arise in the physical environment.
- the socio-political climate that determines whether women have security or a life dominated by fear; women’s political voice; autonomy and power
- the economic climate that determines women’s ability to survive and thrive; poverty and wealth; spending power
- the philosophical and religious systems that provide a base for the values and beliefs of the society;
• the past, which is presented to the women through legends, myths, proverbs, riddles and songs that justify the existing social order and reinforce customs;
• the family and community who act as models of expected behaviour;
• the village, which presents a variety of situations calling for prescribed behaviour.
• the city that determines a different more hectic pace of life;
• technology and scientific advances
• access to medical facilities; transportation and distance
• women’s control over their own bodies; freedom of choice

The configuration of these dimensions determines the kinds of supports (or detractors) present as women give birth. One way to analyse possible configurations is along a continuum. In an analysis of childbirth practices in Africa, Malaysia, America and Britain, childbirth practices can be represented along a continuum related to degree of modernisation. At one end of the continuum are traditional cultures. These are defined as cultures within which childbirth practices and beliefs are based on inherited and orally transmitted knowledge. The context is more or less stable and there are adequate resources to support the traditional way of life. Such traditional cultures are more characteristic of rural than urban areas.

Societies that would be placed along the continuum between the two ends are characterized as transitional, such as Malaysia. For these societies there is a shift away from traditional practices, especially in urban centres, as they are exposed to new ideas and/or there are changes in the environment, which threaten their survival, forcing them to make changes. Negussie (1990) suggested that those migrating from rural to urban
areas and/or living in marginal communities could be characterized as in transition. Within societies that are in transition, childbirth practices and beliefs include a mix of the traditional and modern, and the mix is different depending on what is required of women.

The other end of the continuum can be defined as modern. Cultures located at this point on the continuum have access to and are using non-traditional health care and education in place of traditional systems. Negussie found that those living in peri-urban and urban areas, for example in Africa, or Malaysia, are most likely to be placed at this point on the continuum. I would argue that the continuum goes beyond the modern and into advanced modernity where post-industrial nations such as Britain and America have moved into an advanced technological era that some would describe as postmodern (Harvey, 1989; Lyotard, 1984; Leitch, 1996). This way of defining contexts is elaborated on below.

*Traditional reliance on inherited and orally transmitted knowledge.*

In traditional societies women in childbirth to both protect themselves and prepare themselves for giving birth use imagery in many ways. What a woman does, what she eats and the rituals that she undertakes are all opportunities for symbolically influencing herself and her unborn child. In the west we have forgotten the language of images, preferring instead to concentrate on analytical and explanatory modes of thought and communication. These are very necessary, of course, but are inadequate for communicating with ourselves and for viewing our situations and ourselves holistically.
Many of the studies of childbirth beliefs and practices in Africa and Malaysia conducted last century captured the childbirth practices found within traditional societies (see Priya, 1992). Priya believes that we should learn from women in traditional societies and find ways of using images to engage with that part of our primal selves. Images can be used to change bodily processes in her view and we too should use these to help women give birth. Clearing doorways and untying knots are images used by women in childbirth in Malaysia and Africa, but Priya urges, western women and those following the western path to childbirth, must find their own images that are derived from their experience of life in western (modern) society.

While attending women in England, I frequently used the image of an opening flower to describe the process of cervical dilatation. I encouraged women to imagine this as they thought about their impending birth and ‘see’ their baby being easily delivered. On many occasions this appeared to work. The images have to be useful and meaningful to the woman who uses them, however, and I encouraged women to create their own images and share these with their birth partner. Individual preparations of this nature, as Priya (1992:130) asserts cannot on their own foster radical shift in childbirth practices in Britain, America or elsewhere where the western model has been adopted. While childbirth continues to occur in hospitals where the ethos and physical focus are different and where power rests with the medical fraternity rather than the woman giving birth, then real change may be impossible.

In some countries there are pockets where these cultures continue to exist, but these are few and far between. In most countries, traditional childbirth practices, both positive
and negative, are changing as women are exposed to other beliefs and practices. Where traditional practices have been interrupted the society may be classified as in *transition*.

**Transitional: the shift as a society that relied primarily on traditional wisdom begins to adopt alternative beliefs and practices.**

If the goals set by the 'modern society' [are] different from those earlier set by the indigenous society, the individual follows the former. The result is the disintegration of the earlier set of goals and values. Nigerian society and culture is one undergoing such disintegration. The generally set goals seem to be western, materialistic and individualistic. In the rural area though, there still seems to exist traditional values, but these too are rocked by the waves of principles of democratization and modernisation, the vehicle of which is education—western education. (Akinware & Ojomo 1993, 40)

Ghanaian, Malawian and Malaysian cultures can be characterized as in a time of *transition* as a result of changes which impact on everyday life. These changes indirectly affect childbirth beliefs and practices and the growth and development of children. Women and their communities are in transition as a result of:

1. *Changes in the traditional functions of the family.*

One particularly important support to women has been the community and the extended family system. In the past, close family ties provided a built-in measure of economic,
emotional, and social security to women and families, but this traditional support for
women has been disrupted as families are moving from the rural to urban areas.
Families are migrating in search of work, and individual family members leave the
village in search of educational and economic opportunities. Many of the previous roles
of the community are being taken on by the wider society resulting in fragmentation,
reduction in support systems and instability.

2. Changes in the structure of the family.

The size of families in the case study countries is declining. In Africa and Malaysia this
is due partly to the fact that people are having fewer children, but more significantly the
decline in family size is due to a move from multi-generational family groupings to the
nuclear family. In Britain and America, increasing numbers of women are remaining
childless and some women claimed that they no longer felt that was necessary for them
to have children to feel complete.

Women and girls have become the focus of international attention. Child rearing
practices, which relied on the older girl child to care for younger children in the family,
are being challenged. Girls who have traditionally been responsible for the care of
younger siblings are attending school at an increased rate and being encouraged to
complete their education.
3. Changes in the nature of women's work.

Women all over the world have always played multiple roles that compete for their time and physical and emotional resources. Regardless of the context within which children are raised, care of children, particularly young children, is still the woman's responsibility. In addition, the woman is responsible for household management and operations, and economic/productive activity. New economic pressures on and possibilities presented to women mean that increasingly they work outside the home, often for long hours and following timetables that limit their availability and thus the time they can devote to family life.

In rural areas women often work in the fields. While in many cultures women have historically constituted a majority of the agricultural work force, in other settings the out-migration of men who are seeking employment has increased women's agricultural role. In addition, in some agricultural settings, plantation economies and cash crop production have meant that women are increasingly being exposed to the demands of rigid time and work schedules similar to those common in urban environments.

In both urban and rural environments there is an increase in the number of women-headed households. This necessarily impacts the woman's workload.


Until recently men were the most likely to migrate in search of paid employment. In recent years, however, with the creation of free market zones, increasing numbers of
women are migrating to obtain work. Women interviewed who had migrated to urban centres in Ghana, Malawi and Malaysia expressed nostalgia for the security of their old way of life and community, for within traditional societies, the norms, beliefs, and practices were relatively stable. Expectations in terms of childbirth behaviour were clear. For women in transition childbirth and childrearing practices are not clear. These women may lack the skills to live in the state of flux represented by transitional cultures. In this situation women may have a sense of powerlessness and be less self-confident in terms of their body skills. This can lead to childbirth practices that are inconsistent and/or overly restrictive. For those women who have been living in urban areas for a generation or two, they may well have incorporated more "modern" childbirth beliefs and practices.

In regard to migration and the distance between family members, this presents major challenges to the maintenance of traditional practices despite the indication that some grandmothers are able to travel to the city to care for their daughters following delivery. To quote one grandmother:

*I travelled to the United States of America for the birth of my granddaughter.*

*We were able to conduct the rites as we do here. My daughter was able to have a complete rest and I taught her the traditional ways.* *(Chan, 1994, Malaysia)*

Moreover, female employment in the formal sector is directly pertinent to grandmothers who work and are unable to take time from their jobs to provide the traditional care for their daughters or daughter-in-law.
Modernity: when non-traditional health, education, and social supports are available and relied upon more than the traditional.

Technology has made a wide variety of supports available to families that are not available within traditional cultures. While there are advantages and disadvantages to every piece of technology that has been introduced, the availability of these technologies has radically changed people's lives. For example, bottle-feeding has made it easier for women to enter the labour market. But the introduction of bottle-feeding and the decrease in breastfeeding has resulted in high infant mortality and morbidity rates due to improper use of bottles and infant formula.

Modern women are defined by their openness to new experiences, including family planning and birth control. Their assertion of increasing independence from traditional authority figures and belief in the efficacy of science and technology leads to an abandonment of passivity and fatalism. Modern women are ambitious for their children to achieve higher educational and occupational goals as was identified in the analysis of six women's roles in the Malaysian case study.

It is interesting to note that the traditional and modern Malaysian families were only one generation apart. The parents of the more modern women who were included in the study were illiterate farmers from the traditional village in the study. Thus, while in some instances there are several generations between the traditional societies and the modern, this movement has generally occurred within only one generation.
The negative aspects noted in the research included:

- A dehumanisation of the social environment (with increased use of the bottle rather than the breast; babies left with other carers rather than carried on their mothers back; and a reliance on mass media rather than human interaction for entertainment). For women in childbirth, the dehumanisation process was reflected in impersonal treatment of women, standardized care, routinization of practices which were claimed to be individual but were in fact standardized to a set formula for care in childbirth. Women were frequently separated from their social support networks in hospital settings in Africa and Malaysia, sometimes being left unattended in corridors or in the middle of large labour rooms to labour in public without her attendants to nurture her.

- The disintegration of family and community units and of commitment to each other. Smaller units of ownership and residence lead to less sharing and more individualism. There was an expression of a distinct loss of community among participants in the study. In Ghana, however, elements of this community feeling still existed and were manifested in ordinary people willing to share whatever they had with friends and strangers alike.

- Decrease in traditional education mirrors the increase in modern education. Consequently traditional knowledge is being reduced (closing of the mind) not without consequences for women in childbirth. The traditional methods of child spacing served their purpose so long as taboos, rules and traditions were observed. With the introduction of instrumentalism in fertility control, have come pressures
that have reduced the respect for and contribution of these traditional practices, especially in urban areas. The increase in modern education and decrease in traditional education has also played its part. Many people do not know about traditional methods of fertility control and the lack of sex education in schools has resulted in an increase in the numbers of unwanted pregnancies, pregnancies outside marriage and pregnancies and births that are too close, especially in urban settings.

In sum, in Ghanaian, Malawian and Malaysian cultures great importance is placed on having children. Thus it is not surprising that there are numerous beliefs and rituals that support the birth and raising of a healthy child. What follows is a description of some of the beliefs, rituals and childbirth practices associated with women's lives.

*The degree of traditionalism (traditional, transitional, modern) evident in current childbirth practices and beliefs;*

This thesis has demonstrated that traditional childbirth practices in different parts of the world continue, although the forces of modernisation have influenced them. For example, pregnancy is no longer as sensitive a subject as it was. The reason for this is that there is considerable modern information available and being provided to women. When they receive this information they are encouraged to talk about their own situation. Pregnant women, for example, are now eating foods, which they are advised will benefit the unborn child, although traditionally these foods were taboo.
Traditional practices related to the birth of the child are still persistent, with TBAs and close relatives playing a crucial role in helping to deliver the child. However, increasingly children are being born in health facilities and the traditional practices are not being followed. Also, the 'confinement' period is breaking down for those who deliver their child in the hospital or birthing clinic. This is due to short hospital stays and being exposed to the public on discharge from the maternity hospital.

The rites and observances emphasise equal care and attention for the mother and child during the puerperium, instead of concentration on the child to the neglect of the mother, as in the American health care system. A reduction in postnatal services is also creeping into the British maternity care services partly as a result of budgetary constraints. Puerperal rites and practices promote cross-generational maternal health. They provide a unique opportunity for the young, inexperienced mother to learn about baby care, family and home management in their home. This promotes child and family health both directly and indirectly. These rites provide older women with a new and highly valued role within the family and society contributing greatly to their self-esteem, reputation, and general well being. The fact that during puerperal period the grandmother is a figure of authority within the family teaches children to cherish, respect and trust these women. In this way, these rites create a bond between the woman's nuptial and natal families, and thus enhance family life and social integration.

On the societal level, these rites clearly underscore the crucial importance of the neonatal period for the survival of human beings and society as has been shown by demographic and medical research. Under the conditions of modernity the prospects for the survival of these birth rites is in the balance. There are three obstacles in modern
African and Malaysian society, namely female employment in the formal sector, urbanization, and migration out of the villages.

In sum, there are instances where more 'modern' practices are replacing traditional practices. In some instances the replacements are of benefit to the mother and child, as in the situation where women have more information about conception, pregnancy, and the birth process, and they are using this information to assure the birth of a health baby and to take care of themselves physically. However, there are a number of instances where the more 'modern' practices have supplanted the traditional and this has had a negative impact on the child and/or the mother. This is true in the case of child spacing and the introduction of bottle-feeding.

Discussion

It is against the background of individualisation as a process that calls for increased self-responsibility and self-reflexivity that dominant tendencies in the theory and practice of obstetrics are to be understood. In this perspective it is also too understandable that it concentrates upon the individual survival of women in the turmoil of risks and chances that are involved in the lifestyles that belong to the risk society. And it is only a logical development, in accordance with processes of individualisation, that childbirth has applied itself to a diversification and individualisation. Depending on the specific circumstances and practical needs of the women, the provision of maternity care in the western world is offered in new "tailor-made" forms and concepts, like epidural birth; instrumental birth; caesarean section births – "to keep the honeymoon
passage fresh" as one billboard proclaims in the USA; standardized hospitals birth; birth centres; home birth and home-like births in hospital; domino delivery; Lamaze birth; active childbirth; water birth and so on. In a way this seems a necessary and pertinent response to the challenges of the risk society. So one might rightly claim that these new practices and concepts in maternity care are significant institutional adjustments to the highly individualised childbirth needs of today’s society. But at the same time these practices and concepts confirm and reinforce the ongoing processes of individualisation. For that reason, obstetric practice and midwifery might also be considered as a medium that intensifies the characteristic experiences of self-responsibility in the risk society.

The unique experiences of women in rural areas of Africa, Malaysia and among the Amish in America show a different picture. TBAs have a long established knowledge of the women and families in their localities. They are able to ‘speak their lineage’ in a way that midwives in urban settings are unable to do. Mary, the Amish midwife in Pennsylvania, for example, had lived and worked in her community all her life. She knew every person, their health and social histories, their problems and their joys. Every birth was recorded by the women she had delivered on a quilt where the names of the baby and parents, date of birth were embroidered onto each square in a colourful history of childbirth. Mary was able to tell the stories of every birth and the history of the families from looking at the quilt.

Florence, a TBA in Malawi was able to name every person in her village and recount their histories. She knew that a labouring mother had had more than the usual amount of blood loss following her last delivery but also that the woman’s own mother and
grandmother had the same experience. Florence was prepared for a repeat of such an event.

_The women in that family always bleed too much – so I give them herbal medicine to prevent it._⁹ (Florence, 1991, Malawi)

The majority of the populations in Africa and to a significant extent in Malaysia still reside in rural areas. On the whole, foreign health researchers comfortably place themselves away from the common people’s reach. Increasingly, indigenous people who are obtaining their scientific education in health, become involved in different policy planning meetings, dialogue with different scientific and literate communities and implement finely-tuned strategies and technologies that are all aimed towards the development of health and practitioners of the country. In the process, however, they ignore women’s knowledge and their own aspirations, culture, tradition, age-old knowledge and beliefs. The result has been short-term progress in reduction of maternal and neonatal mortality and fertility rates but the gains have not been sustained.

An African focus group of senior nurse-midwives made the point that:

*Western researchers believe that their approach is purely scientific. They tend to disregard women’s knowledge as non-specific and based on traditional faiths*

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⁹ The herbal remedy used was a secret but the Nurse-Midwife revealed that she knew that it was a mixture of papaya leaves and other herbs that helps the uterus to contract and so hinders bleeding.
Sometimes, as a convention and as warranted by different development programmes, researchers engage in learning practitioner’s local knowledge but they may fail to completely realise its meaning and relevance to such development efforts as some may stay isolated from the local environment and the people. On the other hand, African researchers with a background in modern western style education readily became influenced by westernised culture and begin craving for the urban life style that consciously or unconsciously places them at odds with the heritage, culture and traditions of rural people. For those researchers who become absorbed with their own short-term goals and preferences may become blind to the world beyond. They may fail to take account of the fact that local practitioners, with their roots embedded in that particular locality, could provide very useful information needed for exploration by the outsider, one time researcher. This may well be, in fact, a by-product of a particular feature of modernity, that is, specialization.

Specialization and the Creation of Experts

Fachidiot

A man lay bedridden, seemingly ill and near death's door. Fearing the worst, his wife summoned a hakim, the esteemed town doctor. For a very long time, the hakim tapped around on the patient and listened; he checked the man's pulse,
attended to his breathing, put his head on the man's chest, turned him onto his
stomach, and then his side and back again, raised the man's legs and torso, opened
his eyes, looked into his mouth, and then said with a great deal of conviction, "It is
with deep regret, my dear woman, that I must tell you the very sad news that your
husband has been dead for the last few days." At this moment the ailing man
raised his head in shock and whimpered anxiously, "No, my dear wife, I'm still
alive." The wife gave her husband a hefty slap on the head and said angrily, "Be
quiet: The hakim, the doctor, is an expert. It is he who ought to know." (Persian
folktale – source – Moghaddam, 1997:9)

Like the wife in this ancient folktale, Moghaddam (1997:9) reminds us that we place
considerable faith in experts - one of the products of increasing specialization. Out of a
lack of confidence, a lack of skill, respect for science, fear of authority, or simply being
too lazy to think for ourselves, people rely on experts rather than on their own insights.
We now seem to need experts to tell us, for example, that pollution is destroying the
ecological balance on earth; that infants are healthier when they are loved; that the
family does have an important social role in the development of children and that the
health and education systems are in trouble. What may be obvious to us only achieves
the status of 'truth' when endorsed by experts. It is interesting to consider this
statement in view of the almost manic demand for 'evidence-based practice' in health
care globally. Socialisation processes in modern societies are such that when faced with
even the slightest personal or societal issue, people often look to experts for answers.
Modern cultural habits, which are particularly apparent in the United Kingdom and the
United States, tend to transform every moral crisis into a technical problem for which there should be an expert solution.

For the rich, the experts are available through private consultations, for which clients are charged vast fees. But experts have also made themselves available to the masses, through the mass media and through thousands of 'self-help' publications. The internet now places thousands of 'experts' all over the world at the fingertips of anyone who has access. Without these information sources, it seems, it would be impossible for us to do anything well, from building cabinets to having children. But the credibility of experts has not entirely escaped questioning, a fact made apparent by the common wisdom of many different cultures where a person may know a great deal in a narrow field but is, in fact, an idiot.¹⁰

**Expertise and "Power to the People"**

The general mistrust of the 'idiot expert' is often coupled with a call for an 'empowerment' of the general public, to put lay-people on a more equal footing with experts. Based on the dictum, "Knowledge is power", this movement involves efforts to provide the public with more medical, legal and other types of information that have traditionally been monopolised by professionals. Presumably, by more fully informing the public about various important issues, we help to transfer power from experts to lay-

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¹⁰ For example, the German term Fachidiot implies a person who knows a great deal about a narrow subject matter, but is in fact an idiot. In Farsi, the term, be-savaad means, "uneducated". This term may be used even in reference to individuals with PhD degrees, because being educated and having expertise in a narrow domain are not seen to be equivalent in Persian culture. The education of a complete person is very much emphasized by the Japanese concept of bunburyodo, a reminder of the Latin phrase, "men sana in corpore sano" (sound mind in a sound body).
people. Such empowerment strategies gained momentum in the 1960s and have subsequently become particularly strong in the areas of the environmental protection and animal rights, although the issue of power relations between experts and the public is by no means the exclusive concerns of modern societies.

In America and Britain, what has become increasingly apparent is that women, particularly middle-class women, are informing themselves about childbirth, their rights and choices to a much higher degree than those encountered five years ago. With the advent of the Internet, women have comparatively easy access to a much broader range of information from all over the world. It is interesting, however, that the Americans dominate the Internet with much less information coming from other countries. This might be viewed yet again as a way in which American ideologies and culture is transmitted globally. It is important to note that the internet, however, gives a platform for alternative ideologies to be expressed than other media forms, since it is not censored and controlled by the dominant medical organisations and publications. Thus, one could argue, women are exposed to ideas and values that would have otherwise been screened and hidden from them.

In terms of ‘knowledge as power’, however, I would argue that it is only authenticated, authoritative knowledge held by people in power positions that is powerful (see Jordan, 1993; Davis-Floyd, 1997). TBA knowledge is not power - midwifery knowledge is not power - women’s knowledge is not power, because their knowledge has little status within the dominant medical system and so are not recognised as authentic creators or controllers of knowledge.
Individual freedom versus personal growth: a paradox of Western capitalism

It is a paradox of Western capitalist societies that while advocating individual freedom, they have severely restricted personal growth. On the one hand, these societies place great emphasis on self-help, individual responsibility, individual rights, and individualism generally. On the other hand, these same societies make individual persons subservient to the requirements of group productivity. This subservience is particularly evident in the education sector. The products of the education industry, each year's crop of graduates, are designed primarily to meet market demand. When a major shift in the nature of demand occurs, supply changes to eventually meet new market needs. In this way specific education received by individuals is adapted to fit the needs of the market. It is assumed that by serving the interests of society as reflected by market forces, individuals will also contribute to their own happiness. Individuals thus become instrumental in the progress of society, and they supposedly benefit as a result.

In practice, then, individuals achieve their ideal roles through the parts they play in collective production. Less and less emphasis is being placed in how persons develop as whole and distinct entities for themselves. This trend is being accentuated by shifts in the education system to meet what seems to be more specialized market demands, so that over the last century, specialization has dramatically increased and specialized training now plays a far greater part in the education of individuals. Symbolic of this whole process are the newly graduated PhDs who, with very few exceptions, are not equipped to teach courses outside their own, very narrow, speciality areas - areas that
are becoming narrower with each generation of PhDs. More significantly, the marketplace drives the narrowing of the curricula for midwives particularly in the United Kingdom where the focus is on competence development (that is the psychomotor skills) to perform the role. In the UK universities are commissioned by the local health systems to educate specific numbers of practitioners. Senior managers and practitioners are closely involved in curriculum design and are in the driving seat when defining what is ‘really useful’ knowledge and skills. Thus more liberal studies are excluded from the curriculum that would inform a broader curriculum and a rounder individual.

**Oppressed Behaviour Among Midwives: Maintaining the Status Quo**

Dominant groups often perceive change generated from those outside the group as inherently threatening and potentially damaging to their power base, therefore they struggle to maintain the status quo by generating fear of freedom through the creation and promotion of myths and positions of influence (Blank, 1994, 2000; Prosono, 1993). The health system is a classic manifestation of a hegemonic institution.

The behaviour reported by midwives in the case study countries has been attributed to oppressed groups and described as (Freire, 1972; Hedlin 1986; Roberts 1994). It is also recognised that the violence increases with the level of enthusiasm and challenging of existing practices that occurs by the innovative practitioner (Hastie, 1999).
Freire (1970) describes oppression as any situation in which one person hinders another's pursuit of self-affirmation as a responsible person (Hedin 1986:55). Oppression can also be defined as the imposition of one person's or group's wants, needs and interests over those of another. Manifestations tend to take subtle forms of divisiveness, lack of cohesion, lack of participation in professional groups, back biting, destructive gossiping, fault finding and other forms of violence and contradictory behaviour characterise oppressed groups (Hastie, 1999 see also Gramsci, 1971). The oppressed individual or group tends to internalise the view of themselves held by the oppressor and imitate patterns of oppressor behaviour (Freire 1972).

Hegemony is the ability of the dominant class or culture to exercise social and political control (Gramsci, 1971). Power, technology and ideology combine to produce forms of knowledge and social relations. Knowledge is defined by the political, social and historical context in which it is developed and reflects the world-view of the dominant group (Doering 1992:26). To ensure compliance, dominant groups tend to present reality in segments, whilst keeping the complete picture to themselves, thereby restricting complete knowledge of others. Rules and social structures that allow those at the top of the hierarchy to view activities in every direction, thus having a total picture are able to curtail autonomy.

I would argue that the position of midwives in the health care system in any of the case study countries reflects and parallels the submissive position of women in society generally. Caring is generally viewed as a female attribute and consequently is a pivotal theme of midwifery. Curing is seen as the province of medicine and involves valued
male attributes such as analytical thinking and a scientific approach. Medicine, however, is an extension of politics that moves it beyond the story of science and advances, to a 'story of control and access' (Chamberlain 1989). The caring versus curing dichotomy, which fragments health care generally and midwifery in particular, creates moral dilemmas for practitioners.

Conclusion

In the environment of modern obstetrical care the support and confidence that women need to give birth successfully is often destroyed or diminished. They find it harder to give birth without medical intervention. The advent of globalisation of modernity in the wake of different colonial experiences has brought with it an orientation held by medical men and midwives of the superiority of western health delivery systems.

In Africa and Malaysia, many of the western educated practitioners I came across regarded indigenous knowledge as native tales, proverbs, and sayings of some rural illiterates that were mostly devoid of any scientific foundation or signification. Thus, in those countries well planned scientifically conceived programmes, for example, TBAs training, ended up as failures since those programmes were planned at city based offices by high technology personnel who failed to listen to rural people.

In the wake of economic downturn experienced in Malaysia and Africa, however, there has been a turn-around in the utilization of indigenous knowledge and technologies. There is a wealth of indigenous knowledge held by TBAs and healers that could be
blended with modern scientific evidence to produce technologies that are relevant, affordable and sustainable in an African setting.

It is clear from discussions with local people that the influence of western science and more significantly the value placed on measurements, is increasingly changing the ways of thinking about childbirth in both the developed and developing countries under study.
Chapter 10

Symbolic Exchanges in Childbirth: The Influence of Science and Medicine

Science and Numbers: The Politics and Policy of Risk

One of the key symbolic exchanges in childbirth is associated with the notion of obstetric risk. Risk is built on the technology of numbers and the ideology and practice of scientific calculation. Medicine needed quantification to acquire credibility as a science. Medicine represents a ‘cultural association between the notions of professional expertise, objectivity and the impersonality states, (depersonalization....) afforded by the technology of numbers’ (Oakley, 2000:110).

Quantification, according to Oakley (2000:103) is a social technology and as such it raises all the sorts of problems associated with other technologies. Technology is not value-free. It is shaped by the social and economic context that gives rise to it. It is designed to meet certain needs, but as Oakley points out these are not everyone’s needs. Technology often has all sorts of unforeseen consequences in specific social contexts; some of which, are likely to damage the very goals those technologies, were designed to espouse. Such is the case in the context of childbirth.

More than one hundred years ago, science and social science had come to mean the use of quantitative methods to discover the laws governing the universe. The view was
taken that everything that was worth anything could be represented by a number (Thomas Hobbes 1588-1679, and John Stewart Mill,).

Porter (1995) argued that numbers form an approach to communication that impose remoteness and dispassion on what would formerly have been familiar relationships.

Most crucially, reliance on numbers and quantitative manipulation minimizes the need for intimate knowledge and personal trust. Quantification is well suited for communication that goes beyond the boundaries of locality and community. A highly disciplined discourse helps to produce knowledge independent of the particular people who make it. (Porter, 1995:ix)

If this is taken in conjunction with the rise of professionalization and specialization in modern society, this creates a situation in which expertise is inseparable from objectivity. This in turn, according to Oakley (2000:113) allows objectivity to be aligned with the reduction of everything to numbers. Equally there is a conceptual link to the idea of validity. Consequently the most valid knowledge is produced, or described, by using numbers. Oakley points out that the Latin root of ‘validity’ means ‘power’. Power, therefore, derived from knowledge expressed numerically and those most powerful are in a position to know better, or more, than others are.

The emphasis on precision created the frame of mind, which made the inventions of the Industrial Revolution possible. The growth of abstract numerical calculations is a feature of an increasingly complex society. (Oakley, 2000:113)
When coupled with the social regulation of time, the rise of quantification became part of a professional move towards standardized rules that could be communicated between people, across continents, thereby diminishing the human element in knowledge production. In medicine, this process served to impose a distance between practitioners and their patients. The increase in mechanical and electronic ways of knowing what is happening inside a person’s body obviates the need for the person to tell doctors what they think and feel is happening to them. A prime example of this is when a woman consults a doctor about her pregnancy. The doctor will inevitably turn to either chemical agents to test the veracity of this belief and will follow up with an ultrasonic scan to confirm the date the baby is due to arrive. From years of personal experience working as a midwife in England and observing other practitioners in hospitals during fieldwork, the woman’s estimation of her due date is practically never accepted as fact (see Oakley, 1992). In Africa, where electronic devises and pregnancy tests are not readily available except in large hospitals, the woman’s estimation of her pregnancy is the only means of assessing when the birth is due. However, the point is that some numerical measurement of time is still required.

Medical technologically produced information about the body has a numerical form. For example, the ultrasonic scan produces a picture of the fetus along with measurements of its size; the electronic monitor churns out computer printouts with speed of the fetal heart rate, and the strength and length of uterine contractions. Midwives using their hands to estimate the strength and length of uterine contraction or to listen to the fetal heart using a fetal stethoscope did not provide 'objective' data for
anyone else to hear or feel or challenge. The machines, like the flexible stethoscope effectively acts to create a distance between the practitioner and the woman. Oakley (2000:115) sees this as one of the unforeseen consequences brought about by the introduction of technology.

Furthering the numerical paradigm: ‘Measuring’ the Risk of Childbirth

In the modern world people are expected to live and die subject to known, measurable natural forces, not subject to mystical, mysterious moral agencies. Science wrought this change in thinking between the modern and premodern world and as Douglas and Wildavsky, (1983:49) argued, has actually expanded the universe beyond that which we can talk about with confidence. As science delves deeper into the unknown through research and investigation, Douglas & Wildavsky argue that one can assume that human kind can now be more informed about the smallest sources of danger as well as the largest. But perception of infinite risk introduces the double-edged thrust of science, generating new ignorance with new knowledge. The same ability to search out and see causes and connections between the smallest parts of the universe can leave more unexplained than was left by cruder measuring instruments. As experts disagree, they have to find more and more evidence. This results in ever-deeper analysis. But expanding measurement only increases the area of ignorance. The frustration of scientists is a characteristic feature of modern times.

The estimation of risk is a scientific question – and therefore, a legitimate activity of scientists. The acceptability of a given level of risk, however, is a political question, to
be determined in the political arena. The moment there is disagreement or controversy, that is to say, when someone says a risk is unacceptable, the question becomes political. We now see that the question needs to move from establishing facts to establishing acceptability of childbirth risk, from correct answers to agreed conclusions. Inevitably we need a way of scaling the warnings and promises of science to the limited realm of political possibility. In health care generally and obstetrics in particular, one such way of making such assessment is by ascribing cost-effective measurement to risk analysis.

To accomplish this purpose, techniques of obstetric risk calculation and comparing probabilities have been developing for the last three centuries. Do the methods of obstetric risk assessment tell us what risks women face? Or does the choice of method imply a prior choice of the risks we have already chosen to face or to escape?

The political argument over obstetric technology is conducted between the heavily risk averse and risk takers. The risk-averse side starts from the point that nature and the natural environment are unpredictable and need structure. That women’s bodies are flawed and need to be monitored and controlled in order to avoid harm. That pregnancy and childbirth are pathological in prospect and only timely intervention can reverse the decline into complications and abnormality. The level of surveillance required and the technology and instrumentation needed to correct or avoid dangers exert a substantial cost. Governments and individuals need to weigh the costs in order to make decisions about the relative cost-benefits of certain obstetric activities.
The risk-takers side says that nature is good and that women's bodies are robust. Pregnancy and childbirth are normal, everyday processes and advises women that if they trust their bodies and live a normal, healthy lifestyle, pregnancy and childbirth risk will be reduced with very little or no obstetric intervention. The risk averse will have no part in this argument. They insist that human life must be preserved at all costs and that means control and intervention. But this may not be simply a feature of modern society. In traditional societies in Africa and Malaysia, for example, pregnant women, traditional healers, and birth attendants practice all sorts of rituals to avoid danger or intervene when things go wrong.

Risk assessment would be easier in a settled society so certain of its values that its processes for discovering facts and making political decisions would be judged fully adequate. That would be a trusting society, but it is not the world in which we live. There is neither agreement over appropriate methods to assess neither childbirth risks nor acceptance of the outcomes of public processes. The problems have subjective and objective facets and risk assessment needs to deal with each.

The exercise of rational choice must include selection of focus, weighting of values, and editing of problems. But this editing process cannot be well done as a specialised exercise in thinking about risks. Specialised risk analysis impoverishes the statement of a human problem by taking it out of context. The notion of risk is an extraordinary idea, essentially decontextualised and desocialised. Thinking about how to choose between risks, subjective values must take priority. It is a travesty of rational thought to pretend that it is best to take value-free decisions in matters of life and death.
One salient difference between experts (obstetricians) and the lay public (women) is that the latter, when assessing risks, do not conceal their moral commitments but put them into the argument, explicitly and prominently. The private person does not isolate risk elements to address them directly. When she consults, she tries to consult people who understand her situation (the midwife, the TBA). This is paramount in her choice of midwife or general medical practitioner. Only when desperate does she consult the unbiased, technically superior expert (the obstetrician). Instead of submerging the risk elements in the larger pattern of social commitments, the medical expert can speak to a narrow issue beyond which professional requirements forbid him to go. The ordinary woman admits that her loyalties and moral obligations are largely the matter at stake, but the risk expert claims to depoliticise an inherently political problem.

One of the oldest and most accepted generalizations in decision-making theory is that people are generally risk averse. They are also assumed to prefer certainty to uncertainty. Their simplifying is evidently different in the face of risk of loss from what it is in the face of probabilities of gain. Given the choice between 90 percent chance of winning 3000 and a 45 percent chance of winning 6000, the majority will tend to go for the best probability and half again. When both probabilities are reduced so that the chance has almost evaporated, the majority will switch their choice to the largest gain. By what is called the reflection effect, the usual choices between sums concern prospects of losing. In this way risk is chosen over certainty. Against

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11 Consider this - would you choose the certain loss of 3000 or take some low probability of losing 6000? Most people would not choose the certain loss but hope that the probability would work out so that they would not lose anything at all.
established theory people are not risk averse for negative reasons, only for positive ones. We are creatures that habitually tolerate risks.

Humans are not isolated individuals. Their sociality should be included in the analysis of how their minds work. In risk perception, humans act less as individuals and more as social beings who have internalised social pressures and delegated their decision-making process to institutions that act as problem simplifying devices.

When pressed to give an account of a decision, the pregnant woman will refer to the experts or indeed her partner or family. She will also make a show of objective consideration of the problem. In private life as much as in public life, no one undertakes the kind of cognitive analysis that the risk assessors do when they try to separate the problem from everything except the pure calculation of probabilities. The risk assessors offer an objective analysis. We know that is not objective so long as they are dealing with uncertainties and operating on big guesses. They slide their personal bias into the calculations unobserved. The expert pretends to derive statements about what ought to be from statements about what is. The individual tends to start from ought and so does not subscribe to the ancient fallacy. If this were the difference between experts and lay people, good logic would be on the side of the latter. But the separation of ought from is cannot be clearly made. Ought depends on what is possible. The limits of the possible depend on what is known about the conditions of physical existence. Consequently, the question of whether development ought to reduce maternal mortality has to consider what is possible under the conditions under which women are living. What is known about the conditions is small compared to what is
not known that risk assessors are not the only ones who fill the gaps in knowledge with educated guesses. The kinds of guesses made about childbirth depend very largely on the kinds of moral education of the people doing the guessing.

Everyone, expert and lay person alike, is biased. Knowledge of danger is necessarily partial and limited; judgement of risk and safety must be selected as much on the basis of what is valued as on the basis of what is known. Thus the difference diminishes between modern people and non-modern. Science and risk assessors cannot tell us what we need to know about threats of danger since they explicitly try to exclude moral ideas about the good life. Where responsibility starts, they stop.

Individuals who pass on their decision-making process to institutional processes are not washing their hands of responsibility. The responsible action is to have built good monitoring devises so that one's own friends and neighbours will defend principles. Family life and work life focus and restrict the individual vision. Careful to avoid disgrace and conscious of the need of support, the social being is a sensitive scanner of safety signs in a universe of critical fellow human beings who share her commitments. It seems that rational behaviour does not use elaborate calculation for making crisis decisions, nor does it separate out risks one by one. Rather it focuses on the infrastructure of everyday conduct, establishing the conditions for survival by building flexible, feasible aims in a way of life. Individual decisions are in a way less complicated than national decisions but the methods of simplifying are still sound. Serious risk analysis should also focus on the institutional framework of decision-making. The real choices that lead most directly to dangerous decisions are choices
about social institutions. Instead of being distracted by dubious calculations, we should instead focus our analysis on what is wrong with the state of society.

People’s first and fundamental choices are personal, moral, and political; the intellectual arguments justify that has been decided: first the good society, the good life, and a place in it; explanations later. If we agreed on what polity we desired, we could consider what risks would be worth facing for establishing it.

To understand risk perception in the context of childbirth we should ask what makes a danger seem highly improbable when the psychologists does not provide percentages on the probabilities. We should ask how gains are ranked when there is no clear money standard on which to compare them. The current theories of risk perception steer badly between over intellectualising the decision process and over emphasizing irrational impediments. It is as if the individual would shun them forthwith if only she could perceive the dangers to health and safety that the expert knows. This is to intellectualise the use of knowledge beyond all reason. The satisfactions in smoking and drinking, for example, are not private pleasures. Even if they were, habits would still be hard to change because they are locked into lifestyles. But most habits good and bad, are social, rooted in community life. One does not always feel free to admonish friends to change their work and leisure patterns or even to utter the silent reproach of deviation, and to drop out of the shared occasions is asking too much. It is quite enough of an effort to meet the criticisms of fellows by coming up to their standards; getting them to adopt new ones decreed by the health authorities is quite another thing.
This is the point: anyone who lives in a community is monitored, the more close-knit, the more mutual monitoring occurs. Such monitoring constitutes the social bond. In a tight community a woman has her work cut out to meet the neighbours' standards. This is where she acquires health education, advice and referrals to experts when things are appearing to go wrong, she cannot ignore. When the community bond is weaker, she can relax. She can pick and choose among her friends; but unless she is totally isolated, her acquaintances to whom she goes for solace are her source of risk warning. A real life risk portfolio is not a selection made by private rationalisation. In real life the social process slides the decision making and the prior editing of choices onto social institutions. Shared values do more than weight the calculations of risks. They work on the estimates of probabilities as well as on the perceived magnitude of loss.

Nothing influences the estimate of probabilities more than the sense of future time. Most people conceive time as a straight extension of the present, but there are large variations. Oscar Lewis maintained that the condition of poverty foreshortens the future. The very poor, not knowing where their next meal will come from, get the habit of living so entirely in the present that they do not imagine the future at all (Lewis, 1966).

Comparison of risk perception should allow for local conceptions of time. The official view of how to assess the future starts from the experience of time as measured by clocks and calendars and by the projections upon these measures. Everyone committed to a social life is committed to an appropriate structure of time. Deep differences in attitudes toward risk derive from institutional life and these can be traced over time.
Apart from estimating a timescale for a problem of choice, even the size of a problem is differently estimated according to the cultural bias that is part of institutions for organising actions. People who have recently suffered a catastrophe are more likely to imagine it happening to them. The more distant the disaster or experience, the more difficult to imagine oneself in that situation. The more dramatic a loss, the easier to remember it. Some institutions keep the story of past trials and disasters alive, while others consign them to oblivion and cherish only the good ones. On assigning magnitude to a possible disaster, everything depends on which items of information are included and which ignored. So, for example, one of the functions of obstetric practice in the United Kingdom is to remind those involved of each and every maternal disaster, through a process of repeated reviews. At local level each hospital has frequent reviews of cases to consider where they went wrong and what risks they represent for other women. The statistics gathered over a three-year period from all maternity units are complied into a report and distributed widely to remind all those involved, of the dangers associated with childbirth. Thus the emphasis is on pathology and complications of pregnancy and childbirth rather than on the majority of women who have 'normal' births.

General social orientations, for example, a zero-sum or expanded-sum view of health, short or long-term horizons, concentration on losses or gains – guide selection of risks. Overall goals provide the selective principles, and there is reason to believe that the latent goals of the organisation are more influential than those openly stated. Taken for granted latent goals may well be built into the fabric of the organisation.
When organisations present choices to their members, they may present either the loss or the gain as the dominant element according to the kind of institution. Some institutional types create problems that can best be solved by expansion (Douglas & Wildavsky, 1983:89). So for example, in terms of obstetric practice in high technology hospitals, problems of childbirth can only be dealt with through the expansion of instrumental and surgical intervention. The overwhelming advantages of expansion of obstetric services in risk management of maternity cases may be so dominant in everyone’s minds that the gains would come to the fore in any presentation of a choice about alternative approaches, and the chances of losses, that is to the woman, would recede. On the other hand, people who have general confidence in the counteractive and anticipatory powers of their institutions may be disposed to estimate probabilities of loss differently from those people who mistrust their institutions. These three factors, the editing out of losses, the confidence in assessment procedures, and the feeling for future time, affect both estimated probabilities and magnitudes.

Cultural analysis does not ask about people’s private beliefs. It asks what theories about the world emerge as guiding principles in a particular form of society. To apply this kind of analysis, Douglas and Wildavsky assume that a social form is always precarious because members of civil society try to alter it. Consequently there is always a debate about culture, about beliefs and values. If a social system remains stable over a period of time, twenty or thirty years, it is because the guardians of the present constitution were able to wrest control and gain public agreement to the supporting beliefs and values.
Western social thought, according to Douglas and Wildavsky (1983), habitually reverts to a typology of two, bureaucracy contrasted with the market. The organisational limits of these types are known, as is their style of decision-making, hidden assumptions and manifest priorities. An individual who spends her life exclusively in one or another such social environment internalizes its values and bears its marks on her personality. It also follows that she will adopt the organisation's distinctive attitudes toward risks. Bureaucratic behaviour is included under the more encompassing heading of hierarchy for the purposes of this analysis. Hierarchies include churches, industrial corporations, hospitals, and political hierarchies. They also include some forms of family and community organisations. Contrasted with hierarchies, Douglas and Wildavsky use individualism for the behaviour that includes strategies market orientation and sustained private self-interest. Each type creates a social environment in which distinctive strategies have to be adopted if both the individual member and the form of organisation are to survive.

The obstetric hierarchy has successfully endured over time and spread its area of control and in so doing has managed to suppress internal and external rivalries so that influential individuals were unable to disrupt its progress. Its success depends on not allowing one member's personal glory to be distinguished from the collective honour. Likewise no one member can be forced to take the blame provided they stay within the confines of the rules. Collective responsibility is undertaken by making roles anonymous. Decision-making should ideally be so collectivised that no one is seen to decide. If all operate on fixed instructions, everyone executes and no one decides policies (see Mannheim, 1960).
According to Frosch (1999) American specialists act as a cornerstone of the international science, technology and health communities; ‘communities that share a common culture across national boundaries and are thus themselves a force in the conduct of foreign policy (1999:16). Frosch provides some interesting statistics in the area of scientific and technical publications (appendix 4).

One could surmise that the United States clearly represents the most influential nation in the world if quantities of articles published are an indicator. North America, as the richest country, is well able to dispose some of its income on research, and are thus in a position to drive scientific, technical and health ideology in whatever direction it chooses. The total number of articles published by authors in America, Europe, the former USSR and Canada taken together, amount to a 345,265 articles. In contrast, Asia (including Japan, China and India) only published 53,549 articles in 1995 whilst not being insignificant may represent a much lesser degree of influence. The key significance for this thesis is the level of American influence on childbirth and midwifery education and training. To that end, I will now explore the issues concerning the dominance of the medical discourse in childbirth.

National, regional and local economies depend ultimately on the dynamics of the global economy to which they are connected through networks and markets. It reaches out to the whole planet but manages to exclude the significant proportion in an uneven geographical distribution that largely impacts negatively on women and children who populate an emergent Fourth World.
Making Motherhood Safe: The Role of International Research

International health researchers have been, for the past two decades, directing increased attention to the major and widespread problem defined as maternal mortality. The first new estimates in a decade show that almost 600,000 women die in pregnancy and childbirth each year. According to the July-October 1992 volume of WHO's Safe Motherhood Newsletter about 94 percent of these deaths, which are by definition attributed to pregnancy and childbirth, take place in the economically disadvantaged southern part of the global divide, the so-called developing countries. And for every woman who dies, 30 more suffer serious pregnancy-related injuries. According to the Progress of Nations (Adamson, 1996) report, the delivery of adequate obstetric care to women in developing countries would not be expensive. Affordable basic training in obstetric care could be provided for doctors, midwives and nurses. This would ensure safer deliveries for most pregnant women.

You don't need five-star hospitals, says the report. "There are thousands of hospitals in the developing world that, with minimum upgrading, could provide adequate obstetric care. But many are unusable for the lack of a hundred dollars worth of maintenance, a repair to an anaesthesia machine, the installation of proper lighting. (Adamson quoting Deborah Maine, 1996 http://www.unicef.org/)

As researchers began to respond to a call to action on this problem by WHO, the prior "neglect" of maternal mortality was attributed to the underestimation, or even absence, of information about this serious health issue. With increased interest, a variety of
groups with different political agendas have expressed concern. These groups range from feminist non-governmental organizations such as those associated with the international Maternal Mortality and Morbidity Campaign (Women's Global Network for Reproductive Rights, 1992) to the United States Agency for International Development (USAID). Well known for its protracted commitment to population control in the Third World (Alexander 1990, Hartmann 1987, Mass 1976), USAID is a cosponsor, with the World Bank, of the Safe Motherhood Initiative (Bolton et al. 1989: 80).

Sociomedical studies of maternal mortality recognise social and cultural influences but generally exhibit certain analytical limitations, notably their inadequate consideration of nation state policies. As Staudt and Col (1991: 241), among others, have remarked, "Like cultures, states have gender ideologies and rules, and these are as relevant to study as the gender ideologies and rules of cultures."

Also worthy of consideration is the impact on nation-states' agendas for social transformation of historically variable global political-economic relations. In this regard it is important to consider the directives of international financial institutions that pressure Third World nations to compromise state welfare programmes in favour of privatised economies. For health development specifically, the intensification of the struggle for comprehensive primary health care during the 1970s coincided with an attempted challenge to global power relations and negotiation of a "new international economic order" (Navarro 1986: 217-19). In contrast, the selective health strategies laid out for the ensuing decade (Walsh and Warren 1979), of which an emphasis on
maternal mortality was one, represented policy orientations befitting the following decade of structural adjustments (Barker and Turshen, 1986).

Focused on Africa, this chapter addresses maternal mortality in relation to state-sanctioned selective health strategies promoted by international agencies. I present an alternative to ahistorical epidemiological analysis of the risk factors associated with these strategies (Morsy and El-Bayoumi 1993). Central to the methodological orientation of my analysis is consideration of the impact of historical changes in state policies on women's health in conjunction with their role in production and social reproduction. Examination of the state's current policies regarding maternal and child health brings attention to the priority of population control as imposed by international aid donors. Far from "putting the M back in Maternal and Child Health" (Rosenfield and Maine 1985), the selective focus on maternal mortality appears to be a medicalized form of fertility regulation. Thus population control is endowed with "an image of respectability and safety that [does] not 'generate rumours' or 'embarrass politicians'" (Van der Vlugt et al. 1974, as cited in Punnett 1990: 107; see also Shapiro 1985).

**Biomedical Concerns**

Interest in maternal mortality in African societies developed as an extension of the Safe Motherhood Initiative, which was promoted by international health agencies and adopted by national bureaucracies (World Health Organization 1986). In Ghana and Malawi the popularisation of maternal mortality as a major public-health problem coincided with the implementation of the state's economic policies under the increased
influence of U.S.-dominated international development and financial institutions in supporting health programmes and research. Since the end of the seventies a number of quantitatively orientated studies involving doctors have been conducted that continued to point out that maternal mortality is underestimated in official statistics. This concern with its precision in unravelling death attributed to pregnancy from the web of other mortality-conducive conditions, generally remains removed from consideration of historically delineated class relations and the attendant variation in risks to general health and to life.

As for other developing countries, the maternal-mortality ratio for Ghana and Malawi is considerably higher than that reported for industrially advanced societies. The national maternal-mortality ratios for Ghana of 210/100,000 (UNICEF)-740/100,000 (World Bank, World Development Indicators (WDI), 1999) depending upon whose statistics are used. Malawi’s ratio is 620/100,000 live births (WDI, 1999). These figures stand in sharp contrast to 9/100,000 (WDI, 1999) for the United Kingdom and 12/100,000 (WDI, 1999) for the United States and 34/100,000 (WDI, 1999) for Malaysia. Mortality ratios varied in each country according to a number of multiple factors as described in the case study chapters.

Beyond addressing the problem of accurate estimates of maternal mortality in Africa, researchers have considered the causes of maternal deaths. Within the conceptual boundaries of a biomedical perspective, wherein identification of cause is predicated upon the definition of maternal mortality as pregnancy-related, there is a limited choice between direct and indirect obstetrical deaths. In accordance with such medically
defined causation African doctors focused on the identification of antepartum and postpartum complications such as haemorrhage, pregnancy induced hypertensive diseases, and infection during and after labour as major causes of maternal deaths. Additional medically defined causes include obstructed labour and ruptured uterus, anaemia, as well as embolism, complications associated with heart disease, rheumatic heart diseases, blood incompatibility, and infectious hepatitis.

Socio-medical interpretations: The Limits of Epidemiology

International agencies' interest in women's health, begun during the Women's Decade (1975-1985) and sustained by promoters of primary health care, has yielded a series of significant policy recommendations involving areas well beyond the boundaries of the health-care system. Consistent with support of the comprehensive primary-health-care strategy, WHO's advocacy of "safe motherhood" called for "changes in the broader socio-political and economic spheres" (Mahler 1987, as cited in Bolton et al. 1989: 81).

Far from the integration of maternal mortality into a programme of health activism—such as the one in Brazil supported by feminist organizations, the politics of African women's reproductive health is clearly tamed by medicalization. This position is consistent with that of the World Bank, the co-sponsor of the Safe Motherhood Initiative where the focus is on excess fertility. Also noteworthy is the World Bank's stipulation of population control as a condition for economic aid to Africa.
Although contradicted by political reality, the mere call for social transformation associated with the Alma-Ata Declaration of 1979 has helped bring attention, and professional legitimacy, to socio-medical interpretations. As a result of conceptual movement beyond the analytical boundaries of biomedicine, sociocultural correlates of maternal mortality noted by researchers now includes "the status of women," "their living conditions," and "attitudes towards women" (see the Ghana and Malawi Demographic Surveys). Professional commentary on the social and economic determinants that affect the morbidity of women also brings into focus the characteristics of the individual woman consisting of her educational level, economic activity, institutional and social support network. As for relevant elements, these include factors articulated in social values, legal systems and production structures that govern society's view of the duties and rights of women, foremost among them being the reproductive function of women.

The attention now devoted to elements of both the individual and social bodies in reproductive-health research in Africa is indeed a welcome development. However, the dominant conceptual framework is in certain respects problematic as it fails to account for how enhanced risk is both socially produced and historically specific.

Conclusion

The impact of the World Bank surpasses economic aspects. For Escobar (1995), this institution should be seen as an agent of economic and cultural imperialism at the service of the global elite. As perhaps no other institution, the World Bank embodies
the development machinery. It deploys development with tremendous efficiency, establishing multiple agents from among recipients in the developing world, from whom the discourse extends and renews itself.

Despite the crucial importance of this issue, it is necessary to keep in mind that indigenous resistance reflects more than the struggle for land and living conditions; it is above all a struggle over symbols and meanings, a cultural struggle. The description of the TBA’s struggle against cutting the umbilical cord in rural Africa, for instance, illustrates well the contest over views of history and the ways of life the new medical technologies foster (chapter 4). Studies of resistance, however, only hint at the cultures from which resistance springs. The forms of resistance and the concept itself are usually theorised in relation to the cultures of the west. It is more difficult for the researcher to learn to inhabit the inner interpretive design of the resisting culture, which would be the prerequisite for a representation that does not depend so much on western knowledge traditions (Strathern 1988).

No standardised recipes or "packages" -- such as those of homogenised American medicalised childbirth practices -- can on the whole hope to encompass the diversity of local customs and acts of resistance. The prescription of scientific obstetric norms for "proper" birthing practice that are documented and followed by the majority of practitioners in western cultures is alien to many traditional indigenous cultures. Traditional practices and events, according to individual traditional midwives observed and interviewed (Focus Groups, Ghana & Malawi, 1991; Malaysia, 1994 and 1995) are seldom repeated out of a pre-established scheme for each practitioner; on the contrary,
knowledge is continually re-created as part of a commitment to strengthening and enriching reality, not to transforming it. Language is alive, its meaning always dictated by the context. Language is never permanent or stable. Conversation implies the re-enactment of events talked about; words refer to what has been lived rather than to far-off happenings.

Much of African and Malaysian traditional cultural knowledge and practices have been eroded, yet the women interviewed emphatically assert the validity of many long-standing practices among rural communities. They believe that village people have learned to use the instruments of modernity without losing much of their vision of the world. In Africa and Malaysia, communities are struggling to articulate and set into motion a process of cultural affirmation that includes, among its guiding principles, the search for ethnic identity, autonomy, and the right to decide their own perspectives on development and social practice.

The process of gauging experiences from western perspectives is not easy. Academics in the west tend to fall into the trap of dismissing these experiences as romantic expositions by activists or intellectuals whose vision is coloured by their own worldview. These critics fail to acknowledge the crude realities of the world, such as capitalist hegemony. Others fall into the trap of embracing such experiences uncritically. Both extremes should be avoided in Escobar’s (1995) opinion. Instead of true or false representations of reality, these accounts of cultural difference should be taken as instances of discourse and counter-discourse. They reflect struggles centred on the politics of difference, which often include an explicit critique of development.
As Alonso (1992) remarked, one must be careful not to naturalise "traditional" worlds, that is, valorise as innocent and "natural" an order produced by history. These orders can also be interpreted in terms of specific effects of power and meaning. The "local," moreover, is neither unconnected nor unconstructed, as it is thought at times. The temptation to "consume" grassroots experiences in the market for "alternatives" in the western academic world should also be avoided. As Chow warned (1992), one must resist participating in the reification of developing world experiences that often takes place under such rubrics as multiculturalism and cultural diversity. This reification hides other mechanisms:

The apparent receptiveness of our curricula to the Third World, a receptiveness that makes full use of non-western human specimens as instruments for articulation, is something we have to practice and deconstruct at once.... We [must] find a resistance to the liberal illusion of the autonomy and independence we can "give" the other. It shows that social knowledge (and the responsibility that this knowledge entails) is not simply a matter of empathy or identification with "the other" whose sorrows and frustrations are being made part of the spectacle.... This means that our attempts to "explore the 'other' point of view" and "to give it a chance to speak for itself," as the passion of many current discourse goes, must always be distinguished from the other's struggles, no matter how enthusiastically we assume the non-existence of that distinction. (Chow, 1992: 111, 112)
The struggle over representation and for cultural affirmation should be carried out in conjunction with the struggle against the exploitation of and domination over the conditions of local, regional, national, and global political economies. The two projects are, indeed, one and the same. Capitalist regimes undermine the reproduction of socially valued forms of identity; by destroying existing cultural practices, while development projects destroy elements necessary for cultural affirmation. In World Bank discourse, indigenous people have to be regulated by new technologies of power that transform them "into the docile subject of the epic of progress" (Alonso 1992, 412). In many parts of the developing world, however, rural life is significantly different from what the World Bank would have us believe.

What does this mean for the development of educational programmes for midwives globally? In the next chapter, the education of practitioners in the case study countries is analysed and discussed.