THE DEVELOPMENT OF MIDWIFERY KNOWLEDGE AND ITS RELATIONSHIP TO THE CURRICULUM

An Investigation of Two Cases

A Thesis submitted in partial fulfilment of the requirements of the University of Surrey for the degree of Doctor of Philosophy

By Huguette Comerasamy

June 2001
DEDICATION

This thesis is dedicated to my late mother and father, particularly to my mother who has been a great inspiration to me and pivotal in my academic aspiration.
There is no better way to gauge the development of a field than to critically examine its body of knowledge.

(Brocket 1991, p. 121)
<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgement</td>
<td>i</td>
</tr>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Preface</td>
<td>1</td>
</tr>
</tbody>
</table>

**PART 1**

**Chapter 1**

- Background and Context of Study 7
- Conceptual Framework of Study 8
- Nature and Legitimation of Knowledge 9
- Domains of Knowledge 13
- Socio-philosophical Theories 15
- The Thesis 29
- Structure of the Study 29
- Literature Review 31
- A Word About Style 31
- Conclusion 31

**Chapter 2**

- Research Methodology and Design 32
- Aims of Research 33
- Philosophical Underpinnings 33
- Quantitative Paradigm 34
- Qualitative Paradigm 35
- Critical Theory 37
- Case Study Approach 43
- What is A Case Study 43
- Issues Surrounding Case Study Research 47
- Conducting The Inquiry 48
- Case Study 1 49
- Case Study 2 51
- Data Analysis 64
- Findings 67
- Ethical Considerations 68
- Conclusion 70

**Part 2**

- Introduction 71

**Chapter 3**

- The Ecclesiastical Discourse 78
- The Witchcraft Theory 78
- Ecclesiastical Organisation of Midwifery 85
- Criticism of Ecclesiastical Control 91
- Conclusion 92
Other Dimensions of Dais’ Practice 222
Conclusion 223
Conclusion to Part Three 225
**Part 4**
Introduction 227

**Chapter 10**
Western Construct of Midwifery Knowledge 229
Contextualising the Debate 230
Scientific Assumptions 234
Decontextualisation of Childbirth 236
Legitimation of Knowledge Through Language 244
Methodological Issues 246
Conclusion 247

**Chapter 11**
Premodern Midwifery Knowledge 248
Religious Knowledge 249
Experiential Knowledge 253
Practical Knowledge 246
Context of Knowledge Production 260
Linguistic representation 262
Conclusion 264

**Chapter 12**
Introduction 265
Midwifery Knowledge Reconceptualised 270
Philosophical Assumptions 272
Religious-Metaphysical Assumptions 273
Production and Legitimation of Knowledge 274
Conclusion 275

**Chapter 13**
Cultural Transformation of Midwifery Education 278
Decontextualisation of Midwifery Education 279
Knowledge and The Curricula 281
Midwifery Practice as a Field of Learning 283
Conclusion 285

**Chapter 14**
About Reconceptualisation of Midwifery Knowledge 286
About Legitimation of Midwifery Knowledge 288
About The Curriculum 291
Reflection on The study 291
Limitations of The Research 294
Future Research 279

Appendices 300
References 347
Bibliography 366
ACKNOWLEDGEMENT

Many people have assisted me in making this study possible- too many to name all of them individually. However there are a number that I specially want to thank for the part they have played in enabling me to achieve my goal.

First of all I would like to thank the Wolfson Institute of Health Sciences for granting me scholarly time to undertake the research work required for my doctorate.

I owe a special depth of gratitude to Dr J.C Mohith, Executive Director of the Mauritius institute of Health, Mr N.Gopal, the then Nursing Officer-in-Chief, and other members of the Mauritian Ministry of health for their co-operation and support whilst I was conducting my fieldwork. Thanks also to all the nurse-midwives and midwives who were so willing to participate in my study.

I am grateful to the dais that taught me so much about what midwifery is and what it is not. I have great respect for their perspective of childbirth, midwifery practice and their epistemological orientation. This has not only led me to question my own professional acculturation but has also inspired me to delve deeper into the meaning of midwifery. Additionally they have had an impact on my understanding of spirituality and its significance to childbirth.

I would like to thank Gerry Stones for reading part of this manuscript and for providing assistance with the computer setting of my thesis.

I am very grateful to Annette Stannet for the advice given on literary style and to Baba Dason for providing assistance with proofreading my material.

I am indebted to my supervisor, Professor Peter Jarvis of the University of Surrey for his encouragement, support and guidance throughout this work. Through the vast literature introduced to me he has played a significant part in the development of my thinking.
Finally I would like to thank all members of my family for their unfailing support and understanding, especially my sister Lisette who took time off work to assist me for the entire time I was in Mauritius conducting my fieldwork. Words cannot express the depth of my gratitude to her.

Most important of all, I offer thanks to God, my ultimate source of energy, for intellect and strength in achieving this goal. To him be Honour and Glory.
ABSTRACT

This study examines the nature and development of midwifery knowledge and its relationship to the curriculum. Central to this examination is the thesis that its origin and development is linked principally to a radical cultural transformation of society. Ideas from three socio-philosophical theories are used as a conceptual framework in this analysis. These are modernity, postmodernity and premodernity. They represent the cultural shifts that have taken place as midwifery has evolved and play a central role in providing the tools for questioning the impact of cultural transformation on the construction of midwifery knowledge and to even question whether there is such a thing called midwifery knowledge.

This study uses a non-experimental research approach. In combines two stages of enquiry, which involve two cases. The first entails a theoretical investigation of the evolution of midwifery in the UK. The second phase was conducted in Mauritius. The data was analysed using the perspective of critical theory.

This study shows that midwifery knowledge is a social construct, culturally determined, relative and embedded in the historical context. It is interpreted within two contending worldviews, one scientific and the other religious. Both of these have to be kept in balance in order to reach a total representation of midwifery knowledge.

Whilst there is a unity of purpose, which is assisting women in giving birth, the conclusion about the examination of midwifery knowledge suggests that there is no single body of midwifery knowledge but that there are different knowledges, which stem from different epistemological positions. How should we integrate these positions into the development of the curriculum and in tailoring our practice that must be relevant to a population that is increasingly culturally diverse? This study concludes by addressing this question and suggests that there is need for further research into the context within which midwifery knowledge is produced and legitimised. Other areas for future research are also identified.
Preface

PREFACE

Questions about midwifery knowledge are not new. A number of scholars in the field have raised it in various contexts. This study brings together my search for a better understanding of midwifery knowledge over a number of years. Embarking on this present research has been like a voyage of discovery; at times the roads have been thorny, precisely because I began to unearth many issues that were antithetical to the foundation of contemporary midwifery knowledge.

To lead the reader into my research voyage I would like to begin with a selection of my biography. This provides the background against which the scholarly inquiry is set. It gives the experience that generated the interest that spurred on the research.

Born in Mauritius, I spent my formative years in this little island situated in the Indian Ocean. As a young adult I came to the UK to start a career in Nursing Studies. This later led to specialising in midwifery practice and latterly in education. Acculturated in the Western school of thought my understanding of midwifery knowledge is framed in that context. I trained at a time and in a locality where hospital birth was the accepted norm. Home births were a rare event. Other than an academic perspective there was little insight to be had about the reality of birth occurring in women’s own social space and the perspectives of knowledge that this could have offered. Consequently the hospital was the main area in which my learning and my perspective of midwifery knowledge were oriented.

My professional education has led me to understand that midwifery has a distinct area of knowledge. This is mainly based on biomedical sciences— a collective term that describes all allied medical sciences such as anatomy and physiology, anaesthetics, pharmacology neonatology, upon which the curriculum was founded, all interlocking with one another in one epistemological region. Little attention was paid to other forms of knowledge. In a sense then this defined a medical paradigm. Indeed this is what has shaped my professional script and for sometime has guided my practice as a teacher of undergraduate and graduate midwives.
Several interests of mine have led to this inquiry, which I now know is not the straightforward epistemological study that I had envisioned. The first emanates from my midwifery training some two decades or so ago. In an effort to fathom what was distinct about midwifery knowledge, (given that the knowledge base that underpinned it was no different to that of my nursing programme) I found the main distinction to be in its application. Unlike the clientele of nursing, childbearing women in the main are well and undergoing a natural phase in their lives. In that sense rather than viewing midwifery knowledge as being distinct, I came to the conclusion then, that midwifery knowledge was contextual.

My second line of interest emanates from my encounter with Mauritian educated midwifery practitioners who were pursuing further studies in the UK. Interesting dialogues with them about midwifery in Mauritius instilled further doubt in my mind about my assumptions of midwifery knowledge, which in turn deepened my interest into finding out what midwifery knowledge actually entailed.

My third line of interest and perhaps the most determined occurred during one of many vacations in my homeland. One evening whilst socialising with a number of kinfolks, the conversation veered towards midwifery matters, as it often happens when members of the same and allied professions meet. My elder sister, a midwife and midwife manager of some considerable years of experience recounted an experience that made an indelible impression on my mind, in response to which I expressed a desire to study the Mauritian Midwifery system. In what appeared to be some form of protection, others present categorically expressed their dissatisfaction, and to quote them “don’t you even dare think about coming and comparing us with your UK system”. Undeterred by this comment I began to develop ideas about realising this desire. For sometime, however, the idea of undertaking research in my own cultural setting remained dormant.

In the year of 1992 I was fortunate to visit Mauritius in the capacity of researcher. At the time I was reading for a Master of Science degree in education. As part fulfilment of my MSc degree I conducted a small ethnographic research in midwifery education in my native land. This original study sought to understand the curriculum development (with particular relevance to content and how it was
delivered) and the clinical setting as a learning environment. It was during my fieldwork that I engaged with a group of women who did not only open up ways for me to pursue my search for understanding midwifery knowledge but would also later influence my thinking in a significant way. I was compelled to review the professional script that guided my practice. Consequently I began to question who I had become, my assumptions about midwifery knowledge and my practice as a midwife and midwife teacher. This began a gradual process of shifting out of the biomedical paradigm into a new conception of midwifery.

These women were traditional birth attendants, commonly known as dais or sagefemme. Up until then my knowledge of them and their practice were very vague, I even thought that both they and their practice was extinct. Not so. Indeed it was the realm of traditional midwifery that fuelled my doctoral thesis.

Traditional midwifery, as these women led me to understand, is embodied and embedded in traditional medicine and is viewed as a sociocultural phenomenon. It incorporates values long held by the people irrespective of socio-economic status and is embedded in a world of rituals in which women play a significant role. At that point in time I was confronted with an array of cultural differences and practices that began to shake my midwifery foundation. Examples of these issues included the spatial and temporal context of birth, the meaning that they attached to childbirth, midwifery practice and the rituals pertaining to childbirth, the significance of practice as “THE” field for learning and the inseparable relationship between knowledge and practice far beyond what western contemporary midwifery holds.

For the first time in my career I was exposed to a different midwifery that is so dichotomous to the western culture in the philosophy of care, approach to practice and to the socialisation of learners. This dichotomy is firmly laid in the conceptual framework and the boundaries that are placed on midwifery. The fundamental difference as I observed at the time, is that traditional midwifery incorporates everyday life and views childbirth as a continuum in women’s lives- a rite of passage (Van Gennep 1909); practical forms of knowing were advocated and the knowledge was and is embedded in the practicalities of everyday life. For the traditional midwives, midwifery practice and its base knowledge are framed in a broader
sociological context. From this observation my attention was drawn to the extent to which the western midwifery construct has excluded the “every day life” aspects inherent in traditional midwifery. At this juncture I was struck with the realisation that I might only have a partial understanding of midwifery and its knowledge base. A theoretical framework for understanding the development of midwifery knowledge began to emerge; it contained three concepts: premodernism, modernism and postmodernism.

Tentatively, this points to a first proposition, as it has evolved western midwifery is culturally limited. It is a fragmented construct that is wedded to the medico-scientific representation. The second suggests that midwifery is an articulation of multi-realities and as such its knowledge base does not and cannot rest on biomedical sciences alone. I acknowledge that these are important because they have brought midwifery a long way, but in an equally significant way, the social and cultural embeddedness of everyday life must form part of midwifery knowledge. Heller (1984, p.3) made the point that “everyday life exists in every society and indeed every human being who has his/her own everyday life ought to be taken seriously”. In my own mind I began to raise other issues that would further guide the present inquiry. They were forms of representation and legitimation.

A final observation in my previous research was the extent to which Mauritius was fast becoming part of a global society. In the realm of health care, Mauritius is linked with different universities in the United Kingdom, France, United States of America, Australia, Africa and India. Researchers, as well as students, travel to and from Mauritius either on exchange visits or to conduct research either individually or collaboratively. Inevitably as people travel they interact, adopt and adapt to different cultures; they begin to reconstruct their lifeworld. As they do so the context begins to shift. This is further accelerated in all spheres of development by modern communication that is gradually compressing time and space. This, as the traditional birth attendants informed me, is posing a gradual threat to traditional midwifery practice.

Mauritius is at an interesting stage of development, to my understanding- an intersection of premodernity and modernity. Whilst the developments of modern
institutions are rapidly taking place, Mauritius has not made a break with tradition, which remains important, especially in the field of religion. It has crystallised a system which impacts and permeates all aspects of Mauritian lives. The cultural transmission therefore remains situated and contextualised. Although issues of modernity expressed in social, political and economic spheres are infiltrating social and everyday life, retention of local diversity remains a characteristic of Mauritius. It is the strong adherence to religious value system that allows the people to stick to local cultures—a process that is referred as "glocalisation" (Robertson 1995). (A fuller account on Mauritius is included in appendix two).

The time frame within which I was working at the time of my research precluded an in-depth inquiry of midwifery but on my return to UK, following my first research experience I began to look at the way I was involved in preparing learners to practise differently. I began to question how my knowledge was influenced by the spaces and the culture that I had become a part.

Against this background I developed the ideas that could be subjected to empirical and theoretical investigations. Studies into the nature of midwifery knowledge began in earnest in view of this doctoral thesis. My search about further empirical evidence took me back to Mauritius in the autumn of 1996. This study therefore started with a single epistemological question into the nature of midwifery knowledge and the need to study it within the two cultures to which I belong. This therefore led me to begin my inquiry within the UK context. The intention to do so was primarily to address the problem I identified with my personal understanding of the western perspective of midwifery knowledge. The reason for returning to Mauritius is two fold. Firstly to inquire in more depth into the field of traditional midwifery, to dialogue with the traditional birth attendants, to observe their practice, to obtain a better perspective of their interpretation of midwifery and how they construct their knowledge. Secondly I speak the same language as my informants, the likelihood of meaning being lost in translation will be minimised.

As I delved into the literature and became immersed in my fieldwork, I soon recognised that the difficulty that I encountered with my personal understanding of midwifery was also a problem in Mauritius. The problem lay in the core knowledge,
which as I stated earlier is biomedical sciences. For the traditional birth attendants the core knowledge is religion / spirituality; they were encountering major difficulty in accepting the paradigm shift that was being imposed by modern perspective, which is what the governmental midwifery system is about. My concern then was no longer what is the nature of midwifery knowledge but how has it developed. We will see that midwifery knowledge is determined by societies, culture and era. In Mauritius we see that knowledge is grounded in experience and that knowledge is interpreted by a premodern value system, which falls in the realm of anthropology; whilst in the UK it is grounded in experimentation and interpreted by modern and postmodern value systems. Accordingly, this opens a new set of questions with which began: what is the origin of midwifery? What does it mean? How has midwifery knowledge, as we know it developed? How is it legitimised? What has been preserved or lost with the advent of modernisation? What should midwifery knowledge constitute? Can there be such a thing called midwifery knowledge? Clearly all these questions could not be addressed within this study; these help to reframe the question into a more appropriate one for the purpose of the study which is as follows: How has midwifery knowledge developed and what are the implications to the curriculum?

The United Kingdom and Mauritius were chosen as two cases upon which the inquiry is based. This is not a comparative study. The intention of using the two cases was simply to understand something about the relationships between premodernity, modernity and postmodernity, essentially seeking how midwifery knowledge has been interpreted across societies, cultures and eras. The conceptual framework of this study, which borrows from these three concepts, is expanded in chapter one.

My engagement with both the theoretical and empirical investigation that this study entails has enabled me to think about midwifery and midwifery knowledge more complexly. The conceptual framework discussed in the next chapter reflects that complexity. Part of the findings of my study have been presented at different forums within midwifery, locally as well as internationally, which has stimulated many midwives to rethink their midwifery paradigm.
PART ONE
CHAPTER ONE

Introduction

The subject of midwifery knowledge is indeed very complex. Central to its examination is the thesis that its origin and development is linked first and foremost to a radical cultural transformation of the society and its societal value system. Since midwifery first became subject to scrutiny some five centuries or so ago, the development of its knowledge has revolved around the safety of childbearing women and their infants. According to my survey of the literature, to ensure the above aim, midwifery knowledge, has been created predominantly through the perspective of a patriarchal culture, which not only determined what knowledge is important but how the search of knowledge ought to be conducted, how it is utilised and how it is imparted (Witz 1992; Jacobus et al 1990; Foucault 1980). This is based upon the positivist school of thought that has crystallised a structure through which midwifery knowledge is understood, legitimated and represented (Wagner 1994).

Within that particular worldview midwifery knowledge has been defined as a scientific construct, which entailed accepting a particular concept of knowledge. However, as will be demonstrated in this study, what is taken to be scientific knowledge is not purely scientific; in reality it is a discourse that has been constructed by employing scientific methods. Furthermore, the literature review shows that midwifery knowledge is not based on pure scientific experimentation, but encapsulates other dimensions that are manifestations of everyday life- an aspect, which positivist ideologies have suppressed. Consequently, these dimensions have remained largely unexamined and unresearched. There are different ways of looking at knowledge, as there are approaches to knowledge construction that would allow for other forms of knowledge to be discovered and integrated in the existing midwifery knowledge. I do not, however, dismiss scientific knowledge in favour of other knowledges, what I do in this study is problematise and challenge the dominance of the positivist view of knowledge and its assumption that scientific
methodology is the only path to knowledge, as the positivist school of thought advocates.

**Conceptual Framework of the Study**

Placing midwifery within a larger socio-philosophical frame and investigating the factors that have impacted its knowledge is required. The justification for doing so is simply because it enables me to see the construction of midwifery as part of a wider pattern. There are two major theoretical standpoints that constitute the conceptual framework of this study. The first is an overview of knowledge and knowledge legitimation. The second is based on ideas borrowed from socio-philosophical theories; these are premodernity, modernity and postmodernity. They have been chosen because they represent the cultural shifts that have taken place as society has evolved. They offer a central role in providing the tools for questioning the impact of cultural transformation on the development of midwifery knowledge, that is the criteria that knowledge presupposes, and the thinking that has influenced the criteria upon which knowledge is legitimised.

Additionally, they provide a broader theoretical basis to explain the development of knowledge in a variety of settings and across cultures and eras as we attempt to arrive at some consensus about midwifery knowledge. My survey of the literature indicates that the debate of knowledge development is situated mainly within modernity and postmodernity, with less emphasis on premodernity. Any discussion of knowledge development would be incomplete without the tenets of premodernity on knowledge construction. Both will serve as a guide throughout the study. The following subsections give an overview of knowledge, which is followed by a discussion on the concepts of modernity, postmodernity and premodernity, inside which I locate the debate about knowledge development. I have chosen to address premodernity last, simply because I am starting from the western perspective. The discussion here is restricted to knowledge.
Midwifery Knowledge

Modernism

Post Modernism

Premodernism
Chapter One: Background and context of study

The Nature of Knowledge and Knowledge Legitimation

As the concept of knowledge is vast and complex, only the legitimation aspect of it will be addressed here. This will then serve as a guide throughout this study. But it might be useful to define both legitimation and knowledge.

Jarvis (1992, p 27) defines legitimation as

The process of making things appears as if they are natural. It is different from legislation, which means making actions right in law. Legitimation requires social processes that give actions, beliefs, behaviour, and so on appearance that they are right things to do, to say, and to think. In other words, the presumptive behaviour becomes viewed as the only correct way to behave in specific situation.

Knowledge, according to the Oxford English Reference Dictionary (1996), is

Awareness or familiarity gained by experience”; “a person’s range of information”; “a theoretical or practical understanding of a subject, language, etc”; “the sum of what is known;” something which is true as opposed to a belief or opinion.

Although somewhat general, this definition offers some insight into what passes for knowledge and how it is acquired. A second view developed by Scheffler (1983, p 32) outlines knowledge as, firstly

Including familiarity with things, places, persons and subject, competence in a variety of learned performance and possession of ostensible truths as matters of fact as well as faith.

Hence there seem to be three different kinds of knowledge: knowledge of things or objects (knowing-of or knowledge by acquaintance); knowledge of how to do things (knowing-how) and knowledge of statements or propositions (knowing that or propositional knowledge) (Musgrave 1993; Jarvis 1999). Scheffler’s second idea indicates that “knowledge” is closely associated with notions of understanding and controlling nature so as to sustain and enhance civilised life (1983, p 20). This resonates with the modern understanding of the development of knowledge (Habermas 1984; Hamilton 1992). Scheffler (1983, p. 25) maintains that knowledge “is also associated with contemplation, absorption and appreciation” and from this view derives three approaches to the study of knowledge, namely: rationalistic, empiristic and pragmatic each with its own orientation. Each approach will place the
examination of the development of midwifery knowledge within a wider perspective of the positivist viewpoint.

**Rationalistic Knowledge**

The rationalistic approach emphasises the role of reason and rationality as ways of legitimising knowledge (Moser and Vandernat 1982; Hamilton 1992; Jarvis 1999). Stemming from Descartes’ methodological theory (which rests on the claim that the laws of natural action could be accurately represented in mathematical formula) the rationalistic approach attempts to define knowledge in terms of mathematics, in which quantification is the locus of interpretation and classification of the domains of knowledge (Foucault 1970). On the assertion that mathematical truths do not rely on experience or objects outside their own problem, their arguments are contained within its own logic; it is legitimated by the process of reasoning (Scheffler 1983; Musgrave 1993; Jarvis 1999). The overall perspective of rationalist thinking is about objectivity and value-neutrality, which give authority to external factors of knowledge. The mathematical formalisation explicit in rationalism constitutes the objectivity of its methods. By its very nature objectivism/objectivity holds that knowledge is a sense fixed and absolute. To a large extent the rationalist thinking has dictated and controlled the construction of midwifery.

**Empiristic Knowledge**

In contrast to the rationalistic approach to knowledge construction, the empiricist places primacy on the role of sensory experiences as providing a basis for scientific knowledge. Essentially, then, knowledge is apprehended through our sense organs (Moser and Vandernat 1983; Hamilton 1992; Jarvis 1999). In the empiristic approach natural science is used as a model in which natural phenomena are understood on the basis of human experience and a scientific approach to those phenomena (Hamilton 1992). Emanating from the empiristic school of thought is that which counts, as knowledge must be grounded in experience. In “knowledge and Human Interest”, Habermas (1978) engages in a critique of the empiristic approach and maintains that this kind of science is driven by our human interest in
controlling physical, biological and social environment. Whilst seeming to be a critique of rationalist school of thought, this approach, mounts a case for the legitimacy of knowledge claims in experimentation. Positivist’s methodology derives its root from the empiristic school of thought.

**Pragmatic Knowledge**

Pierce first developed pragmatism as a philosophical approach to legitimation of knowledge in the late nineteenth century (Rorty 1991) and James and Dewey redefined it in the late twentieth century. It indicates a distinctive notion of epistemology, which suggests that knowledge has an ineliminable pragmatic component; it takes the theory of knowledge beyond the data of sensation that is expressed in empiristic school of thought to include the interpretation of these data in the acquisition of knowledge. Thus the emphasis is on the person experiencing the experience (that is the person is the knower, not necessarily the one researching about it), whatever that experience may be. In effect, the knower is an active participant in the act of knowing and the knowers’ act of interpretation relative to the data of sensation is heightened (Dewey 1933; Dewey 1938; James 1995). In reality pragmatism postulates that human beings are reasoning agents who apply knowledge to their contexts of action reflexively in their production of action and interaction (Bottomore and Nisbet 1979; Jarvis 1992). According to Freire (1972) the pragmatic approach to knowledge involves a dialogical relationship between knower and known. It gives voice to human experience as it is. Essentially, then pragmatic theories stress the experimental nature of empirical science (Scheffler 1983; Jarvis 1999). As Scheffler (1983, p. 5) attests:

To learn something significant about the world, we must do more than operate logically upon basic truths that appear to us self-evident, and we must go beyond reasonable generalisation of observed phenomenal pattern in our past experience.

Rorty (1991) brings another argument to pragmatic epistemology that is exceptionally relevant to this study. He claims that the work of James, Dewey amongst others should not be viewed as distinctive theory of knowledge and suggests that pragmatic epistemology should be concerned with actual cultural practices that gave rise to our use of the terms like "knowledge" and "justification",
Chapter One: Background and context of study

erly staking an explanatory claim for the development of knowledge in the cultural
domain. Freire (1972) further points out that all knowing begins with experience
which in his view is the actuality of lived experience, the data of everyday life that
contain our reality. This perspective resonates with Kant’s philosophical basis in
which he postulates self-knowledge, that is one’s ability to use one’s own
understanding without the control of another. The focal point of Kant’s philosophical
basis is that human being is capable of enlightening itself, and all that is needed to
achieve this is freedom. (Kant 1724-1804, cited in Cahoone 1996).

Significantly, experience takes a different meaning in the pragmatist view in
which knowledge is actively constructed by the knower. The pragmatic approach,
thus insists that there is room for a variety of interpretations and meanings and that
beyond knowledge lie socio-cultural processes. Additionally, pragmatism suggests a
move from knowledge as objective, value-free to socially orientated knowledge
embodied in everyday life.

The above analysis of knowledge shows that it is hardly neutral. Collectively
those approaches suggest that knowledge construction can be seen from several
perspectives, which would accommodate the incommensurability that accompanies a
single approach. In the case of midwifery the literature review indicates that this has
been the positivist methodology. This study suggests that the western representation
of midwifery knowledge is problematic, since it defined in a narrow set of ideologies
which not only determined what knowledge is important, but how the search for
knowledge ought to be conducted.

In the last decade or so midwife researchers have begun to examine the
philosophical basis of midwifery and the relationships between philosophy, scientific
method and knowledge development in midwifery and how appropriate is this
knowledge. I personally question whether the contemporary representation of
midwifery knowledge can indeed be justifiably so called. To challenge this position
we need to consider what are the domains of knowledge.
Domains of Knowledge

Scheler (1980, p 73) identifies seven domains (which he calls types) of knowledge. These are:

1. Myth and legend— undifferentiated, preliminary forms of religious, metaphysical, natural, and historical knowledge.
2. The knowledge implicit in everyday natural language (in contrast to learned, poetic or technical language).
3. The religious knowledge in its various levels of fixation, ranging from pious, emotive and vague intuition up to the fixated dogmas of a priestly church.
4. The basic forms of mystical knowledge.
5. Philosophic- metaphysical knowledge.
6. The positive knowledge of mathematics and of natural sciences and the humanities.
7. Technological knowledge.

Scheler further explains that the development of knowledge depends on several factors. These are:

- The types of leaders (i.e. religious, sage, researcher and technologist).
- The different sources and methods of their acquisition of knowledge.
- The different forms of movement belonging to their development.
- The different fundamental social forms in which acquisition and preservation of knowledge are represented.
- Their different function in society.
- Their different social origins in classes’ occupations and estates.

(Scheler1980, p80)

Of note about these types of knowledge are four important considerations. First, Scheler explains that as knowledge has evolved, there seems to have been an increased artificiality; this he maintains is the origin of the problem of knowledge. However the notion of artificiality or the artificialisation of knowledge is culture related and needs to be viewed in relation to the dominant ideology of any given
Chapter One: Background and context of study

culture and the pace of cultural change. Scheler illustrates this point in his distinction between the religious-metaphysical and positive science, in which the latter appears to have moved; from the first five types of knowledge he identifies. Second, each develops its own special language and style through which it is formulated. Whilst the language of religion and philosophy are nearer to folk-language, the sciences have developed an artificial form of expression, which is universally recognised and understood. Third in contrast to other types, scientific knowledge changes very rapidly. Finally as new knowledge is being produced, old knowledge is disintegrated and the belief in local contexts is undermined. As we will see, it is the increased artificiality, the delocalisation and changeable nature that put the legitimation of scientific perspective of midwifery knowledge in question.

The development of knowledge, in modernist approach, takes its root in the latter two, which are recognised as valid knowledge. Contemporary knowledge is intrinsically tied with science and technology. The essence of the other types of knowledge has been misapprehended or seen as inessential. This, Scheler argues depends on the worldview of the leaders of the development of knowledge and the different methods of their acquisition of knowledge with regards to which types of knowledge are regarded as important. In addition Scheler (1980, p. 70) explains how Knowledge filters downward from the top of society and distributes itself in time amongst groups and social levels, and how society regulates the distribution of knowledge- a process that occurs partially through institutions that regulate it such as schools (hospitals) and partially through restrictions, such as secrets...prohibitions that forbid particular castes, estates, or classed to acquire certain kinds of knowledge.

To this I will add that the importance and priority given to the types of knowledge depend on different societies and their value system.

More recently, although addressing women’s perspective on knowing, Belenky et al (1986, P.15) adopt a similar position. They suggest five major, not necessarily fixed, epistemological positions. These are:

- Silence- a position in which women experience themselves as mindless and voiceless and subject to the whims of external authority.
• Received knowledge- a perspective from which women conceive of themselves as capable of receiving, even reproducing, knowledge from the all-knowing external authorities but not capable of creating knowledge on their own.

• Subjective knowledge – a perspective for which truth and knowledge are conceived of as personal, private, and subjectively known or intuited.

• Procedural knowledge- a position in which women are invested in learning and applying objective procedures for obtaining and communicating knowledge.

• Constructed knowledge- a position in which women view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing.

But when we consider the types that constitute contemporary midwifery knowledge this raises some concern about the limitations that leaders of the development of knowledge have placed on it and the way it is disseminated.

It is essential, however, to consider the factors that have influenced the thinking that has fore grounded the development of knowledge. The arguments posited in the first part indicate that this is due to the cultural transformation wrought by modernisation. In contrast the findings presented in part three show that midwifery knowledge straddles these types.

Socio-philosophical Theories

The Project of Modernity

Modernity is generally understood as a historical period, which has its origin in the Enlightenment. It characterizes western civilisation. Initiated in the late seventeenth century, the Enlightenment heralded a process by which western societies (notably England, France, Germany) came under the domination of asceticism, science, technology, cultural differentiation, individualisation, bureaucratisation of economic and political practices and urbanisation- the project of modernity (Habermas 1989; Best and Kellner 1991; Featherstone 1991; Turner 1990; Frow 1998)). The factors that have contributed to modernity/modernisation include
the Reformation, the Renaissance, the rise of modern European states, the Scientific Revolution, the French Revolution, the Industrial Revolution and the rise of mass urban societies. Prior to the modernisation movement traditional European societies were largely agricultural, authoritarian, religious, small and relatively homogeneous (Hollinger 1994).

The project of modernity laid emphasis on social progress, achievable through scientific understanding. By first understanding how the world functions, the social condition of human beings might be improved. In what ways was the idea of progress related to scientific understanding? First the Enlightenment presupposed that ignorance and superstition was the mainstay of traditional societies. Second, only reason, science and knowledge could eliminate ignorance and superstition; its replacement with scientific knowledge would lead to progress. Looked at closely the project of modernity rests on several claims:

1. The epistemological unity of humankind is the claim that everything worth knowing can be unified into a set of beliefs that all human beings, can rationally assent to, rationally accept, on the basis of a universally valid set of methodological assumptions.

2. The moral unity on human kind is the claim that universal rational moral principles are binding on all rational beings everywhere and provide guides and standards for conduct and judgement.

3. Any beliefs, values, claims, or factors that contradict or impede these two (connected) goals are an obstacle to human progress and happiness. Only a society based on science and universal values is truly free and rational; only its inhabitants can be happy.

4. The truth (knowledge) shall make us free. The more we know about ourselves and the world, the better human life will become, because ignorance is the cause of unhappiness and immorality (Emancipatory).  

(Hollinger 1994, p. 7)
The methodological distinctiveness of the modern perspective lies, in large part, in its supposition that:

Science is the supreme form of knowledge because it seemed to create truths as observation and experiment...There was in principle no domain of life to which it could not be applied...A new man was being created by this scientific method, one who understands, and by understating masters nature.

(Hamilton 1992, p 27)

Amongst others, the literature distinguished a major influence, that of the Cartesian view of science which envisaged the scientific method (experimental method based on mathematics) as the key to expanding all human knowledge (Descartes 1637). It would thus be possible for human beings to gain control over it and liberate themselves from ignorance, ultimately leading to happiness and well being (Callinicos 1989; Steir 1991; Hamilton 1992); in a sense attaining mastery over nature. There knowledge is tantamount to control and emancipation. For Descartes scientific methods were to be used as a universal instrument for knowledge production, something to be assimilated into the life of individuals and society (Descartes 1637). Similarly scientific methods could be applied to the study and control of human nature He also canonised the notions of objectivity, subjectivity and value- neutrality, which became the dominant thought about science. Seemingly values, traditions, experiences, customs, or any knowledge outside the realm of science, do not constitute knowledge. As Lyotard (1984, p. 31) points out the modernity project asserts its claim on the premise that:

All peoples have a right to science. If the social subject is not already the subject of scientific knowledge, it is because that has been forbidden by priests and tyrants.

Within the context of modernity society is interpreted in terms of science, religious/ theological interpretation of the world and human behaviour was no longer relevant. Knowledge was generated in terms, which explicitly disengaged society from the theological foundation of society, thereby paving the way for secular understanding. In terms of the conception of knowledge modernity represents, there is a single method for uncovering it.
Postmodernity

There are as many views on postmodernity as there are writers about it. It is associated with an intellectual movement that developed in France in the 1960s. Broadly speaking it is a critique of modernity. According to Lyotard (1984) postmodernism involves a radical break with the dominant culture and aesthetic, a critique and reappraisal of the underlying values and assumptions of the culture of the Enlightenment. In the context of knowledge postmodernity encompasses a wide range of philosophies which differ from the Enlightenment’s belief in scientific rationality, objectified knowledge, and/or universal theories of knowledge and progress. These include hermeneutics, feminism, poststructuralism and critical theory. Although coming from different perspectives, essentially each conveys the same message; that is, the fallability of science and scientific methods in achieving progress and emancipation. Postmodernity seems to proclaim the end of rational inquiry into knowledge, the impossibility of clear and unequivocal meaning, the illegitimacy of Western civilisation and the oppressive nature of all modern institutions (Cahoone 1996).

Methodologically, it rejects the notion that the study of knowledge of humanity can be modelled on physical sciences and the ultimate reliability and the applicability of objective knowledge to all situations. It asserts that our inquiry must seek to understand experience, (not experimentation), primarily from the person’s point of view – the subject of study. Hence postmodernity is not only concerned with facts but with meaning and how people construe it. This it argues must focus on the entire structure that which makes the individual what he/she/ is. The bottom line of their argument points to the necessity of returning to anthropological ways of knowing, the reincorporation of earlier, traditional cultural forms, thus engaging us in deconstructing the scientific construct (Foucault 1970; Lyotard 1983; Giddens 1991). For this study it is the critical theory strand of postmodernity, on which I intend to focus. This section draws mainly from selected works by Lyotard, Foucault, and Habermas. These works are complex and often difficult to grasp. Nonetheless, their thoughts open fresh and interesting ways of thinking about
knowledge and also open the forms of knowledge guided by scientific and technological interest to questioning.

Drawing on anthropological accounts of primitive societies, Lyotard (1984) introduced the concept of narrative as the principal way of legitimising knowledge and transmission, or communication of knowledge. For Lyotard all knowledge is narrative but science has appealed to what he terms “metanarrative” to legitimise itself. Metanarrative defines the attempt to fit together all individual narrative in a coherent whole and legitimates itself with a reference to a wider overarching explanation of how narratives should generate and validate its knowledge base. Individual or local narratives with their different and possibly contradictory perspectives, therefore, are lost.

He examines two major forms of the legitimation of narrative and demonstrated their gaps and failings. In the first, the narrative of emancipation, which is more political, Lyotard states that people are the subject of science. He argues that the intention of scientific knowledge was to enable human beings to create a society that would be free from constraints. Scientific methodology is justified on the basis that it would improve people’s lives. He further argues that the narrative of emancipation was more to do with the need of contemporary society that is the production of administrative and professional skills necessary for the stability of the state, which would be achieved through the spread of new domains of knowledge. The narrative of freedom became a strategy for the state to assume direct control over the kind of knowledge that would enable people to fulfil their functions. Lyotard illustrates this point with the development of “proper scientific institutions” which de-emphasise higher education (Lyotard 1984, p. 31) In the second, the speculative narrative, philosophy is the subject of science, which seeks knowledge for its own sake

Science obeys its own rules, that the scientific institution lives and continually renews itself on its own, with no constraint or determined goal whatsoever

(Lyotard 1984, p. 31)
He claims that both narratives are problematic, seems to suggest the necessity to return to local narratives as a credible way of legitimising knowledge and claims that:

Scientific knowledge does not and cannot represent the totality of knowledge; it has always existed in addition to, and in competition and conflict with, another kind of knowledge...Scientific knowledge cannot know and make known that it is the true knowledge without resorting to the other, narrative, kind of knowledge, which from its point of view is no knowledge at all. Without such recourse it would be in the position of presupposing its own validity.

(Lyotard 1984, p.6&29)

Essentially Lyotard argues that since the end of the nineteenth century a set of transformations have altered the rules of science; increasingly science has given way to technology, whose goal is mainly about optimal performance, thus bringing the notion of performativity to the fore. Hence for Lyotard, knowledge becomes the principal force of production, changing the composition of workforces. Additionally language begins to play a significant role in the development of knowledge.

Having given a very brief discussion of postmodernity through the perspective of Lyotard, I now turn to the work of Foucault, who exposes the shifts in the structure of knowledge that enabled the transition from traditional to scientific ways of knowing. Like Lyotard, Foucault challenges the Enlightenment’s assumptions about knowledge. His work is of particular interest to the health professions, since it was partly in that area that he focused. Central to his critique of knowledge is the idea of governmentality, which he describes as the range of mechanisms that allow different groups and discourse to regulate, control and constitute individuals, groups and society. His notion of governmentality can be examined from three main points: discontinuity, discipline and punish, power/knowledge and representation. Here Foucault takes us back to history to demonstrate the discontinuity, which he refers to as the disappearance of certain elements in social reality.

Discontinuity- the fact that within the space of a few years a culture sometimes ceases to think as it had been thinking up till then and begins to think other things in a new way- probably begins with an erosion from outside, from the space which is, for thought, on the other side, but in
which it has never ceased to think from the very beginning. Ultimately, the problem that present is between thought and culture.

(Foucault 1970, p.79)

For Foucault, to understand discontinuities requires an understanding of society within its historical contexts, not that history is given primacy over other perspectives, but so as not to undermine important evidence embedded in history, given that history may be the first form of sciences that exists. There is no doubt according to Foucault; the project of modernity has been discontinuous from the fact that only scientific and technological knowledge were considered valid. Thus Foucault questions the modernists’ assumption of progress – that science offered a better understanding of the world than did religious authorities- pre-enlightenment. He argues that knowledge does not only depend on scientific understanding but also on discursive formations, on that basis he rejects the progress in knowledge development as invalid. Hence the enlightenment notion of progress has caused a radical shift in underlying discursive formations rather than advancing knowledge.

In the context of discipline and punish (1979) and power/knowledge (1980) Foucault describes how the growth of specific forms of knowledge, for instance the development of human sciences, in which mankind is seen as both subject and object of knowledge, has been linked to the emergence of subtle mechanisms of social control and to the elision of other forms of knowledge. An example of contemporary mechanism to control is found in the knowledge produced by modern medicine which has interpreted human sciences from the vantage point of biology. Thus the development of knowledge to control nature became linked also with domination of man rather than his/her emancipation and progress. Foucault further points out that knowledge and power are two sides of the same coin and cannot be treated separately. He writes:

We are subjected to the production of truth [knowledge] through power and we cannot exercise power through the production of truth [knowledge].

(Foucault 1979, p 79)
This thesis shows that those in power control the production and dissemination of knowledge. This is manifested at governmental level through to those directly involved in everyday practice at local levels.

In addressing representation Foucault refers to specific forms of articulation and two main ideas are identified: The first “reveals relations between discursive formations and non-discursive domains” (1972, p 162). The latter constitutes institutions, political events, economic practices and processes. Foucault claims that, with the rise of industrial capitalism, health took on a different dimension, the search for pathological causes and origins, became a collective responsibility that was assumed by the state.

He further shows that to a large extent, political and economic changes have determined the horizon and direction of medical interests, their systems of values, their way of perceiving things and the style of their rationality. The second intimates that the process of modernisation necessitated a new linguistic paradigm to express and communicate the knowledge generated by scientific methodologies, which correspond entirely to scientific structures of meaning. Existing structures of language and communication could no longer be used. This Foucault argues is not only hegemonic, in that it disengaged with other ways of constructing and communicating meaning, but is also a distortion of reality and alienates from dominant discourse. Thus knowledge orders reality in a different way to its original purpose.

We also find a critique of methodology in Foucault’s work that concerns the relationship between knowledge and mathematical formulae.

To seek to align all branches of modern knowledge on the basis of mathematics is to subject to the single point of view of objectivity in knowledge, the question of the positivity of each branch of knowledge, of its mode of being, and its roots in those conditions of possibility that give it, in history, both its object and its form.

(Foucault 1970, p346)

Foucault advocates a return to anthropological ways of knowing and states that it is the “anthropologisation” of knowledge that is the biggest threat to scientific knowledge.
Similarly Habermas (1978) holds that scientific knowledge and ways of knowing are not the only valid kind of knowledge. He also maintains that only in modern societies is knowledge legitimated in scientific terms. Although certainly not against modernity per se, Habermas indicates that there has been an overestimation of science in human emancipation from problems imposed by nature. He distinguishes three forms of knowledge (referred to as cognitive-interests), which reflects specific viewpoints through which we apprehend social reality. These are technical, practical and emancipatory; although distinct they are interrelated domains of knowledge:

- The technical cognitive-interest focuses on technical knowledge; it is generated by means of empirical science.
- The practical cognitive interest on the other hand relates to interpretive understanding in social life and can be derived through historical-hermeneutics.
- The emancipatory cognitive interest conveys the idea that knowledge derives from humankind’s yearning to achieve emancipation from domination. In the modernist view, this meant, from domination of nature over mankind. The postmodern perspective emphasises emancipation from domination of power relations amongst members of any given society, group or individual. This calls for critical reflection.

Habermas argues that whilst knowledge created from these two sciences are fundamental in arriving at a knowledge that may be necessary for social existence; it is insufficient to fully understand social phenomena.

Although distinct, these forms of knowledge are interrelated. Habermas thus offers a framework for the examination of knowledge development beyond the modern scientific perspective.

Like Lyotard (1984) and Foucault (1970) Habermas takes issue with linguistic representation. The kernel of his work has been to ground the idea of knowledge legitimation in a particular model of human rationality.

Rationality has less to do with the possession of knowledge than with how speaking and acting subjects acquire and use knowledge.
Chapter One: Background and context of study

In linguistic utterances knowledge is expressed; this know-how can in principle also be transformed into a know-that... The close relation between knowledge and rationality of an expression depends on the reliability of the knowledge embodied in it.

(Habermas 1984, p8)

He uses the concept of system and lifeworld to explain and demonstrate the existence of communicative rationality. Lifeworld is where everyday practice and everyday communication occur. It is through this lifeworld that shared meanings are acquired and communicated- mostly by oral means. Language is specific to a cultural order, which is the way in which a particular society thinks and speaks. He argues that before the establishment of scientific culture, everybody shared existing forms of communication. Thus every member of society could exchange ideas/views amongst themselves as equals. Habermas argues that scientific ways of knowing may be crucial to the implementation of good life, but it lacks the equipment to consider and debate specifications. He argues that when sciences intrude into the realm of communication and assert control in intersubjective relations, the result is loss of meaning.

The concept of modernity enables the examination of midwifery knowledge within the notion of progress and civilisation, which emphasised the scientific approach to knowledge production and legitimation. Postmodernity questions the views of modernity because they are perceived to reflect narrow interests. While science, in modernity, has created society’s reality, many other modes of reality are available. Reality can be deconstructed, that is the structures can be made apparent to enable a fuller development of knowledge. Postmodernity engages us in just that. However, both perspectives have illuminated our understanding of knowledge but they also showed their weaknesses. To understand the present condition of knowledge and to grasp the complexity of midwifery knowledge, it is essential to have recourse to other theories. To my mind, postmodernity, inevitably forces us to enter in dialogue with the past. I believe that this can generate a holistic understanding to grasp the centrality of culture in epistemological debate.
Chapter One: Background and context of study

Premodernity

If viewed within a temporal context, premodernity describes an era that relates to the past. As society and cultures have progressed, it has given way to modern foundations and cultures. However, Woodhead and Richards (1999) indicate that the process of societal development cannot be divided into neatly bounded homogeneous chunks, because modernity, postmodernity and premodernity are not uniform in either socio-political or cultural terms. They link together three dimensions of epistemological spaces, which enable us to understand different perspectives of the domains of knowledge. Friedman (1988, p. 439) sees them as poles of cultural space, and outlines premodernity as the existence of distinct models of identity and specific cultural identities external to and different from capitalist civilisation.

It is therefore associated with different modes of organisation of the spatio-temporal world.

Jenks (1992) argue that at base premodernity is traditional or primitive culture. A number of scholars distinguish primitivism and traditionalism as two distinct phases that mark the progression from one stage of civilisation to another (Levi-Strauss 1967, Bauman 1987; Habermas 1995). According to Giddens (1991) premodernity is a multi-dimensional concept that integrates traditionalism and primitivism; they differ in so far that primitivism involves sole reliance and beliefs in nature and traditionalism represents culture (Bauman 1993; Giddens 1993). The central tenet of premodernity is traditionalism which is defined as:

the respect for tradition (especially religion). It is a philosophical system referring to all religious knowledge to divine revelation and tradition.


In contrast a philosophical perspective suggests:

Traditionalism embraces a structure of legitimate authority, of beliefs, a system of concrete values pertaining to personal relations. It opposes itself to modernity. (Friedman 1988, p249).

In turn tradition is explained as

Custom, opinion or belief handed down to posterity especially orally or by practice. A process of handing down an established practice. It is artistic, literary principles based on experience and practice. In
theological terms, tradition is conceived as doctrine or a particular
doctrine claimed to have divine authority without documentary

All that a society of a given time possesses and which existed when its
present possessors came upon it. It is transmitted from past to present
...these include all the materials, objects, images of persons, events,
practices and institutions. (Shils 1981, p.12)

And

They are images of continuity revealed in human thought and actions
which are continuously sent and received throughout all generations.

(Luke 1996, p.8)

Tradition, thus, is the system that crystallise a structure through which
premodernity can be understood. Campbell, Luke and Thompson (1996) identify
four criteria through which tradition can be further understood. These are
hermeneutics, normative, legitimation and identity

- Hermeneutics: This defines an interpretive process by which understanding
of reality is reached. It is not dependent on particular scientific methods.
- Normative: This is held to serve as a guide for actions and beliefs. Two
perspectives are identified. First tradition is observed for tradition's sake,
second it is routine.
- Legitimation: This concern is both with the establishment of power and
authority. Tradition is used as a base for exercising power for those securing
obedience and order.
- Identity: This refers to personal and collective identity. Both are shaped by
the norms, and values of the group in which individuals belong. Collective
identity refers to the sense of oneself as a member of a social group or
collectivity; a sense of being a part of a social group which has a history of
its own.

In addressing premodernity Giddens (1991, p 102) specifies four principal
contexts in which the complex dynamics of the above criteria can be viewed. These
are:

- Kinship system: This provides a stable mode of organising "bundles" of
social relations across time and space. Although oftentimes a focus of tension
Chapter One: Background and context of study

and conflict, kinship connections are generally bonds which can be relied upon in the structuring of actions in fields of time-space. Kinship, in sum, provides a nexus of reliable social connections which, in principle and very commonly in practice, form an organising medium of trust relations.

- Local Community: This stresses the importance of localised relations organised in terms of place, where place has not yet become transformed by distanciated time-space relations. The local milieu is the site of a cluster of interweaving social relations, the low spatial span of which provides for their solidity in time. The locality in premodern contexts is the focus of, and contributes to, ontological security in ways that are substantially dissolved in circumstances of modernity.

- Religious cosmology: This refers to a mode of belief and ritual practices as a means of providing a providential interpretation of human life and of nature. Two perspectives are identified. First religious beliefs can be a source of extreme anxiety; they are included as one of the main parameters of risk and danger. The second indicates that religion provides moral and practical interpretations of personal life, as well as of the natural world. This represents an environment of security. Finally religion is an organising medium of trust. Deities, religious forces as well as religious functionaries provide dependable support. Most important of all, religious beliefs typically inject reliability into the experience of events and situations and form a framework in terms of which these can be explained and responded to.

- Tradition itself: This expresses the manner in which religious and other beliefs are organised, especially in relation to time. It reflects a distinct mode of structuring temporality which has direct implications across space. Here the notion of “reversible time” is used to explain the temporality of traditional beliefs and activities. Reversible time is the temporality of repetition and is governed by the logic of repetition— the past is a means of organising the future. Neither the “past” nor “the future” is discrete phenomenon, separated from the “continuous present”. Past time is
incorporated into present practices, such that the horizon of the future curves back to intersect with what went before.

Amongst these, community is perhaps the most significant, in that it is the medium that enables the perpetuation of the premodern social and normative frame of reference that give meaning to the lives of the individuals and groups. Like Giddens (1991), Beck (1992) has shown that community affords its members a sense of stability and security; it allows people to work as a collectivity in reproducing the culture of traditional ways of living, that are not detached from everyday reality. Community exists because it has a definite function to discharge in the reproduction of the given society (Heller 1984).

Bourdieu (1977; 1990) makes an important contribution to our understanding of community. He introduces the concept of habitus to explain collectivism and individualism. He writes:

Product of history, the habitus produces individual and collectives practices, in consequence of history, according to the schemes produced by history: It assures the active presence of past experiences which deposits in each organism in the form of schemes of perception, of thought and action, tends, more safely than all the formal rules and all explicit norms, to guarantee the likeness of practices and their constancy across time. A past which exists in the present time and which
tends to perpetuate in the future by being actualised in the practices structured according to these principles...The habitus allow the free production of all thoughts, all perceptions and all actions that are set down within the inherent boundaries of the particular conditions of its production, and of these conditions alone. Through the habitus the structure of which it is a product, governs the practice, not only along the lines of mechanical determinism, but across the constraints and their original boundaries assigned to its inventions...The habitus has an infinite capacity to engender, in all liberty certain products- thoughts, perceptions, expressions, actions- the boundaries of which are always historically and sociologically conditioned.

In other words, the habitus includes all aspects of ourselves which are part of our history, our identity and come out of our formative experiences during our childhood and also from the whole collective history of our family. Jarvis (1999, p 54) adds “habitus does not exist by itself- it can only exist because we are conscious of it in our relationship with those who practice within it”. In the context of midwifery, childbearing women who are the centre of practice should form part of that practice in so far that they inform it. Earlier work by Scheler (1980, p.68) shows that

tradition is not about historical knowledge that is it does not constitute the knowledge of history but rather it is the very possibility of history, i.e. the historicity of life...there is subjective immediate ‘understanding’ (his italics) of other’s experiences.

The ideas expressed in this brief examination of premodernity, as my empirical shows, are important for understanding the premodern perspective of knowledge development.

The Thesis

This study argues that midwifery is a social construct. It is a field where a multiplicity of forces is articulated to create its knowledge base that is culture-bound and embedded in historical context. Through the process of modernisation important domains of knowledge have been suppressed. What we have today is a dilution of its original meaning. The aspect of everyday life, the socio-cultural knowledge that once embraced midwifery has been decontextualised and given a new meaning which reflects the pervasive scientific worldview. Midwifery is far richer and far
more complex that the modern representation. It is more than just giving birth safely and normally. It transcends scientific boundaries; it is about lifeworlds, culture and values, and how each society construes it. We live in an analytically challenging world; midwifery can no longer accept the dominant rationality of scientism as the main explanation of midwifery knowledge and as a basis for the curriculum.

**Structure of the study**

This study is divided into four parts. The first part contains a preface in which I have presented a selection of my biography and how it has influenced this doctoral thesis. The research questions are also set within it. The first chapter is introductory; it has addressed the conceptual framework and presented the outline of the study, whilst chapter two described the philosophical underpinning of the methodology and the approach to my research.

Part two consists of three chapters on the development of midwifery as a field of practice in the UK. It uses historical evidence to show the cultural transformation that midwifery has witnessed as society has evolved. It does so by identifying three principal discourses, ranging from the ecclesiastical to the contemporary eras which show how midwifery became entrenched in modern schools of thought. It concludes with a number of problems raised about the interpretation on the UK midwifery culture that are then subjected to analysis in part four.

Part three presents the findings of midwifery in Mauritius. It serves as a linchpin that unites the whole study together and lays the background for what follows in part four. It contains four chapters. The first delineates the formal midwifery system and shows that it derives from the UK modern culture- a colonial legacy. The remaining chapters describe traditional midwifery, which brings together a meta-conceptual perspective of midwifery. The fundamental difference between the formal and traditional midwifery system is its foundation in anthropological ways of knowing. It ends with a number of issues raised about traditional midwifery practice that forms part of the in depth analysis of the premodern perspective of midwifery epistemology.
Part four contains five chapters, which return to the question posed at the outset of the study. The first two chapters, based on the findings of previous two parts, embark on the analysis of midwifery knowledge. It returns to the conceptual framework of the study to defend the thesis by showing the impact of cultural transformation on the development of midwifery knowledge. The analysis suggests that there cannot be a single unit that comprises midwifery knowledge but a complex of knowledges. This is dependent of the dominant ideology of society and how each society interprets midwifery knowledge. Additionally the analysis suggests that there can neither be a single approach to knowledge production and legitimation nor can knowledge be applied to every situation. In the twelfth chapter I present the conclusion of the study and attempt to develop a framework for understanding and constructing midwifery knowledge- a framework that crosscuts society, culture and era. The penultimate chapter addresses the implications of the study to the curriculum. In the epilogue I consider the implications of the conclusion to the wider field of midwifery.

**Literature review**

It is customary for the literature review to be considered in a separate chapter. But in this study I have chosen to incorporate the literature throughout the study to sustain the arguments as they are raised. Some of the literature I have quoted are in French language. I did so simply because I encountered a few problems with translations. The reason for resorting to original versions, thus, was to obtain as accurate a perspective as possible. I did the translations, which are provided in footnotes.

**A word about style**

In this thesis, I write as both a midwife educator and a researcher, not as a historian or anthropologist, because it was in the former capacities that I inquired into the development of midwifery knowledge. In presenting this material I have chosen to use an analytical as well as a narrative style. This is because the material, which forms the basis of this study, lends itself to this approach.
Chapter One: Background and context of study

Conclusion

I recognise that there are other views on midwifery knowledge and there are different positions that are adopted regarding its legitimation. This thesis is only one way of looking at it. What this study proposes is the use of a framework that is informed by and consistent with principles raised in this chapter. Building on the strength of the literature and the integration of the empirical evidence has enabled me to create a robust framework that can be adapted in any given midwifery setting to examine its own understanding of midwifery knowledge and its incorporation in the curriculum.
CHAPTER TWO

Research Methodology and Design

Introduction

This study employed a non-experimental case study approach to research. It is a specific form of inquiry for studying particular phenomena within their natural setting and uses multiple sources of evidence (Merriam 1988). It combines two stages of inquiry, which involves two cases: United Kingdom and Mauritius. The first stage began with a theoretical investigation of the evolution of midwifery as a field of practice in the U.K. This was followed by an empirical inquiry into the same area, which was conducted in Mauritius. The justification for the selection of cases was to contextualise the inquiry of midwifery knowledge within the conceptual framework of this study. Both cases will show that midwifery is a social construct, culturally determined, relative and embedded in historical contexts. The first shows how and why this construct according to the western representation, which is embedded in the philosophy of modernity, is problematic. The second shows two perspectives of midwifery knowledge: the first reflects the western perspective: the second perspective is entrenched in anthropology. It presents a "rival theory" (Yin 1994, p27), that is the western construct of midwifery knowledge is fragmented and channelled in narrow confining ways because through the process of modernisation important domains of knowledge have been suppressed. It will also enable a better understanding of the complex web of ideas that structure the entire range of methods employed to produce what counts as midwifery knowledge.

The research methodology itself has been used within the perspective of the qualitative and critical theory paradigms, which place the inquiry into midwifery knowledge in a wider methodological framework. The reason for doing so is to acquire a deeper meaning of the factors that have impacted on the nature and development of midwifery knowledge. In this chapter I discuss the main methodological issues related to this study. It falls into four sections; the first presents the aims of the research. This is then followed by an overview of the
philosophical underpinnings of research methodology to contextualise the justification for the chosen research approach. The third discusses the nature of case study whilst the final presents the research design.

**The aims of the research**

As described in chapter one, the overall aims of the research were decided upon the preliminary stage and during the literature review. Early thinking, set within the context of the preliminary analysis of the plans and the literature review, resulted in the two main aims for the research:

- 1. The examination of the nature and development of midwifery knowledge.
- 2. To consider the implications for the curriculum.

Clearly, the second could only follow from the achievement of the first one. Consequently endeavouring to understand the nature and development of midwifery knowledge became the main focus.

**Philosophical Underpinnings**

To understand the nature and development of midwifery knowledge within the context of cultural transformation across these two societies and the eras that they represent, it was crucial to decide which path of inquiry would be the most appropriate. Broadly defined, research methodology falls into three different paradigms, the ‘quantitative’, ‘qualitative’ and ‘critical’ methodology. Often the first two paradigms are used to describe competing philosophical views about the nature of knowledge in the social world and the ways in which social reality should be studied (Guba and Lincoln 1994; Patton 1990). The difficulty in representing the divergences between the two methodologies derives from a tendency for philosophical issues, (that is the epistemological position) and technical issues (the appropriateness of methods), to be treated simultaneously. This section does not argue explicitly in favour of one and against the other methodologies, it is simply to show the theoretical orientation that has informed the design of my research.
The Quantitative Paradigm

The quantitative methodology is grounded in the positivist school of thought, which assumes that there is a single objective reality about the world that can be defined by the use of methods that are reliable, valid and value-neutral. These are exemplified by experimental research and social surveys. The reasoning explicit in quantitative methodology is held to be hypothesis testing for the purpose of establishing cause and effect relationship (Denzin and Lincoln 1997). It divides a phenomenon into component parts, commonly termed “variables”, each being capable of, and manageable as, independent study. There are two stances in the positivist schools of thought: the first is Comte’s inductive/deductive approach that can be used to verify hypothetical statements. He made this claim on the basis of his identification of reality being constituted by events that are governed by general laws. The second is Popper’s hypothetico-deductivism, which postulates that only deduction can be considered as providing the logic of inquiry (Tiles and Tiles 1993; Hall 1999). For some considerable time Popper’s position of hypothetico-deductivism dominated the culture of research in midwifery.

The subject of study is based on the notion of probability, and data are obtained from direct observation. Results are produced by means of quantification and thus being capable of being generalised to other situations (Silverman 1985; Merriam 1988; Polit and Hungler 1989; Schwandt 1990; Denzin 1997).

Amongst the criticism of quantitative research, is the fragmentation of phenomena into variables and the assumption that the researcher can manipulate the variables being studied. More often than not the inquiry is conducted under artificial conditions, in artificially created settings. In that sense a great deal of control is exercised over the research situation (Merriam 1998; Robson 1993; Denzin and Lincoln 1997; Hall 1999). It would appear that the cultural significance of a phenomenon counts for little or nothing in the conceptualisation of quantitative paradigm. Whilst I recognise that this may be appropriate for some natural sciences
it is problematic for studying how people make sense of their world and of social life.

As Kemmis (1983, cited in Merriam 1998, p 164) points out,

The fragmentation of social life into manageable bits conceals from us the context-embeddedness of social phenomena, their dynamical coherence, their reflexive effects and their true significance.

In essence then, by dividing a phenomenon into different examinable parts quantitative research decontextualised personal as well as social events, which are important considerations in midwifery. This paradigm was rejected because it is incongruent with the nature of my inquiry and the conceptual framework within which it is set.

**The Qualitative Paradigm**

Qualitative methodology is embedded in the naturalistic paradigm, that is, the natural setting itself provides the resource for data collection and development of knowledge. (Bogdan and Biklen 1982; Burgess 1985; Denzin and Lincoln 1998.). In contrast to quantitative research it places emphasis on holistic treatment of a phenomenon (Schwandt 1994). Qualitative research works interpretatively and its advocates are interested in constructing meaning that neither has a separate existence from the human being, nor is one that is being imposed on him/her. In terms of approaches it covers an array of perspectives connected to cultural and interpretative studies (Denzin and Lincoln 1998). It questions the ontological status of the social world as presented by the positivist school of thought and assumes that the world is not made up of a single objective reality but consists of multiple realities- concepts, names, labels, symbols, for describing, making sense and negotiating the external world (Schwandt 1994; Denzin 1998). In this paradigm, reality is not an object that can be measured but rather a construction of the human mind; it centres individuals as subjects of knowledge rather than as objects of knowledge. Therefore, it starts for the perspective and actions of the subjects being studied and beliefs rather than facts, from the basis of perception (Merriam 1992). It focuses on exploration, insight and understanding from the perspectives of those being studied. It is concerned with
process, that is, with what has transpired, as much with the product or outcome and meaning in context, which scientific tools cannot elucidate.

Qualitative research acknowledges that social settings are complex and made up of individuals with different perspectives, ways of acting out in the world and in constructing their world. Within this perspective, the social world is seen as created by people’s interpretive processes: the processes by which they give meaning to the world. Any supposed causality therefore depends on how people give meaning to their own actions and those of others; this meaning may change as they interact with others and as they continue to reflect on their own experience (Patton 1990; Denzin and Lincoln 1997). Hence, the goal of research is to seek to understand this complexity without dissociating from the place and the situation in which it occurs, giving due emphasis to the lived experiences and meanings that are attached to them.

Thus the researcher becomes the key instrument in data collection—a characteristic peculiar to qualitative research (Merriam 1988, Paton 1990; Denzin and Lincoln 1998); this emphasises the intimate relationship between the researcher and what is studied. Furthermore the researcher does not attempt to manipulate the setting but enters into a dialogue with the situation/case being researched. The consideration of open, indistinct material, and the focus on such material is a central criterion. Thus data is obtained by open-ended free response questions based on informal loosely structured techniques and other sources that reflect openness.

Data are analysed inductively and are essentially concerned with what things mean, that is the why as well as the what (Bogdan and Biklen 1982; Merriam 1988, Patton 1990; Denzin and Lincoln 1997), and do not require statistical interpretation. One of the problems of qualitative research is that it yields large amounts of data; researchers are required to begin processing them from the start of the collection (Leninger 1987).

Qualitative research is subjective, and has been criticised as being less "scientific"; consequently it has met with resistance in the field of medicine (in which, according to its historical development, midwifery appears to be encompassed) as probably in most natural sciences disciplines. First it must be recognised that qualitative research is less concerned with measurements and
establishing causality, it is exploratory and focuses on interpretation rather than testing and is concerned with developing concepts to explain or to enable us to understand social and cultural phenomena.

Hence the debate is not quantitative versus qualitative; methodology must be viewed in relation to its respective orientation and particular research problem, the questions it raises, the methods best suited for collecting and analysing data to answer them. Sometimes this may necessitate a combination of both methodologies (Bourdieu and Wacquant 1992), which may offer opportunities to better understand the entire range of inquiry’s practices. However the positivistic and naturalistic traditions are not the only ones that offer ideas on the nature of research.

**Critical Theory Paradigm**

Critical theory derives from German philosophy (of which Habermas is now the dominant contemporary figure) and its orientations. These include the French postmodernist (such as, Foucault and Lyotard) and feminist researchers. It is a vast and not at all easy subject to examine, at least within the remit of this section. Only the central tenets are presented to contextualise its use and relevance in my study.

The origin of critical theory can be traced to three very diverse philosophers in the German intellectual tradition who have had a major influence on the foundation of this approach to research in the social sciences. The key ideas are presented below. The first is the Enlightenment philosopher, I. Kant (1724- 1804) who argued that knowledge could not be taken for granted. In his critique of knowledge and reason, Kant (Moser and Vandernat 1987;Cahoone 1996) maintained that all knowledge produced, was from the result of interaction between the outside world and human consciousness, in other words knowledge consisted of human being’s world of experience. Kant understood that knowledge cannot be established entirely within this realm because this is different from the world of things as they actually are, that is there is a reality independent of human consciousness and its interaction with the external world; knowledge can only come from critical engagement with the conditions that make it possible. To view it otherwise would only lead to a superficial understanding of knowledge. This entailed separating
human experience as the basis for the production of knowledge into a subjective and objective world.

The second application of critical theory was made by Hegel (1770-1831) who argued that through human knowledge (self-knowledge) it was possible to uncover how people construct reality and that Kant's approach was limited on the basis of its fragmentary characteristic. His answer to knowledge production is connected to human history, which he contended, has contributed to the progressive development of knowledge and human emancipation from the constraints imposed by ignorance and superstition. This emancipation and a closer approximation to truth, he suggested, could be seen to have gradually emerged through the various struggles in which humanity has engaged. Examples of the landmarks of human progress, according to Hegel, were the emergence of Christianity and the Reformation. Hence for Hegel knowledge cannot be understood outside the spiritual context of human life (Held 1980; Cahoone 1996; Hall 1999). Whilst endorsing Enlightenment ideals:

The idea of consciousness as individual freedom, and as the objects of consciousness as value-neutral objects of potential utility.


He also pointed out that

The Enlightenment consciousness is one-sided and unbalanced, the freedom of solipsistic, empty individual who sees others as mere objects for use. It is a necessary but incomplete stage through which the human spirit must pass in its journey to complete self-understanding.


For Hegel, therefore, the concept of spirituality and spiritual reality are important considerations in the understanding of knowledge and knowledge development. Although coming from a different perspective, this resonates with ideas expressed in Lyotard and Foucault's work discussed earlier.

The third, Karl Marx's position is also embedded in historical process. Central to his work is the attempt to know how society developed and changed in any given time. Unlike Hegel, he contended that history unfolded as a dialectic of material conditions, specifically the social and economic relations pertaining at any
given time. To understand how society had evolved, it is necessary to examine the material condition and the forms that have driven the process of change. In contemporary society the material condition is capitalism and the historical, social and economic forms were those who were in control whilst the rest having little or no control. The Marxist perspective brings a different dimension to knowledge production- knowledge that can be produced by society and acquired from it (Lyotard 1984; Hall 1999).

Stemming from these key ideas critical methodology provides a paradigm within which the examination of knowledge entails delving beneath the taken-for-granted, established ideologies of other research paradigms, uncovering how knowledge has been distorted in unequal and exploitative society, and finally to point the way to less distorted forms of knowledge and to rediscover other domains of knowledge that have been displaced by according supremacy to scientific knowledge on the account of its objective and value-neutral, factual nature. (Steir 1991).

The main tenet of critical theory is emancipation and it argues that the basis for developing knowledge derives from treating people as knowing subjects who play an active role in constituting their world, from accepting their self-understanding and their views of the world (Carr and Kemmis 1986). It rejects the positivist view of emancipation based on science and technology as the sources of human well being. In the context of knowledge it challenges the positivist view of emancipatory knowledge derived from mathematical and probability theory. From a methodological standpoint it departs from the beliefs and practices that have become dominant in research and calls for a re-examination of the links between methodology and knowledge to learn more about the phenomenon under study. It seeks to free human thinking from the one-dimensionality of positivist research.

In the critical theory paradigm,

Knowledge consists of a series of structural/historical insights that will be transformed as time passes. Transformations occur when ignorance and misapprehension give way to more informed insights by means of a dialectical interaction.

(Denzin and Lincoln 1994, p113).
Several authors point out that within this tradition, the relationship between the object for research and the whole social and historical context is a key criterion (Angus 1994; Denzin and Lincoln 1998). Denzin and Lincoln (1994, p. 114) explicates that socio-historical context further includes political, cultural, economic, ethnic and gender antecedents of the studied situations and the aim is to “erode ignorance and misapprehension thereby providing a stimulus for transformation of existing structure.

As Alvesson and Skoldberg (2000) assert, facts do not stand alone in social contexts. They are part of it.

Given the expansive range of possible observations, this context lends itself to a dialogical approach where the researcher is not only involved in data collection and interpretation of the data but includes his/her own learning as part of the process and outcome of research (Alvesson and Skoldberg 2000). Thus critical research calls for consideration of broader contexts than tightly empirical research advocated by other research approaches.

Consequently attempts to generate knowledge by means of positivist or pure naturalistic methodology is displaced in favour of a paradigm that recognises that

Society and human nature are human constructions that can be altered through people’s progressive understanding of historically specific processes and structures.


Unlike the positivist and naturalistic approaches, critical research tends to use secondary empirical material (Hall 1999). Alveson and Skoldberg (2000, p. 133-135) present three arguments for not regarding primary material as a decisive path to knowledge.

• The first maintains that many empirical studies allow little scope for the emancipatory interest of knowledge to fully work because things that “are simple to observe or to extract from interviews are not really what critical theory sees as an essential subject of research…both totality and subjectivity- at least the deeper blockages in our consciousness which most urgently call for study-escape simple empirical methods- things that do not allow themselves to be observed”.
Chapter Two: Research Methodology and Design

- The second concerns the social conditions, ideologies and communicative processes operating behind the back of the subjects, in their subconscious. These may affect the way answers are given, in the sense that this may be governed by their adoption of the ideologies. As such the data gained from such sources may be only partially representative.

- The third suggests that primary empirical data that concerns with contemporary situations fix our attention on the actual, the what “it is” and draw it away from what “can be”. As an example they cite empirical studies of unemployment, which tend to the exclusive consideration of existing social organisation with its rigid categorisation of people according to their location inside and outside the labour market. Sticking strictly to the empirical material means also sticking to the bounds of thought and imagination which it imposes. In adhering strictly to empirical material then means to be non-dialogical.

Critical research is not entirely opposed to the use of primary empirical material; its role in the research process, however, differs to the orthodox view of qualitative research. In the case where data are gained from primary sources, the empirical work should be less central than as advocated by the qualitative paradigm. Alvesson and Skoldberg (2000, p 133) explain that in instances of primary empirical work the “focus shifts away from the empirical work towards the interpretation and reasoned appraisal of the empirical material”.

Critical research works interpretively, requires a theoretical frame of reference that will enable the researcher to go beyond surface meanings to provide the phenomenon under study with content and deeper meaning, that is, it should address and explain the unquestioned beliefs and values upon which taken-for-granted assumptions rest. According to Morrow (1994) interpretations contain elements of both understanding and explanation. What seems evident and natural should be problematised, which includes researcher’s assumptions about conducting research; it brings another issue to the fore- that of power, the exercise of which may restrict the production of emancipatory knowledge. Thus it draws our attention to the political dimension of research, the political nature of social phenomena and argues that neutrality and objectivity cannot be applied to the study of social phenomena. It
raises our consciousness of the constraints imposed, particularly, by the positivist, and to develop our ability as researchers to reflect critically upon those taken-for-granted realities that we are examining and of which we are also a part. In a sense critical methodology behoves the researcher to scrutinise the apparently progressive and emancipatory social changes and ideas.

The primary purpose of research is to generate knowledge. Each methodology expresses a particular point of view and involves a different set of procedures for conducting the inquiry. The debate in the philosophical positions revolves around the significance of induction and deduction as ways of finding out about reality. The naturalistic research focuses on natural settings; it emphasises on process and is concerned with understanding perspectives and meanings.

Critical research is about creating hypotheses or raising questions about crises that are facing society at a point in time and it differs from quantitative and qualitative research in that it develops arguments for future possible ways of conducting social life, based on the notion of emancipation. Because of its strong political stance the critical paradigm may raise some thorny issues and poses a great challenge to the imperialistic position established by positivist researchers.

Several authors appear to adopt the view that research ought to be conducted within one or other paradigm. If one proceeds to approach research in either mindset of a particular paradigm, when clearly the subject under inquiry indicates otherwise, it would be failing to do full justice to the guiding principles of other methodologies, to uncover the deeper meaning on the phenomenon under study and other dimensions of knowledge that the research may generate.

In the last decade or so trends in research and philosophical underpinnings of research appear to be changing; because the positivist paradigm is no longer tenable as the main approach to research inquiry, methodological multiplicity is emerging as a new way of conducting research (Letourneau and Allen 1999). The aim and nature of my research, which has been discussed in the first chapter, demand that it is pursued with a more careful and politically sensitive interpretation of the range of cultural transformations that midwifery has witnessed, so as to understand the possible restrictions on the construction and methodology in the construction of
midwifery knowledge. This clearly implies a study that falls within a combination of the naturalistic and critical inquiry. Hence it is within the methodological framework that this Case Study approach to my inquiry is placed. The theoretical frame of reference, which situates my inquiry in the broader socio-historical context, is explained in chapter one.

The Case Study Approach: Principles Underlying the Study

In the context of my research, the case study approach is in some respects, unique. I realise that very few midwife-researchers inquiring into the phenomenon of midwifery knowledge have the background that I brought to my research. To my knowledge very few have studied it in two separate cultures and at the same time, in a significant way, being a part of both cultures. First I am examining the nature and development of midwifery knowledge within the context of my professional socialisation. As stated earlier this is entrenched in the western schools of thought, which reflects my western acculturation. In the Second I am studying it from the vantage point of a native of Mauritius who has an insider perspective of that culture from a macro-cultural perspective and to a much lesser extent the particularities of midwifery.

In a sense this study can be classified as an “auto-case study research”- auto-study is a term defined by Hayano (1982) to describe studies in which researchers are involved in the cultural study of their own people, and in the case of United Kingdom, I was studying a profession run by people like myself. It is important however to explore the principles that underpin the particular approach to case study.

What is Case Study Research?

First it should be recognised that the term case study is conceived in various ways and not all are classified as research. In some usages it is treated as an alternative to quantitative research in a sense of an approach to be used when appropriate and that offers findings that are as reliable (Yin 1994). In this section I look at case study as an approach to research in its own right and I discuss how it has influenced the way I have understood, situated it within the qualitative and critical paradigm and design my research to contextualise the requirements of the approach.
Merriam (1988) suggests that case study research tends to draw from various disciplines such as anthropology, sociology, psychology and history to inform the case study inquiry. For my study I have borrowed methods from two of these disciplines, the historical and anthropological tradition. The U.K perspective of midwifery is studied within a historical frame of reference. For the Mauritian perspective I used ideas drawn from anthropology.

However I did not embark on this study neither as a historian, nor anthropologist, but as a midwife-practitioner, midwife-educator and as a native of Mauritius, seeking a wider and deeper view of the development of midwifery knowledge in order to establish what counts as midwifery knowledge from a western and non-western perspectives. My concern was to understand the impact of cultural transformation on the nature and development of midwifery knowledge and to draw on the findings in both cases so that I may recast the framework in which midwifery curricula are set. I did not aim to apply the tenets of pure history, or anthropology to study the midwifery phenomenon so I could write about the U.K and Mauritian midwifery cultures; rather the approach I used in the two cases drew on the principles and theoretical orientation of historical, anthropological case studies (Morse 1994) to understand the phenomenon under study.

In keeping with Yin’s (1994) observation, that case study is a research design particularly suited to investigate a phenomenon without separating its variables from their contexts, I have been particularly careful to view both cases within as far a holistic perspective as could possibly be had. This has been achieved by building upon the criteria identified by Stake (1998, P.91). They comprise the following:

- the nature of the case.
- the historical background.
- the physical setting.
- the political, economic, legal, ethical and aesthetic.
- the informants through whom the case can be known.

These criteria are also the focus of critical theory methodology. Without a doubt, therefore, case study research crosscuts the qualitative and critical research and is suited for cultural inquiry. Because my focus was on culture and cultural
transformation and the effect on the construction of midwifery knowledge, the
adoption of these criteria has facilitated the elicitation of factors that are particularly
relevant to address the culture “boundedness” of midwifery knowledge that is
within its totality.

Merriam (1988, p111-12) describes four special features of case study
research, which have guided my data collection analysis and synthesis been
embraced in my study. These are particularistic, descriptive, heuristic and inductive
and are explained as follows:

- Particularistic: the focus is on a specific situation, event, program or
  phenomenon.
- Descriptive: the case study provides a rich “thick description of the phenomenon
  under study, that is, a complete literal description of the entity being studied. These
thick descriptive data are used to develop concepts, illustrate, support or
challenge theoretical assumptions.
- Heuristic: illuminates the researcher’s understanding of the phenomenon under
  study. It achieves this by enabling the researcher to discover new meaning and
new experiences. Similarly, it may enable the researcher to discern important
  general problems about the cases under study and to interrogate one case with
another so as to achieve better interpretation.
- Inductive: germane to this characteristic is inductive reasoning, that is, patterns,
generalisations, concepts or hypotheses come from the data.

Case study research falls roughly into three major categories:

- Intrinsic- In this type the researcher wants to better understand a case. Other
  curiosities are subordinated so that the case may reveal its story. It is not about
understanding generic phenomena, and the purpose is not theory building.
- Instrumental- In this situation the case is of secondary interest: it provides a
  supportive role to facilitate our understanding of something else. This type is
often looked at in-depth, its contexts scrutinised, its ordinary activities detailed
because it helps to pursue external interest. It usually involves longterm study of
a single case.
Collective- this describes a number of instrumental cases (involving several research sites) that are studied jointly in order to inquire into a phenomenon. They are chosen because it is believed that understanding them will lead to better understanding and perhaps better theorising about a large collection of cases. (Stake 1998, p 88-89).

With my study the starting point of the inquiry into midwifery knowledge was a phenomenon that had intrinsic interest but as I got immersed in the literature it became apparent that this study could not be contained within a single case study. The collective case study design was considered most suitable to address the research questions. As Yin (1994) observes, the evidence from collective case study design is more compelling and makes the overall study more robust. But it requires extensive time and resources beyond a single case. I limit to two cases only, in which the tools for data collection have been borrowed from the principles of historical and ethnographic research. Additionally insights from Merriam’s (1998) description of case study have been found to be pertinent, particularly in obtaining “thick description”. According to Geertz (1973, p. 73) thick description includes inner and meaningful aspect of any culture, which he sees:

As interworked systems of constructable signs, culture is not power, something to which social events, behaviours, institutions, or processes can be causally attributed; it is a context, something within which they can be intelligibly- that is “thickly described”.

Thick description provides the first step in the interpretation of culture. This is then followed by the creation of theory that is achieved through a pattern-finding process, unlike the procedure adopted by positivist research, which constitutes a deductive subsumption of a set of observations under a governing law.

Finally the notion that “a case study is both the process of learning about the case and the product of our learning” (Stake 1998, p 87) is an important issue underlying the case study approach to research. This suggests that the researcher plays a particular role whereby it is necessary to learn from the subjects being studied. It then becomes important to adopt a more flexible approach in which the researcher does not manipulate or control the situation but sets about developing understanding through dialogue (Usher and Bryant 1997)- a position that indicates that research ought to be reflexive. The researcher’s learning process through reflexivity involves reflection on philosophical underpinnings of the research being
undertaken and the problematisation of researcher’s assumptions, interpretations and interactions with empirical data, secondary or otherwise (Alvesson and Skoldberg 2000). Herein, albeit in part, is the principle of critical methodology. In my experience, whilst conducting field work in Mauritius it became necessary for me not only to enter into dialogue with participants, but to respond also to the challenge that it posed to my own understanding of midwifery in my dual role as teacher and researcher. My experience as a researcher amongst the Dai is incorporated in the epilogue.

**Issues surrounding Case Study Research**

Critics of case study raise several issues. The main and perhaps most significant one is about validity, since its findings cannot be generalised to other settings in the way that positivist research can. In designing this research I have taken into consideration this issue. It must be recognised that the notion of validity takes on a totally different meaning in qualitative and critical research. The assumption underlying this is that quantitative, qualitative and critical research are different in their goal.

Several authors have challenged the positivist approach to generalisation suggesting that it cannot be applied to qualitative research with the same meaning. They argue that naturalistic case study research neither aims for generalisations nor intends to provide a basis for generalisation of the conventional kind. (Merriam 1988; Janesic 1998; Stake 1998). Some qualitative researchers perspective insists that generalisabilty cannot be an aim of qualitative research. For example Denzin (1994, p 133-4) writes:

> The interpretivist rejects generalisation as a goal and never aims to draw randomly selected samples of human experience. For the interpretivist every instance of social interaction, if thickly described (Geertz, 1973), represents a slice from the life world that is the proper subject matter for interpretive inquiry...Every topic...must be seen as carrying its own logic, sense of order, structure, and meaning.

Indeed, generalisabilty or transferability is not a be-all and end-all of the raison d’etre of research (Punch 1998). The research process in not generally, generalisability-oriented, because it is constructionist and is conducted at a level of
"thick" description where the researcher to produce a rich and dense picture of social reality puts context and data together. Sampling is purposive and not geared to abstraction and representativeness. Furthermore the fragmentary nature of contemporary society begs the question of whether anything can indeed be generalised.

In respect of the position discussed above I see generalisation as essentially irrelevant to my study because the whole purpose of selecting these two cases was primarily to make sense of the perceived problem in my own understanding of midwifery knowledge and to try to understand it within a wider social and cultural context. According to Cronbach (1975, p 125) case study research serves to produce 'working hypotheses' that can be used in attempts to understand other cases. Merriam (1988) places a similar emphasis on case study research as a means of generating hypotheses through the insights that the findings may yield.

These hypotheses would offer a basis for structuring future research. The idea of using the findings of my research to generalise to a larger context in relation to midwifery is simply not achievable because the cases chosen are set within a different spatio-temporal context. According to Guba and Lincoln (1994) in qualitative study generalisations are impossible since phenomena are neither time nor context free. Moreover, as Stake (1998) suggests, to place much emphasis on generalisation as it is viewed within the tradition of positivism, would limit the researcher's ability to concentrate on the features important for understanding the phenomenon under study. Consequently this may hinder the researcher from obtaining a "thick" description that each case has to offer. It is within this perspective that this study is set.

**Conducting the Inquiry**

This inquiry has two characterising dimensions. A historical case study strategy was employed to explain how historical events, perceptions, interpretation and meanings interplay to result in what is taken for midwifery knowledge today. It is grounded in understanding historical subjectivity, a knowledge that begins with an awareness of the relationship of midwifery knowledge to the historical contexts in
given time. To understand how society had evolved, it is necessary to examine the material condition and the forms that have driven the process of change. In contemporary society the material condition is capitalism and the historical, social and economic forms were those who were in control whilst the rest having little or no control. The Marxist perspective brings a different dimension to knowledge production- knowledge that can be produced by society and acquired from it (Lyotard 1984; Hall 1999).

Stemming from these key ideas critical methodology provides a paradigm within which the examination of knowledge entails delving beneath the taken-for-granted, established ideologies of other research paradigms, uncovering how knowledge has been distorted in unequal and exploitative society, and finally to point the way to less distorted forms of knowledge and to rediscover other domains of knowledge that have been displaced by according supremacy to scientific knowledge on the account of its objective and value-neutral, factual nature. (Steir 1991).

The main tenet of critical theory is emancipation and it argues that the basis for developing knowledge derives from treating people as knowing subjects who play an active role in constituting their world, from accepting their self-understanding and their views of the world (Carr and Kemmis 1986). It rejects the positivist view of emancipation based on science and technology as the sources of human well being. In the context of knowledge it challenges the positivist view of emancipatory knowledge derived from mathematical and probability theory. From a methodological standpoint it departs from the beliefs and practices that have become dominant in research and calls for a re-examination of the links between methodology and knowledge to learn more about the phenomenon under study. It seeks to free human thinking from the one-dimensionality of positivist research.

In the critical theory paradigm,

Knowledge consists of a series of structural/historical insights that will be transformed as time passes. Transformations occur when ignorance and misapprehension give way to more informed insights by means of a dialectical interaction.

(Denzin and Lincoln 1994, p113).
Several authors point out that within this tradition, the relationship between the object for research and the whole social and historical context is a key criterion (Angus 1994; Denzin and Lincoln 1998). Denzin and Lincoln (1994, p. 114) explicates that socio-historical context further includes political, cultural, economic, ethnic and gender antecedents of the studied situations" and the aim is to "erode ignorance and misapprehension thereby providing a stimulus for transformation of existing structure.

As Alvesson and Skoldberg (2000) assert, facts do not stand alone in social contexts. They are part of it.

Given the expansive range of possible observations, this context lends itself to a dialogical approach where the researcher is not only involved in data collection and interpretation of the data but includes his/her own learning as part of the process and outcome of research (Alvesson and Skoldberg 2000). Thus critical research calls for consideration of broader contexts than tightly empirical research advocated by other research approaches.

Consequently attempts to generate knowledge by means of positivist or pure naturalistic methodology is displaced in favour of a paradigm that recognises that Society and human nature are human constructions that can be altered through people’s progressive understanding of historically specific processes and structures.

(Comstock 1982, p372).

Unlike the positivist and naturalistic approaches, critical research tends to use secondary empirical material (Hall 1999). Alveson and Skoldberg (2000, p. 133-135) present three arguments for not regarding primary material as a decisive path to knowledge.

- The first maintains that many empirical studies allow little scope for the emancipatory interest of knowledge to fully work because things that “are simple to observe or to extract from interviews are not really what critical theory sees as an essential subject of research...both totality and subjectivity- at least the deeper blockages in our consciousness which most urgently call for study-escape simple empirical methods- things that do not allow themselves to be observed”.

41
• The second concerns the social conditions, ideologies and communicative processes operating behind the back of the subjects, in their subconscious. These may affect the way answers are given, in the sense that this may be governed by their adoption of the ideologies. As such the data gained from such sources may be only partially representative.

• The third suggests that primary empirical data that concerns with contemporary situations fix our attention on the actual, the what "it is" and draw it away from what "can be". As an example they cite empirical studies of unemployment, which tend to the exclusive consideration of existing social organisation with its rigid categorisation of people according to their location inside and outside the labour market. Sticking strictly to the empirical material means also sticking to the bounds of thought and imagination which it imposes. In adhering strictly to empirical material then means to be non-dialogical.

Critical research is not entirely opposed to the use of primary empirical material; its role in the research process, however, differs to the orthodox view of qualitative research. In the case where data are gained from primary sources, the empirical work should be less central than as advocated by the qualitative paradigm. Alvesson and Skoldberg (2000,p 133) explain that in instances of primary empirical work the “focus shifts away from the empirical work towards the interpretation and reasoned appraisal of the empirical material”.

Critical research works interpretively, requires a theoretical frame of reference that will enable the researcher to go beyond surface meanings to provide the phenomenon under study with content and deeper meaning, that is, it should address and explain the unquestioned beliefs and values upon which taken-for-granted assumptions rest. According to Morrow (1994) interpretations contain elements of both understanding and explanation. What seems evident and natural should be problematised, which includes researcher’s assumptions about conducting research; it brings another issue to the fore- that of power, the exercise of which may restrict the production of emancipatory knowledge. Thus it draws our attention to the political dimension of research, the political nature of social phenomena and argues that neutrality and objectivity cannot be applied to the study of social phenomena. It
Chapter Two: Research Methodology and Design

raises our consciousness of the constraints imposed, particularly, by the positivist, and to develop our ability as researchers to reflect critically upon those taken-for-granted realities that we are examining and of which we are also a part. In a sense critical methodology behoves the researcher to scrutinise the apparently progressive and emancipatory social changes and ideas.

The primary purpose of research is to generate knowledge. Each methodology expresses a particular point of view and involves a different set of procedures for conducting the inquiry. The debate in the philosophical positions revolves around the significance of induction and deduction as ways of finding out about reality. The naturalistic research focuses on natural settings; it emphasises on process and is concerned with understanding perspectives and meanings.

Critical research is about creating hypotheses or raising questions about crises that are facing society at a point in time and it differs from quantitative and qualitative research in that it develops arguments for future possible ways of conducting social life, based on the notion of emancipation. Because of its strong political stance the critical paradigm may raise some thorny issues and poses a great challenge to the imperialistic position established by positivist researchers.

Several authors appear to adopt the view that research ought to be conducted within one or other paradigm. If one proceeds to approach research in either mindset of a particular paradigm, when clearly the subject under inquiry indicates otherwise, it would be failing to do full justice to the guiding principles of other methodologies, to uncover the deeper meaning on the phenomenon under study and other dimensions of knowledge that the research may generate.

In the last decade or so trends in research and philosophical underpinnings of research appear to be changing; because the positivist paradigm is no longer tenable as the main approach to research inquiry, methodological multiplism is emerging as a new way of conducting research (Letourneau and Allen 1999). The aim and nature of my research, which has been discussed in the first chapter, demand that it is pursued with a more careful and politically sensitive interpretation of the range of cultural transformations that midwifery has witnessed, so as to understand the possible restrictions on the construction and methodology in the construction of
midwifery knowledge. This clearly implies a study that falls within a combination of the naturalistic and critical inquiry. Hence it is within the methodological framework that this Case Study approach to my inquiry is placed. The theoretical frame of reference, which situates my inquiry in the broader socio-historical context, is explained in chapter one.

**The Case Study Approach: Principles Underlying the Study**

In the context of my research, the case study approach is in some respects, unique. I realise that very few midwife-researchers inquiring into the phenomenon of midwifery knowledge have the background that I brought to my research. To my knowledge very few have studied it in two separate cultures and at the same time, in a significant way, being a part of both cultures. First I am examining the nature and development of midwifery knowledge within the context of my professional socialisation. As stated earlier this is entrenched in the western schools of thought, which reflects my western acculturation. In the Second I am studying it from the vantage point of a native of Mauritius who has an insider perspective of that culture from a macro-cultural perspective and to a much lesser extent the particularities of midwifery.

In a sense this study can be classified as an “auto-case study research”- auto-study is a term defined by Hayano (1982) to describe studies in which researchers are involved in the cultural study of their own people, and in the case of United Kingdom, I was studying a profession run by people like myself. It is important however to explore the principles that underpin the particular approach to case study.

**What is Case Study Research?**

First it should be recognised that the term case study is conceived in various ways and not all are classified as research. In some usages it is treated as an alternative to quantitative research in a sense of an approach to be used when appropriate and that offers findings that are as reliable (Yin 1994). In this section I look at case study as an approach to research in its own right and I discuss how it has influenced the way I have understood, situated it within the qualitative and critical paradigm and design my research to contextualise the requirements of the approach.
Merriam (1988) suggests that case study research tends to draw from various disciplines such as anthropology, sociology, psychology and history to inform the case study inquiry. For my study I have borrowed methods from two of these disciplines, the historical and anthropological tradition. The U.K perspective of midwifery is studied within a historical frame of reference. For the Mauritian perspective I used ideas drawn from anthropology.

However I did not embark on this study neither as a historian, nor anthropologist, but as a midwife-practitioner, midwife-educator and as a native of Mauritius, seeking a wider and deeper view of the development of midwifery knowledge in order to establish what counts as midwifery knowledge from a western and non-western perspectives. My concern was to understand the impact of cultural transformation on the nature and development of midwifery knowledge and to draw on the findings in both cases so that I may recast the framework in which midwifery curricula are set. I did not aim to apply the tenets of pure history, or anthropology to study the midwifery phenomenon so I could write about the U.K and Mauritian midwifery cultures; rather the approach I used in the two cases drew on the principles and theoretical orientation of historical, anthropological case studies (Morse 1994) to understand the phenomenon under study.

In keeping with Yin’s (1994) observation, that case study is a research design particularly suited to investigate a phenomenon without separating its variables from their contexts, I have been particularly careful to view both cases within as far as a holistic perspective as could possibly be had. This has been achieved by building upon the criteria identified by Stake (1998, P.91). They comprise the following:

- the nature of the case.
- the historical background.
- the physical setting.
- the political, economic, legal, ethical and aesthetic.
- the informants through whom the case can be known.

These criteria are also the focus of critical theory methodology. Without a doubt, therefore, case study research crosscuts the qualitative and critical research and is suited for cultural inquiry. Because my focus was on culture and cultural
transformation and the effect on the construction of midwifery knowledge, the adoption of these criteria has facilitated the elicitation of factors that are particularly relevant to address the culture "boundedness" of midwifery knowledge that is within its totality.

Merriam (1988, p111-12) describes four special features of case study research, which have guided my data collection analysis and synthesis been embraced in my study. These are particularistic, descriptive, heuristic and inductive and are explained as follows:

- **Particularistic**: the focus is on a specific situation, event, program or phenomenon.

- **Descriptive**: the case study provides a rich "thick description of the phenomenon under study, that is, a complete literal description of the entity being studied. These thick descriptive data are used to develop concepts, illustrate, support or challenge theoretical assumptions.

- **Heuristic**: illuminates the researcher’s understanding of the phenomenon under study. It achieves this by enabling the researcher to discover new meaning and new experiences. Similarly it may enable the researcher to discern important general problems about the cases under study and to interrogate one case with another so as to achieve better interpretation.

- **Inductive**: germane to this characteristic is inductive reasoning, that is, patterns, generalisations, concepts or hypotheses come from the data.

Case study research falls roughly into three major categories:

- **Intrinsic-** In this type the researcher wants to better understand a case. Other curiosities are subordinated so that the case may reveal its story. It is not about understanding generic phenomena, and the purpose is not theory building.

- **Instrumental-** In this situation the case is of secondary interest: it provides a supportive role to facilitate our understanding of something else. This type is often looked at in-depth, its contexts scrutinised, its ordinary activities detailed because it helps to pursue external interest. It usually involves longterm study of a single case.
Collective- this describes a number of instrumental cases (involving several research sites) that are studied jointly in order to inquire into a phenomenon. They are chosen because it is believed that understanding them will lead to better understanding and perhaps better theorising about a large collection of cases. (Stake 1998, p 88-89).

With my study the starting point of the inquiry into midwifery knowledge was a phenomenon that had intrinsic interest but as I got immersed in the literature it became apparent that this study could not be contained within a single case study. The collective case study design was considered most suitable to address the research questions. As Yin (1994) observes, the evidence from collective case study design is more compelling and makes the overall study more robust. But it requires extensive time and resources beyond a single case. I limit to two cases only, in which the tools for data collection have been borrowed from the principles of historical and ethnographic research. Additionally insights from Merriam’s (1998) description of case study have been found to be pertinent, particularly in obtaining “thick description”. According to Geertz (1973, p. 73) thick description includes inner and meaningful aspect of any culture, which he sees:

As interworked systems of constructable signs, culture is not power, something to which social events, behaviours, institutions, or processes can be causally attributed; it is a context, something within which they can be intelligibly- that is “thickly described”.

Thick description provides the first step in the interpretation of culture. This is then followed by the creation of theory that is achieved through a pattern-finding process, unlike the procedure adopted by positivist research, which constitutes a deductive subsumption of a set of observations under a governing law.

Finally the notion that “a case study is both the process of learning about the case and the product of our learning” (Stake 1998, p 87) is an important issue underlying the case study approach to research. This suggests that the researcher plays a particular role whereby it is necessary to learn from the subjects being studied. It then becomes important to adopt a more flexible approach in which the researcher does not manipulate or control the situation but sets about developing understanding through dialogue (Usher and Bryant 1997)- a position that indicates that research ought to be reflexive. The researcher’s learning process through reflexivity involves reflection on philosophical underpinnings of the research being
undertaken and the problematisation of researcher’s assumptions, interpretations and interactions with empirical data, secondary or otherwise (Alvesson and Skoldberg 2000). Herein, albeit in part, is the principle of critical methodology. In my experience, whilst conducting field work in Mauritius it became necessary for me not only to enter into dialogue with participants, but to respond also to the challenge that it posed to my own understanding of midwifery in my dual role as teacher and researcher. My experience as a researcher amongst the Dai is incorporated in the epilogue.

**Issues surrounding Case Study Research**

Critics of case study raise several issues. The main and perhaps most significant one is about validity, since its findings cannot be generalised to other settings in the way that positivist research can. In designing this research I have taken into consideration this issue. It must be recognised that the notion of validity takes on a totally different meaning in qualitative and critical research. The assumption underlying this is that quantitative, qualitative and critical research are different in their goal.

Several authors have challenged the positivist approach to generalisation suggesting that it cannot be applied to qualitative research with the same meaning. They argue that naturalistic case study research neither aims for generalisations nor intends to provide a basis for generalisation of the conventional kind. (Merriam 1988; Janesic 1998; Stake 1998). Some qualitative researchers perspective insists that generalisability cannot be an aim of qualitative research. For example Denzin (1994, p 133-4) writes:

> The interpretivist rejects generalisation as a goal and never aims to draw randomly selected samples of human experience. For the interpretivist every instance of social interaction, if thickly described (Geertz, 1973), represents a slice from the life world that is the proper subject matter for interpretive inquiry...Every topic...must be seen as carrying its own logic, sense of order, structure, and meaning.

Indeed, generalisability or transferability is not a be-all and end-all of the raison d'être of research (Punch 1998). The research process in not generally, generalisability-oriented, because it is constructionist and is conducted at a level of
“thick” description where the researcher to produce a rich and dense picture of social reality puts context and data together. Sampling is purposive and not geared to abstraction and representativeness. Furthermore the fragmentary nature of contemporary society begs the question of whether anything can indeed be generalised.

In respect of the position discussed above I see generalisation as essentially irrelevant to my study because the whole purpose of selecting these two cases was primarily to make sense of the perceived problem in my own understanding of midwifery knowledge and to try to understand it within a wider social and cultural context. According to Cronbach (1975, p 125) case study research serves to produce ‘working hypotheses’ that can be used in attempts to understand other cases. Merriam (1988) places a similar emphasis on case study research as a means of generating hypotheses through the insights that the findings may yield.

These hypotheses would offer a basis for structuring future research. The idea of using the findings of my research to generalise to a larger context in relation to midwifery is simply not achievable because the cases chosen are set within a different spatio-temporal context. According to Guba and Lincoln (1994) in qualitative study generalisations are impossible since phenomena are neither time nor context free. Moreover, as Stake (1998) suggests, to place much emphasis on generalisation as it is viewed within the tradition of positivism, would limit the researcher’s ability to concentrate on the features important for understanding the phenomenon under study. Consequently this may hinder the researcher from obtaining a “thick” description that each case has to offer. It is within this perspective that this study is set.

**Conducting the Inquiry**

This inquiry has two characterising dimensions. A historical case study strategy was employed to explain how historical events, perceptions, interpretation and meanings interplay to result in what is taken for midwifery knowledge today. It is grounded in understanding historical subjectivity, a knowledge that begins with an awareness of the relationship of midwifery knowledge to the historical contexts in
which it developed. This is referred as case study (1) and it is a theoretical investigation.

The second influence is an anthropological methodology that sees knowledge as emanating from human experience with the potential of understanding cultural differences and their respective influence on the construction and utilisation of midwifery knowledge. This is referred to as case study (2) and it is an empirical investigation. The aim of those two was to interrogate and be interrogated by their respective data, and to arrive at some consensus of what midwifery knowledge is. We may even ask whether there is such a thing called "midwifery knowledge".

**Case Study 1- United Kingdom**

The case study explores how midwifery, within the western context, has evolved in order to understand how it has obtained its body of knowledge that underpins the midwifery curriculum. (It questions what are the processes that are involved?). Because of the nature of my research problem and the questions raised, historical evidence was crucial to this phase of inquiry. This approach was chosen because it intended to investigate past events that obviously could not be observed. Similarly conducting primary research about a problem that calls for probing in distant past falls short of finding informants.

According to the principle of historical research the researcher needs to acquire a background about, and be familiar with the issues about which historians argue, in order to read their literature meaningfully. These include dates, names and key events. As midwife-practitioner and midwife-educator acculturated in the UK system I am familiar with such issues in the history of midwifery. Whilst it is important to look at chronological events it is also important to know the context of those events, the assumptions behind them, the impact on the case (Merriam 1988; Tuchman 1998) and controversies about and amongst the individuals in the case.

The task in this case study can be summed up as follows:

- To explicate why the present arrangements, structures and provision exist.
- To probe into the social and ideological movements of the past that are expressed in present activities and
To seek to understand the origin processes and dynamics of change and the resultant cultural transformation of midwifery practice.

The type of historical analysis used in this case study is situational history which Hall (1999, p 209) defines as

Whether keyed to distant past, the recent past or the present, situational history is grounded in the pragmatic and moral demands for knowledge meant to inform understanding of contemporary issues... The task for situational history is to account for a unique course of events, processes and institutional development that are of situational concern. The findings can potentially be used to empower individuals, groups or even intentions of the actors in the situational context, the motives and intentions of the actors in the situation, and the social processes, conjecture, and contingencies that shape future possibilities.

Thus using archival and contemporary material it explores the processes of cultural transformation as they have become manifest in midwifery. This will later be used to examine the construction of midwifery knowledge within the conceptual framework of the study.

Methods of data collection

Data were obtained from documents; these were easily accessible. As stated above some were retrieved from archival material. Documentary data are particularly good sources for qualitative case studies because they can ground an investigation in the context of the problem being investigated and to enable the researcher to construct a clearer reality of the phenomenon than was previously held (Merriam 1988; Yin 1994).

The starting point of this inquiry was a systematic review of published literature on the historical development of midwifery in the UK. The material selected included books, governmental reports, doctoral theses (published and unpublished) and other literature, both in the realm of midwifery and medicine. In accordance with the tools employed by historiography data was obtained from primary as well as secondary sources of literature (Merriam 1988; Tuchman 1998). The first tasks in the collection of data were to distinguish and classify the literature into these two appropriate sources.
Chapter Two: Research Methodology and Design

After reviewing the material specific to midwifery and medicine, which yielded insight into the research problem, the limitations of documentary data were evident, in so far that it was insufficient to answer the research questions raised. The data collection was thus extended to sociological and anthropological literature.

The main problems encountered with the secondary literature were problems of interpretation. It placed primacy on the description of the events surrounding the development of midwifery as they occurred, with little analysis of the factors external to midwifery. This led me to search for the primary sources of historical documentation, which yielded valuable insights and knowledge.

Data Analysis

An initial analysis was made prior to embarking on the second case study. I looked for the causal mechanisms by which midwifery knowledge was produced, through documenting the process that occurred over a period of five centuries and analysing the cultural transformation that occurred. In keeping with the task of this case study the following specific issues were looked for:

- The factors that have shaped the development of midwifery as a field of practice particularly related to the philosophical, social, political and economical factors.
- The key personnel involved in the development of midwifery practice and its knowledge base.
- Issues of representativeness, authenticity and accuracy.
- The rules that govern the production and acceptance of knowledge that is designated as midwifery knowledge.
- The criteria used to arrive at the body of knowledge that exits today.

Case Study 2- Mauritius

For this case study I drew on the principles and perspectives of ethnography, which is derived from anthropological tradition. The fieldwork was undertaken over a period of twelve weeks.

As stated earlier, I acquired a feel for the setting when I conducted a small-scale research in midwifery education, in the Spring of 1992. Gaining access to
conducted fieldwork in Mauritius for this study involved two phases: first I sought approval from the Ministry of Health and the Mauritius Institute of Research. Verification documentation of my research intention from the host university and a synopsis of my research proposal were included in the correspondences to the above authorities. The Medical Board of the Ministry of Health (the equivalent of an ethical committee) considered this information, in March 1996 and approval of a period of three months was granted to conduct the fieldwork. As a non-Mauritian registered health professional I was granted observer status.

The second phase began as I arrived in Mauritius in June 1996. Two separate meetings were held. The first took place at the Ministry of Health and entailed a discussion about the practicalities of conducting my research with key personnel: the Minister of Health, the Nursing Officer in Chief and his deputy. A schedule for my research activities was drawn. This included:

- The places that I requested to visit as well as what was recommended by them.
- The key informants that I needed to meet and interview both at strategic level and operational level.
- A list of the dais who were on the Ministry of Health Register, including their names and addresses. At the time of this visit there were only three dais on the register. Ethical issues, such as confidentiality were taken into consideration before disclosing the potential informants addresses.

There were also activities outside the research that were requested by the Nursing-Officer- in Chief. These included:

- Giving lecture to pupil and student midwives.
- Working session with key personnel at the Ministry, on the development of health care programmes with Nursing.

I had not thought of voluntarily sharing my expertise either in the capacity of midwife educator or as programme developer because I was aware of sensitive issues (of political nature) pertaining to midwifery education there. The request to do so by the Nursing-Officer-in-Chief offered me an opportunity to exchange expertise
with midwife educators and those involved in programme development; this proved to be a valuable experience, in that it offered me greater insight of the curriculum in use, the values and beliefs inherent in curriculum development. I looked for the emphasis placed on knowledge and its development. It was a privilege to enter into dialogue with learner midwives and to obtain their perspectives of midwifery knowledge. Although this session was unrelated to the content of my research it was a source for verification of some aspect of my data already gathered as well as a valuable teaching and learning experience in a setting other than the one I am accustomed to.

A second meeting was held with the Chief Executive of the Mauritius Institute of Research, to identify the support that would be required during my fieldwork. Additionally further information about key informants were provided.

**Sampling.**

Qualitative, empirical research usually needs a non-probabilistic sample because statistical inferences about the population chosen are not required. For this case study a purposive, (also referred to as criterion-based) sampling was used (Goetz and LeCompte 1984; Miles and Huberman1994). I have categorised my sample under two separate categories: institutions and informants. The latter category includes key personnel at the Ministry of Health and the Mauritius Institute of Research, practising nurse-midwives, midwives, midwife teachers and traditional birth attendants.

**Institutions.**

There are five Regional Hospitals and twenty-two Area Health Centres (AHCs) that provide midwifery service and care; not all Area Health Centres serve as learning placements. The time-scale of my empirical investigation did not permit the inclusion of all of them.

A double-criterion based selection was used to identify the places I needed to visit. First, all the selected institutions needed to be learning placements, and second, the geographical location was important, because different ethnic groups tend to cluster in specific geographical areas. All institutions needed to encompass as
wide a geographical parameters to enable as heterogeneous a perspective and as ‘thick’ and ‘rich’ a description as could possibly be had.

All five were Regional Hospitals, situated in the North, South, East and West of the island were included in the Sample. Six of the 22 AHCs (all of which deliver midwifery service and care in one form or another), linked with the corresponding Regional Hospital, were also selected. These are strategically placed, in that they allow targeting areas (they reflect the type of people, in terms of ethnic mix and social background which had great relevance to the topic of my investigation) and accessing those services that were likely to produce the most valuable data.

It is customary in Mauritius, for any individual undertaking research in the department of health, to meet the Regional Medical Officers and the Administrators of the respective Regional Hospitals to negotiate and agree the schedule of visits and activities to be undertaken prior to commencing fieldwork. The terms and conditions of access to the premises (which was mainly to do with ethical issues, adherence to non-participant observer status, identification and security) have to be observed. Although this may appear to be a straightforward exercise a fair amount of time can be lost at this initial stage. Since I had already met the above personnel in my previous research, this initial meeting proceeded swiftly and my observational visits began according to schedule.

Informants

The informants selected were categorised in the following groups in order to examine the case from different perspectives.

- Government officials and people linked with Health services of the country. Included in this group are, the Nursing Officer-In-Chief, the deputy Nursing Officer-In-Chief, the Medical Statistician, the Community Health Co-ordinator who gave me information about specific information about the provision of maternity services. From these sources I was able to gain a deeper understanding of the infrastructure of the maternity services, and governmental policies.

- Research Personnel. Included in this group are the Chief Executive of the Institute of Research, staff involved in the provision of education and research for the Sub Saharan region which is held at The Mauritius Institute of Research.
These informants helped me to find answers about national and international policies, such as WHO and UNICEF, and their influences on the development of midwifery in Mauritius.

• Hospital and AHCs employees. This group constitutes nurse-midwives and midwives with practical experience, ranging from 1 to 40 year posts registration. They provided data about the day-to-day reality of midwifery practice and midwifery knowledge that brought me close to my inquiry. They also enabled me to validate the data obtained from the final group.

• Traditional birth attendants: This group was the key source of data collection. Initially, only three traditional birth attendants were identified. They featured on the register held by the Ministry of Health. However as I began my visits at the hospital and AHCs I made further enquiries and obtained information about potential informants. Midwives from the AHCs provided me with contact addresses and in some cases prearranged meetings with traditional attendants on my behalf. As I began meeting with them others who were willing and interested to participate in my research were introduced to me. This is a recognised sampling strategy, which is referred to by Goetz and LeCompte (1984) as “network selection”. They provided the social and anthropological perspectives of midwifery and filled the gap that existed in my own understanding of midwifery and midwifery knowledge. I discovered a large number of practising traditional birth attendants scattered all over the island. It was not feasible to interview them all.

In addition there was another group that added to my data collection. I would classify them as an “unexpected “ group. They were ordinary members of the public which included family members particularly women who had experiential knowledge of the process of childbirth, those who had availed themselves of government maternity services as well as the services of traditional birth attendants, and finally people within the locality of my residence who were inquisitive of my presence in a capacity other than a vacation which some of them are used to in the years that I have travelled to Mauritius. It was mainly in response to their inquiry that I met with them and held informal conversations. It was through these frequent
informal conversations during various evenings that I not only obtained further information, but also was able to clarify certain things that the traditional birth attendants had mentioned but had not wished to expand. They did not only enable me to verify or crosscheck my data but they were useful in providing further data.

Method of Data collection

I used three main methods for data collection, which are as follows:

- Observation.
- Interviews.
- Documentary evidence.

Each of these methods has its merits and disadvantages. I chose to use a combination of these three in order to reduce the gap that each may present if used singly. Several authors have indicated the use of multiple methods to obtain data that can yield a “true” picture of the subject under study and allow for a holistic interpretation of the phenomenon being studied. (Leininger 1987; Merriam 1988; Paton 1990; Denzin and Lincoln 1998).

Observation

This was an important part of data collection in that it enabled me to gain a deeper understanding of the context of the Mauritian case study. I assumed the role of participant observer, who in this study, carries out the combined task of observing and informal interviewing (Paton 1990). It took place in the five Regional and the selected AHCs and included the following sites:

Regional Hospitals

- Antenatal ward.
- Labour ward.
- Postnatal ward.
- Antenatal Clinic.

Area Health Centres

- Antenatal Clinic (this was the only area relevant to my inquiry).
A modified framework, borrowing Paton's model (1980, p 216-219) the following elements were used to orient my fieldwork:

- The setting: which is the spatial context of midwifery practice.
- The Human Social Environment: How people interact with one another in their environment.
- Activities and Formal interactions: who are the participants? What is being done and how do the participants go about what they do?
- Informal interaction and unplanned activities: These include activities that are outside structured observation and relate to the ordinary activities that would be taking place.

As Paton (1980) points out it is impossible to anticipate what might emerge during observation of unplanned activities; it is therefore important that the researcher remains open to the data. Valuable data were obtained during these unplanned activities. Many issues, too sensitive to pursue in formal research activities, were addressed in non-formal situations such as coffee and lunch breaks. Oftentimes it was the informants themselves who broached the various topics.

Even though I was familiar with the settings, I spent the first fortnight visiting the various places to reorient myself with the settings, the people, to estimate the travelling time from one setting to another and to get to know the people anew. This started with a "catching up" type of conversation with the people that I had met during my previous visit, and included contemporary issues about midwifery and I gave them opportunity to ask about midwifery in the UK. This was also an opportunity to get acquainted with new people and to "catch up" on the development of midwifery since my last visit. It was generally too, to spend time visiting and orientation time and I was able to begin intensive data collection, trying to be as unobtrusive as possible. The staffs were aware of my intentions and of my presence in the practical settings; to a large extent this was facilitative.

There was a small section of staff that gave the impression of resentment when they were seeking to place me. This was obvious on two counts; first, my presence was seen as an intrusion in their working environment. Second, they felt threatened that I had come to make changes to their working culture. They were in
fact the “gate keepers”. Given that I had gained entry in all the chosen settings from the Ministry of Health, there was little there that the “gate keepers” at hospital level could do to prevent me from carrying out my observational activities. I overcame the problem by showing interest in their way of practising midwifery, by acknowledging their experience and by my willingness to learn from them. However, I had to be cautious not to become a complete participant, which might have resulted from the latter criteria, as this can severely limit the range of data that can be collected. The problems of complete participation have been discussed at length in literature pertaining to ethnographic research.

**Interviews**

I used open-ended questions in order to access the perspective of all the informants. Because they are flexible, open-ended questions present no restrictions on the content or manner of the reply that respondents give. They also enabled me to tap the limits of respondents’ knowledge and to probe in-depth and clear up any misunderstandings. At times, especially at the outset, the questions needed to be directive and more probing to initiate the dialogue. As my informants began to get to know me there was less need for directive questions although I needed to keep certain control so as to avoid unnecessary tangents. Some informants tended to deviate so far from the subject of inquiry.

The interviews were informal and oftentimes conversational. The merit of this was that it lessened anxieties, was non-threatening, allowed people to “open up”, encouraged co-operation and rapport between my informants and myself.

To maximise the responses and the quality of data, there were three factors that I needed to take into consideration:

- **Nature of the informants**- (professional status, educational status, area of employment)- Certain informants are less inclined than others to spare time and make the effort to comply with requests to help than others. The midwives, who perceive themselves to be of a lesser status than the nurse-midwives are one such group. (Further details about this group are included in part three.).

- **Subject of my research**- certain aspects of my research, such as religion, religious practices, beliefs and values, politics are sensitive. I was aware that because my
investigation would delve into matters of religion, religious practices and politics, there would be likelihood that my informants may withhold information crucial to this research.

- Environment- The right environment is obviously a factor that influences people’s willingness to collaborate with research and to supply honest and full answers. There are environments such as the hospitals, or wards within the hospitals or other settings where the informants may not feel free to speak their thoughts. A threatening environment wherever it exists can reduce the informants’ willingness to participate. However the researcher himself/herself may be seen as a threat.

Within that context, my first task on meeting with my respondents was to present myself in a way that will not be perceived as threatening. This started by acknowledging each as experts in their own right. From my previous research I know that midwives place themselves on a lower status (professionally and educationally speaking) than nurse-midwives (nurse-midwives are women who are State Registered Nurses and have followed a one year post basic programme in midwifery, whereas midwives are non-nurses and have followed an eighteen months programme Direct Entry Midwifery). I briefed them as to the nature and purpose of the interview and explained the manner in which it would be conducted and recorded.

I obtained each informant’s permission to audiotape the interviews. Some of the informants were apprehensive about having their conversations tape-recorded but upon assurance that the material on tape will not be made available to any one but reserved for my own use and that confidentiality would be maintained at all times, they were less anxious. I also assured them that the transcribed material will bear pseudonyms, thus their identity will be protected. Assent was then obtained and all interviews were tape-recorded.

All interviews were conducted at places chosen by the informants. The key personnel at the Ministry of Health and The Mauritius Institute of Research were interviewed in their respective offices. All the nurse-midwives and midwives involved, with the exception of two were interviewed in their workplace. This was
convenient for me as it involved saving time in travelling. Due to night duty the other two midwives invited me to interview them in their homes. I observed a marked difference in the freedom with which these two midwives entered into dialogue with me. There was some tension observed in the nurse-midwives and midwives who were interviewed in the workplace. They were extremely conscious of the legal parameters of their practice and the political implications on their jobs. Certain issues, particularly, in the realm of politics and cultural knowledge were difficult to ascertain in the context of hospital-based midwifery practice. The nurse-midwives avoided answering them. They expressed fear about the possible implications if they were to answer questions that they perceived as risk taking. To exploit what appeared to be a very significant issue in the whole construct of midwifery knowledge would have necessitated them to step outside what they defined as the legal parameters of their practice. As stated earlier I was able to pursue these related issues during meal breaks; the informants themselves very often initiated the conversation.

All traditional birth attendants, except one, were interviewed in their own home. Because this group gave their time, payment was negotiated and a fee was agreed. The issue of payment is a legitimate action in research (Taylor and Bogdan 1984). Since I had never met any of them, I had planned to visit and conduct the interviews on two separate occasions. The first visit was necessary to establish contact and acquaint myself with the different localities in which they resided. Although I am a native of the island I am unfamiliar to some geographical areas. I expected the first visit to be difficult, in the sense that I might not find the traditional birth attendants. To my astonishment this part of the process evolved relatively easily.

Initially some difficulties were experienced with this group. Before I could explain the purpose of my visit, the question whether the government had sent me (meaning from the Ministry of Health) to check on them, to stop them doing their work as traditional birth attendants, surfaced in each household. These were resolved by telling them explicitly that the authorities knew that I was conducting research, but first I was there solely in the capacity of a midwife and midwife educator trained in the UK; second that I am a Mauritian deeply interested in the traditional
perspective of midwifery and childbirth. I wanted to learn about their way of learning and practising midwifery so that we might preserve a valuable aspect of our culture. Other than giving me permission to do my research, I was neither affiliated with the government authorities, nor were they in control of my work. I carried with me identification from my Host University and place of work respectively as a form of verification that I made available to them. Since most of the traditional birth attendants are non-literate I asked a younger member of the family to check my identification, just as a means of alleviating anxieties that may stand in the way of the quality of data that I would receive. Once convinced that I was not a government official, some asked for an exchange of my experience and knowledge to which I responded affirmatively and saw this as an opportunity to enter in dialogue with them. All the traditional birth attendants, rather than just having a dialogue proceeded to back up their explanation by a demonstration. Others looked for validation of their practice and knowledge.

The interviews were guided by a list of issues to be explored. They were organised in four distinct categories to ensure that all the issues were covered to elucidate people's views on a wide range of issues that would shed as much light as could possibly be had on the subject under study. They are as follows:

- **Midwifery**: this area constitutes practice and knowledge: Definition, area and remit of practice, how is practice defined, how are they socialised in practice, difference between doctors and midwives, development of personal frame of reference, what meanings and value do they place on their own experience, is there a connection between their experience and knowledge, what do they think midwifery knowledge is and is not, how is it developed and is it, taught and acquired, how do they utilise their knowledge, how is knowledge defined, is midwifery knowledge relevant, for whom and why, is there such a thing called midwifery knowledge, if so what is it., do childbearing women contribute to our understanding of midwifery knowledge, the difference between the lay and professional perspective of midwifery knowledge and practice.

- **Childbirth**: how is it conceptualised and understood, what does it mean, what is significant about childbirth, is there any thing special about the pregnant woman,
Chapter Two: Research Methodology and Design

is there any thing special about the act of giving birth, who should be present at this event and why, where should birth take place and why, what difference does it make if the woman gives birth in hospital or at home, if there is a difference what is it, does the woman have a choice in the matter, what role do men play in childbirth, how are they involved, what is the role of the family how do they feature, other factors that may influence how childbirth is conceptualised and how this my dictate pregnant women's behaviour.

- Political/ economical Issues: what are the influences of policies, governmental as well as others on the way childbirth is managed, what are the changes that have occurred and continue to occur since the government and doctors became involved in the conduct of childbirth, how has this influenced our understanding of childbirth, have we had more knowledge and if so what kind of knowledge, what is the relationship between economical development and the conduct of childbirth.

- Culture- How does our culture influence the way we understand childbirth and the way we practice midwifery, what do we mean by culture, where have we obtained our culture, is culture an important part of midwifery knowledge, have been any changes in our culture if so what are the changes, should the cultural aspect of childbirth and midwifery be preserved, how can this be achieved.

The language used during the interviews varied according to each group. English and French were used with government officials, Research Institute staff, nurse-midwives and midwives; French, Creole and Hindi were used to communicate with the traditional attendants. In conducting interviews with the traditional birth attendants I avoided using scientific terms and I employed ordinary everyday language familiar to all. Only one traditional birth attendant requested to speak in Hindi, the language that she is most articulate in. Because my knowledge of Hindi is negligible I hired an interpreter, who understood her purpose within the context of my inquiry. I did all other translation.

Following the interviews the tapes were listened to and notes made. The transcription of the tapes began when I returned to U.K. In discussion with my supervisor it was felt unnecessary to transcribe all the tapes because I had reached a
place where there was not a great deal of new material. In order not to jettison the
rest of the interviews, I indexed and referenced the remainder of them so that I could
make constant reference to them. Therefore only certain ones were transcribed
because they gave me a framework in which I could analyse the rest. A sample from
each group of informants was chosen.

The selective transcription of the tapes had its advantages as well as
disadvantages on two counts: first once the selected tapes were transcribed and all
the non-linguistic expressions such as the “er, hum, the pause, the laughter, tones”
were removed the remaining texts became sterile. I was left with just a set of texts to
look at. Second having to return to listening to the other tapes time and again proved
extremely time consuming. However, the merit of listening to the tapes as opposed
to reading transcribed texts transported me back to the real situation, that is, the
context crucial to non-verbal data. All the nuances and expressions accompanied by
different tones kept the whole thing alive and made analysis a very interesting
exercise which teased out the resultant interpretations as the informants expressed
them.

**Documentary evidence and Artifacts**

Data from documentary evidence were obtained from governmental reports.
These include maternal and perinatal mortality reports, statistical reports, policy
documents (national and international), memorandae, nursing association reports and
other communiqués. Also available were archival material relating to the historical
context of the development of midwifery in Mauritius, midwifery curricula, learner
midwives record books and written evaluation and samples of examination papers.
The documents were obtained from the Ministry of Health, School of Nursing, the
Mauritius Institute of Health, University of Mauritius, Mauritius Museum Library
and the Commonwealth Secretariat in London. Some of the archival documents
found in the Mauritius Museum Library were damaged in parts and therefore not
always legible. A final source of evidence was artifact. These were mainly physical
objects that were found in hospital grounds, by women’s bedside, in the forecourt of
the traditional birth attendants’ home. There were other objects that some nurse-
midwives, midwives and all traditional birth attendants claim to have positive effects
in guiding their practice particularly. These were not available for examination because they are only used at specific times such as when the labour process has begun. Artifacts were an essential component in the traditional birth attendants’ perspective of midwifery and provided a broader and deeper understanding of midwifery knowledge.

Data Analysis

According to Merriam (1988) Miles and Huberman (1994), data analysis is a continuous process. Miles and Huberman stress the importance of early data analysis on three counts. Firstly it enables the researcher to move back and forth between “thinking about the existing data and generating strategies for collecting new and often better data” (1994, P. 50). Secondly “it makes analysis an ongoing, lively enterprise that contributes to the energizing process of field work” (1994 p. 50). Finally, data analysis left to the end of the field work can be overwhelming and may “rule out the possibility of collecting new data to fill in gaps or to test new hypotheses that emerge during analysis” (1994, p. 50) Therefore the timing and integration of analysis (Merriam 1988) is an important part of that process. Consequently the data were analysed in three phases. The first focussed on assessing the quality and relevance of the data, as they were collected. During this phase I took time to make initial analysis and review the data collected by constantly returning to the research questions and the conceptual framework within which my study is set. This provided direction for further data collection in so far that it enabled me to plan data collection and pursue specific lead according to what previous data yielded. Additionally this process initiated critical thinking that enabled me to enter into dialogue with my informants, to become more involved into research process itself and to obtain as wide a perspective of the questions that shaped my inquiry. The first phase of data analysis was crucial. It prevented the risk of “ending up with data that are unfocussed, repetitious and overwhelming in the sheer volume of material that needs to be processed” (Merriam 1988, p. 124). As collection proceeded, all analytical steps were incorporated in an iterative process. In such a way I was able to begin sifting out material unrelated to the research questions and at the sametime to identify emergent themes. Keeping within the parameters of the research question
and the conceptual framework was crucial to prevent against data overload and to enable deeper analysis as data were being collected.

The second phase and more intensive form of analysis began when I returned to the U.K. All the data gathered were organised chronologically and at this stage too, analysis involved an iterative process. For reasons identified earlier only a selection of the tapes were transcribed and the remainder, which had been indexed and referenced. Indexing and referencing were done according to a number of categories ranging from situational factors (that is the place and the type of informants) to emerging themes and concepts. The "untranscribed" tapes were referred to constantly. These provide a framework for analysing the rest. The process of analysing the transcripts and field notes involved making comments, questioning the data and finally isolating what I consider the most important data. The criteria used to denote the degree of importance was based on three main factors. These are:

- The context within which the data were collected (this is detailed on pages 56 and 58)
- The informants.
- The subject of the research.
- The philosophical, social and political and economical factors.
- The issues to be explored (see page 61).
- The regularities and irregularities between the professional and lay perspective of midwifery.
- The conceptual framework that informs the study (this criteria enabled me to keep my focus).

There were a number of major recurrent themes that came out of my empirical analysis. Examples of these are:

- Midwifery specific themes- the emergence of midwifery as a field of practice in its own right, the emergence of education to shape and control practice, paradigm shift form practice to theoretical orientation.
• Sociological and political themes- factors influencing the socio-cultural context of birth social-cultural context of birth, the spatial context of birth, the practices surrounding childbirth, influence of politics (macro and micro politics) on childbirth related issues.

• Philosophical themes- the conceptualisation of birth and midwifery practice, the meaning of childbirth and midwifery, religious assumptions.

• Epistemological themes- the concepts of biography, experience, wisdom and practical knowledge as distinct epistemological orientations.

• Linguistic representation- the use of artifacts and metaphors to make meaning and to convey it to others, that is childbearing women and learners.

From these recurrent themes came very profound questions about the development of midwifery epistemological bases; these then serve as a basis for the final stage of analysis.

In the third and final stage the data from both case studies were brought together and categorised under three main themes that enabled me to arrive at some consensus about midwifery epistemology. These are:

• Contextual issues.

• Legitimation issues.

• Methodological issues.

The comparative method of analysis was used which was based on the theoretical orientation that guided this study. Both similarities and differences were looked for which enabled for complex patterns and themes to emerge. These are:

• Religious assumptions.

• Scientific assumptions.

• Experiential knowledge.

These were then interrogated with the theoretical underpinning expounded in the conceptual framework which it will be recalled consist of three major
Chapter Two: Research Methodology and Design

concepts, modernism, postmodernism and premodernism. It will also be recalled that
the case study approach, which my study employed, has been situated within the
philosophical perspective of critical theory that used the work of Foucault, Lyotard,
and Habermas. It was the bringing together of the perspective of critical theory, the
assumptions of modernity and the brief discussion of the nature of knowledge and
knowledge legitimation that enabled me to unravel the development of midwifery
knowledge as it occurred within the western context. Invariably this pointed that
development of midwifery knowledge is about dominant discourses. It also showed
the role of the Enlightenment in dismantling the religious-metaphysical discourse in
favour of the scientific discourse. As discussed earlier critical theory enables
consideration of broader contexts than the more tightly empirical research advocated
by any qualitative methods. Amongst other approaches the key issue of critical
theory is the relationship between the specific object of cultural critique and the
whole historical and social contexts (Angus 1994). Thus returning to the conceptual
framework of this study it was then possible to critically examine the representation
of the midwifery epistemology as we have come to understand it in the west and to
then reconceptualise midwifery knowledge- a process which led to the question: can
there be such a thing called midwifery knowledge?

Findings

The findings of this research suggest that midwifery knowledge is a social
construct, which is, culture bound and is embedded in historical contexts. They are
presented in parts two and three of the study. Part of the findings is in the form of
raw data which are presented in excerpts and narratives. The purpose of doing so
was to let the data speak for themselves so that the reader may obtain an idea of the
subject under study as it is interpreted and represented by the informants. As
Merriam (1988, p.127)) points out “the rich, thick description transport the reader to
the event”.

Ethical Considerations

As stated earlier the outline of this study was submitted for approval to the
Ministry of Health in Mauritius before any data was collected. The role of the
Ministry in granting me permission to enter the “field” is to safeguard the participants of the research as well as the researcher.

In their discussion on the role of ethics, Frankfort-Nachmias and Nachmias (1992) emphasised the need for informed consent, privacy and confidentiality as well as the right to withdraw from the research at any time. They outlined the responsibility of the researcher in avoiding any harm to the participants and emphasised that the research must be valid and competently executed. The kind of research that I conducted did not require the participants to sign a consent form. From the outset I gave explicit details about the purpose of my research, my presence in the hospital and AHCs, the conduct of interviews. Assent was obtained. The right for them not to address certain issues was respected. Privacy and confidentiality were maintained at all times except in the case of traditional birth attendants where family members were either present or kept intruding during interviewing. This was acceptable to them, a situation that I had to adjust to fairly quickly. From the outset of planned activities I explained my presence and purpose to all involved in my research and made the plan for interviews.

Comment About Insider Aspect of the Researcher

Earlier in this chapter I mentioned that as a native of Mauritius I have an insider perspective of the macro-cultural perspective of my culture. Based on this assumption of being a Mauritian and having previously conducted research in my own cultural setting, I envisaged little problem about my role as a researcher “going native”, to have a deep rapport that would unravel the emic, that is, my informants perceptions, meanings and construction of their reality of midwifery. My ability to get along with my participants was not a concern. Several authors have pointed out that one of the most pertinent problem in conducting field work in a different cultural setting is that of “going native” because the group being researched may be hostile about research (Fetterman 1989; Gilbert 1993). Therefore in order for detailed data to be obtained a decision about what method of observation to use is crucial. This could be either covert or overt. In covert observation the researcher gives the impression of naïveté and humility. The rationale for doing so is not to disturb the
setting. Covert observation restricts the freedom to move about and observe what is appropriate and to take notes in the setting.

In overt observation, access is gained through explicit negotiation the informants (Gilbert 1993). As mentioned earlier I chose overt observation on two counts. Firstly I envisaged that as a native of Mauritius and having previously conducted research there would be no difficulty in being an “insider”. Secondly covert observation was rejected on ethical ground. As the research progressed my informants were interested to know more not only about my research but also about my practice, my understanding of midwifery and its epistemological base.

However as soon as I embarked upon my research activities both within the professional and the traditional midwifery system, I was struck with the realisation the extent to which I was viewed and treated as an outsider looking in. I feel that this is an important issue that needs clarifying. In the case of professional midwifery the problem lay with who I was and the context in which my professional acculturation took place. Whilst recognising my professional status as a midwife and a midwife educator, clearly acculturated in the UK midwifery system did not warrant claim to insider status. Initially there were apprehensions and even scepticism from the host professional midwives as well as the traditional midwives not knowing fully where I was coming from and to what extent they would feel free to disseminate information. So there was an element of marginality in the sense that I was part of the midwifery profession but not of the Mauritian system nor was I a part of the traditional midwifery system. This was evident in some places more than others, the amount of information that the dais were prepared to give and to the extent they were prepared to allow me to get into their “world” of midwifery. This was particularly related to certain practices and knowledge that they guarded with secrecy. In that context being a Mauritian conducting research in my own cultural setting made little difference to my “going native”.

**Conclusion**

The rigour of research is important in any study and the approach adopted is dependent on the research problem posed. In this chapter I have discussed the methodological positions that have guided this research. In the conduct of my
inquiry I have borrowed from the naturalist and critical theory traditions. As I have discussed, the combination of methodologies or methodological multiplism enables research inquiries to be approached from a variety of perspectives.
PART TWO
Part Two: Introduction

The following three chapters that this part contains present the findings of the historical investigation. As with any social phenomena of complex origin, there are numerous competing hypotheses purporting to explain the history of midwifery in the UK. It is a vast subject. Hence it is impossible within the remit of this study to enter into an exhaustive account of each of them. The purpose of this part is to show, through these discourses, how and why midwifery practice became subject to scrutiny and reform, and to later consider the impact on the development of knowledge. In order to make this task manageable I focus on the period from and including the sixteenth to twentieth century. From the extensive material that covers these five centuries I have selected what I consider salient to support the arguments being raised. It will later form the basis of the epistemological debate.

The justification for the historical approach is given in the methodology. As stated in chapter two, the type of historical analysis used here is situational history which Hall (1999,p.209) defines as

Whether keyed to distant past, the recent past or the present, situational history is grounded in the pragmatic and moral demands for knowledge meant to inform understanding of contemporary issues...The task for situational history is to account for a unique course of events, processes and institutional developments that are of situational value concern. The findings can potentially be used to empower individuals, groups or even societies by problematising the situational context, the motives and intentions of the actors in the situation, and the social processes, conjecture, and contingencies that shape future possibilities.

Thus using archival and contemporary material it explores the processes of cultural transformation as they have become manifest in midwifery. The UK case study therefore addresses the development of midwifery both in its micro and macro cultural context. This will later be used to examine the construction of midwifery knowledge.
Historical evidence suggests midwifery in the UK developed in the form of three major discourses: the ecclesiastical, political and medico-scientific, each representing its own value system and documenting the processes involved in its establishment. It is through the political and the medico-scientific discourses that we have come to understand midwifery. A discourse in the context of this study is described as

Structures of knowledge claims and practice through which we understand, explain and decide things.

(Parton 1994, p.32)

Since midwifery became subject to scrutiny in the early modern period, these discourses have become the crucial determinants of major shifts in the way it has been represented, in the way its knowledge has been constructed, taught and practised. In the process of change midwifery has suffered significant discontinuities (Arney 1982). The cultural practices surrounding childbirth and its overall responsibility, which was once firmly that of women, have been dissipated and replaced by a structure totally different to its original one (in so far as historical evidence shows). This has influenced the ways in which women have perceived and behaved in the childbearing process.

The history of midwifery has been studied in great depth by many scholars such as Ehrenreich and English (1973), Donisson (1977), Arney (1982) and Towler and Bramall (1986). From the review of their works, it emerges that the development of midwifery in the UK has been a struggle between doctors and midwives for occupational boundaries over childbirth which for centuries remained the domain of midwives, on the assertion that:

experience of childbirth was the best teacher.

(Donisson 1977, p.11)
However, less consideration has been given to the ultimate rationality and functionality of the various discourses in relation to knowledge development, construction and utilisation.

**Contextualising the UK Case Study**

**Dominant Discourse and the Control of discourse.**

In placing the historical analysis of the development of midwifery within the conceptual framework of the study we shall see that these three discourses are the dominant discourses that form part of a system of making representation. When we take up the analysis of historical evidence in the dimension of representation and question the functions and mechanisms employed in the development of midwifery, in terms of what they are and how they have come into being, we begin to open up spaces to show what midwifery ceased to be and what it became. The following three chapters record a history, but *from* the outset I want to point out that the history recorded is not fact, it is a representation. The interpretation of the midwifery reality, upon which the representation is based, seems to involve certain “fabrication”, because representations are social facts (Rabinow 1986). So basically what I am recording here is an account of midwifery by those who control its development and who, arguably were not in favour of midwifery in the first instance. We do not have any primary sources or autograph written by midwives who allegedly guarded their knowledge with much secrecy (Radcliffe 1967) or were presumably non-literate (Mowbray 1732 cited by Cutter and Viets 1964; Aveling 1967).

The ecclesiastical, political and medico-scientific discourses, which are responsible for the UK (modern) representation of midwifery, determined the mode of its being and was created by

The type of leaders, the different sources and methods of their acquisition of knowledge.  

(Scheler 1980, p. 80)
This means that a certain choice has already taken place because each type of discourse has its own epistemic presuppositions, a system of restriction, which binds individuals to certain types of enunciation (Sheridan 1980). Foucault (1972, p. 74) calls it the “archive”, a term he utilises to refer to the “general system of the formation and transformation of statements” existent at a given period within a particular society.

The three discourses that form the basis of the development of midwifery in UK are related and actualised by three overlapping powers: the church, which lay emphasis on moral rationalisation, the state which developed policies to effectuate changes in the context of practice (spatial as well as temporal) and science as represented by medicine. According to Foucault (1972, p. 42), who forms an important part of the conceptual framework,

discourse has not only a meaning or a truth, but a history.

It is, therefore, essential to understand where and how this history originated. The following three chapters endeavour to do just that and set the scene for the examination of the evolution of midwifery as a field of practice. More importantly different discourses according to Foucault (1972, 1979) are responsible for the process of cultural transformation. As we shall see these three discourses have been using conceptual systems which depend on the early modern and modern epistemological mode of thinking. We shall also see that these discourses created a dichotomy, which opposes modern scientific midwifery and pre-Enlightenment midwifery. In reality this dichotomy is about the power of the modern discourse on midwifery that invented the dichotomy in the first place. These discourses also permit the dissociation, which is characteristic of contemporary midwifery practice, of consciousness and representation. They defined the manner in which midwifery is given to representation in a form that is both positive and empirical. (Foucault 1979). The will to truth (knowledge) has marked the whole of Western civilisation over the last two centuries or so. Greek philosophy, Christianity and modern sciences are all partakers (Sheridan 1980).
Foucault (1979,1980) showed convincingly that truth (knowledge) does not exist outside power. Each discourse that this part addresses has its own regime of truth (knowledge) that decides which types of knowledge are accepted as true and valid. The power of the discourses that invented modern midwifery, as we know it, decided what it ought to be and how its knowledge ought to be produced and utilised. The problem of truth (knowledge) according to Foucault (1972) becomes manifest when the regime of truth (knowledge) of one group is imposed on another. As we shall see as soon as midwifery became subject to scrutiny in the last five centuries or so discourses on midwifery were articulated by a group of leaders who thought themselves in possession of knowledge (Mowbray 1732 cited by Cutler and Viets 1964). This point is expounded in chapter four.

Additionally the following three chapters show that those in authorities controlled the discourse by first positing external rules. Foucault (1970) argues that the production of discourse is at once controlled, selected, organised and redistributed to a certain number of procedures, in order to sustain a discourse about things that is recognised to be true. In the context of the development of midwifery in the UK this is based on a regime of truth (knowledge) that is used the rules of exclusion which in turn is based upon a predetermined set of values belonging to a particular culture at a particular point in time and space. As in its early period midwifery was encompassed in medicine it was clear that only a selective male population could access the field of medicine. In the Foucauldian term, the purpose of this control mechanism is largely institutional and aims at a conservation of power couched in the idea of reason and rationality. An epistemic position that delimits the totality of experiences a particular field of knowledge by applying a number of rules of exclusion. The rule of exclusion, in the context of midwifery is closely related to the will to truth (knowledge), which is of particular importance to the midwifery epistemological debate. The meaning of midwifery and the development of its knowledge base are tied to the time and the space in which it became subject to scrutiny.
Discourse of Opposition

An examination of the three discourses, however, would be incomplete without considering the phenomenon of opposition from midwives with which the leaders of change (clergy, politicians and doctors) were confronted. The discourse of opposition is based on the opposition between true and false. The attempt to exclude midwives and the pre-Enlightenment practices surrounding midwifery and childbirth serve to demonstrate this position. Their incompatibility is constructed on the basis of rationality and scientific practice. In using the discursive practice, to use Foucault’s term “pathologising” childbirth the three dominant discourses attempted to eradicate the old midwifery and give it a new meaning. Underpinned by assumptions of early modernity and modernity, the three dominant discourses appear to be the most powerful form of exclusion and have tended to exercise a sort of pressure upon all forms of discursive practices that existed in midwifery. An example of this is found in the initiation of statutory framework which placed midwifery under the control of people external to it.

It would be inappropriate to assume that all midwives fully accepted the dominant discourses. The evidence suggests that midwives, at least some, objected to the values of modernity, as they were being imposed by ecclesiastical, political and medical leaders, because they were, rightly, concerned about the justification for change – was it entirely in the interest of women and midwifery practice? Throughout recorded history midwives have been in conflict with the dominant discourses especially concerning medical involvement in midwifery practice. Examples referring the delay in calling medical help, midwives criticism of the rationality of the use instruments to assist women giving birth, the struggle to have equal right in the development of institutions and the lobbying of the state for autonomy of the profession, illustrate the control of the discursive formation/practice. The discourse of opposition is made apparent by pioneer midwives such as Sarah Stone (Towler and Bramall 1986, Wilson 1995) who not only attempted to show the impact of cultural transformation on midwifery practice but also provided the backdrop for the discourse of opposition. According to
Foucault (1980) there is no relationship of power without the means of opposition. He explains power as a machine in which everyone is caught, those who exercise power just as much as those over whom it is exercised. Power cannot be captured in a dichotomy of dominators and dominated (Foucault 1980). It is found on both sides of the divide and not only on the side of those who have authority. Applied to midwifery opposition seems to be reaction to power and a deliberate stance to preserve the position of the midwife as the one “with women” in the whole sphere of midwifery practice.

The Historical phenomenon in the context of my thesis is important because it plays a significant role in the analysis of the development of midwifery knowledge. The purpose of the UK case study therefore is to show how dominant discourses operated and then to consider the impact on the epistemology of midwifery.
CHAPTER THREE

The Ecclesiastical discourse

Introduction.

In this chapter I present my survey of literature on the ecclesiastical involvement in midwifery practice. From the literature I synthesise a major hypothesis, which seems to provide a plausible explanation of the necessity for midwifery reform in the UK—its entrenchment in witchcraft, the association of midwives with it and the midwife-witch craze. It concentrates on the micro-level phenomena that explain the beliefs in the reality of “witch-midwifery”. It identifies a process of differentiation, transformation and rationalisation. This is then followed by structure that the ecclesiastical authority established.

Broadly speaking there are two sets of factors that explain the characteristics of midwifery as a witchcraft entity: those that focus on gender and power in the wake of demographic changes in the social infrastructure, and those that examine the needs of those in authority and in societies in general, to establish their identity and power in a time of social change and transformation. My survey of the literature shows that men did most of the writing about the history of midwifery.

The Witchcraft Theory.

According to Towler and Bramall (1986) the discourse of “witch-midwifery” has its roots in the Saxon’s, Angles and Jutes’ settlement in the UK in the fifth century. Seemingly they introduced their superstitious beliefs in incantations, charms and their system of medical practice based on wide knowledge of herbs (Gordon 1970; Towler and Bramall 1986). As Saxon pagan religion permeated the UK social system, it also exerted a major influence in the practice of midwifery.
By far the most significant work relating to the association of midwifery and witchcraft is found in the Malleus Maleficarum - an authority in this subject. First produced in the fifteenth century, precisely in 1480, it makes extensive reference to witch midwives and their practice (Towler and Bramall 1986). Two Dominican priests, Jacob Sprenger and Heinrich Kramer (1928, translated version) wrote the Malleus Maleficarum:

"Our inquiry will first be general, as to the general conditions of women; secondly, particular, as to which sort of women are found to be given to superstition and witchcraft; and thirdly, specifically with regard to midwives who surpass all others in wickedness. No one caused more harm to the catholic faith than midwives."

(Sprenger and Kramer 1928, p66)

In their manuscript, they expounded, in some most vivid and convincing ways, the association of midwifery with demonism. They described midwifery practice as a very fertile ground for demonic practices. Midwives were labelled as witch-midwives. The extent of witchery committed by midwives was greater than that by other witches, and it was noted in the Malleus Maleficarum "no one caused more harm to the catholic faith than midwives" (Sprenger and Kramer 1928, p.66)

The scale of witchcraft related to midwifery is detailed in part one Question XI and in chapter thirteen of their manuscript. The following extracts describe the extent of such practices:

"That witches who are midwives in various ways will the child conceived in the womb and procure abortion: or if they do not this, offer newborn children to devils.

"Herewith is set forth the truth concerning four horrible crimes which evils commit against infants, both in the mother's womb and afterwards. And since the devils do these things through the medium, and not men, this form of homicide is associated rather with women than men."

"The canonists treat more fully than theologians of the obstructions due to witchcraft: and they say that is witchcraft, not only when anyone is
unable to perform the carnal act of which we have spoken above: but also when a woman is prevented from conceiving or is made to miscarry after she has conceived. A third and fourth method of witchcraft is when they have failed to procure an abortion, and then either devour the child or offer it to the devil"

and finally,

And so women in order to bring about changes in the bodies of others sometimes make use of certain things, which exceed our knowledge, but this is without any aid from the devil as we should ascribe evil spells wrought by witches.

(Sprenger and Kramer 1928, p 66 and140)

Central to the argument about witch-midwifery, therefore, are women and the suggestion that they were used as instruments by the demons to fulfil demonic acts. The Malleus Maleficarum elucidates that the devil easily used women because they were viewed as irrational weak, light-headed, impressionable, whimsical and evilly consumed by rage. Thus women in general were particularly liable to accusations of witchcraft.

The association of midwifery with witchcraft needs to be looked at in relation to a broader social reform going on around them, that is, the structure and organisation of society in general and the influence of Europe on U.K. This takes us back to the Black Death, which led to a demographic catastrophe. Following the Black Death, the feudal labour market was fundamentally restructured; women became a part, and consequently, the social and economic position of women was fundamentally altered. Surviving women, through entering the labour market, gained independence and turned away from traditional roles as mothers and wives. This, together with widespread use of abortion, infanticide and contraception, led to a decline in population growth (Trexler 1973). This indicates two reasons to explain the witchcraft theory and the witch craze. First witch persecutions (which would significantly affect midwifery) were the result of
misogynist resentment and hostility towards a new, independent and threatening type of woman that arose in the wake of demographic catastrophe. (Bainton 1971, p. 9-14)

In this instance this indicates men wielding power. The second is politically and economically rooted. In Heinsohn and Steiger’s view, this was an attempt by ruling classes and authorities to enforce the reproduction of the labour force. They state that:

We assume that these five centuries (1300-1800) were dominated by an enforced reproduction of human beings initiated by the clergy and nobility to replenish their stock of labour for the sake of regaining a sufficient source of income. We further assume that this was done through a far-reaching elimination of birth control, and most dramatically expressed by the witch-hunts of Modern Times.

(Heinsohn and Steiger 1982, p. 203)

Heinsohn and Steiger (1982, p. 208) further show that the witch-hunt achieved this objective in two ways: first the public burning of women which

Showed every woman and little girl the dangers associated with witchcraft, in effect with birth control.

Secondly the targeting of midwives helped to eradicate the knowledge and techniques of abortions and contraception. According to Heinsohn and Steiger (1982) the witch-hunt and persecution were a means by which the identity and power of social institutions could be established. In their review Ehrenreich and English (1972, P 26) suggest three main accusations. These are:

First, witches are accused of every conceivable sexual crime against men. Quite simply, they are accused of female sexuality. Second, they are accused of being organised. Third, they are accused of having magical powers affecting health- of harming, but also of healing. They were often charged specifically with possessing medical and obstetrical skills.
Ehrenreich and English (1972) further point out that the attack on women as witches was primarily an assault on their sexuality and an attempt to prevent “wise women” from practising herbal and folk medicine inherited from the Anglo-Saxon’ culture.

Criticism of midwives was already evident in the middle ages. This was rooted in the tension between informally trained women and the predominantly male medical profession, and was expressed in the distinction between the “obstetrix indocta” and the “obstetrix docta” in medical treatise of the time (Biller 1986, p.43). This distinction focused on the differentiation between the formally educated doctor and the informally educated midwife, the high social status accorded to formally organised medical profession and the low status of the female only occupation. Midwives of the time were also healers (Ehrenreich and English 1973). Ben-Yehuda (1985) suggests that the witch craze represented male medical practitioners’ tactic to outpost women from providing midwifery care.

Subsequent literature about the association of midwifery with witchcraft identifies the following: superstitions, infanticides and legends and symbolic significance associated with various by-products of conception. (Radcliffe 1967; Donisson 1977; Carter and Duriez 1986; Towler and Bramall 1986; Wilson 1995). In his work on midwifery and witchcraft Forbes (1962, p.267) claims that:

The moment of birth, a climax and a beginning has ever aroused the imagination. Several aspects of the process at various times, have acquired special meanings. Superstitions surround the placenta, the umbilical cord and the caul. The caul is believed to confer eloquence and protection against drowning, to promote easy childbirth, and to bring other pieces of good fortune.

Forbes seems to have been influenced mainly by the work of Murray (1937) and to a lesser extent by the work of Sprenger and Kramer (1928). The by products of conception mentioned above were considered important elements in magical rites (Moscucci 1993) Other accusations included consuming the flesh of unbaptised
babies, drinking a ritual mixture consisting of the flesh of unbaptised babies and other sordid practices (Towler and Bramall 1986).

Since midwives were at the front-line of childbirth and having access to the by-products of conceptions, it is understandable how they may have been implicated and accused of infanticide. Whilst they may not have practised witchcraft themselves, they may have colluded with witches, if at all there were any, and exchanged the specific by-products, presumably for some goods or for fear of the ills that may have befallen them if they did not conform. Kramer and Sprenger (1928, p 140) further claimed that:

Witches are taught by the devil to confect from the limbs of such children an urgent, which is very useful for their spells.

Midwives were additionally accused of dedicating babies to the devil, and denying salvation of their soul:

They offer them to the demons in this execrable manner. After the child is born, the witch-midwife, if the lying-mother is not alone, pretends that something should be done to restore the strength of the baby, carries it outside the bedroom, and elevating it on high, (offers) it to the Prince of Devils, that is to say, Lucifer, and to all others. (Guaccius 1626, cited in Forbes).

Forbes (1962) also mentions that midwives who were not witches resorted to spells and charms to protect and assist women in childbirth.

That women themselves entrusted their lives to saints for a safe and smooth delivery (Donisson 1977; Towler and Bramall 1986), indicates that childbearing was inherently a dangerous and fearful time for women and their infants-, which adds to the construct of midwifery as witchcraft phenomenon. Similarly, when encountering difficult situations that could not be solved within the expertise of the midwife, presumably because the physiological processes of childbirth were poorly understood, supernatural assistance was sought. Examples of this included invoking saints such as St. Margaret, St Mapurge or the Virgin Mary (Thomas 1973; Biller...
1986). By the very nature of their work, midwives were vulnerable to the accusation of witchcraft.

In examining the 'myth of the midwife-witch', Harley (1990) dismisses the notion of witch-midwifery as a literary convention. (Of course we do not have the midwives’ recorded evidence so we do not know what the realities of midwifery were). He (Harley) suggests that historians have provided a worldview that is not only derisory to midwifery but also detrimental to the integrity of women as a whole. To some extent Harley’s argument resounds with the point made earlier by Ehrenreich and English (1973), that the church in the European Middle Ages sought to reduce contradictions in their dominance and they perceived female folk specialists (who were revered women), healers and priestesses, as witches.

Even though the Malleus Maleficarum and all subsequent developments of witchcraft theory did not have the same authority in Britain as they did in Europe; nonetheless they provided the backdrop against which midwifery developed as a profession. In a sense, at first sight, the witchcraft theory developed the historical and social condition upon which the welfare of childbearing women and their offsprings became the concern of the church. It is possible therefore to surmise that the whole notion of witchcraft is less of a historical fact and more of a stratagem to establish hegemonic power and control. It definitely served to justify the involvement of the church and the subsequent rise of many disciplines in midwifery. It provided an instrument for patriarchal power, which dictated the direction of midwifery practice.

However, the origins and dynamics of witch-midwife craze must account for the following characteristic. Firstly, its temporal dimension. During the early and late Middle Ages, witch-hunts and trials were uncommon; cases were being dealt with by the Inquisition (Heinsohn and Streiger 1982) From the early fifteenth century onwards witches were persecuted with increasing frequency; approximately a thousand people were hanged or burned. The witch-hunt persisted until the mid seventeenth century. It is unclear whether midwives were included in the execution.
Secondly, the church became immensely powerful during the late Middle ages and exerted control in realigning every domain of life according to the philosophy of Catholicism. It is also unmistakably about the assertion of the dominance of the Catholic Church and the necessity to resolve the direct conflict/controversy between Catholicism and paganism, by establishing a society based on the catholic perspective of theology. With the Reformation the church became even more powerful in the organisation of midwifery.

The Ecclesiastical Organisation of Midwifery

The church’s main interest was to extirpate all demonic activities associated with childbirth and midwifery. Midwifery under the ecclesiastical organisation encompassed three main spheres of responsibility:

1. Religious responsibility.

2. Social responsibility.

3. Initiation of statutory framework.

Religious Responsibility

In the sphere of religious duties two main thrusts were identified: First salvation of the infant’s soul and purification/cleansing of the woman after giving birth.

Salvation of the Soul

Salvation of soul was obtained through baptism. A child was not considered to be a Christian unless he/she was baptised. An unbaptised child, therefore, was in deadly peril from the power of the devil (Forbes 1962) Thomas (1973, p. 40-41) emphasises the significance of baptism in the following quote:
The church taught that the ceremony was absolutely necessary for salvation and the children who died unbaptised were usually consigned in limbo, where they would be perpetually denied the vision of God and even according to some theologians, subjected to torments of the damned. At the baptismal ceremony the child was, therefore, exorcised (with obvious implications that it had previously been possessed by the devil) anointed with chrism (consecrated oil and balsam) and signed with the cross in holy water.

Because baptism was considered crucial for salvation of the soul, it became imperative for midwives not only to understand the significance of it but also to know how to perform baptismal rites. Up until the fifteenth century, (at about the year 1277) because midwives were in the front-line of birth, they were obliged to baptise infants in emergency situations, usually in cases of impending death. But in the first instance, if mortality was evident, the midwife was expected to carry the baby to the priest if he was not at hand (Forbes 1962; Donisson 1977, Towler and Bramall 1986). Similarly if a mother was dying in childbirth, the midwife was required to extract the baby from the mother's womb by means of caesarean section so that the infant's soul could be saved (Biller 1986). So strong were the beliefs held about salvation of the soul that baptismal rites had to be performed with exactness for fear that any mistakes made might lose the salvation of the baby. The ecclesiastical duties of midwives were specified in the English Manual for Parish Priest (Towler and Bramall 1986). The practice of midwifery in that respect required midwives to be accountable since according to the culture and values of the time, the salvation of the child depended on her.

Cleansing after Childbirth

Other religious responsibility entailed accompanying the mother to church, and being present at the “churching ceremony” was another important ritual of the Christian religious system. This took place a month following birth; the woman could not go, outdoors until she was churched (Wilson 1995). In accordance with biblical writings, upon which Christianity is founded, childbirth was considered to render the woman unclean and impure until she was ritually cleansed. The churching
ceremony marked the woman’s purification and reinstatement into the church. Midwives were required by the ecclesiastical authority to accompany the woman and be present at the “churching ceremony”. (Donisson 1977; Towler and Bramall 1986). As Wilson (1995, p27) further points out, for the journey to church the woman was “symbolically and socially enclosed, wearing a veil and accompanied by her midwife and gossips”. The churching ceremony entailed thanks giving for a safe birth, recitation of bible texts and prayer. The woman was expected to make an offering to the priest.

Social Responsibility

The social responsibility, which the ecclesiastical authority prescribed, added an important dimension to midwifery practice. Midwives were conferred the responsibility to investigate rape, bastardy, adultery and infanticide. They were also required to report any witchcraft activities. (Donisson 1977; Towler and Bramall 1986; Wilson 1995; Harley 1990). Clearly then a high moral standard of behaviour was expected from all concerned. Her religious responsibility combined with the social, conferred another role on the midwife - that of an agent of respectability. As an agent of respectability the midwife must be respectable herself. The boundaries of midwifery practice encompass much more than specific duties related to childbirth. She was placed in a strategic position of control and gate-keeping on behalf of the church.

Initiation of Statutory Framework

Although the church drew the parameters of midwifery practice it did not establish any form of regulation. There were concerns about the knowledge and skills of not only midwives but other practitioners of medicine and surgery. In collaboration with the state, all “health practitioners” came under scrutiny, which led to the first formal statutory control- King Henry VIII’s Act. The bill for the Act, introduced by the king's physician, Thomas Linacre and Cardinal Wolsey the king's
Chapter Three: The Ecclesiastical Discourse

Chancellor, received royal assent in the year 1511. The justification of the Act is represented in the following quote:

Forasmuche as the sciences and cunningyng of physyke and surgerie to the perfect knowledge wherefor bee requisite cothe grete lernyng and ripe experience ys daily...exercised by a grete multitude of ignorant persones...soofarforth that common Artificers as Smythers Wevers and women bolderly and customably take upon their grete curis and thyngys of great difficulties. In the which they partly use socery and witchcrate partly applie such medicyne unto disease as be verey noyous.

(Notestein 1911.p, 10-11)

Originally the Act established statutory control over medical and surgical practices. The state conferred the responsibility to enforce the Act, upon ecclesiastical authorities. It must be recognised that during that period of time the church wielded considerable influence over the state. Although the law did not include midwifery, the church, using the same legislative framework imposed statutory control over midwifery practice (Gordon 1970). The Act introduced the concept of licensing as a way of controlling and monitoring entry to practice, in effect a mechanism for gate-keeping.

The Licensing Process

The statute required midwives to be licensed and this was obtainable from the bishop's court. The licensing process was fairly rigorous. The criteria for obtaining a license required midwives to produce testimonials from the local clergyman and parish officers (Donisson 1977; Towler and Bramall 1986; Carter and Duriez 1986; Harley 1990) and the evidence of “six honest matrons” whom the aspirant licensee had assisted in childbirth. These “honest matrons” would testify to her skills (Donisson 1977,p.20). Finally after cross-examination by the bishop's court, as a prerequisite for licensure, the aspirant licentiate was required to take an oath. An example of the oath is found in Towler and Bramall (1986, p 57) and Forbes (1962, p. 280), which stipulated of the midwife:
I will faithfully and diligently exercise the said office according to such cunning and knowledge as God hath given me: and that I will be ready to help and aid as poor as rich women being in labour and travail of child, and will always be ready both poor and rich, in exercising and executing of my said office. Also, I will not permit or suffer that women being in labour or travail shall name any other to be the father of her child, than only he who is the right and true father thereof; and that I will not suffer any body's child to be set, brought, or laid before any woman delivered of child in the place of her natural child, so far forth as I can know and understand. Also, I will not use any kind of sorcery or incantation in the time of travail of any woman; and that I will not destroy the child born of any woman nor cut, nor pull off the head thereof, or otherwise dismember or hurt the same, or suffer it to be so hurt or dismembered, by any manner of ways or means. Also, that in administration of sacrament of baptism in the time of necessity I will use apt and the accustomed words of the same sacrament... And I will use pure and clean water, and not any rose or damask water, or water made of any confection or mixture..."

Part of the oath also contained specification of baptismal rites and is as follows:

In the administration of the sacrament of baptism in the time of necessity I will use apt and accustomed words of the same sacrament, that is to say, these words following, or the like in effect; I christen thee in the name of the Father, the Son and the Holy Ghost, and none other profane words. And in that time of necessity, in baptising any infant born, and pouring water upon the head of the same infant, I will use pure and clean water, and not any rose or damask water, or water made of any confection or mixture; and that I will certify the curate of the parish church of every such baptising.

(Strype 1822, cited in Towler and Bramall 1986)

So by the time the midwife was licensed, her clients (the women she assisted during birth), the local clergyman, and the parish officers or the medical practitioners would have given her testimonials. Regarded not as evidence of practical expertise (although this is debatable) but as proof of acceptability amongst respectable neighbours, the process of ecclesiastical licensing set apart midwives from those women suspected of witchcraft (Harley 1990) and at the same time ensured that those midwives who were suspected of practising witchcraft dissociated themselves
from demonic activities. Thus it crystallised a framework within which midwifery was to be understood and practised. At this early stage we can observe a cultural transformation that took place.

Additionally, midwives were required to pay for their license. Equally important, therefore, the ecclesiastical licensing process set apart those midwives who could not afford the licensing fee. The less financially able midwives would automatically be deselected, which consequently curtailed the number of midwifery practitioners. It also affected the livelihood of those midwives. As it turned out to be, unlicensed midwives continued to practice at the risk of being prosecuted if caught. For some this was the only means of earning a livelihood.

**Discipline and Punishment**

In the same way that the church enforced the Act, so it meted out punishment. Midwives who practised without a license were punished but unlicensed practice persisted because licensing was never vigorously enforced (Forbes 1964). Similarly midwives who had obtained their license to practise and were subsequently found guilty of offending the Act were punished. The punishment took three forms - they were prohibited from practising, made to do penance or excommunicated.

**Monitoring of Midwifery Practice**

Who then monitored midwives' practice and ensured that they worked within the legislative framework? Forbes (1962) suggests that the Bishops themselves, so as to uphold the following injunction, did this:

A midwyfe shall not use or exercise any witchcraft, invocations, or prayers, other than suche as be allowable and may stand with the Lawes and ordinances of the Catholic Church.

(Aveling 1967, p 22)
Chapter Three: The Ecclesiastical Discourse

It was customary for Bishops to make periodic visits to local parishes. During these visits the bishops would enquire specifically about midwifery. The information sought is detailed in the following quote:

Whether the midwives at the labour and birth of any child...do use any salts, herbs, water, wax, cloths, girdles, or relics, or any other such like thing or superstitious means contrary to the word of God and the laws of the realm (Frere and Kenedy 1910 cited by Forbes 1962, p. 280).

Additionally, midwives were required to have witnesses at the birth of the baby; this was already in place as defined in the ceremony of childbirth. The intention here was to prevent the occurrence of infanticide by the mother or the midwife herself as well as confirming the legitimacy or illegitimacy. In such cases the woman or midwife would be culpable of offending the law. It has been known that such a crime as infanticide incurred the death penalty. So essentially the purpose of witnesses served to vindicate both woman and midwife in cases where the above crime might be suspected. Similarly, midwives who were witches could no longer practice witchcraft in the presence of witnesses.

Thus, the establishment of a monitoring system in which both ecclesia and midwives were together, could be observed. Midwives monitored society and ensured a high moral behaviour; the priest monitored midwives to ensure that they upheld the law. Herein lay the notion of surveillance, discipline and punishment.

_Criticism of the Ecclesiastical Control_

Criticism of ecclesiastical authorities, in particular by Andrew Boorde, a medical doctor maintained that the church focus on religious matters, was single dimensional. There was a lack of concern, regarding competence or provision of education, where this was found to be lacking, despite the fact that midwives were required to provide evidence of their skills. In the mid-sixteenth century, Boorde expressed that:
Every midwife shulde be presented with honest women of grete gravitée to the Byshoppe and that they should testify for her that they do present: she should be a sade woman, wyse and discrete, having experience and worthy to have office of mydwyf. Then the Byshoppe with the consent of a doctor of physicke ought to examine her and to instruct her in that thynge that she is ignorant, and thus proved and admitted in a laudable thynge, for and if this were used in England, there should not be halfe so many women myscarry, nor so many children perish in every place in England as there be. The Byshoppe ought to look into this.

(Boorde cited by Towler and Bramall 1986,p.45)

Boorde's criticism, although directed at ecclesiastical authorities, in fact addresses midwives' competencies and knowledge in a very direct way and identified the need for education, but most significantly for involvement in the licensing process by medical doctors who, because of their expertise and expert knowledge, would be better placed to judge which midwife was fit to practice. The argument posited by Boorde here is that it is the medical people who have expertise and knowledge regarding childbirth and therefore they should be involved in the licensing process which served not only as a selection device but also as a way of identifying the educational needs of midwives. Boorde's main justification for identifying 'poor' practitioners rests on his observation of high prenatal mortalities that occurred all around England at the time. In a different perspective but still within the same argument he made inroads for the involvement of medicine and medical reasoning into midwifery.

**Conclusion**

The ecclesiastical involvement in the reformation of midwifery practice presents us with a central focus- that of governmentality - which starts a process of cultural transformation. It is manifest in the following ways. Firstly, it is to do with moral rationalisation. The conflict was not just about shaping midwifery practice but was rooted in the tension between paganism and Christianity and the necessity for the church to assert its position, re-establish its identity and re-inculcate Christian values and culture in society in general.
By its very nature midwifery was a vehicle through which the church could establish social control. By the very nature of their work midwives automatically became significant instruments in the ecclesiastical machinery to achieve it. Secondly, in order to bring midwifery under its purview the ecclesiastical problematised midwifery practice, that is, the culture of the time, and the skills of midwives. Unarguably, women needed to be protected against demonic practices. At the same time the church restored the integrity of midwifery practice, because through the church midwives were agents of respectability. As a paradox, midwifery also became subject of male hegemony and boundaries for midwifery practice were created. In the next chapter I present the state involvement.
CHAPTER FOUR

The Political Discourse

Introduction

The purpose of this chapter is to survey some of the most important political constructions of midwifery practice since the ecclesiastical dominance. The political discourse is immense and complex; it contains useful concepts that are fundamentally important for the development of midwifery knowledge. To disentangle all its factors would be almost an impossible task and hence this chapter is able to do little more than point towards the principal themes and the prime movers of change. But, one has to place the midwifery debate within its political context in order to appreciate its significant ideas. Thus, we are predominantly concerned here with the investigation of some of the major forces that have influenced the construct of midwifery; in this way we acquire an understanding of the theoretical developments, which have occurred over the past five centuries. The more distant the historical period, the easier it becomes to identify the pressures and the ways in which they have framed the midwifery discourse. I acknowledge that midwifery 'politics' is not a discreet entity, in that it permeates and manifests itself in every aspect of the development of midwifery. It is important, however, to identify the distinctive areas of politics; namely, the relationship of the state to the public sphere, the factors that have included midwifery in the public sphere and its transformation over its long history.

The political discourse is multi-relational, essentially, involving power, authority and government. This framework shows that decisions concerning the organisation of midwifery ceaselessly involve political judgements and choices. Examples of the multi-relationality, in which these judgements and choices are exercised, are found between the state and the church, doctors, midwives and women and finally in the political influences on economic change and of economic change on politics (Giddens 1993).
In essence, the political discourse involves both macro and micro politics and sets in motion two major areas of development. First, it is about the establishment of legislative control; the background of this was considered in some detail in chapter one. Only the major legislative development will be referred to. The second dimension is the way midwifery developed as a marketable commodity.

**Changing Midwifery Practice Through Legislation**

The politicisation of midwifery, as it has taken shape in history, evolved from Dr Linacre’s and Cardinal Wolsey's idea of securing the welfare of society (Towler and Bramall 1986; Donisson 1977; O'Dowd and Phillips 1994). The state involvement in midwifery practice is reflected in the 1512 legislatory framework. This established the legal foundation of health care. The prime motive of the 1512 Act was to provide better health care for childbearing women and newborn infants, whose lives seemingly were endangered by the practices of unqualified practitioners. (Donisson 1977; Towler and Bramall; Tew 1995; Wilson 1995). As mentioned earlier, justification for the Act was centred on performability, since it heralded questions about the standards of practice, the skills, knowledge and generally the principles underlying pre-legislation midwifery practice, with witchcraft allegedly being the pivotal focus. Thus midwives and their ability and skill to provide midwifery care were seen as the key to government reform.

Following the 1512 legislation, decisions on the reform of health care practices, of which midwifery formed a part, included processes of selection through licensure, of control through surveillance, discipline and rationalisation. These eventually led to the institutionalisation of midwifery and childbirth (Donisson 1977; Arney 1982; Carter and Duriez 1986; Towler and Bramall 1986; Witz 1992).

Although midwifery had become the subject of public concern, the outcome of the legislation did not necessarily result in total reform as might have been anticipated when the justification for the 1512 Act was given; this was not enforced rigorously and to a large extent the situation of midwifery remained the same. Midwifery practice, based on the tenets of witchcraft and ignorance, persisted. A
significant generalisation that emerges from this brief expose of the new legislation, is that those concerned with reforming midwifery practice encountered a problem that could not be attributed to midwifery alone, but one that was deep-seated in society at large. The possibilities of any successful reform needed to involve changing social opinions and lifeworlds themselves (Held 1980).

A great deal of health care legislation followed the Act of 1512, but none of it directly addressed the position of midwifery; therefore it remained encompassed within the whole health arena. Not until mid twentieth century did the real challenge and threat to the position of midwives seriously begin. It was also during that period that midwifery obtained legal recognition to enable it to control and govern its own affairs (Donisson 1977; Arney 1982; Bent 1982; Towler and Bramall 1986; Lupton 1993; Heargerty 1996).

**Men as Political Instruments in The Sphere of Midwifery Practice**

In debating the position of political ideologies, it is essential to understand the processes which midwifery has passed in order to obtain recognition as a field of practice in its own right.

The political discourse became significantly evident in the seventeenth century. It began to take shape with the involvement of men in midwifery practice, initially categorised as physicians, barber-surgeons, surgeon-apothecaries, but who later became known as obstetricians (Donisson 1977; Towler and Bramall 1986), and who seemingly have made great contributions in the field of midwifery (Spencer 1928; Radcliffe 1967). Essentially they were doctors. This section does not intend to discuss men-midwives per se, but to examine the part they have played in the transformation of midwifery practice into a separate institution. It is important to recognise, however, that men-midwives' involvement constituted a patriarchal authority relationship and hence provided a framework within which midwifery practice was regulated. To avoid confusing terminology, throughout this chapter the term medical-men will be used.
The introduction of medical-men in midwifery opened a number of ideologies that have become stabilised in midwifery. These are elements in the emergence of a new paradigm, new forms of control and new ways of understanding and practising midwifery. Medical-men began to make their mark in the field of midwifery in the 17th century (Donisson 1977; Arney 1982; Witz 1992; O'Dowd and Phillips 1994), although they may have been practising long before then, and began to threaten the employment of midwives. Recognising that in the main, midwives were an honoured class. Spencer (1928) pointed out that midwifery itself as a field of practice had failed to progress, and explained that the chief reason for this was that the practice of midwifery was in the hands of midwives, as it had been since the earliest times.

The entry of medical-men into midwifery, in the seventeenth century, was fraught with difficulties. Women strongly objected to male attendance during childbirth (Donisson 1977; Verluyssen 1980; Carter and Duriez 1986). We note here that legislation neither restricted midwifery practice to women alone nor did it stipulate that midwives must be in attendance during childbirth (Donisson 1977). From the legislative viewpoint, women had no grounds to contest men's attendance at childbirth. Their only strategy was not to call them except in dire circumstances, thus preserving the 'feminine' nature of midwifery. Examples of first medical-men in midwifery, such as Willughby and Chamberlain, are cited. Many others have come to play a significant role in the development of midwifery practice.

Objections to male presence were very strong; they had to enter the birthing room in the most unobtrusive manner. Quoting Towler and Bramall (1986, p.73) Willughby, in response to a call to assist a breech birth in the year 1658, had to crawl into the room on hands and knees and perform his life-saving work under cover of a sheet.

Ridiculous as this may appear to be, it is in fact significant. What this suggests is that there is a space intimate to women that should not be invaded by the opposite sex. This also indicates that there is something special about the nature of midwifery as a female entity. I will return to this issue in part four.
This said, the majority of births were still attended only by midwives, so technically the control of childbirth and midwifery practice, at that point in time, remained firmly in the hands of midwives and women. Critics suggest that this was about a protectionism that would prove detrimental to the development of midwifery practice. Indeed Radcliffe (1967, p.1), representing medical views, asserts,

Since midwives jealously guarded the secret of their profession... very little value was handed down in writing.

At that time medical-men, who had received education from secular universities since the thirteenth century, did all the writing (Walker 1972). We begin to understand that since there was nothing written by midwives, the elements embedded in practice were gradually being lost. In keeping with Radcliffe's (1967) observation, there was nothing that the medical-men could include in their texts from midwives' practice other than what they themselves had interpreted.

There are disparate views concerning the acceptability of medical-men in assisting women childbearing. In contrast to the above view, Wilson (1995) indicates that, from the seventeenth to the eighteenth century evidence, not all women objected to male presence in childbirth since some requested medical-men's advice. A system legitimising medical-men's attendance in childbirth already existed in the 'booking call' system, which operated in three distinct ways - an advance call, an onset call and an emergency call (Wilson 1995).

**Implications of the Booking Call System**

In order to expand our thinking on how medical-men played a crucial historical role in the development of midwifery practice and the conceptualisation of midwifery within the political context, one has to understand the nature of the 'booking call' system. In my view, this is pivotal in the development of both the political theories, and the medical ones. The latter will be addressed in the next chapter.
The Advance Call

In an advance call, the woman would summon the medical-man to take up residence in her home at some stage in pregnancy (the exact stage of pregnancy is not specified). The advance call implied advice given by the medical-man about "diet and course of life", and "to be in attendance during birth and to supervise her recovery afterwards" (Wilson 1995, p 50). From this, it would appear that the role of the medical-men in labour was purely observational. We may also ask: Why did women find it necessary to have a medical-man present when there was a midwife in attendance? Could it be that they did not trust the midwives completely? Could it be that they wanted to rule out the possibilities of any witchcraft as alluded to in chapter two, thereby protecting themselves and their newborn infants from such hazards? Or could it simply be that medical-men were viewed as 'experts' in that they had more knowledge?

The advance call system isolates two key issues. First, it gave the medical-man the opportunity to develop a sense of relationship and trust vis-à-vis all concerned. Taking up residence in the woman's home would allow the medical-man time to familiarise himself with the environment. He would also be able to follow the process of birth from beginning to end and thus illuminate his theoretical knowledge. The second issue and perhaps the more significant one was that it provided a good opportunity for medical-men to gain first hand knowledge about pregnancy and the labour process from a pragmatic point of view - an opportunity that would stand medical-men in good stead for contributing significantly to policy-making regarding midwifery practice.

The Onset Call

The onset call literally describes the summons of the medical-man at the onset of labour (the onset of labour is not defined). In comparison to the advance call, this one was far from straightforward. Bound by geographical constraints, it became impracticable for the medical-men concerned to arrive on time unless, of course, they resided in the locality (Wilson 1995). For this reason, this type of call was of little value and hence the medical-men would not obtain the experience that
would enable them to develop expertise in the field of midwifery. The literature does not state the frequency of either the advance call or the onset call.

The Emergency Call

By far the main form of medical-men's involvement in midwifery was the emergency call, which invariably followed serious difficulties in childbirth. In my observation, the 'booking call' system represents an important feature in the development of midwifery practice, but it is the emergency call that had the greatest impact; it also dictated the direction of midwifery practice would take. It is my estimation in my observation it was the emergency call that seriously put in question the skills of midwives, or their lack, as perceived by critics of midwives. This would become a political manoeuvre to reform and shape midwifery practice.

From this debate about the 'booking call' system, we can note that the rise of medical power, the shift of governance of midwifery practice from midwives and women to medical-men resulted. This emphasised medical-men's expertise in difficult birth.

This indicated the embryonic stage of medical conceptualisation of childbirth and its subsequent medicalisation. It would appear, then, on a micro political level, that the 'booking call' system represented political choice. Women as well as their families exercised their judgement and decision about who should be present in labour. It seems clear that there existed disparate views concerning the acceptance of medical-men in midwifery (internal politics). Women themselves were divided over this issue, and this led to the creation of two female camps of thought. As Wilson (1995) observes, these two camps of thoughts were related to women's status and economic standing.

I perceive the last form of call to be the linchpin of the development of political theories; the main influence on the construction of midwifery and the necessity for further reform. The common form of emergency calls related to difficult births, which were defined as obstructed births (Wilson 1995; Radcliffe 1967; Spencer 1928). These latter were characterised by either malpresentation of the fetus or impaction of the fetal head in the woman's pelvis with a unique
pathology and outcome. An impacted head would leave no room for any manoeuvres; therefore it would be impossible for the woman to birth her baby, at least vaginally. In either situation the medical-man faced a difficult task, although it would seem that the first problem could be dealt with by performing a podalic version (turning the fetal head to breech presentation) to facilitate the birth of the baby - a technique that would seem vital to the survival of both mother and baby. Willughby taught midwives this technique (Wilson 1995). Oftentimes it required destructive efforts to deliver the baby which entailed a craniotomy - a procedure that was strictly the province of medical-men (Willughby 1863; Wilson 1995). It required surgical training from which midwives were excluded. This emphasised medical-men's expertise in difficult birth by virtue of their ability to use instruments.

Returning to the debate about midwives' skills or the lack of them, we remind ourselves that whilst it was permissible for midwives to perform podalic versions, craniotomy was strictly the province of medical-men. Since midwives were in the front line of births, why then were they excluded from being trained for such procedures? Why were they taught to perform podalic version and not craniotomy? There is evidence to suggest that some midwives did perform craniotomy as in the case of midwife Sarah Stone (Carter and Duriez 1986). Furthermore, this particular midwife not only performed craniotomy when it was necessary, which was very rare, but she also described various techniques to solve the problem of obstructed labour (Towler and Bramall 1986; Carter and Duriez 1986; Wilson 1995). Nonetheless, from this early stage we can observe the emergence of demarcation of boundaries.

A second point at issue in the problem of difficult births, which militates against midwives, resided in the long delay to call medical help - a delay that could amount to four days after the onset of labour. On the surface this may appear to be a strategy employed to avoid admissions of medical-men to the birthing room, thereby giving the impression of professional rivalry, and the preservation of the 'feminine' nature of childbirth and midwifery practice'. Upon closer examination, however, it becomes apparent that the basis for the delay in calling the medical-men's help was
fear and danger. This is clearly described by Willughby (1863, p.164) who maintained

the delay strategy was potentially a reason to deny the need for intervention.

He suggests that this was due to the

fear of male practitioners and the dread of the operation of craniotomy and what this represented for the woman.

In the same vein, Wilson (1995, p.50) indicates that

craniotomy was perceived as an invasion of the woman's body, the destruction of her child, and, since it was almost only used when the child was dead as a last resort to save her own life, it could ultimately result in her own death.

Visualising such prospects would inevitably induce enormous fear for all confronted with such a situation. It is therefore difficult to accept the scenario of difficult births as a strategy to preserve the cultural institution of midwifery and childbirth as it sometimes appears in historical literature. This may also indicate essentially that women's view of childbirth does not necessarily lie within the above explanation but encapsulates wider societal values and the possible acceptance that childbirth, as part of life, brings with it good as well as adverse outcomes.

This issue of difficult births and the associated delay in calling medical-men's help cannot be attributed singly to women's fears; it needs to be examined within the wider context of midwifery practice. It follows that the notion of performability would yet again emerge as a central theme in the improvement of the circumstances of childbirth. There are two main elements involved in this notion of performability, viz. skills and knowledge, and, in the case of midwives, they were perceived to be lacking. The situation of difficult births was surely beyond the capabilities of midwives. There were limits to their capabilities that indicated that if midwifery was to progress, something needed to be done about it. Seemingly midwives themselves recognised that their skills were lacking in situations like the difficult births they might encounter in practice (Towler and Bramall 1986), and that these problems lay
Chapter Four: Political Discourse

beyond the sphere of their remit. In all, the booking call system opened a discursive way for understanding midwifery and childbirth.

How might this relate to the politics of midwifery? There are a number of factors that would militate against the midwives retaining governance over their domain. First of all, childbirth was fraught with unpredictable difficulties and the labour process itself could seriously endanger the lives of women and that of their infants. Secondly, the problem of difficult births revealed the limit of midwives' competence and cast doubt on the appropriateness of midwives' management of births in general. Herein lay the association of childbirth with risk and danger. The sources of danger can possibly be attributed to the midwives' limited skills and knowledge.

It is also important to analyse midwifery within the context of live births. The majority of births result in a living child; all of this, according to Wilson (1995), was the province of midwives. Arising from this debate, the problem of difficult births and the related delay in seeking medical-men's help could not be ignored. Seemingly it obviated the necessity to improve standards of practice, a task that would be seriously taken up by medical-men.

The Ascendancy Of Medical-men and the Division of Labour - The Role of the Midwife Defined.

This section does not attempt to chart the ascendancy of medical-men in general, but is an analysis of the way the debate about childbirth and the knowledge and skills of midwives was conducted with specific reference to the issue of governmentality and the creation of boundaries between medical-men's and midwives' work. As noted, the ascendancy of medical-men in midwifery revolves around the problem of difficult births. The invention of forceps technology by the Chamberlen brothers (Donisson 1977; Towler and Bramall 1986; Wilson 1995; Luton 1993) to solve the problem of difficult births was a turning point in the annals of midwifery practice. As an example of early obstetric technology, forceps made a significant impact on midwifery. For the first time they enabled births of live babies
who would otherwise have died. As such, this was a significant breakthrough in the problem of difficult births. Only medical-men, however, were permitted to use them (protection of skills and territory, analogous to midwives who guarded their secrets). The Chamberlens guarded their inventions with much secrecy, thus maintaining a strict monopoly over their inventions both for their prestige and to increase their own market control - a market that was restricted to middle and upper class women. Midwives were certainly excluded from using such instruments (Donnison 1977; Towler and Bramall 1986; Wear 1992; Wilson 1995).

The exclusion of midwives from learning to use forceps brought at least three issues to the fore. Firstly, it seriously challenged the institution of childbirth and the role of the midwife within it; secondly, it further undermined the capability of midwives and their ability to learn new techniques. Invariably as women became more and more aware of the capabilities of forceps in the prevention of infants deaths, they would resort to medical help, thereby increasing medical input in midwifery practice. Finally, it assumed that medical-men had superior knowledge and technical skills to midwives (Wear 1992). Indeed Mowbray (1732 cited by Cutter and Viets 1964, p.12) distinguished the special aptitudes of medical-men thus:

> Men...being better versed in anatomy, better acquainted with physical helps and commonly endowed with greater presence of mind, have been always found readier or more discreet to give quicker relief in cases of difficult or prenatal births than common midwives generally understood.

This seems to infer that midwives had fewer capabilities. Referring directly to the use of forceps, Willughby (1863, p.40) stated:

> The midwife's duty in a natural birth is not more but to attend and wait on nature, and to receive the child, and (if needs require) to help to fetch the afterbirth, and her best care will be to see that women and their child be fittingly and decently ordered with necessary conveniences.

thereby defining and restricting the role and the remit of midwives. As described by Witz (1992, p.106)

> the role of the midwife was restricted to "attending" and not "intervening."
This suggests there was a need to create a speciality exclusive to medical-men, presumably with the ultimate aim of serving women's and midwifery's best interests. What was unfolding then was the creation of boundaries (disciplinary boundaries) and the division of labour within the sphere of midwifery. Correspondingly, a differentiation began to emerge between medical-men and midwives. Furthermore, the arguments put forth by Mowbray and Willughby suggest that there existed a competency gap which would militate against midwives preserving their area of employment as female only associated with female culture. Now, it would seem that the lack of midwives' skills and their inability to learn how to use the forceps were overemphasised, and Mowbray and Willughby's arguments are doubtful.

Analysing the problem of obstructed births and the invention of forceps, it becomes more apparent that the medical-men's strategies would lead to social control over midwives, women and childbirth, and the treatment of midwifery as a commodity. Midwives recognised that the problem of obstructed labour was overemphasised and it served as a basis to pathologise the birthing process. The criticism was levelled on two counts. Firstly, the effect of this innovative technology on women and secondly, the real motive of medical-men who were described as a:

Band of mercenaries who palm themselves off upon pregnant women under the cover of their crotchets, knives, scissors, spoons, fillets, speculum matrices, all of which and specially their forceps... are totally useless. (Cited in Carter and Duriez 1986, p 126)

In determining the real effectiveness of forceps, Stephen (1795 cited in Carter and Duriez 1986, p 126-130) asserted that,

since their introduction in the “business of midwife” they have caused more deaths than they have actually saved.

She also recognised that when in difficulty a midwife should call the medical-men, who seemingly faced less criticisms in the event of adverse outcome. Insofar as forceps technology advanced midwifery practice, it was also iatrogenic. Nihell (1760) argued that medical-men misused forceps to expedite birth, impress the family and claim a higher fee. Thus the use of forceps became questionable.
Additionally, the use of obstructed births to classify childbirth as pathology becomes problematical. It is not surprising then that midwives were perceived as a problem - a social, political and economic impediment to the development of obstetrics along the lines members of the profession wished to pursue. (Arney 1982, p 3)

The solution of the 'problem midwives' lay in the development and implementation of institutionalised provision of midwifery care and rationalisation of practice.

So then, this indicates that midwives were opposed to medical-men's intervention in childbirth and had evidence to suggest that it was not always in the best interests of the woman and her baby. But since medical-men were part of the political nexus (Towler and Bramall 1986; Arney 1982; Witz 1992) midwives held little influence in the midwifery struggle. Donisson (1977) points out that some midwives recognised the threat posed by medical-men; they set up their training scheme as a means of improving midwifery practice to prevent the complete medical take over.

**Institutionalisation of Midwifery**

The institutionalisation of midwifery practice is reflected in the emergence of lying-in hospitals in the second half of the eighteenth century. They were founded and administered mainly by medical-men (Verlyussen 1981; Carter and Duriez 1986). Since the general hospitals excluded provisions for childbearing women, the lying-in hospitals were founded to cater for them as a unique group (Wear 1993).

It allowed the medical-men's practice to move from a peripheral position into a more dominant one. The lying-in facilities gave them access not only to the 'abnormal' aspect of childbirth but to the 'normal' as well, thereby breaking the midwives' monopoly over childbirth; invariably midwives became subordinate to them. The problem of obstructed birth necessitated the education of all personnel involved in midwifery practice. The lying-in hospital created a formal environment for the achievement of this objective.
The development of lying-in hospitals was fraught with problems. It engendered competition between medical-men and midwives. Not all lying-in hospitals were served by medical-men; some were owned by charities, but these were obstructed by medical-men who, it would appear, were better able to secure financial support for their own lying-in hospitals (Donisson 1977; Towler and Bramall 1986; Wilson 1995). This also clearly showed the emergence of competitiveness amongst the providers of midwifery service. Under these circumstances midwifery practice became concentrated in medical hands. This also served to divide women into distinct groups; those who were in the higher socio-economic strata availed themselves of the expertise of medical-men, and the lesser group resorted to midwives' expertise (Wilson 1995).

20th century Midwifery Legislation and Midwives' Political Involvement

Midwifery obtained the first legislation in 1902. It followed intense lobbying of the state by midwives. There is an element of paradox in the 1902 Act. On one hand it is symbolic of the end result of the discourse of opposition and on the other it signifies the perpetuation of dominant discourse by the mere fact that it did not emancipate it from medical control. As we showed in the introduction of part two medicine formed part of the dominant discourse.

The Act of 1902 dissociated midwifery from all allied professions and enabled it to evolve as an autonomous profession. It iterated the protection of the public, as part of its justification. The purpose of the Act was to ensure better training of midwives and a more rigorous control system of midwifery practice, which other legislation had not identified. This is reflected in the following:

Secure the better training of midwives, to regulate, supervise and restrict within due limits the practice of midwives.

(The Midwives Act 1902, CH 17)

The major policy in the 1902 Act entailed was indicated by great changes in education, the licensing process and the control of midwifery practice through the establishment of supervision. Whereas previous governmental strategies had been
ambivalent in their inclusion of midwives, their training and licensing, the 1902 legislation consolidated these processes. Education became an important element in the licensing process so that midwives could neither practise unlicensed as they had been accustomed to, nor was it sufficient to learn in the manner they previously used to. Experience of being a mother and, learning by being on the job, were no longer sufficient and the methods by which midwives acquired their proficiency were no longer regarded as legitimate.

The statute, first of all, empowered the Central Midwives Board (CMB) to keep and publish a Roll of certified midwives and to provide training and examinations as a prerequisite for enrolment (Bent 1982). Secondly, it enabled the development of supervisory machinery that would ensure compliance with the CMB's decisions. The ideology of licensing and supervision had obviously developed from the ecclesiastical discourse. Seemingly, the legalisation of midwifery practice eradicated the competition that may have existed between licensed and unlicensed midwives. The Act made provision for all practising midwives to be certified by the year 1910; midwives who were not certified by then were forbidden to attend women in childbirth except under the direction of a medical practitioner. The CMB was also responsible for formulating rules for the practice and training of midwives. Jenkins (1995) points that out the rules laid emphasis on cleanliness in practice. We have here the notion of sanitisation of midwifery practice.

The other major issue that I wish to discuss in the Act is the 'restriction of the practice of midwives' albeit 'within due limits.' What this suggests is that parameters were being drawn to differentiate the midwife's role from that of the obstetrician's. It seems to me that the Act permitted midwifery to develop as an autonomous profession, but it restricted its development. As Wardell (1963) points out, according to the Act, midwives became 'limited practitioners'. Witz (1992, p108) writes:

It was during this period that the division of labour between midwives and doctors, the inter-occupational relations of control between medicine and midwifery, and the occupational infrastructure of midwifery were openly contested.
In an earlier writing, Witz (1988, p56) quoting from the Select Committee on midwives showed that the medical profession had full control over the parameters of midwifery practice. The following quote illustrates the point.

What you want to educate midwives for is for them to know their own ignorance, that is really the one great object in educating midwives.

Midwifery practice was defined within the parameters of normal childbirth; midwives could take professional responsibility as long as the childbearing woman followed the courses of normality. From this orientation the differentiation of childbirth into normal and abnormal can be observed.

In so far that the 1902 Act purported to allow midwifery to evolve as an autonomous profession, it only allowed it to the degree to which it became emancipated from the medical sphere. It did not emancipate it from medical control. This is reflected in the membership of the CMB which consisted of four registered medical practitioners. Initially the Board, set up by the 1902 Act to control midwifery matters, did not include midwives in its membership. Only in the year 1920 were midwives included (Bent 1982; Pritchard 1996). Medical practitioners continued to play a significant role in defining midwifery practice; they were involved in the education and examination of aspirant midwives, a practice that continued well into the late twentieth century.

One would expect that a profession that has fought so persistently to establish its autonomy and independence would have simultaneously a clear definition of the range and scope of its professional responsibilities. Indeed, there exists evidence of a process that has enabled midwifery to develop its strong professional identity (by comparison to other allied professions). Yet, when one searches for the evidence, which would essentially amount to a statement of areas of professional competencies defined by midwives themselves as a way of representing their professional identity, there is little to be found. The 1902 Act legislated the established dominant medical rationality; it reduced the sphere of midwifery practice (Pritchard 1996).
Subsequent Legislation

There has been a number of Midwifery legislations since the 1902 Act, which has mainly consolidated previous ones. The two most significant pieces of legislation since 1902 are, the 1936 Midwives Act and the Nurses, Midwives and Health Visitors Act of 1979. The 1936 Midwives Act was significant in two ways. Firstly, it prohibited unlicensed practitioners as stated in section 17:

A person other than a registered midwife or a registered medical practitioner shall not attend a woman in childbirth. (HMSO 1936: Section 17)

Secondly, it required local authorities to provide a salaried midwifery service (Health Committee Report 1992:VI; Jenkins 1995), which gave all women access to midwifery service. Prior to the 1936 legislation, most women could not afford the service of midwives or doctors- so lay midwives still practised in the back streets.

As the CMB evolved and with further legislation, the Midwives Act of 1951, the sphere of midwifery became more defined through rules protected by statutes and codes of practice. The codes of practice, although not in themselves statutes, were sets of principles upon which practice ought to be based and complied with. The rules regulating midwifery practice and the code of practice, combined detailed principles regarding what midwives could/should and could not/should not do; for instance, they informed midwives when, for instance, they should call a doctor. Additionally, midwives were required to notify the local health authority annually, as still is the case today, of their intention to practise. In the event of practice occurring outside the notified health authority midwives were /are requested to notify the appropriate local health authority. The point here is to illustrate the rigorous mechanism in place as a way of keeping close surveillance of midwives practice; in effect, the policing of midwifery practice.

The 1979 Nurses, Midwives and Health Visitors Act disbanded the existing midwifery statutory regulatory body. It created, the United Kingdom Central Council, a unified regulatory body (for the education and practice of nurses, health visitors and midwives, in England, Wales and Northern Ireland). Once again
midwifery was encompassed in a unified regulatory system. Under the Act of 1979, the United Central Council in collaboration with the National Boards set up rules and a code of practice for each profession, respectively. The rules and code of professional practice are drawn up to reflect the needs of women, thereby appearing to place women at the centre of midwifery practice. For the first time in the history of midwifery, medical practitioners were no longer involved in the regulation of midwives’ policy development regarding education and practice. But the 1979 Act was no less hegemonic. There was a tendency to view midwifery under the generic term nursing. Similarly midwives did not obtain full control to develop as an autonomous profession.

**Governmental Enquiry into Midwifery Services and Policy Development**

It is necessary to examine the part that governmental enquiries have played in the reform of midwifery practice and the organisation of a formalised form of services. This section undertakes a review of the major governmental reports in order to explain the development of the organisation of midwifery services. In all reports, midwifery is referred to as the maternity services. The political strategy, however, was already articulated in the principles of the lying-in hospital - since various committees were set up to look into the provision of midwifery services. This defines the political machinery that was used to reform practice. It is fair to say that the necessity to develop policies in the provision of midwifery services appeared to arise from the concern about high maternal and perinatal mortality. Through the discussion in this chapter, it has evolved that mortality was a major problem. As pointed out by Garcia et al (1990, p 79)

> in the year 1923 and 1926 maternal mortality was the only major cause of death of women between the age of 15 and 40.

Viewed within this perspective, medical opinion held that this could be accomplished through the hospitalisation of childbirth (Garcia and others 1990), although no evidence existed to suggest that this would be so. On the contrary, Tew (1995) argues that hospitalisation of childbirth did not in itself resolve the problem of mortality. The decline in mortalities, as Tew suggests, must be examined in
parallel to what was happening in society in general, which would offer a more realistic picture of the whole scenario.

In the context of the middle of the twentieth century, midwifery reform was significant on two counts. It marked a steady rise in hospital births and intense activity by the government to examine the midwifery services. It appeared that with the steady rise of hospital births women themselves wanted greater access to hospital. Critics of hospitalisation of childbirth (Tew 1995) maintained that the rise of hospital births was due to the fact that women were told the hospitals were the safest places for childbirth. But this issue is not as simple as it may seem. Among the public at large pressure was exerted on the government, which arose from the Women's co-operative Guild, of which midwives formed part, to fund schemes for maternal and child welfare, which amongst many things, included maternity centres with in-patient beds (Donisson 1977; Towler and Bramall 1986; Bent 1983). In response, public funds were made available for the expansion of a similar scheme of lying-in hospitals.

The National Health Service Act 1946

The National Health Service Act of 1946 set in motion a chain of successive governmental enquiries that brought about not only a structural transformation of midwifery practice but opened midwifery to competition. Firstly, the NHS Act made medical care free for all citizens (Bent 1983), a scheme under which childbearing women had access to free maternity care from a doctor as well as a midwife (Tew 1995). It will be recalled that before the 1900's most women had to pay for their own intranatal care. Some women preferred medical services, but only those who were economically able actually availed themselves of medical services (Wilson 1995). This is important as it affects the stance of midwifery as 'women's space' only.

Secondly, the NHS Act of 1946 introduced additional payment for general practitioners who were involved in the provision of maternity care. Eligibility for this remuneration required general practitioners to be on the obstetric list (Bent 1983), which the obstetrical committee was required to set up (Tew 1995). In turn, this aroused doctors' interest in midwifery. Thirdly, the NHS created a tripartite
system, which described services as, shared care between hospitals, local health authority health services and the general practitioners' executive council. However, the tripartite system proved to be problematic both in terms of functionality and economic efficiency. At any given time a childbearing woman could be under all three systems of care, consequently leading to duplication of service (Alexander et al 1995) which undoubtedly raised questions about the economic effectiveness of the NHS scheme.

**The Guillebeaud, The Cranbrook and The Peel Enquiries**

The government's concern over the ineffectiveness of the tripartite system of the NHS Act led to the Guillebeaud enquiry into the organisation of maternity services (MOH 1955) where data were collected from a variety of sources. As evident in the Guillebeaud Report, the organisation of maternity services set up by the NHS was complex; it lacked co-ordination and there was duplication of efforts (MOH 1955). It became apparent that the structure could no longer be considered efficient. Their organisation was subjected to further review. Interestingly enough, it would appear that medical opinion, through the discourse of safety, was the driving force for change (Tew 1995). The following quote asserts the medical and political influence in the organisation of maternity services:

> The college believes that institutional confinement provides the maximum safety for mother and child and therefore the ultimate aim should be to provide obstetric beds for all women who need or will accept institutional confinement. (HMSO 1955 Para 22)

The above emphasised a universal approach to the provision of services for all childbearing women. At the same time, women would retain their freedom to choose the place of birth that was appropriate for them. However, it is not difficult to see how medical opinion could be used in a dialogue of claims for complete governance of midwifery practice.

In response to the recommendation of the Guillebeaud enquiry, the government commissioned yet another committee, under the chairmanship of Lord Cranbrook, to conduct a review of the organisation of maternity services (MOH 1955). In its enquiry the Cranbrook committee examined the structure of maternity
services, the remit of midwives and the position of general practitioner units. First of all it recommended that sufficient beds be made available to provide for a national average of 70% of all confinements to take place in hospital, an average of ten days' stay in hospital and a 20-25% need for beds for women encountering antenatal problems that would require hospital treatment, (which would leave very few homebirths, and therefore selection criteria came into play). This therefore, as the report maintained, called for careful selection of patients for domiciliary birth.

Garcia et al (1990) points out that between the years 1955 and 1965 more maternity beds were made available; the hospital births rate also rose to reach a peak of 80.0% in 1968. In consequence, the increase of hospital birth exceeded the capacity of postnatal beds - a problem that was resolved by introducing early transfer home from hospital. This meant therefore that the role of the midwife took a different turn - from a total provider of care to that of a postnatal nurse. This demonstrates a gradual deskilling process. The expertise of assisting the woman through the birthing process would be lost through erosion.

Relating to the general practitioners' maternity hospitals the following recommendations were made:

General practitioner maternity beds should be situated within, or very close to consultant maternity hospitals or general hospitals with maternity departments. A consultant obstetrician should have overall responsibility for supervision of general practitioner maternity beds.

(HMSO 1959 Para 70-71)

This suggests that the need for expert knowledge and skills was an absolute necessity. Inevitably this placed the consultant in a lead position. It also set in motion a sequence of supervisory activity and initiated a strategy that would make midwifery practice centripetal. In a similar way the role of the midwife was examined and her role acknowledged in that the report stated that:

A midwife should be given opportunity to participate in the maternity care of her patients to the fullest extent to which her skills and experience entitled her.

(HMSO 1959 Para 107)
This seems to suggest that midwives would be working in parallel to general practitioners and obstetricians. As a paradox, however, the Cranbrook report recommended that a:

general practitioner obstetrician should, wherever possible, attend all domiciliary confinements; to safeguard the mother and the baby against unforeseen emergencies...The conduct of a normal confinement is the joint responsibility of the doctor and midwife.

(HMSO 1959 Para 212).

This has far-reaching implications for midwives. The question arises that if a midwife has been deemed competent by the training institution and examining body, why should she not be trusted to the job that she has been trained for? It would seem that childbirth itself was a feared entity by professionals. Undoubtedly as the above quote suggests the midwife would no longer do the job that she had been doing for years without expert assistance, albeit on standby.

It is important to analyse the sources of evidence of the Cranbrook report. As observed in the literature evidence was collected from a variety of sources but interestingly enough yet again the safety issue, held by medical opinion, featured in a strong way. But to meet the countervailing argument of those expressing a differing opinion, it explains why only a 70% hospital births was recommended which at least leaves the impression that the natural process was not totally interfered with.

However, the Cranbrook recommendations led the state enquiry into maternity to two other levels - that of the 'future of domiciliary services' and the question of bed needs for maternity patients (Tew 1995), with which the Peel committee was commissioned, and the provisions of special care for the sick newborn which was undertaken by the Short committee in 1980. In order to grasp the implications of the Peel report and that of its predecessors, the following perspective needs to be critically analysed; location of birth, the changing role of the midwife, the emergence of medicalisation and ultimately the shifts in paradigms.

Based on the same source of evidence as the Cranbrook report and methods of enquiry the Peel report advocated the following:
We considered that the resources of modern medicine should be available to all mothers and babies, and we think that sufficient facilities should be provided to allow for 100 percent hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective...Medical and midwifery care should be provided by consultants, General Practitioners and midwives working as a team...Small isolated obstetric units should be replaced by larger combined consultants/General Practitioner units in general hospitals. In the latter units, all beds and facilities should be shared. (MOH 1970 para 230)

Undeniably the state orientation as made manifest in the Guillebeaud, Cranbrook and now the Peel report held that hospital was the safest place for women to give births. Given the debate that occurred in preceding state enquiries, it could be argued that the sequence of their occurrence was simply to further the goal of transforming midwifery into a recognised field of practice, governed by experts (doctors) in that field. However, it is important to note that the Peel committee mainly constituted obstetric expertise and therefore was only representational of medical opinion and cannot be accepted as representing the whole midwifery population.

The Peel recommendation was implemented and by 1974 hospital and domiciliary midwifery were fully integrated. However, women still retained the choice of giving birth within their own home, but generally speaking birth had now become medical space. But it is important to note that long before the implementation of the Peel recommendation the hospital birth rate was steadily increasing, reaching 80.08% in 1968 (Alexander et al 1995). By inference, therefore, women themselves had a part to play in the development of hospitalisation. This may be due to the fact that, on one hand, women had been socialised into thinking that hospital was the best and safest environment and that it outweighed the benefit of domiciliary confinements. But on the other, paradigms began to shift. It is important to note that all the reports emphasised some form of continuity of care for the woman, although it was not their prime concern.

Since the involvement of the state there has been a repeated need to review maternity services with the aim of improving practice. Following the Peel implementation, the Short enquiry was another major review into maternity services.
The main focus of the Short report was the reduction of prenatal mortality. Like the other reports, it endorsed the ideology of hospitalisation and went further to state that women should give birth in larger units, improved selection for smaller units (consultants and GP units alike) and phased out homebirths. It paved the way for centralisation of the place of births, essentially a universal approach to the conduct of childbirth. Amidst the many recommendations the Short report recommended mandatory antenatal care, emphasised some form of continuity of care and 'humanising obstetric care' (HMSO 1980, p. 36). It also expanded the field of midwifery to include neonatal care, which meant involvement of a different aspect of medicine. Here we observe the creation of yet another labour force.

The Peel report also established The Maternity Services Committee. Led by Allison Munroe, the Maternity Services Committee produced a three-part report entitled Maternity Care in Action, (1982; 1983; 1984). This report addressed antenatal, intranatal and postnatal as discreet sections and made recommendations accordingly. Not dissimilar to the preceding reports it emphasised continuity of care and the provision of flexible approaches. It in also interesting to note that Maternity Care in Action specifically addressed the role and the remit of midwives because, although the previous report had advocated preservation of the midwives role, in reality as hospitalisation had taken shape, the role of the midwives had become blurred. It became apparent also that midwifery skills were lost and midwives, unlike in the recommendation of the Peel report, to work as teams with obstetricians, had been reduced to doctors' assistants. The Maternity Care in Action challenged the underutilisation of midwives. Equally important, it recommended the acknowledgement of consumers’ views.

**Contemporary State Policies**

The NHS Act of 1990 expresses the state’s intentions to shape public health, of which maternity forms part, on the principles of free market economy and consumerism (HMSO 1990). The document made a number of reformist proposals that situates midwifery within the economic discourse. It included the creation of an internal market, which brought radical changes within the health system. The
implications of the introduction of market economy theories in the running of health services are considered. On one level this entailed funding of services directly from Regional Health Authorities and District Health Authorities (Jenkins 1995). Whereas in the previous statute, past funding was automatically transferred to each hospital, the NHS Act of 1990 required care to be purchased. Furthermore before funding was given, agreement has to be reached about the level of service to be provided (Jenkins 1995).

This entailed a new configuration of the services in the form of purchaser-provider through which health care was sold and bought. The providers of health care were all health institutions, which became known as NHS Trusts. Essentially through the scheme set up by the NHS Act of 1990, services would be purchased and regulated by a mechanism of contractual agreements, and arrangements. The implications therefore for midwives are that they must comply with contractual specifications. Invariably issues of performance, economic efficiency and skill/competence became paramount.

All NHS Trusts were conferred autonomy to run their own affairs. It set each trust in competition with others since with the purchaser agreement, it meant that the buyer of service may 'shop' around for better services both in terms of quality and calibre of staff. Women through their general practitioner could exercise power and freedom to purchase midwifery care at an institution that would offer care tailored to their needs. The ideology of the NHS Act of 1990 sought to institute a culture of pure consumerism where services are tailored as commodities and provided by personnel who are expected to function as efficient providers to meet the specification of articulate consumers (Mason 1993). This indicates that the values of the commercial world were increasingly to be found in the midwifery.

Breaking the transference of free market economy down to operational level, midwives are redefined as service 'providers' and the women availing themselves of midwifery services as 'consumers'. This carries with it all kinds of implications. One that is foremost is consumer satisfaction or the lack of it. In thinking of health care as service, there is a danger of considering it as a product, which in effect is what we
have observed in the last decade. The determining principles of commodification that underlie this situation redefine traditional client-professional relations as consumer demand and provider obligations (Mason 1993).

It is essential to consider this background since it puts women in a position of looking at provision of care seriously. It seems the NHS Act also provided opportunity for midwives to develop their practice (Jenkins 1995), at least in theory.

Since the new NHS Act of 1990 the other major reports influencing the policies of maternity services have been the Winterton report of 1992 (The House of Commons Select Committee 1991) and Changing Childbirth (report of the Expert Maternity Group 1993). In 1991, the Winterton Committee of enquiry was appointed by the government to undertake a comprehensive enquiry into maternity services (Tew 1995), which included preconception care, antenatal care, and intranatal and postnatal care. Evidence was gathered from a variety of sources that included key professionals, consumer groups and women as users of the maternity services (HMSO 1992; Tew 1995) in place at the time of the enquiry.

Based on the premise that healthy mothers and babies are the product of a generation of healthy parents’ (HMSO 1992, p.41) the Winterton report expressed the correlation of poor health and, unsatisfactory outcome of pregnancy with the low socio-economic status. The report suggests that the explanation of maternal and perinatal mortality emphasised in other reports, could not be attributed to the place of birth or competencies of midwives. As such it challenged the rationale of the 100% hospital births advocated by the Peel recommendation and the long-held assumption that safety was the main reason for it. The report stated that:

the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety...It is no longer acceptable that the pattern of maternity care provision should be based on unproved assertions...The phasing births taking place at home or in small maternity units was misguided and regrettable.  

(HMSO 1992, p. 33 and 76).

From this debate it could be observed that, the medical rationality and dominance over childbirth and midwifery practice, for the first time, was being significantly
challenged. Coming from the perspective that hospital births were no safer than home births; it suggests a return to the "old system" of the past. It advocated an acripetal approach to reform.

The Winterton Committee findings, all of which are mounting evidence militating against the pervading medical paradigm, made ninety recommendations. It is inappropriate to examine all of them. The main tenets of the Winterton recommendations can be summed up in three categories. Firstly, it emphasised the need for women to have continuity of care, choice of place of births, to be involved in decisions about their care, and for women experiencing a normal pregnancy to be cared for by a midwife (Green et al 1998 HMSO 1992). Secondly, the Committee viewed maternity services in a wider social context. Juxtaposing the statement about the correlation of poor health, unsatisfactory outcome of pregnancy and low socio-economic status, the committee recommended measures with a wider socio-economic significance.

The third and final tenet is the recognition of professional boundaries between doctors and midwives, their associated problems and conflicts- the resolution of which the committee urged respective colleagues to attend to them. (HMSO 1992). However, arriving at a time when the state's policy was geared to reducing public spending, its economics did not harmonise with the state's general economic programmes. Nonetheless, as part of its response to the Winterton recommendations, the state established the Cumberledge Expert Committee to review current policy on care provided for women during childbirth and to make recommendations for change (HMS0 1992). The Committee's remit was to consider various options/arrangements for care, including homebirths. The report of the Executive Committee entitled 'Changing Childbirth' seemed to place the woman at the centre of maternity care. Based on choice, control and continuity, changing Childbirth places control firmly with women.

Women should become actively involved in the planning and delivery of maternity care, and that a flexible service be provided to meet their needs.

(HMSO1992, p. 214)
This is also combined with the idea that women should exercise individual choices. At a glance it appeared the ‘Changing Childbirth’ might revolutionise maternity care and midwifery practice, but upon closer examination it becomes obvious that it was another instrument in the political machinery to keep the governance of midwifery within the medical professional sphere. In contrast to Winterton’s report, ‘Changing Childbirth’ placed primacy over safety as the bedrock of maternity care (Tew 1995), consequently supporting the Cranbrook and Peel’s ideology. As such it thwarted the Winterton recommendations for radical reform. Whilst it acknowledged that midwives should take more responsibility for the care of women experiencing normal pregnancies, it did not significantly address the boundary conflict or social dimension identified in the Winterton report. By reinforcing the safety argument rather than critically examining its justification, Changing Childbirth perpetuated the medical view and medical governance of midwifery practice. It lost an opportunity to differentiate midwifery from obstetric practice. This leads me to question whether we are practising midwifery or obstetrics. However it is also essential to recognise that the changes brought about by the political discourse was concerned with the professionalisation of midwifery. Whilst important to the discussion of knowledge professionalisation is not discussed in depth in this study. Only a brief discussion is undertaken here. We can articulate six principles upon which a profession is based. These are:

- Possession of skill based on theoretical knowledge defined by a particular view of correct knowledge and ethicability.
- Provision of education and training to acquire knowledge and develops skills.
- Testing of competence of members.
- Organisation.
- Adherence to a code of conduct.
- Occupationally defined public service.
Jarvis (1983, p. 28) further suggests that Professionalisation is about

Commitment to the occupational organisation and decision to be a master of the knowledge and a skilful provider of service stemming from the knowledge upon which the occupation is based.

As this study evolves we shall see that the centrality of the development of midwifery knowledge is based on the above ideology of professionalism which has been significantly influenced on the one side in a state-national reliance on legitimation to develop midwifery for the service of the public and on the other, by sociocultural changes occurring in the wider society.

Conclusion

This chapter describes the changes, which occurred in midwifery practice as shaped by political ideologies both within the macro and micro perspectives. As observed throughout this discussion, there has been a growing shift in perspective, away from an exclusively women-centred, towards a more universal profession-orientated phenomenon. In this process "difficult births" have almost been a dictum that decided the direction of midwifery practice. This can be observed in the legislative control, development of state, the performability of practitioners and the role of midwives in midwifery practice. The gravity of difficult births justified the need for reform. Out of this debate arose the notion of safety - a notion held by medical opinion. Indeed safety became a crucial factor in determining the future of midwifery practice and the evolving paradigms. Inevitably "difficult births" reinforced the dominance of a specific medical perception of childbirth and how the birthing process ought to be conducted. Unmistakably, medical-men have been instrumental in the transformation of midwifery practice. Through the organisation of institutionalised places of birth, medical control of childbirth and midwifery practice have moved from a peripheral position to occupy a central and hierarchical position.

A major driving force in shifting midwifery along the medical paradigm has been the emergence and implementation of state policies, which were drawn from
state appointed committees to enquire into maternity services. In examining early state policies we have seen the building of a midwifery practice based on the development of large institutions, which have resulted in the collapse of other forms of midwifery services. Most significantly the 100% hospital birth advocated by the Peel report brought about the collapse of domiciliary midwifery practice (home births). The wider implications of the collapse of domiciliary midwifery are seen, firstly, in the dislocation of the place of birth, thereby distancing women from their own space, their social context of childbirth longheld and established through history. Secondly, it distanced midwives from their space as well and dissolved their area of practice and their autonomy.

The implementation of early state policies created a hierarchical and patriarchal structure in which power and control were conferred on medical-men. The consultant obstetricians were given ultimate control over midwifery and all professionals involved with it. The recommendations of state reports prescribed an organisational framework for midwifery practice- a framework that differentiated the roles of the consultant obstetricians, the general practitioners and the midwives and as such established boundaries. It placed midwives at the margin. In short governmental policies placed birth in medical space and created a kind of medical imperialism and hegemony.

The recent state policies situated midwifery within the economic discourse, which has brought radical changes to midwifery practice. As stated at the outset of this chapter, the political discourse is multi-relational, involving power, authority and government- effectively a framework which shows that decisions on the organisation of midwifery continuously involves political judgement and political choices. Political judgement and choices should have been and should be a coalition between women and midwives but as it has evolved women and midwives were left out. The state, influenced by medical opinion, took responsibility for the reform of midwifery practice. Finally, the political discourse set the development of midwifery practice along secular lines and raises another set of questions. What effect has governmental change on the nature of midwifery practice? Has it altered the meaning of childbirth? If so how? How has it influenced the construct of midwifery?
Why did the political discourse not consider the wider social aspects of childbirth and midwifery?
CHAPTER FIVE

The Medico-Scientific Discourse

Introduction

The analysis of the political discourse, in the last chapter, explained the processes involved in the development of midwifery as a field of practice. This development has given rise to the establishment and growth of institutions, which have dislocated the place of birth from the woman's home and situated it in the medical space. The central principle, as I have highlighted, is about governmentality, which can be described as a mechanism of power and control over childbirth and midwifery practice, in the form of a system of surveillance.

This chapter takes the analysis of the development of midwifery practice further, by proposing to examine firstly how it became a scientific construct, and secondly, to explore the association, and pervasive relationship, of medical science with the control and the surveillance of childbirth and midwifery practice. I outline the schools of thought that have influenced this perspective and I analyse the impact of the full realisation of the medico-scientific discourse on childbirth and midwifery practice; that is, how it has altered the conceptualisation of childbirth and defined what midwifery knowledge constitutes, and how it has shaped the practice of midwifery. Fundamentally this chapter suggests that there are some questions to be raised about the discourse of medical science, the methods and the criteria it has used to develop its own knowledge and how it became deeply embodied in midwifery practice.

This chapter is divided into six sections. Section one considers why it was thought important to create a scientific framework within which midwifery ought to be understood and practised. It outlines the epistemological bases of medical rationality. In section two I trace the roots of scientific knowledge, and address what
it constitutes. Section three discusses the basis of scientific knowledge. Section four addresses the emergence of institution-based specialities and their interdependence on science. Section five considers the implications of scientific management of childbirth. Finally, section six addresses the criticism of the medico-scientific discourse.

Situating Childbirth and Midwifery Practice Within the Discourse of Science - the Medical Debate.

Evolving in the late seventeenth century, the medico-scientific discourse is about the establishment of scientific rationality. Central to its development, as in the previous discourses, is the concern over the safety of women and their infants (Tew 1995) - a notion that has pervaded midwifery practice to this day. In order to stress the ways in which scientific and medical ideas and practices, in the context of midwifery, are shaped, it is essential to conceptualise the processes through which this happened. The justification to "scientise" midwifery rests on two main premises: first, it is based on the assumption that midwives were ignorant and they used witchcraft knowledge as one of the main principles in the conduct of childbirth (Aveling 1977; Forbes 1964). Second, it is based on the morbid phenomenon of difficult births, which were linked with the care and skill of the midwife, rather than socio-economic deprivation (Wilson 1995). This led medical-men to associate childbirth with risk and danger (Lupton 1993), thereby disempowering women and midwives (in that women would lose control over childbirth and midwives would lose control over midwifery practice). These two premises initiated the process whereby childbirth, a domain of life, came under the aegis of medical practitioners/medical theories/science (Jordanova 1995).

In keeping with the notion of risk, danger, and midwives alleged deficient know-how; the medico-scientific discourse legitimised the necessity for medical-men’s intervention that claimed to have the necessary expertise (Aveling 1977). Indeed, it is the combination of expertise, competencies and their transmission that gave medical-men a high degree of clinical autonomy and authority over midwives and women. Inescapably, childbirth became the subject of medicine and medical
surveillance, monitored by and centred on technology (Oakley 1992; Jacobus et al 1990). This became a model of progressivity in which medical know-how, based on scientific rationality, is dominant. In order to solve the problem of midwifery, the medico-scientific discourse placed primacy upon the development of scientific and technological expertise.

As discussed earlier the main form of medical encounter with childbirth related to difficult birth, specifically protracted labour (Wilson 1995). It is clear that the fatal consequences suffered by women and their infants created a disquieting and perturbing view of childbirth and midwifery practice. Midwives were inculpated as the instigators. Although they were not unaware of the nature of the problem, seemingly, they did not have the "know-how" to deal with such complications (Spencer 1928; Radcliffe 1967; Aveling 1977). Historical literature is replete with midwives' alleged hazardous practice; the following quotes, not only capture the magnitude of the problem, but also mount a compelling argument for the necessity to improve the understanding of childbirth and midwifery practice:

Many fatal consequences have happened to women and to their children, through the ignorance and unskilfulness of midwives in this country and city, who enter upon that difficult sphere at their own hands, without the least trial taken of their knowledge of that principles upon which they are to practise that art.

(Edinburgh Town Council "Town Council Records" 9th February 1726, cited by Hoolihan 1985, p.39)

The midwife was a woman of inferior education. Her opportunities of obtaining written or oral instruction in midwifery were very few, and consequently nearly the whole information must have been gained by experience, often, it was found at the expense of the poor women she sought to succour.

(Aveling 1977,p. 1)

Interpreted in humanistic, as well as in professional terms, it is indisputable that the necessity to reform midwifery, scientific or otherwise, was not only justified, but imperative, both on a practical as well as epistemological front. Nevertheless, the question about the kind of evidence to sustain the claim made by medical-men in the above quotes, arises, and warrants closer examination. On the surface it would
appear that the problem lies with the insufficient education of midwives, and the juxtaposition of competence and caring, but in reality this was making significant inroads into the scientisation of midwifery practice. Unquestionably the issue of performability surfaced as a ground to advance the medical debate.

Aveling's argument is problematic; his orientation seemed to imply that experience could not be given the same status as theory. By inference, therefore, theory was by far the more appropriate method of learning. Experience, consequently, from that perspective, was not a valid way of learning how to practise midwifery. Thus from the outset scientifically derived knowledge is seen as different to and better than the knowledge that arises through experience (Cervero 1991). This is in direct contrast with Donisson’s (1977,p.11) view "that experience is the best teacher". Habermas (1978) argues that it is necessary to understand the activity of the knowing subject and maintains that the knowing subjects play an active role in constituting the world they know. Yet Aveling’s method of education, which dissociated the woman as the knowing subject, still prevails.

Deriving from the notions of difficult births and midwives’ alleged ignorance and incompetence, however, the medico-scientific discourse has problematised midwifery practice. It has construed childbirth as "pathology"- a view that has brought profound transformation to the conceptualisation of childbirth and consequently, midwifery practice. Viewing childbirth as pathology, the medico-scientific discourse placed primacy upon the development of scientific and technological knowledge, and delegitimised experiential knowledge, thus directing midwifery along a bio-medical paradigm, which emphasised bio-physiology and technology as its main tenets. In so doing it has oriented the midwifery practitioners towards specialised lines. The section that follows presents the development of scientific knowledge within the positivist schools of thought and confirms the centrality of anatomy and physiology in the medical paradigm. It also demonstrates how normal anatomy and physiology and pathology have become indistinguishable in the medical worldview.
Towards the Construction of a Scientific Knowledge Base.

Creating a scientific foundation for midwifery practice has been a slow process until the twentieth century, when a marked escalation has been observed. The scientific basis of midwifery describes knowledge that has been developed from observing midwives' practice. This knowledge has been expanded in the search for an explanation to the morbid phenomenon of difficult births. Emanating from the Greek, Roman, Arabic and French schools of thought, the scientific base of midwifery, as it was known then, centred primarily on anatomy, bio-physiology and the anatomo-physiological as an explanation of the processes of childbirth (Moscucci 1990; Lupton 1993; O'Dowd and Phillip 1994). This was later expanded to explain dysfunction in that process. The implication of the expansion of the knowledge of anatomy, in the context of midwifery, has been largely unexamined, at least to my knowledge.

The most significant work relating to the scientific basis of midwifery is found in "Soranus Gynaecology", which details the bio-physiological basis of childbearing. This Soranus considered, important for midwives to learn. Additionally, "Soranus Gynaecology" specifies the characteristics and distinguishes two types of midwives, thereby creating a hierarchy. Soranus also issued a code of conduct and gave the principles for practice, based on science rather than superstition. Soranus (Temkin 1956, p.27) asserted:

The midwife will be free from superstition so as not to overlook salutary measures on account of a dream or omen or some customary rite or vulgar superstition.

An authority in the scientific development of midwifery, the work of Soranus became a model, which oriented the bio-medical paradigm in which contemporary midwifery practice and midwifery curricula are contextualised. The major work in anatomy, however, is found in the work of Galen, which, regarded as the absolute truth, has dominated the field of medicine until the advent of the enlightenment - a period which engendered an "enquiry mode of thought". Thus fundamental questions about the existing medical knowledge were raised (Donisson 1977; Towler and Bramall 1986; Lupton 1993; Jordanova 1995). The Galenic theory of anatomy,
derived mainly from studies of animals, was rejected; this led to new investigation, on the proposition that the truth could only be reached by "dissection of human bodies" (Vesalius, cited Carter and Duriez 1986, p. 99). Once this proposal was implemented, it wrought radical changes in the generation of knowledge and in particular in advancing medical knowledge. However, dissection of human bodies was opposed by the church because it was viewed such practice would secularise childbirth. For proponents of scientific development it was regarded as impeding progress (O'Dowd and Phillip 1994).

Whilst it is not the intention of this section to enter into the minutiae of the development of the knowledge of anatomy and physiology, it is important to understand its significance and how it altered the meaning of childbirth and all the practices surrounding it. The first evidence of the anatomical structure of the human pregnant uterus, in the form of an atlas or other artistic representation, was produced by the famous artist Leonardo da Vinci (Cater and Duriez 1986; O'Dowd and Phillip 1994). Da Vinci's work stood between ignorance and medical knowledge, in the sense that it provided a means of interpreting the woman's reproductive anatomy, of seeing its form and nature and establishing its reality; which Foucault (1973, p.107) described as a "clinical gaze", thereby opening the subject to scientific investigation and research. This underlies the importance of medical discourses and shows its centrality in the evolution of the medico-scientific discourse. Poignantly, Armstrong (1983) maintains, the reality of the body is only established by the observing eye that reads it. This suggests it is a matter of interpretation.

The Exponents of Scientific Knowledge and Their Influence on Midwifery Practice

The theme of this section is by no means original; nonetheless, in my view it merits attention, because it has become a body of knowledge taken for granted which demands critical review. Foucault (1973) places the relationship between the knowledge of anatomy and power firmly on historians' agenda and raises our awareness of its implications on scientific investigation and research. One of his most influential ideas has been the "clinical gaze". In his account he postulated a
Chapter five: The Medico-Scientific Discourse

historical discontinuity and a radical shift in medical power. The crucial factor in creating new anatomical knowledge, expressed through the "clinical gaze" was the classification of pathology, which, is illustrated in the explanation of the phenomenon of difficult births and later discovery of all kinds of pathological conditions.

The clinical gaze described by Foucault led clinical thought towards other forms of correlation between anatomy and physiology in the attempt to explain the nature of childbirth. Eminent British medical-men, such as William Harvey (referred as the father of midwifery), Percival Willughby and William Hunter made great impact in that area of knowledge (Donisson 1977; Towler and Bramall 1986; O'Dowd and Phillip 1994).

Adding to the existing corpus of the scientific base of midwifery knowledge, Harvey introduced two theories: first, fertilisation and development of the embryo, second, the physiology of labour (Spencer 1928; Radcliffe 1967; Towler and Bramall 1986). Whilst his first theory is valid and one which has engineered screening programmes as well as health promotional programmes as a means of safeguarding the fetus against hazards during this crucial stage of life, his second theory which considered the physiological process of birth, produced a generalisation.

Based on his practical experience and on his study of animal embryos (chicken embryo to be precise), Harvey's theory of embryology presented two main ideas: the process of differentiation and growth - a theory that has contributed to the understanding of normal as well as dysmorphologic development of the fetus and the relationship of environmental and drugs related factors to dysmorphology. His second theory postulated that the process of labour was initiated by the fetus (Spencer 1928; Radcliffe 1967; Towler and Bramall 1986). His thesis suggested that the "time of starting labour was induced by the failure of the liquor amnii to nourish the fetus anymore" (Radcliffe 1967, p 17). Though not unaware of the contractile nature of the uterus observed during labour, Harvey drew on the findings of his
study (which showed that the chick, not the mother, broke its shell to emerge to new life) to support his thesis, thereby aligning human and animal physiology.

Furthermore Harvey's theory dissociated the symbiotic relationship of the fetus and its mother, therefore negating other explanations, such as the role of the maternal and fetal physiology as a functioning unit in the process of birth. The end point of this analysis is the mode in which reality was being presented, depicting the concept of fragmentation (Foucault 1970). Clearly it rested on his interpretation. Inevitably, this raises questions about the way scientific knowledge was constructed and equally important how it was utilised. Notwithstanding this is a strand that opened up spaces for further scientific exploration.

Willughby (1863) described certain pathological conditions of childbirth such as haemorrhage, convulsions and their association with causes of maternal and infant mortality (Towler and Bramall 1986). Interestingly he observed that midwives used interventions, which he claimed, contributed to pathological turn:

There have been some midwives, who, through ignorance or impatience, or being hastened to go to some other woman's labour, do tear the membranes with their nails or scissors and let forth the waters, to the great hurt and danger both to the mother and her child (Willughby 1863, p 21).

Deriving from this perspective Willughby advocated the education of midwives as a means of resolving this problem. Another and equally influential medical theory in the field of development of female reproductive anatomy and physiology exemplified in the work of Smellie, which opened new frontiers in the scientific development of midwifery (Radcliffe 1967; Arney 1982; Garcia et al 1990). Smellie's area of study constituted mainly, the measurement of the pelvis, the fetal head, and the correlation of the fetal head and the pelvis. From these findings, Smellie explained the manner in which the fetus passed through the pelvis to be born, essentially what is known as the mechanism of labour. Additionally, Smellie discovered pelvic deformities as a cause of dysfunction of the natural course of labour (Radcliffe 1967; Arney 1982). This yielded new insights into the aetiology of difficult births and pathological anatomy - a notion that shaped medical ideas of antenatal and intranatal surveillance.
In applying this theory to the development of midwifery practice, Smellie undertook to transmit his knowledge to all midwifery practitioners, doctors and midwives alike. He maintained that:

Students should be perfectly taught the art and practice of midwifery and performance of deliveries of all kinds even the most difficult with the utmost decency and dexterity by means of a contrivance made on the bones or skeleton of a woman with an artificial matrix (of glass), whereby all the inconveniences which might otherwise happen to women from pupils practising too early on real objects will entirely be prevented: for by that method and contrivance each pupil will become in a great measure proficient in his business before he attempts a real delivery.

(Smellie 1752 cited in Radcliffe 1967, p 87)

In addition to the above, Smellie's educational programme included:

A course of lectures on theory and practice of midwifery wherein all the branches of that art would be fully explained, and the whole illustrated with proper machines so contrived as to represent real women and children. (Smellie 1752 cited Radcliffe 1967, p 92)

At this juncture, the emergence of formal education to prepare midwifery practitioners to serve the childbearing woman better than by practical experience alone could be observed - an ideology that prefers simulation to enable learners to develop skills and knowledge in a contrived environment, where mistakes likely to be made would not affect women's lives, as it was claimed to have done (Aveling 1967). Accordingly, learners were being socialised in a way exclusive of the reality of everyday life situation.

In support of learning in real life situations Stone, a prominent midwife of the early eighteenth century (Donisson 1977; Towler and Bramall 1986; Wilson 1995), claimed that this new "professional socialisation" was insufficient to learn the required skills for practice. She asserted that medical science and its educational strategy had little capacity in providing learners with the experience, knowledge and skills, that could meaningfully be found in real life situations. Using the example of her personal training, Stone (Towler and Bramall 1986) emphasised that skills for midwifery practice needed to be acquired through apprenticeship, having been herself an apprentice to her mother for six years. Antithetical to Aveling's
perspective (in which practice, as illustrated in experience was pushed into insignificance) Stone's concern about medical educational strategy opened up the issue of pragmatic knowledge, which needs to be the focus of any education, be it medical or midwifery. Invariably then not only scientific but pragmatically knowledge as well ought to underpin practice.

Returning to the development of medical theories, William Hunter expounded the concepts of human reproduction and suggested how those should be taught (Towler and Bramall 1986; O'Dowd 1994; Arney 1983). Hunter's ideas about anatomy and physiology were shaped by his institutional situation and by his collaboration with other medical men, students, artists, printers and engravers (Jordanova 1995). Through the concepts of human reproduction, a different form of dealing with childbirth would emerge (Garcia et al 1990), in the form of monitoring pregnancy through various screening programmes, technology and regular attendance of antenatal clinics. Numerous textbooks have been since published in this area.

Essentially the concentration of anatomy and bio-physiology reflects the growing relationship of midwifery to medicine, and its transformation into a speciality for doctors, which is referred to as obstetrics. This has resulted in the medicalisation of childbirth (Arney 1982; Witz 1992) - a process aided by hospitalisation. The axial principle of scientific development, however, was maternal mortality and morbidity which was used as an index of the effectiveness (or lack) of the care of childbearing women. Therefore medical theories in the form of anatomy and physiology, to some extent, explained certain elements in the process of childbirth and subjected it to further scientific investigation. However, the ideas of medical science at the time became conflated with those of scientific management. It is also important that at this stage in medico-scientific discourse, early medical theorists attested to non-interventionist approaches, except in absolute cases (Willughby 1863; Carter and Duriez 1986; Towler and Bramall 1986; Hoolihan 1985) in that sense, a clear distinction between normality and abnormality was retained. Fundamentally they upheld the concept of birth as a natural event in women's lives. However, the development of midwifery practice along medical
thought has not always upheld this precept. This is because as the understanding of the physiological process deepened so did the necessity for intervention. These are illustrated in induction and augmentation of labour by surgical means and/or with the use of drugs.

**Shaping Midwifery Practice and Midwifery Knowledge as an Institution-based Speciality - twentieth century development.**

This section focuses on the development of institution-based medical specialities, in which reform activities, in terms of scientific development of midwifery, are examined. It addresses different forms of specialisation within the academic, medical realm, as functional division of labour, which divided medical work into procedures performed by a range of personnel. The division of labour changed the work of midwives and required a multiplicity of personnel to care for the woman during the whole childbearing period. The concept of medical science described in the previous section was shaped by the hospitalisation of birth, which offers an interpretive framework for understanding the transformation of childbirth and midwifery practice into an institution-based specialism. In the context of institution, the way childbirth was viewed and experienced changed radically.

Emerging in the eighteenth century, institution-based midwifery expanded rapidly in the mid twentieth century (Garcia et al 1990). It derived its significance from pathological perspective. In the context of total transfer of birth in institutions (medical space) scientific knowledge was also expanding on the basis of encounter with normal as well as abnormal birth, of which the latter up until then was the most common type. Following the Peel report's recommendation of total hospital birth and the resources of modern medicine to be made available to all mothers and babies (HMSO 1970, p. 23), the midwifery profession has witnessed the emergence and growth of a plethora of medical and scientific disciplines, such as radiology, anaesthetics, ultrasonography, perinatal medicine and reproductive technologies. These disciplines are specialities in their own right; as such they contain special, expert knowledge. They have had a far-ranging influence on midwifery practice in that they have given childbirth a new meaning, further distancing it from its socio-
cultural values by replacing it with scientific ones. They have fostered the growth of multidepartmental/multidisciplinary collaboration in dealing with childbirth. Such specialisation (reciprocally) fostered the rapid growth of technology, thereby raising the scientific status of midwifery and mechanising it, which early medical theories sought to establish.

\textit{The Development of Technology}

Initially, technology was developed to deal with pathological conditions of childbirth. In its rudimentary form it was constituted of instruments such as forceps, which were first invented by Chamberlen and expanded later by others (Donisson 1977; Carter and Duriez 1986; Towler and Bramall 1986; Wilson 1995). By the early twentieth century the use of technology was developed for diagnostic, surveillance and therapeutic purposes. Starting with the X-ray machine, which was used to detect pelvic dysfunctions, pelvic measurements, correlation of fetal head to maternal pelvis and later diagnosis of multiple pregnancies, today's technological progress amongst a very wide range, involves sophisticated techniques for surveillance. Examples of these include ultrasound, electronic fetal monitors, amniocentesis, fetoscopy, and antenatal-screening procedures. Over the past two decades new technologies in the form of reproductive technologies to assist in human procreativity, have emerged. This has offered solutions to fertility problems that some women and men face. But it has placed childbirth as a commodity, not only in the economic market place but also in the ideological and social market place (Sawicki 1991). There is access to a variety of reproductive services made available to women who may afford these services to choose to get pregnant by artificial means. Such is the capacity of technology. To illustrate the point a brief examination of ultrasound technology, electrical fetal monitoring and anaesthetics is undertaken.

Radiology superseded by ultrasonography expanded the clinical gaze described by Foucault (1973) by visualising the fetus alive in utero, thereby permitting investigation into the minutiae of its anatomy and physiology (Garcia et al 1990). As well as making possible diagnostic and therapeutic measures, such as fetoscopy, amnioscopy, amniocentesis, chorionic villus sampling (Wagner 1994) it
has placed emphasis on fetology. In providing a 'window on the womb' ultrasound has enabled doctors to penetrate the women's internal space—knowledge that was once hers alone. This has articulated a new view of pregnancy. The pregnant woman is viewed as two persons and treated as such: herself and her fetus (Gregg 1995). The well being of birth is considered exceedingly important; any deviation by one or the other necessitates closer surveillance and the necessary action taken accordingly. In so far as ultrasonography has advanced fetal medicine, it has thwarted pregnant women's autonomy. Gregg (1995, p 25) asserts that:

A focus on the fetus is a focus on the product, not on the process of pregnancy. When the process is de-emphasised, the woman's role is too.

With such a mechanistic view, the notion of the body as a machine emerges (Wagner 1994; Foucault 1973). Unmistakably women lost control over childbirth, although it would appear that the majority of women are not conscious of that fact. However visualisation of the fetus in its internal environment cannot be seen only as the vantage point of scientific development; women have wanted and still want to see their unborn and to have the certainty of normal development (the notion of perfection). It is thought that this enables women to bond with their fetuses. Women were inculcated with different values.

Electrical monitoring in labour, which has become the norm, enabled a different form of surveillance. Information transmitted through a cardiotocograph indicates how the fetus fares in labour (this could be seen as the language invented for the fetus to use to communicate with medical and midwifery practitioners alike). This has been shown to dictate intervention (Tew 1995). Anaesthetics (including analgesia) have provided virtually "pain free" labour, thereby making it easier to bear. There is no argument about the use of technology in whatever form, where appropriate. But the question arises about its liberal use. Primarily science and technology developed to find the cause of pathological birth; its use is now extended to all birth, thereby blurring the boundaries between normality and abnormality. Its use has been extended to encompass normal and abnormal pregnancies and birth. What this also demonstrates is that meaning is not absolute but constantly construed.
Chapter five: The Medico-Scientific Discourse

anew, as knowledge develops. In this way it allows medical-men to retain control over their work. Therefore governmentality surfaces anew. According to Foucault (1980) governmentality describes a range of mechanisms that allow these different specialities to regulate, construct and constitute the individual woman and childbearing women as a group.

Additionally scientific and technologic development emphasise the ideology of mastery of the bio-physiological basis of childbirth and expose the medical view of reality, and its notion of what counts as expert knowledge. Consequently the concept of childbirth is wedded into the reality of bio-medical representation.

The advent and proliferation of specialities and their respective technology has resulted in the crystallisation of new patterns of medical specialisation. Oakley (1993, p.196) points out that:

Technology has brought a profound shift in the knowledge base of medicine. Whereas early medical knowledge was composed of women's biography, that is their personal experience of the childbearing process, in modern practice medical knowledge extends beyond women's biography to encompass' technology derived data.

Similarly, early medical specialisation was structured around the examination of the woman by one or two at most two persons; the new institution-based specialities were deployed in the spaces between appropriate professionals. This, in conjunction with the fusion of science technology and industry, has led to the emergence of a new form of ideology based on technologic justification of monitoring and conducting the "business" of childbirth thereby, recasting the framework in which childbirth is understood.

Thus in the medical interpretation and representation of childbirth, the body is treated purely as a machine in its reproductive capacity (Jacobs et al 1990; Wagner 1994). The medico-scientific discourse has come under increasing criticism for this scientific representation of childbirth and its corresponding conduct. In what follows, I broach the criticism of the medico-scientific discourse as a topic in its own right in order to put the evolution of midwifery practice and its knowledge base in perspective.
Criticism of the medico-scientific discourse.

The medico-scientific discourse has attracted diverse interests in midwifery practice. Individual men, women midwives, as well as organised groups representing natural childbirth movements, have challenged the medical approach to childbirth. Additionally, the challenge has come from sociological, philosophical anthropological and feminist perspectives. Two main criticisms can be distinguished: the influence of science and technological views on the construct and conceptualisation of childbirth and their relationship to the conduct of childbirth. It can be argued that the scientific perspective has offered fresh insights into the phenomenon of childbirth; as a result, it has advanced the cause of midwifery. Its problem, however, lies in the overproblematisation of childbirth and the generalisation of scientific knowledge to all childbearing women. The application of proliferation of scientific knowledge and technology has created a clear dichotomy in the reality of childbirth. This dichotomy is firmly laid in the conceptual framework within which childbirth is understood. The fundamental problem with the medico-scientific paradigm is that it has rendered the sociocultural aspects inessential.

The conceptual development of childbirth since it first became subject to scrutiny introduced an interpretation that substantially altered the meaning and culture of childbirth. Women's personal narratives and the socio-cultural representations of childbirth are separated (Coslett 1994; Matus 1995); on the basis of their subjectivity these were not acknowledged in any medical and midwifery language and texts. Jacobus et al (1990) pointed out that the medico-scientific discourse created a linguistic paradigm that expressed the medical perspective of childbirth, in which professional authority and institutional structures are the principal constituents - a language that alienated women and still alienates women from the discourse of childbirth.
Using anatomical knowledge as a micro-level phenomenon that explains the scientific and technological foundation of midwifery, Foucault (1979, p 31) draws our attention to the manner it has altered the way the body is viewed, which he described as "something docile that could be subjected, used, transformed and improved" This reflects the notion of the body machine referred to earlier in this chapter. Gregg (1995) expounds this idea further by pointing out that within the medico-scientific discourse the body is treated as having distinct components - pregnant women and their unborn babies are viewed and treated as two beings. In antenatal surveillance for example, women's bodies which house the unborn infant are inspected to judge their status; they are analysed to identify their deficiencies and are monitored to evaluate their functioning, each according to its own set of criteria.

Gregg is not far off from medical reality as I observed and continue to observe in contemporary institutional based practice; the worrying fact is the extent to which midwives and women alike (some more than others) subscribe to the medical rationality believing that it is midwifery. Thus the clinical gaze turned from investigation of pathology to encompass the transient changes in healthy pregnancy. However, it is essential to recognise that in the medico-scientific schools of thought, pregnancy is defined as pathology or potential pathology. Pathology denotes the need for intervention. So far as it emerges, the medico-scientific discourse considers birth as an abnormal event and it therefore separates it from the context of everyday life (Oakley 1993); hence the necessity for different machinery for surveillance, which Illich defines as diagnostic imperialism.

Illich (1990, p.113) describes the medico-scientific discourse as iatrogenic. He identifies two forms of iatrogenesis: social and cultural, and maintains "medicalisation has sapped the will of people to suffer their reality". Using anaesthetic to illustrate his point, Illich asserts that medical specialisation tends to "turn pain into a technical matter and thereby deprives suffering of its inherent personal meaning" (1990, p 140) and therefore rewrites the meaning of pain in childbirth anew. Consequently it altered and imposed a new system of meaning consistent with the modern way of giving birth -"a painful labour represents going back to the Dark Ages" (Kitzinger 1992, p 142). In a similar vein, Walcock et al
(1997) expressed that medical historians have largely ignored what childbearing meant for those who went through the experience. Childbirth, Kitzinger (1992) argues, is a social act not just a biological one; therefore it needs to be considered within its socio-cultural context as well. Resituating childbirth in the socio-cultural context means redressing the imbalance caused by medical science.

Pursuing the notion of social and cultural iatrogenesis, Illich (1990) argues that hospitalisation has rendered the woman’s home unsuitable for birth. It has thus done two things: firstly, it has created a distrust in viewing the home as the natural setting; secondly, hospitalisation has alienated women from their environment and incapacitated them to cope with their own socio-cultural milieu and rendered them incompetent to cope with the hospital milieu. This is so because childbirth is interpreted according to a set of abstract rules in a language that women cannot understand. Language is taken over by doctors expressed in scientific terms. Additionally, the creation of specialities has produced different forms of labour and has drawn further boundaries. Consequently, it has transformed childbirth and midwifery practice from a socio-cultural orientation to an unrecognisable field of scientific realities. It has thus changed childbirth into a materialistic secular discourse (Miller 1995) and distanced the midwife from the woman contrary to what the initial definition “with woman” suggests.

Similarly, feminist arguments arose against the background discussed above. At the heart of the feminist critique of medico-scientific discourse is “the transformation of pregnancy into a disease, and the takeover of a female centred natural process attended by skilled and caring midwives, by a group of male physicians interested in establishing and expanding their practices, occupational status, authority, and their control over women” (Sawicki 1991, p 75). The intention of the feminist discourse is to shift the control over childbirth achieved and maintained by the dominant medical culture, thereby empowering women to define their reality (Jacobus et al 1990), essentially, suggesting de-medicalisation of childbirth. Feminists also take issue with the effect of reproductive technology. Whilst accepting that it is enabling for women with specific problems, they argue
that it is especially dangerous to women because it decontextualises further the conception and the meaning of childbirth (Sawicki 1991).

Anthropologists take the debate to another level- that of the socio-cultural perspective of childbirth. Upon this premise, they contest the medico-scientific interpretation of childbirth in which childbirth is written in biological terms; as such it underwrites the socio-cultural interpretation. In the socio-cultural perspective childbirth is viewed as a rite of passage in which rituals are an integral part (VanGennep 1909), the meanings of which cannot be underestimated, particularly when asking what midwifery knowledge contain (The notion of the rite of passage is explored in part three). Anthropologists advocate a return to the socio-cultural orientation of childbirth and call for it to be recontextualised (Kitzinger 1992, Jordan 1993; Tritten 1999- personal communication). The last two decades or so have seen a move towards this goal, which is illustrated in the increase in homebirths, which, since complete hospitalisation of childbirth has been a rare event. Essentially critics of medico-scientific discourse indicate symptoms of a crisis. These include crisis of representation, legitimation and of confidence in medico-scientific knowledge. Associated with the critique of the medico-scientific discourse are the demands for reassessment of the dominant ideas across midwifery practice and asserting the need for the reality of childbirth to be articulated within women’s lifeworlds. In a way, the anthropological perspective advocates humanism which Davies-Floyd and St John (1998, p 83) maintain:

 Requires treating the patient (woman) in a connected, relational way as any human being would want to be treated- with consideration, kindness and respect.

**Conclusion**

This chapter has presented and discussed the continued changes in the conceptualisation of childbirth, shaped by medical ideologies. It has also demonstrated how the field of medicine established itself as a dominant rationality within the domain of midwifery practice. Undoubtedly medical knowledge is important, but whilst it may appear to have improved midwifery, it has in fact transformed it into a medical speciality- a paradigm, which engineered its
management within a scientific framework underpinned by scientific knowledge and technology. Unarguably, medical knowledge has pursued the development of midwifery along the one-dimensional line of biomedicine, which has not the same content, organisation, or function and meaning to be found in the social organisation preceding the medico-scientific discourse. In so doing it has inhibited and stultified development in any other non-medical arena. As with the other two discourses, illustrate, it reflects a process of cultural change.
CONCLUSION TO PART TWO

Where are we now after our brief excursion into the study of the evolution of midwifery and what is the relationship of the findings to the development of knowledge? In order to extend our grasp of midwifery knowledge it is essential to understand how it has developed over time. The data show that central to the development of midwifery practice, is the concern with providing safer care for childbearing women and their unborn/newborn.

Collectively the ecclesiastical, political and medico-scientific discourses have contributed to ever increasing power differentials between the experiential reality of childbirth and the scientific claim of midwifery. We can see in the three chapters that undertook the examination of these three discourses how dominant discourse operated. The main theme that runs through these discourses refer to the fact that midwifery practice and its epistemological base are linked to societal changes that reflect a shift from early modernity to postmodern schools of thought.

The centrality of knowledge was anchored in a national reliance to legitimation. The pattern of development is hierarchical with the ultimate authority in the development of knowledge residing with the leaders of society at that point in time. In each discourse we see the claims to knowledge as embedded within particular traditions and the need to shape midwives into practitioners fit to perform their roles according to the needs of the state. In accordance with the social theories presented in chapter one we begin to see the infiltration of the ideals of modernity in the development of epistemological positions. The ecclesiastical discourse concerned the development of the spiritual person and addressed the development of knowledge through the perspective of theology. The main thrust was salvation of the soul and about asserting the authority of religious knowledge as the dominant ideology through which society and midwifery practice were governed. It was also about the development of a spiritual culture. The power of religious knowledge lies in the notion that it comes from above. It is a type of revealed knowledge. Within the ecclesiastical interpretation, which represents Christian culture, knowledge of revelation indicates the concept of the Divine in the control of society. It is the
special province of theologians and priests and those who communicated/dictated it down to the people. The problem with ecclesiastical authority is the exclusion and prohibition of other forms of knowledge antithetical to religion. It appears that the teaching of the church was a most powerful form of exclusion and tended to exercise a sort of pressure upon all forms of discursive practices. There is no doubt that if witchcraft existed and was harmful to childbearing women and any practice that endangered the lives of women and their unborn, then it needed to be transformed.

Not all practices and knowledge constituted malevolence. An example of other practices and knowledge that was not allowed to develop includes naturopathic medicine and, experiential knowledge. Hence the production and utilisation of midwifery knowledge were controlled by ecclesia and midwifery practice became entrenched in ecclesiastical epistemological orientation. It is important to recognise that the ecclesiastical attempt to develop a knowledge base for midwifery practice was in response to wider societal changes.

In the political discourse we observe the emergence of a different epistemological position which reflects the pervasive ideals of Enlightenment philosophy which is meant for a different kind of reality and different notion of knowledge. Based on the premise of safety, midwifery became the territory of politics. The significance of knowledge lies in the development of politics itself and the growing separation of the church and the state, with the latter assuming full responsibility for the welfare of childbearing women and their infants. The political discourse set in motion a series of events that distanced midwifery from the religious foundation and spiritual culture. These include the development of institutions controlled by the medical profession, state enquiries in midwifery and state policies which led to the conclusion that all women must have care on the basis of parity. Placing the political discourse in the context of the Enlightenment philosophy we see the gradual erosion of the local context of childbirth and midwifery practice and the permeation of universalism. The main function of the political discourse in the development of knowledge is the decontextualisation of childbirth and midwifery practice. In locating childbirth in medical space, it threw open the possibility for it to be reshaped. The process of decontextualisation
involved disarticulating the set of relations established by the ecclesiastical discourse and redefining it within the context in which it was now situated. The political discourse paved the way for the scientific development of midwifery.

The medico-scientific discourse situated the development of midwifery knowledge firmly within the interpretive framework of modernity. As we saw in chapter five midwifery knowledge was interpreted in terms of science. The religious/theological interpretation of midwifery was no longer relevant. Underpinned by the assumptions of modernity the medico-scientific discourse had profound effect on the “field” of midwifery insofar that firstly it became secularised and, secondly, it fragmented the woman’s state of being into component parts, that is, the separation of the spiritual and the biological and placing primacy on the latter. The development of disciplines and the proliferation of technology further endorsed the Enlightenment notion of knowledge, removing it further from everyday social reality.

The examination of the three discourses has been based principally on Foucault’s notion of power/ knowledge and discursive practices who sees discourse as constitutive of the construction of meaning, knowledge and truth. As we have seen meanings are tied up to the time and space in which they originated or more aptly it which they are forced to enter. Hence the claims of modernity which generated an increasing homogenisation of all practices surround childbirth (as it appears in UK midwifery) regardless of its origin and social context-embeddedness are thrown into question.

The next case study, which is about the Mauritian midwifery, presents a different set of arguments about the epistemology of midwifery. Unlike in the UK it is entrenched in the premodern culture and raises fundamental questions about modernity and its impact of midwifery knowledge. The premodern perspective of midwifery presents us with the challenge that the modern construct is more of a representation of obstetric than midwifery.
PART THREE
Part Three: Introduction

It will be recalled that the idea to study the premodern perspective of midwifery started from a personal encounter with traditional birth attendants in the spring of 1992. This encounter began a process of critical reflection and serious questioning about the development of midwifery knowledge. Consequently I could no longer accept the assumptions upon which my understanding of midwifery was based. The search for midwifery knowledge became imperative. I returned to Mauritius in the autumn of 1996 to undertake fieldwork for the doctoral thesis.

Data were collected over a 3-month period beginning at the end of June 1996 and was completed in September. As discussed in chapter two, three main methods for data collection were used: participant observation, open-ended interviews and documentary evidence. This part serves as a linchpin that unites the whole study. It lays the background for what follows in the final part.

The findings are presented in four chapters. The first addresses the professional aspect of midwifery. We shall see that the Mauritian Midwifery system is entrenched in the British Professional culture - a colonial legacy. Although to a lesser extent than the UK, the permeation of the modern culture in professional midwifery is evident. The remaining three chapters expound traditional midwifery as a field in its own right. In addition to fundamental concepts that are important to understand midwifery epistemology, traditional midwifery throws open the possibility of reshaping midwifery.
CHAPTER 6

The Professional Perspective

Introduction

This chapter offers a brief analysis of the Mauritian health care system so as to contextualise the debate about the nature of midwifery practice and its relationship to knowledge. It begins with an overview of the health care system and then focuses on midwifery

The Health Care System in Mauritius.

There is a dual system of health care in Mauritius. The one system represents the formal, government-based system and is staffed by professionally educated personnel. The other involves the practice of traditional medicine of which traditional midwifery forms part. Traditional medicine incorporates the values long held and valued by the Mauritian people—some more than others. Within the formal midwifery system two distinct models exist.

The Formal System.

The formal system of health services comprises the following:

- Primary health care—this deals with preventive medicine. Its service embraces diversity of services, ranging from family planning, maternal and child health to school health and environmental health programmes (Manick 1989; MOH 1985). The provision of primary health care is locally based, through Area Health Centres. Within each centre are maternal and child health centres.

- Secondary Health Care—this is referred to as Curative Medicine and provides health care through regional-/specialised institutions (MOH 1984; Roussety 1996). In relation to midwifery care however, women
who live within the vicinity of regional institutions seek it at the appropriate institution.

The Traditional System

The traditional system, on the other hand, encompasses an array of services, which fall into the realm of naturopathic medicine. Examples of these are Chinese medicine (of which acupuncture and other herbal remedies form a major part) and Aryuvedic medicine (which embraces the Indian philosophy of care and relies on herbs and massage, and recommends abstinence from certain foods).

The basis of all alternative medicines is religion or spirituality. Traditional midwifery, as well as observing the principles of traditional medicine, is also based on the practitioners' biography. In order to explore the nature of Midwifery in Mauritius it is necessary to understand the context within which it developed.

The Emergence of Midwifery as a Distinct Field of Practice

Midwifery in Mauritius evolved as a distinct field of practice in the last century, primarily through the necessity to educate midwives about childbirth, which took place in the women's own homes. Midwifery also evolved through medical concern about the high maternal and infant mortalities. The mortalities were attributed directly to the ignorance and incompetence of lay midwifery practitioners (Balfour 1921)- a justification akin to that which triggered the development of midwifery practice in UK, and similarly led to the emergence of the notion of performability. Poor conditions of living and lack of sanitation were also recognised as contributory factors, but were of less importance than midwives' knowledge and competency. At this juncture, childbirth and midwifery practice became public and political concerns. In order to lessen the high infant and maternal mortality, specialised units within the general hospital were created which served a dual purpose- firstly, to provide women a safe environment to give birth under the supervision of a medical doctor; secondly, to provide education for the midwives. Thus midwifery became incorporated into the realm of medicine, which controlled what, how and by whom it was taught. By so doing it inculcated a medical culture and worldview in childbirth.
Chapter Six: The Professional Perspective

Up until then the conduct of childbirth and midwifery practice was not a problem; it was the domain of traditional midwives. It was the concern of women who had learnt the art of midwifery by assisting one another in a process with which they could identify. But in problematising midwifery practice a different philosophy emerged - one that associated birth with risk and danger. This subsequently dictated what knowledge should form the basis of midwifery practice and curricula. Thus education became the key vehicle by which practice began to take shape, and has since played a significant role in the development of midwifery as a field of practice. Similarities can be drawn from the UK case study, in that the problematisation of midwifery practice related to the high maternal and perinatal mortality rates, which were directly attributed to the incompetence (skills as well as knowledge base) of the lay midwifery practitioners. Similarly midwifery practice and childbirth became the medical as well as the public and political concern. Dr de Chazal's concern about the necessity to educate lay midwives (Balfour 1921), to some extent, reflects Smellies' idea (as explained in chapter four). Although it could be argued that concepts were borrowed from the West, Mauritian midwifery retained real life situation as the mainstay of education. Thus childbirth and midwifery were not decontextualised. Nonetheless this ushered in an important political change in the Mauritian Midwifery System - the provision of maternity care in government hospitals. Following this, medical power and authority were further underlined by various social and political changes (Roussety 1981).

Transforming Midwifery Education

Until 1948 midwifery education formed part of nursing education. Evolving as mainstream professional education in the mid-nineteenth century, (when Mauritius was still a colony of Britain), midwifery education is entrenched in the British Professional culture. Current midwifery curricula, or more aptly midwifery syllabi, can easily be recognised as replicas of British Midwifery Education. Despite the educational similarities the practical context is fundamentally different (this will be expanded further in the next chapter). Unlike UK, Mauritian midwifery admits only women to the profession, since it is perceived by everybody as women's business. Until about 1968 midwifery education was provided by midwife teachers
from Britain, since, development in that area had been slow. However, midwifery education, faces its greatest challenge- the influence of Western philosophy of higher education is becoming increasingly apparent and midwives as well as nurse educators have to respond to major changes which are likely to impact upon midwifery education and practice. In the early part of this year, the Ministry of Health entered into contractual agreement with Middlesex University for the development and provision of graduate and undergraduate programmes in nursing and midwifery.

**Relationship between practice and education**

Midwifery education in Mauritius is a recent development. Prior to the establishment of the first educational institution, midwifery education was clinically based. Thus education was led by practice. The absence, or limited availability of texts and literature meant that the epistemological base of midwifery practice and education was predominantly pragmatic in nature. The examination of practice, in turn, points to another important consideration in the exploration of midwifery knowledge- the notion of continuities, (Foucault 1970; Giddens 1991). The midwifery continuum of pregnancy, labour and postnatal, to use the Western linguistic and conceptual construct, was located in one and the same clinical setting. Although circumstantial, it reflected a non-fragmented approach to practice as well as learning- an ideal situation.

Clearly it is possible to extrapolate the focus of learning was the practice itself. By comparison the theoretical input was minimal. Although doctors who were overall responsible for the education of midwives did the teaching of theory, in the form of lectures, it took place in the practice area. More often than not lectures were preceded by a period of questioning students about their knowledge and practice. - a practice, which was described by my interviewee as

> Keeping them on their toes with practice. You had to know what was going on with your patients and you had to be prepared about every aspect of midwifery- You know... they could ask you anything about the pregnancy or labour or postnatal." (Excerpt from interview July 1996)

Inadvertently, theory was not separated from practice. The learners learned how to practise midwifery by being with licensed midwifery practitioners.
Fundamentally this model of education reflects the principles of apprenticeship and places primacy on practical experience as a legitimate way of socialising learners to the profession. Although the practitioners of midwifery worked in the medically controlled environment of the hospital, they were able to develop their own knowledge, which they described as emanating from their encounters with women in daily practice and to train learners according to their own criteria. But this pragmatic approach soon gave way to a more structured approach which dissociated education from practice and set it in a contrived/artificial environment, with a specific educational programme. At this juncture a shift in emphasis, from practice-based to theory-based system could be observed.

**Formalisation of midwifery education - the paradigm shift from practice to theoretical orientation.**

At the time of conducting my fieldwork and writing, midwifery education in Mauritius has two programmes: the basic midwifery and the post basic. This model has been imported from UK, although it is now obsolete in UK. There is a time lag of about thirty years in the organisation the professional education system in Mauritius.

**The Basic Midwifery Programme**

Basic midwifery is an eighteen-month programme designed for non-nurses. Its purpose is to prepare women for midwifery practice only. The content of the programme incorporates knowledge based on bio-medical sciences, midwifery and appropriate nursing subjects and skills. It includes two examinable parts: the first is of six months duration and comprises theory and hospital-based practice of midwifery and nursing; the second, lasts for twelve months and is divided into two equal periods of hospital-based and community-based midwifery practice.

Progression through the programme requires all pupil midwives to pass the part one examination, for which two attempts only are permissible. The process is rigorously controlled. Second attempts however are granted by the Ministry of Health, on recommendation of the Board of Examiners (Government notice 1963). Failure at a second attempt leads to the discontinuation of the programme. However,
the regulations for the second part differ slightly; three attempts are allowed and similarly failure at the third attempt results in discontinuation of the programme.

The Post basic Programme

The post basic midwifery programme evolved alongside the basic midwifery programme. Today it is by far the commonest form of education. Currently this programme is of one year's duration, only accessible to those nurses who have successfully completed a three-year programme in nursing and are on the Mauritian Register of Nurses. Entry to the post basic programme is not comparable to that of the basic midwifery one since the applicants have already undergone a rigorous selection process for entry in the nursing programme. The progression through the programme is similar.

The post basic midwifery consists of two distinct parts - part one is hospital based and lasts for six months whilst part two incorporates three months community based midwifery practice followed by three final months of study in hospital. Post basic midwifery education is compulsory for all female nurses. However, midwifery training does not automatically follow nurse training. Access to midwifery programme is on a waiting list basis and each year, or whenever the programme is scheduled to run, course participants are informed by the Ministry of Health of their nomination to undertake the programme (MOH 1981). This is because Mauritius uses an industrial model for professional education which is based on manpower projection. On successful completion of the post basic programme the practitioner is known as nurse-midwife.

What, then are the issues that emerge from the formalisation of education? Clearly there is a dichotomy between the two midwifery programmes. By its very nature it creates an elitist structure- a feature that is easily apparent. Nurse-midwives are perceived to be higher calibre practitioners and function mainly in hospitals. They are viewed as experts whilst, the midwives practice mainly in the community. Clearly there is a distinction in knowledge domains in that the curriculum/syllabus for the basic programme was more practical in orientation. Viewed from another perspective, two different models of midwifery practice can be observed. By the mere fact that nurse-midwives work in a medically contrived environment they
function within a medical paradigm and their conceptualisation of childbirth mirrors the medical representation in which scientific knowledge appears to be dominant. Community midwifery practice, by definition is midwifery-led and endorses the view of childbirth as a natural- social phenomenon. Essentially both educational programmes endeavour to produce expert practitioners- expertise in this context is subsumes changes in the nature, organisation and utilisation of knowledge.

The impact of education on the development of Midwifery as a field of practice.

From the outset, education was seen to play a major role in organising practice as a formal institution. Such a transformation represents a fundamental ontological shift for midwifery practitioners and gives an entirely new meaning to midwifery practice- one that would seem to alter the ways in which to conduct practice itself. Thus by using education to reform practice and to bring the conduct of childbirth into medical space, it also brought knowledge into control- a view that has been articulated by Foucault (1980). Institution-based midwifery practice identifies two forms of practice, namely hospital-based and community based. These two institutions are clearly connected- they share a medico-political paradigm, which includes affirmations of legal control of midwifery practice and beliefs in expertise as demonstrated by licensure and certification.

Hospital-Based Midwifery

Hospital-based midwifery appears to be more entrenched in medical rationality in which the conceptualisation of childbirth is grounded in scientific and technologic knowledge- a western representation, mostly deriving from British roots (a colonial legacy). Scientific and technologic knowledge, however, is less developed in the West and is utilised in a very different way and for different purposes. Therefore, the kind of expertise and speciality that accompany technological development and reliance is not yet so obvious in Mauritian midwifery practice.

Notwithstanding, ultrasound technology is making inroads in midwifery practice, thereby expanding the medical boundaries. The worrying aspect about the
infiltration of ultrasonography as a speciality is the way it is communicated to women. Unmistakably it is having the same influence on women in Mauritius as it did on women in the western context. Mauritian women favour ultrasound technology because it enables them to visualise their developing babies. Whilst this may be so, simultaneously it is allowing medical practitioners to venture on new grounds and to gain new knowledge. Ultrasound technology is not readily available in government institutions, so women are turning to private midwifery practice where it is more accessible. Such technology is viewed as progress. This instance is an example of the infiltration of modern values.

The Evidence of a Midwifery Paradigm

Although hospital-based midwifery practice exists within a structural context that supports the medical model, paradoxically, medical knowledge expressed in science and technology, is not the only knowledge that underpins practice. Because of the entrenchment of religion, religious rituals and practices in childbirth, as in any other aspect of life, and the nurse-midwives' beliefs in and respect of such value system, they accommodate their practice to the cultural and religious diversity that they encounter in everyday experience. Such is the power of religion and indeed this reflects an ontological view of practice albeit inadvertently. Only a minority of nurse-midwives appeared to be challenging religious orthodoxies. Clearly, within the medical paradigm, there exists another model that articulates another form of knowledge that can best be described as cultural knowledge. The childbearing women bring this knowledge with them, (something that seemed to give them certainty) - this knowledge is neither written in any text, nor is it part of the curriculum/ syllabi. As it transpires, even though they have to give birth in a strange environment, women are neither completely dissociated from their day-to-day life, nor are they intimidated by the nurse-midwives' authority. I want to illustrate this point through a scenario that I observed whilst conducting my research.

This scenario took place in a district hospital

A primigavid woman, well into labour, was asked by the nurse-midwife concerned to stay in bed and on no account should get out as she was nearing time to give birth. Indeed the behaviour of the woman suggested so. The midwife spoke pleasantly but without any doubt, authoritatively. As she left to make the necessary preparation to assist the woman to give
birth and was out of sight, the woman rapidly got out of bed and squatted on the floor and gave birth to her baby. The midwife had no option but to assist the woman in the position dictated by her body.

(Field notes July 1996)

What this indicates is that scientific management cannot always control birth. Returning to the issue of cultural knowledge, what exactly it entails was difficult to ascertain in the context of hospital based midwifery practice. Although having yielded some insight into the explanation of midwifery knowledge, this did not provide further information of culture as a form of knowledge-base. It became certain that science is not the key to expanding midwifery knowledge and that medical knowledge does not entirely dominate Mauritian thought.

Community- Based Midwifery.

In contrast to hospital-based, community-based midwifery takes place in Area Health Centres located all over the island. Principally midwives who, it will be recalled, had a different education- one that is more practical in orientation staff them. Indeed in dialogue with midwives it became clear that their knowledge was pragmatic. Interestingly enough, midwives perceive their knowledge to be lacking and consider their practice and knowledge base to be less credible. In consequence pragmatic knowledge is undermined. Community-based midwifery practice appears to be autonomous, unbeknown to the midwives because they view themselves as less able practitioners. In a sense, community midwifery practice reflects midwifery-led care (DOH 1993) in every sense of the term. Although Health Centres are designed to accommodate women during the birth process, they are very rarely used for that purpose. Birth takes place, for most of the time, either in the women's own home or in hospitals. If the women do not come to the Health Centres to give birth, midwives have to go to them and assist birth in their home.

Homebirth, in the midwives' experience, poses several problems. These appear to relate to two main issues. The first concerns the organisational structure of the community care settings. To start off midwives do not have a choice in the location of their place of work. The Ministry of Health, reserves the right to send midwives to any Area Health Centre in the island as it can all health care workers.
Consequently midwives have little control over their area of practice. One of the criticisms of the Ministry of Health's deployment lies in the lack of recognition of geographical constraint between midwives' place of residence and work place. Midwives have to find their own means of transport to attend the locality of the childbearing women. For midwives this is a problematic situation, particularly in responding to night calls, where their personal safety is at risk; although there have never been any reported untoward incidents. Additionally midwives feel that they are not adequately equipped to deal with possible complications that may arise.

The second issue concerns the modern conceptualisation of birth. Emanating from medical construct, the modern view postulates that childbirth is life threatening. - a view that has transformed women's trust in their ability to give birth in their own social space. Of course there are differences among midwives some of whom see no problem in assisting women to give birth in their own environment, but these are rare. Consequently homebirth as a distinct area of practice is fast disappearing. The latest statistics indicate that 99% of birth takes place in hospital (district and regional) (MOH 1995). Very few women resist the idea of giving birth in hospital. Thus community-based midwifery offers little insight into differentiating the medical from the social perspective of childbirth and midwifery practice. As such it offers little explanation about the nature of midwifery knowledge.

Additional function of Area Health centres

The Area Health Centres are points of reference for the traditional midwifery practitioners (the dais) who are required by law to notify any birth that they attend. Very often they come in contact with midwives either through referring women in their care or for renewal of their kit (a small case which contains basic instruments and sterilising solution). Community midwives are at the interface of traditional and professional midwifery practice. On the one hand they work in collaboration with obstetricians and on the other with lay midwives. Unfortunately, the relationships with traditional practice is not explored and developed. Traditional midwives are perceived to be lacking scientific credentials, unintelligent and lacking skills required to prevent mortalities. There is no dialogue; therefore their expertise and knowledge remain untapped.
Conclusion

This chapter has demonstrated that western schools of thought, particularly UK, have influenced the development of professional midwifery. One of the interesting observations about midwifery in Mauritius is that it remains exclusively the women's domain. Central to keeping midwifery practice gender distinctive, is society's strong view, which is embedded in the notion that childbirth is private to women; men should not invade such privacy. Thus the female collective culture and identity are preserved. This is a crucial point in the analysis of the nature of midwifery knowledge. In the next three chapters I present the lay perspective of midwifery, which provides us with a different conceptualisation.
CHAPTER SEVEN

The Traditional or Lay Perspective of Midwifery

Introduction

In the previous chapter I have given an overview of the development of midwifery as a professional entity. The next two chapters present the axioms upon which traditional midwifery practice is founded. In the traditional understanding, midwifery is a socio-cultural phenomenon embedded in a world of rituals and symbols in which women play a significant role. It is a continuum in women’s lives.

This chapter has three sections. In the first I contextualise traditional midwifery practice in Mauritius, critically examining some of the differing perspectives concerning the practitioners of midwifery. The second addresses the socialisation of traditional birth attendants in midwifery whilst the third examines their education and the impact of social changes on their practice.

Contextualising Traditional Midwifery Practice in Mauritius

Biography of the Traditional Birth Attendant

Until the mid-twentieth century midwifery practice was entirely the domain of traditional birth attendants. It was and still is deeply rooted in the socio-religious history of the island. Who are the traditional birth attendants? How do they constitute themselves? They are women known as either dais or sagefemme, deriving from our Indian and French cultural heritage. The latter is more commonly used. By comparison to professionally educated midwives the dais are lay practitioners. According to the World Health Organisation (1979, p.10) the traditional birth attendant is:

A person (usually a woman) who assists the mother at childbirth and who initially acquires skills delivering babies by herself or by working with other traditional midwives.
Stemming from this definition is an over simplistic view of the dai and traditional midwifery practice. A closer look at their biography indicates a complex relationship between the dai, the woman and what constitutes traditional midwifery practice and midwifery knowledge. There are basically four types of dais in Mauritius:

- Those who believe they were called by God.
- Those who followed in their mother / mother in law’s path. This group is not dissimilar to the first; they too claimed that there was some divine influence over the family as a whole.
- Those who had personal experience or encounters with problem births.
- Those who are ex-hospital maids.

In all groups, to a greater or lesser extent, there is a relationship between the dai and supernatural calling.

The vast majority of dais work independently. Except amongst family members, there is no communication amongst them. During my fieldwork it became readily apparent that it is crucial for dais to secretly safeguard their skills and knowledge which they will only pass on to the next generation in their families. Thus each dai has her own set of principles to inform and guide her practice. However they all share the following essential characteristics that give them their identity

- maturity.
- marital status.
- fertility status.

Naturally these are not necessarily isolated from each other; they are often amalgamated and are directly related to value bases of other social phenomena that encroach on childbirth practices and beliefs. In what follows I present these attributes, through the lens of dais, and their association to midwifery practice.
Chapter 7: Traditional Perspective

Age

The contemporary Mauritian dais are typically elderly women from all religious persuasions. It is essential for the dais to have passed childbearing age. Of the thirty dais in my study only one was under the age of fifty, the remaining twenty nine were between sixty five to seventy five years of age. Although the MOH/UNICEF/WHO survey (1985) reports a younger age group, it is uncommon in Mauritius to see women below the age of forty undertaking traditional midwifery work. Women and the whole community in which they reside who believe that they possess knowledge superior to their younger counterparts, hold the older dais in high regard. This knowledge is treated as authoritative. This is rooted in two fundamental beliefs: First, because the older dais have considerable experience (both personal and practical) accrued over their many years of practice they are viewed as experts. Second, it is associated with wisdom, which can only be achieved through ageing.

Older dais are always present during labour birth. They utilise their personal and practical experience to guide women through the birthing process. The value of experience is recognised by the younger dais. In seeking clarification about the importance of age and its relationship to experience and wisdom as perceived by the Mauritian dais the following explanation was offered during an interview with individual younger dais.

You see, those women when you arrived at their houses and they see that you are not as old looking as the other dais, they get worried and they would not allow you to assist them in giving birth But you see the mama dai (which refers to the older dai of the village) after we have been with her for a while, she tells us to go on ahead and she will follow. But the women, they always want the mama dai to be there first before they do anything. When you arrive at the house first, they always ask, "Where is the old one?" You know, the mama dais, because they are old, they have done this work many times over, they know a lot of things...you know what I mean... like what to do if things go wrong... about bad omen ... about religion ... things like that. The spirit tells them what to do. you know what I am trying to say. Besides the women think that the older dais know what they are doing ... as I already told you because they have done this work many times over. Also all the people know them.

(Field notes July 1996)
In most situations there is a hierarchy of dais, with those who are elderly functioning in the capacity of practitioner, teacher to learner dais, in that respect they enjoy an elevated status. This is an important criterion upon which women base their choice about who assists them in giving birth- a choice that is borne out of trust. The main context of trust in this situation is that women have known the older dais and about their work all their lives. What emerges here are three main concepts:

- The concept of expert and accumulated knowledge expert knowledge that is seemingly based on practical know-how developed over considerable time.
- The concept of wisdom.
- The concept of spirituality and its relationship to the authority of the older dais.

Those older dais they know what to do if things do not always go in the right way. If you ask the women in the village they will tell you... You see because a younger dais is still learning... How can she know what to do? Whilst the older dai they have seen so many women given birth in front of their eyes... all kind of births I tell you... Babies who are born by their feet, twins... sometimes three babies at a time... sometimes the hand comes first, sometimes bottom or the feet. In this case it is difficult, but the older dais, they know what to. All this the women have heard, therefore they feel secure with them. There are other things as well. You must know what they are... I mean all the religious practices... you have to learn how to do them. If you do not do them correctly you offend the gods and the women will be very unhappy. That is why they like the older dai.

(Excerpts from interview notes June 1996)

What are we to make of such knowledge generated through experience and wisdom? Clearly the knowledge produced tells us something about ways of knowing and identifies a crucial epistemological principle in relation to understanding the role of culture in the construction of knowledge and the limitations of approaches to knowledge that ignore it. An important theme emerges from this perspective- the relationship of wisdom as an aspect of the dais ways of knowing. One of the
criticisms of the modern midwifery system in relation to age is the admission of younger single women who know very little about what it means to give birth.

Nowadays, those who are educated and go to school of nursing... This is what they call it. Isn't it? They are so young... What do they know? Sure, they learn in school. They have passed examination. They have got certificate for all what they read. I am not telling you that all that is bad but I am saying apart from all that what experience do they have? You know what experience I am telling you. The experience that comes from traversing the road first. You understand what I am trying to tell you. (This means to having gone through the process of childbirth). Without that how can they know? But what to do... This is new time. We must accept that this is what it has become. Long-time ago, even in hospital you would not see such young unmarried ones doing that job. It is not right

(Excerpt from interview held in July 1996)

In so doing they question the validity of the theoretical programme that prepares them to do a work which, in the dais' view, require personal experience. The necessity for dais to appeal to personal experience of giving birth was emphasised in almost all interviews. It is almost as if there is a dialogue between personal experience and practice.

**Marital and Fertility Status**

Women, as well as dais consider marital and fertility status to be extremely relevant, in particular to the legitimisation of knowledge. Women who have given birth to many children are given considerably more respect than those with fewer children. High parity is associated with more experience; it designates any woman in that category as expert. In describing "experts", dais identify a relationship with knowing what giving birth is about, understanding what women go through and the ability to make judgements that are based on knowing the reality of birth. Dais conceived of knowing how to assist others in childbirth as a process that involves self-knowledge as well as observing others. More emphasis is placed on self-knowledge, because this is what enables them to connect with childbearing women. Knowledge obtained otherwise is more or less viewed as artificial (See chapter one for explanation about the notion of artificial knowledge)
In addition, most dais that I interviewed shared the view that childless women are dangerous to pregnant ones. Arising from this perspective are two sets of assumptions that are used to exclude them (childless women) from traditional midwifery practice. First, as they lack personal experience of giving birth, they cannot fully relate to childbearing women in the same way that those who have gone through childbirth; the argument being that only the latter are sufficiently knowledgeable to undertake midwifery work. Second, they are more likely to cast cursing eyes thereby causing lifelong damages to the childbearing woman, her newborn infant or both. Hence it is exceptionally rare to see a childless or an unmarried woman working as a dai. According to the dais:

Unless you have had the experience of carrying a baby in you and bring it to life, how can you know what to do and what to tell the woman when her turn arrives? You know, when you see the woman throwing herself about when that pain takes her, oh oh oh! You know what she is going through... You can feel it... You can tell that you have been through it yourself and that it is going to be all right or if she makes too much fuss you can tell her off... You know what I mean. You know, when you are in labour you need some one to let you know you will be all right. Also the woman will listen to you because she knows you have traversed this road too.

(Excerpt from interview July 1996)

In explaining the connection between childless and unmarried status the dais, reflecting women's collective views maintain:

Those women who have never had children, how can they know? It is like pretence, is it not? Sure they can learn by watching other women giving birth, but if they themselves never traversed that journey, how can they know what it is like when that pain takes you. So how can you trust them? Also they can be dangerous... Not all of them... but people say mostly all of them ... So we need to be suspicious of what they might do... We need to protect our mothers from them. They can do bad things. You know like casting a cursing eye.... you know what that means don't you? ...Then both mother and baby will be harmed.... Also they give our work a bad name.

(Field notes July 1996)

This entrenched subjectivist position about the reality of childbirth appeared in almost all of my interviewees’ responses. Whilst the first may hold true to certain
extent, the second assumptions, to my mind raises questions, in the sense that all childless women are treated as suspect.

Marital and fertility status is an issue that serves to demarcate different positions on recruitment within professional and traditional midwifery practice. As long as traditional midwifery exists this issue is likely to persist because what constitutes a practitioner of midwifery is not simply some one who has obtained a license through the formal education system, primarily it has to come from personal knowledge of the birth process. Clearly, childless women could not be entrusted with the care of childbearing women. When asked about mono-parental women they did not seem to raise any objections. Essentially this has to do with a collective identity in which only women who had gone through the processes of childbirth could identify with one another in what the dais describe as the 'the road they have to traverse- a road that is full of dangers'.

Marital and fertility status additionally, determines that the dais have a physical, social and moral position in the field of traditional midwifery practice. This also reflects that the stock of knowledge they have is the accumulation of previous experiences, which in addition to a certain “female-mysteryness”, it is a kind of private knowledge that forms the basis of dais’ practice. Additionally we see that the dais are a select group with select knowledge. They formulate meaning from their personal experience. However as a counterargument to the dais insistence of fertility status, this select knowledge creates inequality which emanates for unequal access to traditional midwifery practice, including the capacity to recruit for practice. Dais are powerful, because they make utterances from a position of authority which has been vested upon them by their supernatural calling and by women themselves. They are powerful because they lay down rules and procedures which if infringed or breeched may bring sanctions and retributions in their wake. (This is will become evident as we discussed the underpinning of, and the scope of traditional midwifery practice in the next two chapters). Here Luke’s (1996) notion of power is evident, insofar that dais and childbearing women have the capacity to control who enters traditional midwifery practice.
Educational, literacy and socio-cultural background

Most of the dais in my study were either non-literate or had been educated at elementary level. Elementary education comprises the first five years of schooling (from the age of five to ten); even then some may have completed only three or four years. Hence their ability to read or write is indeed very basic. They are often dependent on their children or other family members for written communication. Their 'non-literate' status put them at a great disadvantage vis-a-vis the professionally educated nurse-midwives and midwives, in terms of their practice, intellectual abilities and general standing in society. Quite central to this view, as discussed in the overview of Mauritius (Appendix 2), is the level of educational attainment. Any one falling short of, at least, a secondary level education is “achievement” inferior. Questions about what and whose knowledge counts thus, becomes critical. The comparatively high level of education of midwives and nurse-midwives puts them in a privileged position with respect to formal scientifically derived knowledge, but it does not represent the entire picture of what midwifery practice and midwifery knowledge is about.

In general the dais come from lower socio-economic background. Many of them do this job to augment the family income. Those with higher socio-economic standing are primarily healers. The healing methods are based on natural principles such as herbal remedies, massage and heat therapy; it also includes a whole range of supernatural means. People seek their help for all kinds of ailments and for varied reasons; such as, distrust in conventional medicine or failure of conventional medicines. They are usually well reputed in and outside their community.

Another dimension of cultural background concerns religion, which forms an integral part Mauritian lives- in itself, the very essence of mauritianism. Indeed there are inseparable relationships between religion and people’s everyday lives. For further details about the place of religion see appendix two. As Mauritius contains a plurality of religions the dais have an extensive knowledge of their clients' religion. Each religion involves a set or sets of rituals that are inextricably linked with childbirth and midwifery practice. Dais are expected to adhere to and perform rituals
according to their clients' religious beliefs. Hence traditional midwifery practice is set in a wider context of symbolic understandings of childbirth processes and the role of the dais within it.

**The Socialisation of Dais in Midwifery**

The socialisation of dais in midwifery practice involves two main processes:

- Supernatural calling.
- Education.

**Supernatural Calling**

That God or the spirit (as defined by some) had called them to do this work was a common assertion, which almost creates the conditions of their learning to become dais. Either having a revelation through dreams or supernatural experiences describes this; on this premise many of dais claim to be endowed with spiritual powers. This has led some women to go to extremes to fulfil their calling. To illustrate the point I want to draw on a particular story of a dai, who was influenced by the context of her environment.

Born and acculturated in a Christian value system the dai in question now lives in a village in the North of Mauritius. This village comprises mainly of the Tamil community. She felt compelled to undergo the rituals associated with Tamilism before she could truly understand what midwifery practice entails and before she could fulfil the demands of that practice. She chose to subject herself to this religious phenomenon because it was value relevant and culturally significant to the community that she has been called upon to serve. Additionally she felt this acculturation would facilitate her understanding of the meaning that those rituals reveal. Moreover this would enable her to apprehend the reality of the Tamil’s everyday living, to understand the significance of those rituals, to the practices surrounding childbirth, and finally to enable her to incorporate that reality in her practice of midwifery. Examples of those rituals include walking on fire, climbing on a ladder of seven swords for which a set of complex rules and rituals had to be observed and performed in preparation to the main ones. Upon successful completion of this acculturation process she gained personal knowledge of a religious value system embedded in a completely different philosophy to that of Christianity. She earned the trust of her
extended community. Furthermore, in her own words, being granted authority, which she expressed as follows, sealed her calling to midwifery. "Now I am the mama of the village. The whole village call me so".

(Field notes August 1996)

To a lesser or greater extent most dais undergo some process of religious acculturation, although, this is not necessary. In addition to the claim of supernatural calling the group of dais, primarily learned by being apprentice to an older dai conducting birth in women's own environment. I will address the apprentice model of education later in this chapter.

**Educational Process- Two Educations**

The education of the dais contains two forms.

- Informal education: this takes place in cultural and environmental settings of the dais and is sustained through oral tradition and apprenticeship.

- Formal education: This takes place in the academic setting of a classroom (which is situated within the hospital compound) away from the real life situation.

**Informal Education**

The informal education of the dais varies according to the types of dais. To begin with each group had a unique story to tell about their education which involves a varying degree of complexity. As stated earlier, there are four types of dais in Mauritius. The environmental as well as social context of the education of the ex-hospital maids differentiates them from the other three groups. By far this group's education is the easiest to understand. To some extent it reflects the reality of professional worldview of midwifery practice. However they share one important common feature- the practice setting is the field of learning.

As the number of licensed midwives was comparatively low during night hours it was a common occurrence for hospital maids to be midwives' handmaiden
in the labour room at time of birth. By assisting and observing midwives they learned the know-how of practical midwifery. The number of women in the labour room often exceeded the number of midwives. More often than not only one midwife staffed the entire premise. Maids took it upon themselves to assist women. It was apparent that the intention was never to work in the capacity of midwives, but frequently the unavailability of a midwife left them with no alternatives. For most of the ex-hospital maids I interviewed this was a great achievement. It was with a sense of pride that they recounted their experiences.

Very often whilst the midwife was attending to one woman, another would start giving birth. Often time the doctor was somewhere else in the hospital and besides there was not as many of them as there are today. It was quicker to get on with it yourself. You could not leave the woman to born the baby by herself. The women were afraid, they kept on screaming and calling for sister... so we had to answer instead, and by the time sister came we had already deliver the baby. The midwives knew they could count on us. The doctors too were pleased with us. You see this is how it was in those days.

(Excerpt from interview August 1996)

Hospital maids’ involvement in midwifery practice, thus, was dictated by circumstances. In the process most of the maids who had then become dais had acquired complex midwifery skills such as breech births and perineal repair. These they had learned, through assisting the obstetricians. They had in-depth understanding of the anatomical structures involved in perineal injury. With great precision they articulated the principles underlying such complex skills, laying emphasis on prevention and complications. Additionally, their encounter with the birthing process included deviation from normality. In the process they acquired knowledge of pathology. Up until late in the twentieth century homebirth was the norm; the ex-hospital maids were often called to assist women in their own locality, thus developing their skills further. The encounter with normal and pathological births enabled them, in their everyday practice as dais, to know when to refer women to hospital. What emerges here is the significance of practice as the field of learning. They make no claim to supernatural intervention.
The Apprentice Model of Education within the Context of traditional Midwifery Practice.

The apprentice model is associated with informal educational processes and takes a considerable length of time to learn all the necessary skills and fully understand the duties that constitute traditional midwifery practice. Most of the dais reported an average of seven years apprenticeship.

It is based on the assumptions of learning, primarily by observation and later, at a time deemed appropriate by the “teacher dai”, by doing. In this context observation does not mean simply “sitting by Nellie’. The dais’ perspective on learning by observation attributes a more active role to learner dais. They are constantly allocated tasks according to their ability, which is judged by the “teacher dai”.

In the main the apprentice dais is usually the daughter or daughter-in-law of the older dai. Two factors are particularly important: firstly, the claim to divine/supernatural calling was given as the main criterion for entry to the world of traditional midwifery practice. Special dreams were defined as the means through which their supernatural calling manifested. It was unclear how this was judged to be true. It appears that the claim of aspirant dai of such experience was accepted without further or other means of validation. Often-times dreams of the supernatural calling of the next generation of dais dream come to other members of the family, usually via matriarchal line. In very rare circumstances it comes via patrilineal line. This seemed to promote certain ideologies and values about midwifery practice as special and even sacred. Limiting apprenticeship to family members, in that sense is a way of preserving and safeguarding the specialness of midwifery expertise. If younger family members select not to respond to their calling, then the knowledge simply does not get passed on to any one outside the family. Only in exceptional circumstances will an elder dai step outside their unwritten governing principles to admit a non-family member in their community of dais. The second factor as already discussed relates to childless women. Such exclusion requires a tight grid of protection. In this, dais and childbearing women unite. This illustrates the power and
authority of dais within their own community. I was led to understand that exercising this type of power was to raise the significance of their personal accountability and reputation. Dais’ accountability is both socially and personally constructed. It is necessary for them to maintain a balance between commitment to childbearing women’s welfare and the integrity of their practice.

**Teaching Strategies**

Learner dais’ initiation to practice begins by observation. The principal methods that the dais employ to teach their apprentice dais are demonstration technique and story telling. These methods are the ultimate context within which practice is understood and knowledge produced. In dialogue with the dais it became apparent that it was difficult to communicate their knowledge into logical sequences without recourse to visual aids. Most of them were very creative. An example is given below:

During an interview, the dai in question encountered difficulty in articulating how she would assist women in giving birth by simply talking about it. She expressed the need for visual aids. Attempting to put her at ease I asked her to keep on talking through it. Determined to demonstrate her skills, she used the most unimaginable aid, reaching her dupatta (a long scarf) that covered her head she created a model that so resembled a real baby. This is most effective simulation that I have come across. Treating her innovation as the real she proceeded, with great acuity, to explain the process of birth. She also advised me to bring a doll with me at my next visit in order to enable her to create a more realistic picture.

(Field notes September 1996)

There are no textbooks in the “school of dais”. All they have is real life practical situation. It became obvious to what extent their reliance on demonstration was crucial, it is the main strategies employed to disseminate knowledge. Learning activities include a complex combination of midwifery skills and of life. The following extract taken from an interview, explains the process that the apprentice dai had to go through before gaining credibility to practice:

You know, when you first receive the call and you accept it you have to do what the older dai tells you. First you have to watch what she does and how she does it... otherwise how would you know. You have to
learn how to help with the birth of the baby, how to cut the umbilical cord and then how to bring the flower forth. You can't straight away do those things. You have to bathe the baby, massage its head and all that... the baby when it comes out, if it does not breathe immediately what to do.... hum, you see these things they are not easy... On top of all that there is the flower...what to do with it? There are rituals to perform you know. When you don't know it becomes a danger. You know the older one; because they have done this work many times over they know what they are doing.... They tell you of a lot of things they have seen in their lifetime... This is how you must learn. You must wait your time.

(Excerpt of interview July 1996)

Very often the apprentice dais do not get to assist women in giving birth until the mentor dai decides that she is ready to do so. This is to ensure that the apprentice dais has enough experience. In their judgement, practical know-how and wisdom cannot be transferred to another, they must be experienced. As the complexities are being mastered the apprentice dais must be involved in repeated, specific yet diverse practice as will be discussed in the next chapter. Consequently, the hand over usually happens when the older dai thinks that she is ready to let go because she is getting to old to get about with ease, particularly during night time. There is normally a hand over time, which in itself is a gradual process, in which the dai takes a step back and allows her apprentice to step in her role. In turn, she assumes a supervisory role and ensures that all the principles are adhered to. Only when her confidence and trust in the apprentice dai has grown will she hand over completely. One of the key skills that the dai uses to judge the readiness of her apprentice lies in the cutting of the umbilical cord. Certain principles of cutting the umbilical cord are vital. Examples of these are: when to cut the cord, the distance from the baby's abdomen and, finally, how to ligate it. If there is any breach in the above principles the apprentice dai will not be allowed to practice unsupervised. A fairly rigorous system can be observed in the dais apprentice system. There is little margin for errors, because they are dealing with real lives.

Other Routes of Admission to Apprentice Model

Earlier in this chapter I mentioned that apprentice dais are in the main family-members. In what follows I present a different perspective to that discussed in the previous section. To illustrate the point, excerpts of the narratives of two dais'
socialisation into traditional midwifery practice are used. In both cases narratives were used to explain how they constructed their understanding and convey what they believed to be essential truths about themselves and their role as traditional midwifery practitioners. They are elderly women, aged 70 and 75 years old respectively.

**Narrative one**

Yes! For my first baby I had a caesarean section. My mother's sister was working at Civil Hospital at the time. In this epoch you had to wait for the baby's umbilical cord to fall before you get your discharge home... Normally it took twelve days for the baby's umbilical cord to fall. So I stayed in Civil Hospital for twelve days before I returned to my house. My second baby, I had her well (which she explained was a normal vaginal birth). For my third I had another caesarean. This means I had two caesareans. I became pregnant but I aborted and had curettage. All my treatment was done at Civil Hospital. But who did my treatment? (At this point she lowered the tone of her voice and she paused and gave a sigh of contentment). It was Dr Le Bourgier. He is my father (this is not in the real sense of the term. The term father is a mark of respect for someone who has done remarkable things for a particular person)

Eh Dr Le Bourgier, he was the chief in the hospital... After my caesarean I was in the hospital for a long time. So the other women, when it was their times to give birth, they were afraid and they cried. Some of them said 'my sister don't leave me alone, come with me'. No one was allowed to be in the birth room with other women. Only midwives and doctors were allowed to do so. But Dr Le Bourgier, he did not make any problem. If Dr Le Bourgier- my father, did not make a fuss, the midwives could not say anything. So I went with the women. AH AH (Nervous laugh!) I watched Dr Le Bourgier well, how he brought the baby out, how he cut the umbilical cord and everything else. I already had some intelligence with my own births, then I as time went by I kept on thinking about the idea of doing this work (meaning assisting women giving birth). I did not rush into doing this work. The first birth that I had assisted was my own aunt. She had great difficulty. The intelligence that I had helped me. You see, when a baby is coming out, that head or the buttocks come out first, but with this one, the face appeared and the colour was dirty, something was not good. There was a midwife and a dai there. The midwife looked and said I can't do it. I have never seen this before. When the dai saw this she was scared and said "Nein sab"(which she translated as, I will not be able to do that one. The dais fear is deep-seated. An abnormal child signals
danger of supernatural connotation. Therefore many dais would not associate with the birth of an abnormal child. It takes a lot of courage for anyone to deal with abnormal babies) Then I look long and hard. God gave me an idea how to do it. I helped my aunt give birth. When the whole baby came out, it was already dead. It was a little boy. On one hand he looked so good and on the other he was a monster, his head, at the back looked like voile, the bones were not there. God gave me a spirit, I wrapped the baby's head in a little white bonnet, I tied it neatly, and the ugliness did not show. When the dai saw what I did, she said, "all that you have done, now let me see how you cut the umbilical cord". I had no choice I had to cut it correctly. I remembered as Dr Le Bourgier did in hospital. I measured 4 inches from the baby's abdomen. I tied with fine thread. I then put the baby's clothes on and laid it on the canopy. I light the candle and together with the statute of Virgin Mary I placed it by the baby's head and pronounced the prayer. The dai gave two slaps on my head and said to me you know all this you can now do this work. I refused. She then said, "Would you let women die?" But you know it was in the old time. It was 1950. From then I earned a reputation. People from the village came and said "tantine (meaning aunt) we heard that you can do this work and would you come and assist our wives to give birth. EH how can I refuse? From then on I began to do this work and with time I became the mother of this village." So many of those children you see running around and some of the grown up too, they are all mine. As dais we are second mother to all the children that we assist women bring to the world

(Excerpt from interview August 1996)

This particular dai did not have to undergo the usual apprenticeship required of other dai. The two slaps that she received from the observing dai in the story is symbolic. Because of the hierarchical system of dais it would have been inappropriate for the dais of this village to allow the dai in the story to enter traditional midwifery practice without some formal validation. The act of slapping can be seen in parallel to anointing through the imposition of hands. She had certainly accumulated a stock of the knowledge of birth primarily through her personal experience of giving birth and through observation whilst being an impatient, acting as support to women. Whilst this is not certainly acceptable in today's practice, it was certainly a common occurrence in the late 50's.
Narrative Two

I was carrying my second baby. The journey was almost over.... only one month more to go. One afternoon the baby's house was still (baby's house refers to the uterus). I knew that something had gone wrong...aah yah! (This is an expression that is often used to express sadness, anger or disappointment. The meaning lies in the intonation. In this particular case it indicated sadness). Life had departed. The next morning before sunrise I gathered a small blanket, a towel and I woke my firstborn and asked him to accompany me to my sugar cane field (this is normally tended by hired workers). I gave him the bundle to carry. I did not tell him what was happening. I wanted to arrive at the field before the workers got there. We began to walk, as we got nearer the field I took the bundle of clothes from him and urged him to return to the house and tell no one where I was heading. There in the field I squatted alone and beckoned the baby's house to let go of the baby. I was alone and yet not alone, my maker was with me. It took sometime, but the baby came. As I already knew it was no longer in life. The flower came out straight away. I took the towel and the blanket and wrapped the baby up, carried it to my house and asked my husband to arrange for burial. This was my calling to become a dai". (Excerpt from interview September 1996)

What are in these two stories? In a sense we see the importance of private knowledge and its relationship to practice. Based on her experience the second dai advocates a completely hands off approach to assisting women giving birth. Any interference, whatever the nature, in her view is an absolute insult to the woman and the baby, and is even iatrogenic, in the sense that it disrupts the synergy that exists between mother and baby in the process of giving birth. Her story does not end there; she also challenges my socialisation into midwifery practice. To some extent the role was reversed as she became the interviewer and I became the interviewee. This was one of the most powerful experiences for me.

Formal Education- Changing context of learning

The justification for formal education arose in the early1900's. It is perceptible on two levels: Firstly, the necessity to reduce the high incidence of perinatal and maternal mortality- a pervasive problem that was associated with dais' practice and lack of knowledge. Whilst the principal cause of infant mortality was
tetanus resulting result directly from the equipment used to sever babies’ umbilical cord, maternal mortality was significantly linked with sepsis and haemorrhage. Second, it made it possible for the government to control the practice of dais, which was associated with progressive social reform. The first formal programme was only launched in 1971. This led to legislative development in the same year. It became compulsory for all dais to undertake the programme prescribed by the government. At the same time it became illegal to practise. In a sense then, traditional midwifery practice came under the purview of the Ministry of Health. The dais became organised and integrated in a way appropriate to the nature of the governance of professional midwifery practice.

The role of formal education was to provide all dais with basic content knowledge so as to improve their practice. Examples of the content knowledge include:

- Principles of hygiene.
- Maintenance of asepsis.
- Nutrition.
- Dealing with complications.
- Referral system.


All dais are provided with a kit containing appropriate equipment, especially for severing babies’ umbilical cord. The kit is symbolic of license to practise and differentiation from, unofficially untrained dais. There was a sense of pride in demonstrating their kit to me. It certainly marked an achievement. The officially trained dais spoke of themselves as superior to the unofficially trained ones. There was clearly a division between them. However a distinction has to be made between unofficially and officially trained dais. Dais who have not participated in the government training programmes have undergone an intensive informal
apprenticeship during which they observe, carry out apprentice duties and, finally, are assessed before being declared qualified to practice as a dais.

Formal education initiated a change in the context of learning, from a practice-oriented approach steeped in the socio-cultural ethos of tradition to an academically and clinically based system acculturated and legitimated by the state.

**Monitoring of Practice**

The system in place for monitoring traditional midwifery practice includes the following:

- **Link with local AHC** - this is the focal point where dais activities are monitored. All practising dais are accountable to the District Nursing Officer (who is also a midwife). Within all localities they are known by, and know their District Nursing Officer. It seems that a register containing the credentials of the dais is kept but this was not available for perusal.

- **Record of attendance** - the dais are required to keep a record of women they attend in labour. They must present this record, in person to the District Nursing Officer of their respective AHC, within twenty-four hours of any birth that they have attended. The District Nursing Officer duly signs this record.

- **Inspection and Renewal of kit** - the District Nursing Officer is responsible to carry out this duty. This is done normally on a monthly basis when the dais are required to bring their kit to the AHC for renewal. This involves replacing antiseptic solutions, umbilical cord ligatures and basic instruments. At the same time the District Nursing Officer or her designate reinforce the basic principles taught during their training.
Impact of Changes

The linkage of traditional midwives to area health centres characterises modern reflections on traditional midwifery practice. This became a turning point. Although critical of the professional midwifery system, the dais began to embrace medical knowledge and saw such knowledge as desirable. They see formal training as a means of raising their social status and their credibility as, midwifery practitioners in their own right. One of the consequences of formal education is that it brought about conceptual changes and introduced new ways of thinking about childbirth and traditional midwifery practice.

The Status of dais today

Views about the position and status of dais vary from group to group. Whilst there were some informants who were categorical that the demise of traditional midwifery practice was necessary, others unreservedly, claimed that they had a significant role to play. The differences lie in the cultural, ethnic origin of the informants and in a very significant way, their adherence to religion. As traditional midwifery practice does not separate religious and social issues from it, the dais are respected for the knowledge and the skills of religious practices pertaining to childbirth that are not found in professional midwifery system. Certainly the beliefs in supernatural calling had an influence, in the sense that the dais were considered more than ordinary women and midwifery practitioners. Those who hold such view argue that:

Although they are non-literate they know an awful lot about the religious ceremonies that are important. They know exactly how and when to do them. It is important that we follow what our priest and the holy book tell us what to do. Besides they have had a special calling, so generally women believe that they have a special relationship with the gods. Unless you are part of our religion it will difficult for you to understand why we still hang on to our roots but our beliefs is important to us. We must not and cannot allow our intellectual knowledge or other positions in life take over what our religion has taught us through the years.

(Excerpt from interview July 1996)
One of the research personnel, a medical doctor and obstetrician with considerable years of experience said this:

These women hold valuable knowledge that with the reform of midwifery and the adoption of the western system, have been forgotten. The cultural knowledge that once formed the bedrock of midwifery and gave it its meaning must be recaptured.

(Excerpt from interview August 1996)

Conclusion

This discussion in this chapter has demonstrated that the definition of the dais is far more complex than the one given by the WHO. We can begin to identify issues that are central to the analysis of knowledge production and legitimation. This chapter has begun to engage us studying ways of knowing in the non-empirical realm as well as demonstrating the introduction of knowledge that is generated by value-neutral empirical methods. In the next chapter I broach the subject of traditional midwifery practice as a continuation of the development of arguments that will enable the reappropriation of midwifery knowledge.

As modern thinking permeates the Mauritian culture a gradual dilution of traditional midwifery practice can be observed. This is a concern expressed by most practitioner of traditional midwifery. Undoubtedly, childbirth and midwifery practice were fraught with problems. These were mainly related to environmental and ecological factors. Unfortunately critics of traditional midwifery underrated such factors and lay the problems firmly on the practice of traditional birth attendants. Consequently a large component of midwifery knowledge has been largely unresearched. Today it exists only on the periphery of the Mauritian midwifery system.
CHAPTER EIGHT

Underpinning of Traditional Midwifery Practice

Introduction

This chapter concentrates on the philosophical assumptions of traditional midwifery. It is a field where a multiplicity of forces is articulated to express the reality of that practice. The most significant of these, is the Mauritian society's construct of childbirth. Childbirth is influenced by cultural and environmental factors which carry with them a whole array of meaning. In turn traditional midwifery is influenced by the societal value system of which it is a part. This chapter falls in two sections. The first addresses the cultural concepts discussing the conceptualisation of childbirth. The second presents the rituals associated with childbirth. In so doing I sketch the wider context within which lay perspective and experiences of childbirth and midwifery practice take place. Thus this chapter engages us in studying ways of knowing that do not appeal to experience that is not mediated by value-neutral empirical methods.

Cultural Concepts in Traditional Midwifery.

The assumptions, upon which traditional midwifery practice is based, rest on the society's conceptualisation of childbirth. This is as follows:

It begins with conception of the baby and ends when the child, as a person is ready to depart from life. It is about the beginning and ending of life. It is life itself.

(Field notes July 1996)

Within this worldview childbirth is understood not as a set of disconnected actions or isolated events or an end in itself but in terms of a dynamic whole. It is a continuous process in human life- a rite of passage (Van Gennep 1909)- a global notion that is interpreted in varying ways. In Mauritius there are two main and inextricably linked concepts that govern this worldview. These are:
Chapter 8: Underpinning of Traditional Midwifery Practice

- Vulnerability.
- Danger.

There is a strong relationship between this particular worldview and religion, religious teachings and other societal beliefs. At the base of most religions, in particular Hinduism and Islam is a construction which juxtaposes two extreme positions about traditional midwifery practice. The two positions that provide reference points on the axis of religious belief and traditional midwifery practice are:

- Pollution.
- Sacredness.

From these two positions are derived the various rituals that enable women and dais to reconcile the paradoxes that these positions create. Similar beliefs are recorded amongst the people of India, Africa, Malaysia, and Indonesia and in some part of United States of America (Hoch-Smith and Spring 1978; Vincent-Priya 1992; Lindenbaum and Lask 1993; Graham 1999) and are recognised in many parts of the world. They are influential in establishing elements of control and surveillance that both dais and women exercise over the childbearing process. Each of these concepts is presented below with the aim of explaining the wider cultural contexts of childbirth and the symbolic meanings that accompany them.

**Vulnerability and Danger**

This is central to the explanation of disease causation in childbearing. Attitudes toward vulnerability and danger differ amongst dais. The majority, however, holds that childbearing signals a vulnerable and dangerous time. It is a period of heightened awareness that calls for extra caution to avert danger. In assessing vulnerability and danger, two broad classifications that are central to the explanation of disease causation in childbearing, emerge:

- Internal forces: These relate mainly to biological factors and the woman’s general state of being.
• External forces: These relate mainly to malevolent forces that are believed to be seriously capable of endangering the lives of women and their unborn/newborn infants. Consequently most dais and women pay special attention to those forces.

**Internal forces**

Childbearing is generally held to be a state of imbalance. This is mainly to do with body humours.

**Pregnancy- The state of “Hotness”**

Pregnancy is generally regarded as ‘hot’. This is linked to several causes. A common one is the placenta. It is associated with increased blood supply flowing through the body, thereby producing extra heat. Even more significant, the placenta is believed to be potentially a source of danger to the baby. This is based on the myth that the placenta consists of an accumulation of menstrual blood. Women are very aware of the health of their unborn infants, thus guided by that concern, the childbearing woman assumes responsibility to protect her unborn baby against all potential hazards. Within this discourse, the women are often held responsible for the cause of any problem/anomalous development in the baby. This perspective recognises that there is tension between the anomalies caused by internally imposed dangers and the responsibility of the mother. Sometimes, although rarely, women who have borne children with deformity/ abnormality may find themselves stigmatised. The potential problem posed by the state of “hotness” is controlled by the regulation of dietary practices including the common practice of avoiding “hot” foods.

Dietary practices differ markedly among the different ethnic groups. In the Hindus and Islamic culture, foods are characterised as “hot and cold”. Examples of these are illustrated in the following table:
Great care is taken in dietary practice. In addition to what is permissible and safe to eat, there is a set of implicit rules about the preparation of food. Amongst Hindu and Moslem women there is a widely held belief that food in the hot category, (if eaten during pregnancy) produces a whole range of somatogenic anomalies of varying nature and severity. Additionally during the early weeks of pregnancy (as soon as the woman recognises that she is pregnant up until the third month) she is permitted to undertake selective chores only. For instance, she must not use a knife during the first few months following conception. This period is described as the forming stage, the act of cutting at that point is held to interfere with normal development and is likely to cause dysmorphologic features. Cleft lip and palate are cited as dysmorphology directly attributed to the act of cutting foodstuff or other substances.
Dysmorphology is equally a major concern for women since it does not only look unsightly but may have long-term implications for the child. In the context of such beliefs and their relationship to vulnerability and danger, pregnant women, more often than not, are exonerated from involvement in food preparation. These claims are not demonstrated by empirical evidence. They are based solely on women's encounters. Thus there is a sense in which the significance of the causation of such physical/dysmorphology is misunderstood. Nonetheless this indicates the dais and women's way of control of anomaly through physical control.

**Postpartum- The State of “Coldness”**

This defines the period immediately following the birth of the baby, placenta and lasts forty days when recovery is thought to be complete. It would seem that forty days (six weeks) following childbirth is a generally recognised as recovery period in western as well as non-western cultures. The state of coldness is held to be the most hazardous in that resistance to illness is generally lowered. It poses different threats; these are mostly associated with the status of the uterus which is viewed as tantamount to an open wound in need of rapid healing. The emphasis is on restoration of homeostasis. Here nature is not allowed to take its own course. In contrast to pregnancy, women are expected to adopt a sick role, for instance, they are unable or not permitted to do any chores, confined to bed and required to maintain certain dietary regulations to expedite the healing process. Part of this process involves the rapid expulsion of blood from the uterus. It is based on the assumption that blood stagnates and leads to infection of the open wound. Here too food plays a major role. In this instance various substances such as turmeric (mostly referred to as haldi), ginger, lemon grass, ginseng and wine are added to food preparation. These, in particular haldi, are held to produce heat that serves two purposes: firstly, it cleans the uterus of all impurities (i.e. blood); secondly, it starts the healing process. The use of “cold foods” is prohibited.

Equally significant are problems imposed by the natural environment. Examples of this include windy and wet weather, cold and draught, which are held specifically to cause uterine cold. It seems that air enters the vagina and causes an
imbalance in thermal capacity of the uterus. This in turn destabilises the normal coagulation of blood, the end result of which is clot formation that may be fatal to the woman. Although it is apparent that all women do not hold this view, it is nonetheless not unusual for them to follow the advice given by the dais. This focuses on the avoidance of cold. It is customary, therefore, for women to be confined to the internal boundaries of their respective houses. The practice is also based on beliefs related to pollution which I address elsewhere in this chapter.

Another component of the “cold theory” focuses on wearing protective clothing which if going outside, is deemed essential. In this instance it is usual for women to wear extra undergarments and sanitary protection, cover their heads with a scarf or some other form of protection to safeguard themselves against chill and the possible consequences on their general well-being. It appears that by following such course of action, any anxiety or fear associated with the vulnerable period is dispelled.

External Forces

In externally imposed dangers, emphasis is placed on malevolent forces. These forces are defined as “met li yeux” - a creole term that is literally translated as “cursing eye”. It is used collectively to describe all malevolent acts. In most literature reference is to the “evil eye”, which is believed by some more than others to account for any physical as well as supernatural dangers that may occur in pregnancy. The morbid process of the cursing eye operates in silent ways. It happens almost by insinuation.

When some one cast a cursing eye on you will not know when it happens. It is always afterwards, when you find that things are not going too well. The woman may loose her baby or the baby may have some illness later. So you have to take precaution so that no harm will come your way.

(Excerpt from interview July 1996)

The rationality governing the belief is that misfortune occurs because another person who possesses the cursing eye bears the woman or her unborn baby ill. Ill feeling or resentment may be borne out of sheer jealousy or out of a desire to seek
revenge for an offence that had been committed against another person. It may also be due to unresolved conflicts that may have arisen at some stage. The difficulty for the pregnant woman as for any one else, as demonstrated in the quote above, is that it is not always possible to identify such a person. In dialogue with the dais, in reality, this is merely a way of thinking which is seldom accompanied by actual experience. It is a symbolic way of accounting for otherwise inexplicable misfortune and it is found to be widely held also by the traditional birth attendants of Karimoga (Graham 1999). In most cases this area of concern emanates from stories that have existed in the community through the ages. Nonetheless women are fearful of the "cursing eye." For them it a question of significant interrelationship which is embodied in discourses of power. As one Dai pointed to me

Sometimes other people's spirit may be stronger than others.

(Excerpt from interview September 1996)

Dais or family members advocate some form of protection.

**Protective Measures**

The manner in which protective measures are adopted against malevolent forces takes a form that is culture-determined. Differences exist in the ways each ethnic group and subculture shows their forms of protection. For instance in Islamic culture an extract of prayer from the Qu’ran is placed on the lintel of the front door. It is seen either on exterior or the interior of the lintel. The mode of display may vary according to the different sects of Islam. The Hindus place a little earthen lamp that continuously emits a flame, at the entrance of the gate or at the front door. Fire is held to give out energy; its flames destroy evil (Baker1990). Hence any malevolent or ill spirit that may venture into the home environment is disempowered. Protection is guaranteed. During my fieldwork I encountered an intriguing experience related to this:

This is an experience that occurred on 8th August 1996 at 3p.m. It happened during a visit at a dai’s house who lives in Quatre Coco, a little village in the North of Mauritius. The visit had been arranged by my sister who is a senior midwife at one of the District Hospital in the Northern Region. She had met this particular dai, who agreed to be
interviewed, on numerous occasions when she accompanied her clients to hospital. As our vehicle approached the entrance of her house on the appointed day and time, the community came out in consort and followed us to her house. We passed by the little burning lamp to her front door. But the dai delayed in coming out. I asked one of the many people that had gathered around, whether she is in. There was a peculiar response, in the form of a giggle and then one of the people said: "I am her sister-in-law, she is in but she had said not to come." This message certainly had not reached us. After about ten minutes or so, emerged a little woman, with a very defiant behaviour. She stood erect with both hands on her hips, literally running her eyes from my head to toe. Unperturbed by her behaviour I bowed my head (This is a mark of respect to older people) and greeted her "Namascar" which is good day in Hindi. In an authoritative voice she uttered, "Didn't I say to you not to come? I sent a message to the matron of that hospital down the road. that matron who told me about you. At this point my sister intervened and said, "I am that matron." The dai then laughed and took a good look at my sister and said "But you have not got your uniform on, I did not recognise you. Oh come in, come in. She then came to me and gave a hug-a sign that all was well. The explanation of her behaviour became evident during the course of my dialogue with her. According to her there are bad spirits that interfere with childbirth and midwifery. Therefore she must always vet the person that she is called upon to assist. Similarly she would vet any stranger that ventures in her space, as I was. "You must know what kind of spirit the person brings or has". Sometimes, she explained the bad spirit might prevent you from gaining access. You must pacify them. Bringing an offering to them does this. Then only can you gain power over them and do your work undisturbed) (Field notes August 1996)

Of the thirty dais that I interviewed she was the only one who expressed spiritual beliefs of this nature. Within the local context of that village as in many parts of Mauritius the practice is a spiritual dimension which pervades knowledge of everyday life; it forms part of deliberate actions in determining the intention of a stranger within their midst. The practice manifests in different ways and forms. Spirituality is an integral part of the social reality and since childbirth and by extension midwifery practice form part of that reality, such practices like the one described above are common phenomena. The dai explained that tensions might arise if there are conflicting spirits, which will subsequently hinder her work. Thus to avoid problems and safeguard the well-being of the woman that she is called upon to serve, she must in the first instance assert her authority and bring conflicting spirits in subjection to her wishes. Tackling malevolent forces often demands a
confrontational approach that is indicated above. This behaviour is demonstrated at each labour that she is called upon to attend. In that context, midwifery within the domain of everyday life poses demanding challenges. The encounter with traditional ethos and practice in the day to day life of the people did not change my view as much as it enabled me to draw similarities with the western perspective, in the sense that we try to put the woman at ease thereby removing any psychological barriers that may impede progression of normal labour and birth- a practice that is encompassed in our role as advocates (UKCC 1993).

Other forms of protection include wearing amulets. These are believed to contain protective powers against malefaction. It is not uncommon for men, women and children to wear amulets throughout their lives. But particular ones are worn during pregnancy until the completion of the postpartum period. Because they have been blessed by special prayers dais claim they offer the childbearing woman and unborn/newborn infants a new kind of security.

Additional measures include guarding the knowledge of and about the pregnancy with great secrecy. Women scarcely engage in conversation about their pregnancy to anyone outside their immediate relations. When asked about the baby's due date, a natural question that most people ask pregnant women, they will not disclose it, most often the answer given is "not too sure". Dais maintain that others could use the knowledge of the women's gestation to harm her and her unborn infant either during pregnancy or birth; secrecy, therefore, insures that nothing untoward will happen to them during or at the time of birth. Reluctance to disclose knowledge about the pregnancy is not specific to the Mauritian society; it is also prevalent in other premodern societies (Chalmers 1987).

**Spatial Disjuncture and the challenge to power**

The final perspective in vulnerability is spatial separation. Spatial separation is exemplified in admission to hospital during childbirth that is viewed as a crisis. Separation and estrangement from their familiar social context invoke a great deal of deep-seated fear. However, the fear is not so much to do with separation as it is with the consequences of the suspension of religious practices surrounding childbirth
which can cause cultural conflict. The hospital exerts considerable control over the conduct of birth and does not permit the dais to stay with the woman in the labour ward. It is strictly the province of hospital staff.

The dais' position of authority vested by her community is no longer recognised. Transfer to hospital is not seen as a favourable outcome, thus it puts the credibility of the dais in question. The dais’ disenchantment with hospital is expressed below.

L’Hôpital l’enfer- literally translated, as Hospital is hell. Only when you are really ill would you go to hospital. Apart from serious illness everything that is normal takes place at home Once you are in there everybody (meaning nurse-midwives and doctors) tells you what to do. You have to birth your baby in bed. You can't do it other way; they will not allow you to do it in any other way. They will not allow you to use the remedies that you know. I do not tell you that we do not need the hospital, but it is the way that they deal with birth that we do not like. Their ways are different to ours. They do not take notice of all the religious things. They tell us off when we ask to come in with our women so we could make sure that they are done. But they do not agree. They tell us they do not want us to interfere and that all the religious things we can do when the woman returns home.

(Excerpt from interview June 1996)

Dais seem to resist governmental strategies because their power and knowledge are being challenged. As exemplified below, clearly, giving birth in hospitals is not well viewed.

In days gone by there was no one else except dais to do midwifery work because there were few doctors and nurses. We got on with our work, nobody bothered us We have our "connaissances" (meaning skills and knowledge) but nowadays it is not good enough so the doctors and nurses keep saying. Nowadays the population is increasing, many young people are going to other countries to study. When they return they need jobs. They start to tell us what to do. Our (connaissance) are no longer good. They think that what they have learned in the other countries is better and we must do as they say. They think they know better, what to do we must listen. But in reality they do not know- just making the baby come out is not enough. But all the religious things they do not do. In hospital how can you do those things? There is a problem you see. On top of that, they are telling off women that are better to give birth in hospital because of dangers. Some women keep this in their head. Hence they have started to have fear and they do not trust themselves any more.
They do not trust the power that, in our beliefs, we say that God has
given us. All of them want to go to hospital now.

(Excerpt from interview June 1996)

In addition to power, issues relating to role differentiation and creation of
new jobs resembling the western development, emerge as a significant factor in
Mauritian midwifery system. As a paradox, if the necessity to transfer the
childbearing woman to hospital arises, the dais will not hesitate to do so. They are
keenly aware of the implications of complicated births.

Unless the woman’s relative indicates otherwise, dais always accompany
their client to hospital. They stay in the outer area of the labour ward until the
woman has given birth and leave when they have ascertained that both the woman
and her baby are well. The reason for this is two fold. Firstly, it is out of fear that
some damage may have already occurred whilst the woman was labouring at home;
secondly, to collect the placenta for burial. This is further explored under the dais
sphere of practice later in the next chapter.

Pollution

Many of the beliefs surrounding pollution and its relationship to childbirth in
Mauritius can be traced to Eastern socio-philosophical schools of thought (Baker
1990), which crystallised a structure through which existing rules and practices
surrounding traditional midwifery practice are understood. Central to the concept of
pollution are the ideas of purity and impurity which are associated with the post-
partum period during which both the woman and her infant are in extreme danger.
The unclean blood associated with birth and the postpartum period is the cause of
impurity. The woman, in the context of pollution, is in an extremely vulnerable
position as well as being a source of danger to others. The source of pollution is
found in the placenta, umbilical cord and the Lochia. As in other parts of the world
contact with any of the above is considered highly polluting and transmitting danger
(Douglas 1966; Lindenbaum and Lask 1993). She is required to undergo a process of
purification. Until the process is complete, she must avoid contact with her family
and community; she is also segregated from holy places.
Engaging in traditional midwifery work is strongly viewed by some as defiling. This is expressed through two main ideas:

- **Sacredness** - There is a strong sense in which all that is considered sacred must not be mixed with what defiles.
- **Caste system** - Generally only low caste women undertake traditional midwifery work. It is not uncommon, however to see women of the middle caste acting as dais; but they only restrict their service to family members.

Views about dirt, pollution and sacredness in relation to childbirth are illustrated in the following excerpts. The first is obtained from a woman in the “unexpected” group and represents the views of others present at the time of my meeting with them.

No, this work is too dirty. If I get involved in it I will not be able to sell the milk from my cows. Because you see the cows are sacred and the blood loss after the baby is born is dirty. You cannot mix the too. More over I too will be made dirty if I touch the woman, her baby or anything else that is soiled with her dirt. How can I tend my cattle at the same time? Besides nobody if they know that I do this job will buy milk from my cows. I will then lose my business. I do not want this to happen.

(Excerpt from interview August 1996)

In our caste we do not do this kind of dirty work. This is normally for those low caste people. But I do it for my daughters only; they are family. In that case it is all right. My mother used to do for us, my sister and myself. Therefore I must do it for my daughters also and hopefully they will one day do it for their daughters. I most certainly will not go out and attend to anybody else.

(Excerpt from interview June 1996).

The emphasis is on the protection of sacred places. This idea is not new to Mauritius. Many anthropologists in other parts of the world have explored it. For instance Van Gennep (1909, p 59) reported similar beliefs and practices amongst the Toda of India.
Le femme doit vivre dans une hutte spéciale; elle est rituellement séparée de la laiterie, industrie sacrée qui est le pivot de la vie sociale des Todas.

The woman must live in a special hut; she is ritually separated from the milk farm, the sacred industry that is the pivot of the social life of the Todas.

Exploring the idea of dirt Douglas (1966) shows that how beliefs about dirt (pollution) is used as a claim to reinforce status. She also shows that it has symbolic significance, in the sense that, firstly, it expresses a general view of social order, and secondly, it opens up ways through which the relationship between religion and the social world can be understood.

The more we know about primitive religions the more clearly it appears that in their symbolic structures there is scope for meditation on the great mysteries of religion and philosophy. Reflection on dirt involves reflection on the relation of order to disorder, being to non-being, form to formless, life to death. Wherever ideas of dirt are highly structured their analysis discloses a play upon such profound themes.

(Douglas 1966, p5-6)

In linking a basic notion of dirt with such philosophical notions of being and non-being of life and death, Douglas’ idea is important in enabling a deeper understanding of what religious knowledge constitutes, particularly since in dais’ perspective, childbirth is linked with the process of life and death. (See dais’ conceptualisation of midwifery and childbirth). She also draws a parallel with modern scientific interpretation of the rules of purity which I will return to later in the final part of my study.

**Rituals**

The process of purification involves a set of long and complex rituals that are categorised as follows:

- Rite of separation - this involves separation from the previous state, place, time and status.

- Rite of aggregation - this is about resumption of normal everyday life.
As the period of uncleanness is associated with the postpartum period, ritual performances are specifically related to it. The post partum is the liminal stage in the woman’s rite of passage which is described as the “floating stage”. The conceptualisation resonates with Van Gennep’s explanation of the rite of passage. (1909) Which he likens to a house. I will return to the notion of the house later on in this section

According to Van Gennep (1909) the liminal stage is a key and risky period in all rites of passage. Recognising it as being the most risky, most women adhere to their respective religious teachings. I would like to expand on the notion of liminality further in order to provide deeper insight into the significance of rituals and the ritual process.

The concept of Liminality and its relationship to the rite of passage

It is useful first to define rituals. One of the well-known definitions suggests that they are;

Prescribed behaviour for occasions not given over to technical routine, having reference to beliefs in mystical (or non-empirical) beings or powers regarded as the first and technical causes of all effects.

(Turner 1982, p.79)

Douglas (1966), Marcus and Fischer (1986), Davies-Floyd (1992), Anderson and Foley (1997) indicate that rituals are about patterned shared behaviour. They are interpretative acts through which meanings are created and endowed upon experience. Stemming from the perspective of religion, Alexander (1997, P.139) points out that:

Traditional religious rituals open up ordinary life to ultimate reality or some transcendent being or force in order to tap its transformative power.

As stated earlier the ritual process begins in the liminal stage of the rite of passage. Expanding on Van Gennep’s idea of rites of passage, Turner (1991) explains it as movement from structure to anti-structure and back once more to structure. Liminality is anti-structural, a state of “betwixt and between”. Turners’
examination is based on his knowledge of Ndembu ritual. There are some points that are relevant to our discussion on the values of traditional midwifery. Firstly, the person in the liminal stage is expected to remain silent and to adopt a servile position, representing submission

to an authority that is nothing less than that of the total community...which is the repository of the whole gamut of the culture’s values, norms, attitudes, sentiments, and relationships.

(Turner 1991, p 103)

Secondly, aspect of liminality relates to stages involved in returning to structure.

It represents partly a destruction of the previous state and partly a tempering of their essence in order to prepare them to cope with their new responsibilities.

(Turner 1991, p. 103)

Turner sums up liminality in the following way

Liminal entities are assigned and arrayed by law, custom, convention, and ceremonial. As such, their ambiguous and indeterminate attributes are expressed by a rich variety of symbols in the many societies that ritualise social and cultural transitions. Thus, liminality is frequently likened to death, to being in the womb, to invisibility, to darkness... Liminality, marginality and structural inferiority are conditions in which are frequently generated myths, symbols, rituals, philosophical systems, and work of arts. These cultural forms provide men to action as well as to thought. Each of these productions has a multivocal character, having many meanings, and each is capable of moving people at many psychobiological levels simultaneously.

(Turner 1991, pp 95 and 128-9)

As we shall see the rituals associated with childbirth and traditional midwifery practice is explicated by the tenets of liminality defined by Turner and are grounded in the experience of everyday reality. Recognising the liminal as being the most risky, most women conform to the rules prescribed by society. Dais perspective of liminality is as follows:

After birth we are neither here nor there, neither one thing nor another. We are floating .We are connected to the earth and the sky. We stand between the two but the earth is our mother because on it we can set foot. We must be clean to be able to set foot on mother earth. A woman
who has given birth, because of all the dirty fluid that comes out after birth (This refers to lochial discharges in the sense of pollution and is considered more potent than menstrual blood) for a certain number of days she is not clean because of that she must not stand on the earth until she passes that stage and is clean again. It is like she stands on air. If sets foot on it before she is clean, she will sully the ground; it is an offence, isn't it? It will cause her harm because she would desecrate what we believe is sacred. It is important that she stays inside until such a time that she has been made clean. Of course she does not become clean just like that. There are systems that need to be done. For forty days she remains in that state.

(Excerpt from interview July 1996)

The ritual process begins with the rite of separation and lasts for forty days.

The Rite of Separation and Integration

Although all religious persuasions recognise the importance of rituals, the degree to which they are observed varies according to individual families and their adherence to religious teachings. It seems that Hindus and Moslems are strictly observant of them. Within Hinduism and Islam the rituals begin with the rite of separation which last for forty days. Van Gennep (1909, p.79) found in the case of Punjab women:

Mais la séclusion dans la maison dure 40 jours, pendant lesquels la femme passent par une série de cérémonies dont le rite principal est le bain et qui ont nettement pour objet de réintégrer progressivement la mère dans la société familiale, sexuelle et générale.

*But the seclusion to the house lasts for 40 days, during which time the woman undergo a series of ceremonies out of which the bath is the principal rite and with the clear intention to reintegrate the mother progressively in her family, sexual life and in society in general.*

In order not to lose the emphasis placed on rituals by the three dominant religions I have dealt with them separately.

The Hindu Perspective

Rituals relating to the woman

With its emphasis on purification, ritual practices are directed towards the regulation of cleansing activities. Seclusion begins as soon as the woman enters into
labour, during which time she is invisible to the rest of society, and last for forty days.

Common practices during the seclusion include the following

- Avoidance of contact with others.
- Avoidance of contact with sacred objects and places.
- Avoidance of preparation of food.
- Avoidance of sexual relations.

Of the forty days that constitute the period of seclusion, the sixth and the twelfth day are most significant. They represent the gradual process of reintegration in the family and society.

The first six days are considered the most defiling because of fresh Lochia. During this period she is confined to her bedroom and forbidden to step over the thresholds of that room which marks a break with other spaces in the house that must be kept undefiled. The deeper significance of act of not crossing the threshold, as explained by Van Gennep (1909), is because it is associated with sacred space. This is a belief common to other religions and societies. As Van Gennep (1909, p. 33) said:

Quelquefois la valeur sacrée du seuil se trouve dans tous les seuils de la maison: j’ai vu en Russie des maisons sur le seuil de chaque chambre desquelles était cloué un de ces petits fers à cheval qui protègent le talon des bottes: or, dans ces maisons, chaque chambre avait son icône.

En tout cas, pour comprendre les rites relatifs au seuil, il convient de la porte de se rappeler que le seuil n’est qu’un élément de la porte, et que la plupart de ces rites doivent être pris au sens direct et matériel de rites d’entrée, d’attente et de sortie, c’est-à-dire de rites de passage.

Sometimes the sacred meaning of the threshold is found in all the doorsteps of the house: In some houses in Russia I have seen either a small horseshoe which protects the heal of boots fixed on the threshold of each room or each in those houses each room has its icon.

At all events, to understand the rites related to the threshold, it is essential to recall that the threshold is but on element of the door, and
that almost all those rites must be taken in the direct and literal sense of the rites of entry, waiting and of exit, that is the rites of passage.

I now want to return to Van Gennep’s notion of the house to further illustrate this point. In viewing the rite of passage as analogous to the house, Van Gennep (1909) indicates the following: the house constitutes the sacred and the profane. He draws the distinction between sacredness and profanity by claiming that the inside of the house constitute the profane, what lies outside constitutes the sacred. Each passage mediates the one and the other. To my mind there is a deeper meaning that goes beyond the notion of seclusion; it is to do with the state of being. The interior of the house represents the physiological being which is the causation of the defilement after birth. It will be recalled in chapter eight that postnatal women will not set foot on ‘mother earth’, which is considered sacred. Thus the inner sense of profanity must be regulated (to use Van Gennep’s term) to achieve the state of sacredness. So there is more than just a social reality but one that is inseparable from the biological and spiritual self. Thus the relationship between the childbearing woman, her biological spiritual and social reality are embedded in the tension between these two counterposing tendencies of profanity and sacredness. In so far as the threshold mediates between one physical space and another it also mediates between one biological and social state to another state of being.

Therefore, for the first six days the women are confined to their bedroom and are forbidden to cross the threshold. Similarly others, except the dais and her mother or sister, are denied access to her bedroom. Additionally as a measure of protecting against intrusion of malevolent forces a “Fataque broom” is placed on the threshold of the main door of her house. It is a symbol of protection and is held to avert danger. It often features in traditional midwifery practice, particularly in difficult birth. Fataque is a wild plant. It yields longstem sturdy flowers that are collected specifically to make brooms, which are used for cleaning purposes. It is a primitive tool that is still seen in use today despite the wide availability of modern facilities.

(Field notes July 1996)

All activities, which include bathing and eating, are carried out within the boundaries her room. The utensils that she uses to eat are removed and washed by the dai. Similarly all soiled clothing are taken away and laundered daily by the dai.
On day six the woman has a ceremonial bath, it is called a 'cleansing bath'. Water, which symbolises purification, is taken to the woman where the special bath takes place. Special herbs containing purifying properties are added to the water. The dai and the woman's mother are involved in the bath ritual; thereafter the woman's mother usually carries out, a religious ceremony. After the ceremony the woman wears everything new- she steps over the thresholds of her bedroom as a new person. With the exception of the kitchen she may move about anywhere in the house. She is still not allowed to prepare food or even touch any kitchen utensils or cutlery lest her state of uncleanness defiles these."

(Field notes July1996)

The isolation of the woman during and after birth is significant, just as is the rite through which mother and baby are welcomed back to the family.

Before she resumes every day activities, particularly the activities relating to personal hygiene other rituals have to be performed. Examples of those rituals are cleansing of the taps before she could touch them. Running water is considered a source of life, nobody can live without; it must therefore be kept pure. This specific ritual involves the woman and her mother. Before she is allowed to open the tap to obtain running water, a cleansing ritual must be carried out. This involves the following: First the woman has her bath in the usual way. She is given some flowers, usually white, which symbolises purity. She places this by the sink. Her mother then lights a fire using a little earthen lamp and chants a prayer whilst rotating the lamp around the woman's hand. After this ceremony she is free to touch the taps. An elaborate feast is then held in honour of the new mother. Many guests are invited. The foods that are prepared and offered must contain seven types of different vegetables.

(Field notes August 1996)

After the sixth day ritual the woman emerges as a new person. In the context of Hinduism, the performance of these rituals is closely tied with Van Gennep (1909) and Turner's (1967) analysis of symbolic experience that mark the assumption of new social status. In this case, the rites of purification become a collective one. Furthermore, the objective of the cleansing bath and other associated cleansing rituals denote the progressive reintegration of the woman into her family circle and society in general and to personal sexual health. (Van Gennep 1909).

A similar, but less elaborate ritual is carried out on the twelfth day, which renders the woman virtually clean, although certain activities like food preparation
are still prohibited. Finally, on the fortieth day she is no longer vulnerable or defiling. She may step out of the house, with a new status. When we compare the fortieth day rituals with Western midwifery practice, a striking similarity emerges—the six weeks postnatal examination which confirms the woman’s return to prepregnant status and restores her to full economic potential. It allows her to resume all household activities as well as return to work.

Rituals relating to the Baby

A similar process is involved in the case of newborn babies. Firstly, the priest is consulted to find the most auspicious time for the baby’s bath. The advice given will be according to the time of sunrise. The bath must be taken where the sun faces and should be between 9 o’clock and 11 o’clock in the morning. A similar process is involved for the naming ceremony. In this instance the priest is given the date and time of the baby's birth (these are important information for the right name), which is used to consult the "holy book."

On the first day the priest visits the baby. He presses a bright red or black dot on the baby's forehead. This symbolises a third eye, which seeks out, detects and counteracts any evil on behalf of the baby. Often a black bracelet is simultaneously worn to potentiate the effect of the third eye.

(Field notes August 1996)

On day six, in addition to the cleansing bath, the baby's hair is shaved. and a religious ceremony is performed. Underlying this practice is the belief that the baby's first hair is contaminated by contact with mother's blood. This practice varies amongst Hindus; in some instances shaving of the baby's hair is not carried out until the first birthday. Thus by comparison to the cleansing rituals of the mother, the practice of hair shaving as a cleansing ritual is more relaxed.

The Islamic Perspective

Similar practices are identified among Islamic women. They too are expected to enter into seclusion, to avoid contact with others, and are forbidden to perform certain acts of worship such as praying— an issue that is tied up with Douglas’
analysis (1966) of the concept of pollution, especially with reference to protection of sacred things and places from defilement.

In addition to the 6th and 12th, the 40th day is also very significant. By way of contrast to the Hindu’s approach, the first twelve days is a period of complete confinement to bed. The dai attend to daily care and hygiene. The cleansing rituals, which begin with a similar ceremonial bath on the sixth postpartum day, initiate a series of rituals which culminates on the 40th day. Among the main characteristics we see a fundamental feature that mark a point of departure between Hindus’ and Islamic observation of rituals.

A special prayer constituting a blessing and praise to the prophet Mohammed, the "Miladu Nabi" (Miladu Nabi is done at every ritual) concludes the first of the series of ritual cleansing. In addition the woman is given "Subil water" to drink. Subil are bitter crystal that are dissolved in water to make a drink. It is taken for internal cleansing.

The second cleansing bath, which takes place on the twelfth day, renders the woman partially clean. She may step over the threshold of her bedroom and access any part of the house. The major part of the twelve-day ritual, however, constitutes a ritual of sacrifice which is at the same time a celebration in honour of the woman and her baby (this will be addressed under rituals relating to the baby) for which an elaborate feast is given.

The final ritual of purification occurs on the fortieth day and follows the same pattern as the previous. It is particularly significant because the woman is blessed and rendered completely clean. Another feast is given to celebrate this event. Amongst the many guests invited which includes family members, friends, is the dai. The woman is now free to engage in all social and religious activities such as praying and attending sacred places. She emerges as a new person.

(Field notes July 1996)

The phenomenon is similar the six weeks postnatal examination that confers pre-pregnant status anew.

**Rituals relating to the baby**

In the Islamic context ritual practices occur on the 1st, 12th and 40th day. The first involves three distinct phases which appear to be based on the doctrines of Islam
• **Cleansing bath:** This takes place soon after the baby is born. It is carried out by the dai. No one else will undertake this because maternal blood and other intrauterine fluid that is found on the baby’s body is highly polluting. It is described as the “proper bath.” Particular attention is paid to the baby’s hair to ensure that all blood particles, remnants of amniotic fluid and other debris are removed. Any pollutant left will invalidate the subsequent rituals. The dai is aware of the significance of these rituals as they are all significant for the spiritual well-being of the baby. A slight “faux pas” not only puts the dai’s credibility in question, but also carries major implications, as childbirth pollution is a serious concern in the Islamic culture.

• **The Azane:** This is a ceremony that signifies the "call to prayer." It serves to initiate the newborn baby to the Islamic religious culture. It is carried out either by the father of the child, an orthodox Muslim man or the Imam. First, ablution, the ceremonial washing is performed. The baby is then held facing Mecca. Any of the identified persons then begins the call to prayer by whispering in the baby’s right ear and then repeat it in the left.

• **The Doualis:** The final part of the first ritual involves a very interesting process; it is called the “Doualis.” In it the Imam is given something sweet, usually a date or honey which he first taste and then places it in the baby’s mouth. Sweet symbolises pleasantness. Thereafter a drop of "Subil water," which has a bitter taste, is put in the baby’s mouth. Sweet and bitter symbolise that life is made up of pleasant as well as difficult experiences, which represents the reality of life. The Imam concludes the ceremony by blessing the baby.

(Field notes August 1996)

The twelfth day ritual, which is perhaps the most significant one, leads us to a deeper knowledge of the Islamic culture and its relationship to childbirth. By such time the umbilical cord, a remnant of the placental structure would have separated. It signifies the independence of the baby as a being in his/her own right. Like the first, it comprises three distinct elements. These are:

• **The rite of circumcision:** In general this rite is carried out mostly between the 8th to the 12th day. It is a ritual that is exclusive to males.
- **The rite of shaving of the hair**: For the same reason given earlier this rite is performed. But in this context the shaven hair is weighed and a monetary offering equivalent to the weight is given to a charity of choice. This is in keeping with the fourth pillar of Islam.

- **The rite of sacrifice**: Termed the "Hakika", (also reported by Van Gennep (1909, p79) to be observed found in the Punjab culture and known as l'agiga) or the rite of sacrifice involves the slaughtering of an animal. Closely tied to Douglas' analysis of the rite of sacrifice (1960), the "Hakika" specifies what kind of animals shall be used. This is based on economic ability and gender of the newborn child. For a male child a pair of goats or other specified animal is required whilst it is only necessary to bring a single one for a female child. Similar records are found in the Biblical writings. There are specific rules regarding the procedure for the actual sacrificing of the animal. This includes allowing the blood to flow until it automatically ceases. The bones must not be broken. The flesh must be removed in such a way so as not to damage the bony structure of the animal. The flesh is then divided into three shares. One share is specifically set-aside for the poor and the dai; the remaining two are distributed to family members and neighbours.

(Field notes August 1996)

What is the real significance of animal sacrifice? In the Islamic view the rite of animal sacrifice takes a different meaning to that postulated by Douglas (1966) who associates it with danger. It is understood in the context of birth and death. It is also consistent with the lay perspective of midwifery given earlier. This is additionally linked to the perception of death that bounds the deceased for another world.

To get to the new world, according to our beliefs, every person must cross a bridge (metaphorically speaking) which separates this world from the destined new world. If the child dies before puberty he/she requires to be carried across the metaphorical bridge. The animal sacrificed during the time of birth will fulfil the final destiny of the person. Hence the rationale for keeping the animal’s bony structure intact. For the child, therefore, the rite of animal sacrifice is symbolic of a process that unites life and death. The association of childbirth with life and death.

(Excerpt from interview September 1996)
As well as being a religious event it is also a great social celebration that marks the end of the twelfth day. A feast, at which many guests including the dai are invited, is held in honour of the woman and her newborn. It is also the time when the woman receives many gifts.

The final ritual held on the fortieth day is a repeat of the previous one. Whilst it officially marks the restoration of the woman's purity and welcomes her back to the community, it also heralds the baby's altered state from fetus to child and he/she is introduced to the community as such.

**Rituals - The Christian Perspective**

The Christian observation of rituals varies markedly to the Hindi and Islamic perspectives. The idea of pollution and cleansing rituals is non-existent. The main rituals associated with Christian denominations are as follows: Christening (a ritual that is observed by Catholics) and dedication ceremony (which is observed by other Christian denominations). Baptism marks a significant rite of passage, the beginning of the baby's life within the community of Christians. The theological significance of baptism hinges on the death and resurrection (salvation of the soul) beliefs of Christianity (New Testament- Holy Bible 1984). In the catholic faith as held by my informants, the transition period from birth to baptism is a vulnerable one replete with malevolent forces. In some instances the baby is kept in seclusion until the baptism. More significantly is the belief that if the newborn dies before being baptised, its salvation is lost.

How can I explain? the baby when it is newly born, in the spiritual sense is nothing yet. It is in 'limbo'. Of course the baby has a life. the little girl or person no doubt. but the spiritual aspect is very important. But if the child dies before baptism what will happen. ah be (this is just an expression that denotes realisation of the seriousness of the situation) who will get the child. All that you must think about. We cannot let the child go to the devil".

(Excerpt from interview August 1996)

However, views differ amongst the Christian dais, some of whom claim that this is not contemporary Catholic teaching. Deriving from the above perspective is
the notion that the child is not safe from the snares of the devil. Here we can observe that the child too is in liminal stage. The idea of liminality according to the excerpt expresses the idea that the baby without spiritual blessing is a non-being. The ritual of baptism, a sacred celebration, thus, serves two main purposes—firstly, it acknowledges the newborn as a child of God and initiates his/her spiritual wellbeing and protection. It is a symbol of God's care for the child and the beginning of the religious socialisation of the child. Thus the baby, through baptism is converted from a state of non-being to a recognised state of being, in which the biological, social and spiritual are given equal significance. As Anderson and Foley (1997) explain the rite of baptism initiates a special relationship with the divine. Secondly, it entrusts and commits the immediate family, godparents and the wider church family to the Christian upbringing, and protection of the child. In so doing everyone involved is reminded of their religious precepts and in a sense it is a renewal of commitments to God in the duty of inculcating Christian values.

Dedication on the other hand circumvents all the rites that are performed but the symbolic meanings are not dissimilar. It simply commits the child to the care of God by a prayer and then commissions the parents and immediate family to bring and nurture the child along biblical precepts. This ritual is not performed at any specific time—it can be any time within the first month of birth. The baptismal as well as the dedication ceremony is conducted in the church in the presence of the community of believers. A social celebration is held in honour of the new mother and child. It marks the baby's introduction to society. Unless the dai is a Christian she is excluded from the baptism ceremony. Nonetheless, it behoves the dai to be aware of such value system so as not to offend their clients. Most dais are very conversant with their clients religious beliefs and practices.

Conclusion

In this chapter I have presented the philosophical underpinnings of the traditional perspective of and the Mauritian dais conceptualisation of midwifery. Collectively, across all ethnic groups and subcultures the practice of rituals reveals a discourse about the way in which they maintain and renew the world which they
live. Midwifery is part of that world. As we have seen the world of traditional midwifery is entrenched in religion. The next chapter unfolds with an examination of the sphere of traditional midwifery as field of practice.
CHAPTER NINE

The Sphere of Traditional Midwifery Practice

Introduction

It is evident from the discussion in the previous chapter that childbirth events constitute a complex web of interesting ideas, beliefs and practice. These are set in a wider context of dominant symbolic understandings which frame the processes involved in a normal human activity. Thus traditional midwifery is understood as such, because it is in the domain of symbolic relations of human activity that it exists. In the Mauritian traditional midwifery practice those symbolic relations interweave on three levels of activities:

- The clinical level.
- The social level.
- The spiritual level.

As these are equally valued by the Mauritian society, the dais' practice (know-how) have to be grounded in an in-depth knowledge of these three levels of activities. In what follows I examine the role of the dais at each of these levels. It is essential first to point out that most dais work in the locality in which they reside. They usually restrict their activity to the local area. Hence they are readily accessible to women. Often women would travel to them if they cannot find one in their locality. They adhere to women's beliefs and ritual practices. Due to governmental control over their practice and the severity of punishment meted out in instances of malpractice, dais do not advertise their services. Knowledge of their whereabouts and services are spread by words of mouth.
Chapter 9: The Scope of Traditional Midwifery Practice

Clinical level of Traditional Midwifery activities.

As it has become the norm for women to give birth in hospital, prenatal and postnatal care form the main part of the dais' remits. Intranatal care comprises a small but important part of the sphere of traditional midwifery practice.

Prenatal Activities

Antenatal care at governmental level is widely available and readily accessible. As a rule almost all childbearing women avail themselves of this form of care. Within the traditional perspective antenatal care is suffused with emphasis on abdominal massage. Massage seems to be widely employed by traditional birth attendants worldwide. (Vincent-Priya1992; Lindenbaum and Lask 1993; Lefeber 1994; Graham 1999). Either ordinary cooking or coconut oil is used. Dais are known for their skills in that area.

According to the dais it serves three purposes:

- Helps to prepare the uterine muscles to function effectively in labour.
- Keeps the baby in the optimal position (cephalic) for labour and birth.
- Helps quick restoration of the abdominal shape and muscle tone, and the internal healing process after the birth of the baby.

During visits at antenatal clinic at different Area Health Centres I observed that the medical officers recommended abdominal massage early in the course of pregnancy and advised women to seek the dais' expertise for abdominal massage. Underlying the biological basis of abdominal massage is the connection of impurity, in the sense that the uterus should be in the optimum condition for postpartum physiological function. However most of the dais informed me that the massage is also about maintaining a sense of spiritual wellness, although no sources to sustain such claim were made available.

Additionally pregnant women seek the dais as and when they deem necessary. One of the main reasons given is to seek a second opinion about information given and decision taken by professionals before trusting such judgement. In crosschecking the data with the second group of informants (which
comprises professionally educated nurse-midwives and midwives) I obtained the following information.

A young primigravida, 38 weeks pregnant was booked for a caesarean section because at the time of antenatal examination at the AHC, the fetal head was still not engaged and in fact very high. At the appointed time the woman did not arrive for her CS. She turned up in labour the following night. As the nurse-midwife admitting her I soon realised that she was a complicated case and alerted the RMO (Registered Medical Officer) immediately. Whilst we began to get the operation room ready the woman started to push, the baby's head was visible and she gave birth normally to a live male infant within half an hour of arrival to labour ward. We later asked her why she had not turn up when she was asked to, knowing that she required a caesarean section. She then said “I know, but when I left the clinic I went to see the dai, she felt my tummy and then gave me an examination down below. She said it was true that my baby's head had not entered my passage yet (meaning the pelvis), but the baby was only small and that once I start the labour pain it will go in alright and that I will be able to give birth normally and that I do not need a caesarean operation”.

(Excerpt from interview September 1996)

Examination of pregnant women is based on the same criteria set in midwifery textbooks. It will be recalled that majority of the dais are either non-literate or have minimal education to use literary sources. This entails palpating the woman's abdomen to establish the following:

- Gestational age- its compatibility with dates given by the woman.
- The baby's position.
- The baby heart beat. Unlike in the professional set up which uses either a pinard stethoscope or sonic aid, fetal movements determine this. Such information is ascertained by palpating the fetal heart. If this proves difficult as it sometimes does, the dais questions the woman about fetal movements. Their personal knowledge is built into the explanation.

To question their clinical abilities relating to the above I asked them to explain how they would assess gestational age. In the most convincing and accurate ways, they demonstrated, on their own person, the various points at which
gestational age of the infant is assessed. For instance the xyphisternum was used to show that:

When the baby has reached there you know that there is not long to go...about one more month...When the bay begins to’’besse’’, literally meaning descend you know that she is getting closer because the baby’s head is beginning to enter in the woman’s passage.

(Excerpt from interview June 1996)

To probe beyond their understanding of normal physiological development of pregnancy I asked how would they recognise any deviation from the normal process. The following information was given:

By feeling the woman’s belly you can tell if the baby is "entravere" (This is literally translated as a transverse lie) or if the baby's bottom is in the lower part of the belly. The baby must be turned to the correct position. But if you do not turn the position the baby will be in danger. You will take a risk if you do not do it. But what will happen if the woman break her water, then what will you do...The baby’s umbilical cord will come out won’t it! All this, doesn’t it pose a danger to the baby. So when the woman comes to see you for a massage all this you must also find out, otherwise how can you practise? All this we were told is important by the other dais from whom we have learned.

(Excerpt from interview June 1996)

Malposition, as defined by the dais, is predictive of possible obstruction in labour and symbolises danger. Standing in the doorway at some stage in pregnancy, a legendary belief is held to be responsible. It is also held that the baby will try to overcome the obstruction by finding an "escape route". For instance the baby may force its way through the abdomen and in the process kill itself and the labouring woman.

Malposition of the baby in utero is as much a concern for the dais as it is for nurse-midwives, midwives and doctors. The implications for the maternal and fetal wellbeing are recognised. Consequently malposition detected during an abdominal examination will be corrected. The dais described this as:

_Tourne baba_- this is translated as cephalic version

The procedure for turning the baby includes a sequence of events involving a combination of the supernatural. It begins with abdominal massage that usually takes approximately fifteen minutes. Coconut oil renowned for its refreshing and calming
properties is used to sedate the baby. This is then followed by a gentle manoeuvre guiding the baby's head in the lower abdomen where it should normally be found. Of enormous importance throughout this procedure, however, is the supernatural invocation that ensures its success. Most of the dais remarked that, when faced with this kind, as any other problems, they would be helpless unless they call on divine guidance which may vary in the form it takes. In this instance a silent prayer is said. Such is the power of religion. On completion of the procedure the woman must take precautionary measures to avoid recurrence of fetal malposition. Such measures include a three-hour complete bedrest immediately following corrective procedure, avoiding standing in doorways, which as mentioned earlier is symbolic of obstruction.

Another aspect of antenatal activities includes dealing with complications. In as early as the first few weeks of pregnancy, women seek the assistance of dais. A key example of the complications reported is retroverted uterus as illustrated below. This excerpt is in fact a dialogue between the interviewer and I. The interviewee initiated it.

**Interviewee:**
The man called me two doors away to come to his house because his wife was in very bad pain. So I hurried there. When I arrived I found her rolling about in bed. I asked her husband to send for his mother to help hold her down. First I tried to feel her tummy, but it was impossible. So we, her mother and myself helped her to turn on her back and to lift her bottom up by resting on her knees. I then examined her through her passage (meaning the vagina); the baby's house is upside down.

**Question posed to interviewer:** You said you are a midwife. How would you deal with a baby's house that is upside down?

**Interviewer's Reply:** This is a gynaecological problem. In UK midwives are not taught to deal with such problem. It is the responsibility of the gynaecologist/obstetrician. Midwives are taught to deal with normal pregnancies.

**Interviewees' response:** Then you cannot be a midwife. Every midwife ought to know how to deal with this situation. Furthermore you tell me you have learnt about midwifery in UK. What kind of training did you have? No, you cannot be a midwife. What kind of midwife makes distinction about pregnancy? From the time the woman conceive, she is pregnant, is she not? Us dais we do not talk like you. Never mind I will teach you how.
Interviewer’s response: Oh please do. I am very willing to learn.

Interviewee response:
When this happens you must turn it back the right way. You must first differentiate between the blood vessel and the uterine tube. Once you have ascertained that there is no pulsation you then proceed to turn the baby’s house. This, she demonstrated by pressing her thumb and forefinger intermittently to simulate a pulsating blood vessel. If felt this would undoubtedly be left well alone. Once the uterine tube is identified, which serves as a guide the uterus is slowly turned to the normal anteverted position. The procedure she employed was similar to that observed during my learning placement as student nurse. The dialogue continues:

Question posed to interviewer: Now when you have turned the baby’s house, how would you know that there is a baby in it?

Interviewer’s response: Well, as I told you before, turning the baby’s house is not the midwife’s remit of practice. Once the gynaecologist/obstetrician has turned the baby’s house in its right position, the woman should be allowed to rest.

Interviewee’s Interjection:
What nonsense is this? You cannot be a midwife! You must make sure that there is a baby in that house. In the first place don’t you know, when a married woman rolling about in pain indicates that she may be pregnant and the reason for the pain may be in the baby’s house? What you must do is this: As you turning it with the fingers that are in the woman’s passage, the other one that you place on her tummy will tell you. Will not the baby’s house feel bulky? You must also know how many weeks old the baby is.

You see, this woman who I was called to help, there was a fourteen week old baby in the baby’s house. I asked her to go hospital the next day. I asked my son to write a letter for the woman to take to the doctor the next day. In it I asked him to put everything that I had done and stated that there was a baby in the baby’s house and I put my thumb on it as my signature. Now let me also tell you that at the same time they (meaning the Ministry of Health in association with the School of Nursing) were calling the entire dais to go to school to teach how to practise midwifery. I went. On the first day, the doctor came in that big classroom and he called out:

Is there a dai by the name of Amla? (This is a fictitious name to protect the dai’s identity)

Yes Sir, I replied.

Are sure there is a baby in that woman’ baby’s house?

Yes Sir, I am.
Chapter 9: The Scope of Traditional Midwifery Practice

If there isn't a baby in that baby's house I will make sure that your kit is removed and that you never do midwifery work again.

I told him this- Sir, if there is a baby in that baby's house who will take your license away and stop you doing your work? With that he walked out of the class and I never saw him again.

Now and, guess what! This woman gave birth to a baby at thirty-six weeks in her pregnancy.

(My brief comment: At the outset I found it extremely hard to accept what this dai was recounting to me. I needed to crosscheck this information with the personnel who were in attendance during the initial education of the dai. They confirmed that indeed this was a true story. In this story therefore we see the confidence of the dai, both in her knowledge and competences. I will return to this aspect in my final chapter).

(Excerpt from interview and field notes September 1996)

Abnormality of this nature is a common occurrence in traditional midwifery practice, thus dais are skilled at executing the above procedures. Unlike the western perspective that sees it as the remit of obstetric gynaecology, the dais see it as part of the reality of pregnancy. Therefore dealing with such complications is unproblematic. To the dais, as stated earlier, midwifery is part of life, as such they do not put boundaries on it- a pregnancy is a pregnancy whether it is at ten weeks or forty weeks gestation. The classification of early pregnancy as gynaecology therefore is artificial. As practitioners of midwifery they consider it important to attend to the woman at any given time during pregnancy. They are conscious, however, that any deviation must be referred to the hospital.

In addition to the above, the dais also provide treatment based on naturopathy for a wide range of pregnancy associated problems. For instance:

- A preparation of barley and linseed is used to cure urinary tract infections.

- A mixture of green lentils and a special plant known as “L’herbe tourterelle”(literally translated as turtle dove plant and also known as Wikstroemia Indica (Gurib-Fakim and Gueho1994)) is used to combat anaemia.
Chapter 9: The Scope of Traditional Midwifery Practice

- Coconut milk is used for more serious conditions such as preeclampsia. It seems coconut water acts as a diuretic and helps the elimination of excess fluid.

These methods have been used from generation to generation and they work. Whilst I am familiar with the first two in general usage, I had doubts about the latter. In crosschecking the data with some nurse-midwives and midwives, they confirmed its efficacy. The following excerpt illustrates this:

Yes, there are times when women have been diagnosed with preeclampsia and referred for admission; they have asked to go home to collect personal items before coming to hospital. Instead of coming to hospital they have gone to the dai and have turned up at antenatal clinic and the signs have cleared. They all have said that the dais have given them coconut water to drink.

(Excerpt from interview September 1996)

It would have been easy for me to discredit their knowledge and practice if my western understanding was applied, namely the necessity to use medical intervention to treat the conditions. Preeclampsia is a pathological condition of serious implications both for maternal and fetal wellbeing. It was evident from the discussion which followed with dais, nurse-midwives and midwives albeit independently that the rationale for their practice was clearly understood. No mortalities or untoward incidents were reported in governmental statistical evidence which is where such details would be found. Thus the evidence underlying what they did was valid.

**Intranal Activities**

Birth involves the whole family. When labour starts the prospective father summons the dai who then remains with the woman until she gives birth. As a rule the dai work with an apprentice. It is customary for the mother-in-law and the woman’s sister to be also present throughout labour. Their role is specifically one of support, trust and security, thereby safeguarding the interest of the labouring woman. No other family member is permitted to enter the childbearing space either during labour or at the time of birth.
Women rely on their kin to safeguard their wellbeing and that of their infants at a time they are most vulnerable. Kinship provides a stabilising network of relations that creates trust (Giddens 1991). Dais themselves acknowledge the necessity to have female family members participating in the birth events. In that sense the responsibility is shared. In addition to its practical value, the presence of female relatives during labour and at birth provides witnesses in case anything untoward happens and the dai is later accused of bad practice or act of malevolence. It is therefore common practice for four women to be in attendance during labour.

**Assessing progress in labour.**

The methods employed to assess labour varies amongst dais. Ex-hospital maids tend to use vaginal examination more readily than other dais who seem to rely on natural means. It involves the following:

A dry and almost withered flower (the name of which is guarded with much secrecy) believed by the dais and women of Islamic and Hindu persuasion to be sacred, endowed with supernatural powers, is placed in a vase on a table in the woman's room at the onset of labour. The dai pronounces a prayer, which is held to activate the flower and have its power released. This is then carefully observed throughout labour. Of its efficacy the dais stressed certain behaviours expected of the woman: she is required to wear loose garments, removed any items seen to be constricting such as necklaces, bracelets, rings. Her hair should be worn loose. These are held to symbolise closure and may negate or nullify the power of the flower. This is seen tantamount to obstruction that featured in a different stance during pregnancy. She must be in harmony with nature, embodied in the flower.

It seems the flower begins to open as the woman's labour advances. The opening of the flower indicates the opening and progressive dilatation of the cervix. When the flower is fully opened, the dais and the woman know that it is time to engage in active pushing to birth the baby. After the baby is born the flower closes again; it is removed and kept safely until required again.

(Field notes August 1996)

Although most of the dais I interviewed claimed that it was sufficient to observe the changes occurring in the flower to know and interpret the progress of labour, a minority admitted to performing periodic vaginal examinations as well. This was done to confirm the reliability of the flower. It seems that the flower can be a source of comfort to the woman, in that she can measure her own progress by
intermittently looking at and observing it opening; as the pain of labour gets unbearable the female kin in the labour room directs her attention to the flower, from which sustained energy is derived. Further explanation about the relationship of flowers and the indication of progress can be found in the work of Harvey and Cohcrane (1998) and Wildwood (1998). They suggest that flowers symbolise vital energy and the sparks of life itself. It denotes the beginning of actions and strengthens the will power; it is associated with explosive imitation of a person's behaviour. Equally significantly, as the dais themselves recognise, the flower can be a source of anxiety in so far that it may fail to open, signalling danger. Unreservedly then, doctors expertise is deemed necessary and transfer to hospital is done accordingly.

Equally significant, the efficacy of the flower is also dependent on its colour. It has to be either white or yellow. It seems that these colours have a religious significance; the preference of which depends on religious persuasion. For instance Islamic belief stipulates that white must be used. Beyond its association with purity no other plausible explanation was given. Hinduism (particularly Tamilism) places significance on yellow. In some measure this diversity exists because of a direct association with deity. In seeking to understand the rationality underlying the emphasis on flowers, I obtained the following explanation from the dais:

In our beliefs flowers are important. The gods like them. We use yellow because the god rested under a yellow flower-yielding tree when he was tired from a long journey. Before he resumed it he blessed the tree and gave the flowers special power. At least that is what we believe.

(Excerpt from interview September 1996)

This conceptualisation of flowers is not isolated to non-western cultures; Scheffer (1986) and Wildwood (1998) have indicated that there are remedial properties in flowers (which is illustrated in the Bach Therapy) that function on the psychological as well as spiritual level. Although there are no other cogent theories about the symbolic meaning of flowers, it certainly produces a narrative, but these are narratives which distinguish between lay and modern ways of knowing.
Chapter 9: The Scope of Traditional Midwifery Practice

**Dealing with birth.**
The dais are concerned with three main issues: position during birth, hands off approach and preservation of perineal integrity. It is normal practice for women to squat on the floor to give birth. As in other cultures female kin stand behind the woman supporting her while she gives birth. The dais either sit or kneel in front to receive the baby (Kitzinger 1992; Jambai and MacCormack, cited in Davies-Floyd and Sargeant 1997; Graham 1999).

Linked with the necessity to preserve perineal integrity, the position adopted during birth is fundamental in achieving it. On the assumption that squatting is the natural way, it is held to be less likely to cause perineal injury, the avoidance of which is important for the woman's future sexual and general wellbeing. Several dais alluded to instances of marital breakdown in which the causal factor was perineal damage. Longterm social implications of childbirth trauma are the concern of dais; damage to the perineum is a grave offence and must be avoided at all cost. The practice of episiotomy is heavily criticised.

In hospital they are impatient. They do not wait. They are quick to cut. The cut (episiotomy) cause problem. It does not heal properly, and then the woman has to go back to hospital to have it sutured again. She is not the same afterward. Her husband may not want her. You see this is a big problem. To avoid all this you must massage the perineum. During labour the skin gets dry, because when the sac containing water breaks after a while the water that come from it dries the skin. If you do not massage how would the woman do? Of course there will be problem. The oil that you use, it will soften the skin. Therefore no damage will occur.

(Excerpt from interview August 1996)

Lest a romantic view be portrayed, it is essential that I point out, despite dais' claim of the effectiveness of perineal massage and hands off approach to birth, damage of varying degrees do occur. In justifying their claim, any damage is often attributed to lack of corporation on the woman's part, thereby protecting themselves from accusations and safeguarding their reputation. Nurse-midwives reported that often women are brought to hospital for perineal repair.

The delivery of the placenta is a major concern. As soon as the baby is born the woman is encouraged to push it out. Placental complications, in particular
Chapter 9: The Scope of Traditional Midwifery Practice

retained placenta, present the greatest difficulties for the dais, in that they lead to severe haemorrhage and possible death. Conscious of the seriousness of maternal mortality and the recognition that its occurrence is seen tantamount to crime punishable by law (which is usually associated with a protracted period of imprisonment and the defaming publicity that is carried by the media) dais do not attempt to remove it manually. In most instances the woman is transferred to hospital immediately.

For some dais, whilst this kind of anomaly is considered dangerous, it is also controllable. They claim that there are several ways of dealing with it. The most efficient way of treatment is by inducing vomiting that is achieved through the most unsophisticated, yet non-invasive method. The woman is made to chew a mesh of her hair. It seems that this produces the most violent emetic effect. Describing how it works the dais simulated how the heaving produced by chewing hair exerts pressure on the diaphragm and abdominal muscles thereby disengaging the placenta from its embedment. It is not difficult to trace the physiological reasons inherent in the practice. If this method fails the woman is transferred to hospital immediately.

Dealing with the umbilical cord.

Cutting the cord is one of the most important skills in the dais’ practice. There are specific criteria pertaining to cutting the cord. Examples of these are: cessation of cord pulsation, distance, and methods of ligation. The reasoning underpinning the former associates the placenta with a being in its own right, a biological and spiritual element of equal importance. In the dais’ worldview it cannot be reduced to just a biological organ as is suggested in medical and midwifery literature. Whilst not denying the complexity of its biological reality, the perspective given above is worthy of note.

The placenta, which is always referred to as the flower, is held to be the giver of life; cutting the umbilical cord, through which the placenta allows life to flow to the baby, before it stops to pulsate leads to its premature death; it is an offence.

Before the cord is cut you must make sure that it has stopped beating. Because as long as it is beating, it means the flower (meaning the placenta) is still alive. When it stops to beat then you know it is ready to
let go of the baby and let it take its own life. It is then dead. Only then it is safe to cut the cord, not before. If you do it before, as if you are killing the flower it is a danger. That! (the exclamation mark represent the emphasis that the dai placed on her explanation) is not good. For the mother and the baby it will cause problem to their health. You know what I mean its spirit would not be able to rest we must respect the flower.

(Excerpt form interview August 1996)

Once pulsation has stopped the cord is cut. There is a routine that is described by all dais. This is illustrated as follows:

First the cord is measured. A distance of four fingers distal to the baby's abdomen indicates the right length. It is then ligated in two places with thick thread that has been soaked in disinfectant. This is simply to protect against bleeding. The cord is cut with scissors that has equally been soaked in methylated spirit or other form of disinfectant is used to sever the cord. A small dry dressing is then placed on it. This is renewed everyday.

(Field notes August 1996)

Dealing with the placenta

Equating the placenta to a being in its right also is significant justification for its right to burial upon death. Words had to be carefully chosen when broaching the practices relating to the placenta. For instance words like disposal or discard were literally understood as throwing away. As such this indicated disrespect of an organ that is the “giver of life”. In the way of thinking described above, and with regards to the issues involved, burial is both an expression of and giving respect to life. At the same time it marks the end of a process and signal beginning of a new life- that of the baby’s. Hence as soon as it is expelled, the placenta is wrapped in ordinary cellophane sheet, placed in a box and buried in a select place, out of sight and out of reach so that nothing or no one will have access to it for nefarious reasons. Removal of the placenta from the burial site is believed to cause misfortune.

The placenta is usually buried under a flower or fruit bearing-tree. Mango tree is the favoured type because it has some religious connotations. Certain rituals follow the burial. These include daily offering of food to the placental spirit for seven consecutive days, when it is held to be capable of causing adversity to the baby. This is a belief that is not shared by all dais; some dismiss it as pure myth.
Chapter 9: The Scope of Traditional Midwifery Practice

Postnatal Activities

The most significant contexts of postnatal activities are daily bath of the mother and baby. Massage and heat therapy form an important part of the dais' role in providing postnatal care. It will be recalled that in the Mauritian construct of childbirth, the postnatal period is classified as a state of coldness and represents a time of crisis. During the period, the woman is vulnerable to all kinds of problems, some of which we have already discussed earlier. Postnatal care restores balance between cold and hot to achieve a state of homeostasis. Particular emphasis is placed on the healthy restoration of the reproductive organ, because in the uterus is supposed to be an open wound that is susceptible to infection. In addition to the ideas of contagion and pollution, blood, if left to stagnate in the uterus, is believed to cause uterine as well as fallopian tube infection and infection that may ultimately lead to infertility problems or even death. Heat therapy is held to play a significant role in that process; it is applied daily for the first six days (at most twelve) and involves the following:

After the bath the woman stands astride a coal fire for approximately five minutes. The warm air is held to enter the uterus via the vagina and assumes two important functions: first, it prevents blood from clotting, its accumulation in the uterus or vagina and allows for a constant flow, therefore the internal open wound as described by the dais is kept free from debris therefore ensuring rapid healing. The second is associated with restoration of purity. Thereafter she retires to bed for an abdominal massage. Using ordinary vegetable or olive oil, believed to contain properties, moving her hands in circular fashion, the dai then massages the woman abdomen, a procedure that lasts for about fifteen minutes. The dais describe this manoeuvre as bringing the abdominal muscles back together. Following the massage, the woman's abdomen is bound with a piece of cloth that has been warmed on the coal fire. This procedure is performed for a period either six days or twelve days, which coincides with the cleansing rituals. In addition to the above the purpose of abdominal massage in the context of the postpartum period is to enable the woman to get rid of the dirt (meaning the Lochia) and help internal healing quickly and to help the woman regain her shape."

(Field notes August 1996)

Similar practice has been observed amongst the Malay traditional midwifery practice (Vincent-Priya1991)
Chapter 9: The Scope of Traditional Midwifery Practice

Care of the newborn

In addition to daily routine care and hygiene, massage also forms an integral part of neonatal care. Two principal reasons for baby massage were given: The first is to do with the idea that, as the baby’s head is often deshaped during the process of birth, all newborn baby’s should have a head massage beginning in the first few hours of birth. The massage lasts for six days, and is believed to help regain normal shape and prevent permanence of the “ugly shape”. That this is the result of a normal physiological process and will remedy itself is totally discarded; it is steeped in traditional beliefs that unless the baby’s head is put back in shape it will deface the baby for life. A longterm benefit of head massage is held to promote cool temperament. The second is to do with the idea of strong musculo-skeletal system in later childhood development. To this end a full body massage, with particular attention to the limbs is carried out daily for up to a month following birth. The mother may extend this period on request. The technique for the full head and body massage is illustrated below:

Either warm olive or ordinary oil is used. Before massaging the head the dais explain that the baby's fontanelles must be felt for pressure and pulsation. This indicates how much pressure they can apply in reshaping the baby's head. They do not wait for physiology to take its course. Using a doll to demonstrate the head massage technique dais take great care not to put undue pressure. The fontanelles are used as a guide to the amount of pressure that can be applied- a pulsating fontanelle, as I was shown, suggests a headache, therefore gentle pressure needs to be applied so as to relieve it. Even in a simulated situation great caution was exercised so as not to cause any trauma to the baby's head. A full body massage especially the limbs are thought to strengthen the baby's muscles and prevent conditions such as bow legs in later childhood development.

(Field notes July 1996).

A significant observation was made about access to the childbearing woman’s house. On arrival to the woman’s house for daily care of the woman and her baby the dai enters via the front door. After completing her work she always leaves via the back door. This is, as stated elsewhere, once she comes in contact with the postnatal women she too becomes defiled. In order not to desecrate the whole
she must abide by the religious beliefs and practices of each household that she visits.

The Spiritual Context of Traditional Midwifery Practice

Within the spiritual context, I identify two dimensions:

- The dais as ritual specialists.
- The dais as healers.

Dais as ritual specialists

This section describes the relevance of rituals as they directly relate to the dais personhood. Just as women enter a period of transition after giving birth so too do the dais. Attending childbirth places the dais in state of defilement. They become unclean by having direct contact with products of conception and they are at risk of defiling the entire household. Dais are expected therefore to go through self-cleansing rituals to regain their status of purity before they can resume normal activities within their respective families and community. This practice varies from dais to dais and according to religious beliefs. What is most remarkable about dais self-cleansing rituals is the degree to which they uphold the spiritual dimension that governs their lives and that of their immediate household.

The ritual begins before the dais set off to attend women in childbirth. Most of my informants reported that they say a prayer to their gods before leaving the house. Prayer is held to firstly, to provide spiritual assistance and ensure the course of their work will progress unhindered, and to protect against malevolent forces. Secondly it absolves them from the defilement that accompanies contact with the impure substances of birth. In most households a statue of their god of varying sizes encased in a shrine. This is situated at the entrance of the house, can be seen. A continuously burning earthen lamp is also seen there. It is the last place that the dais must pass before leaving and the first place before they enter. The dais explained that their god would not allow them to pass unless they are clean. Therefore on return from attending a birth, they must first of all enter the bathroom that is situated outside the main household, undertake the ritual cleansing, and wear clean garments. Stepping out of the bathroom they then proceed to the shrine and stoop by the earthen burning lamp and allow the flame to purify them from the externally imposed sources of pollution. This ritual is repeated until their
Chapter 9: The Scope of Traditional Midwifery Practice

post-natal related childbirth activities are completed."
(Field notes July 1996).

**Dais as Healers**

In Mauritius, the idea of dais as healers is nothing new. This partly to do with being a woman and a mother. The role of healers is particularly conferred on them as a specific group of women because of their claim to supernatural calling and powers. The primary healing specialisation of dais is midwifery. Combinations of the supernatural and naturopathic treatment constitute a practice specific to healing. They have extensive knowledge of the posology of herbs and plants. As stated earlier they are consulted for a wide range of ailments mainly in the realm of women and childhood illnesses. The main problems in the realm of women’s illnesses listed by most dais are associated with infertility which they assert mostly occurs as a consequence of breaching the principles of the cold state phenomenon of the postnatal period. In this instance heat therapy similar to that used in the immediate postnatal period is applied. Recognising that the cause of infertility may also originate from other sources, other forms of treatment involving supernatural means and complex rituals are employed. Despite the questions I asked it was impossible to discover what these exactly entailed, they were adamant that certain knowledge must be kept in the family only.

**Other Dimensions of The Dais’ Practice**

In addition with dealing with childbirth issues the dais provide counselling in the domain of family planning and deal with infertility problems. They display sound knowledge and understanding of both male and female reproductive functions—exactly how they have acquired such knowledge is difficult to ascertain. However, most of the problems are attributed to the state of coldness that accompanies birth. Dais upheld that the cause of infertility mostly resides in a breach of the principles of reverting from the state of coldness, obviously with long-term consequences. As stated above the heat system the heat system seen in the postnatal period is used. Heat is believed to cure any damage that may have been done to the reproductive organ. Associated with the heat treatment, is a ritual of throwing rice grains into the air, to symbolically rid the body of bad sperms.
Chapter 9: The Scope of Traditional Midwifery Practice

There are other complex rituals that are used to deal with the problems of infertility but the dais would not allow me to trespass into their guarded secrets. They emphasised and reiterated that certain knowledge must be kept in the family only. They claim that their methods are effective but it is difficult to assess them in reality because there are no known studies related to childbirth practices, especially, and in the domain of infertility (at least to my knowledge) that I know have been undertaken in those areas related to traditional midwifery practice. Dais are usually consulted on children's ailments and adult-related diseases. Very often people will consult them after modern treatment has failed.

The social aspects of traditional midwifery practice.

The social remit of the dais very much depends on their involvement in their community. In certain subcultures the person who assists the baby's birth is considered to be the second mother. Thus the dais' responsibilities do not end with the birth but encompass a wider involvement in the baby's growth and socialisation. They feature almost at every stage of the rite of passage and are involved in rituals associated with weddings as well as death. Hence the scope of traditional midwifery practice is not limited to childbearing period only.

Conclusion

In this chapter we have looked at a number of aspects of how traditional midwifery practice is construed and the different levels at which dais function. This includes the complex reality of everyday living. It is evident from the discussion therein that traditional midwifery is far more complex than is conveyed by the World Health Organisation's definition of it. It exists in a context where no boundaries are set; the knowledge base and practices of the dais are embedded in social processes. It is meta-conceptual as well as meta-practice. This chapter has offered a non-western midwifery perspective and has begun to engage us in studying ways of knowing that fall outside the empiristic and rationalistic realm. From an epistemological standpoint it challenges the authority of modern construction and legitimisation of knowledge. In the next few chapters I interrogate the findings of my empirical...
evidence with socio-philosophical and anthropological theories in order to arrive to a consensus of what midwifery knowledge should constitute.
CONCLUSION TO PART THREE

What is the relevance of this case study to the development of midwifery knowledge? The findings presented in the previous chapters suggest several important themes that contribute to our understanding of how different cultures use different interpretive framework to construct and legitimise knowledge. It indicates that traditional midwifery’s approach to knowledge production is pragmatic and provides a challenge to the dominant epistemological assumptions of modernity upon which contemporary midwifery is built. There are three fundamental themes that are central to the analysis of the development of midwifery knowledge. They are:

- Religion-spirituality
- Experience
- Socio-cultural context

From a sociological perspective traditional midwifery fits into the context of premodernity. It is informed by a religious-spiritual/ metaphysical school of thought and takes place within the local contexts. It will be recalled from the discussion in chapter one that the Enlightenment undermined the religious assumptions on the premise that it was nothing but dogma and mere superstition. Consequently religion/ spirituality has been largely ignored in the modern construct and legitimation of midwifery.

In contrast to the modern perspective, traditional midwifery is entrenched in religious-spiritual assumptions that up to the time of my writing have not been subjected to social and political pressures. Hence the first theme to emerge relates to religious-spiritual knowledge.

The religious-spiritual assumptions points to the proposition of different types of revealed knowledge which comes from different form of deity/ deities (some religion are polytheistic) who are the origin of this knowledge. In contrast to the ecclesiastical perspective of revealed knowledge, which is the special province of priests, in traditional midwifery, it also the province of the dais who claim to have
received it in response to their divine/supernatural calling. Revealed knowledge touches on every aspect of human existence and therefore it necessarily colours the whole epistemology of traditional midwifery. It has permeated the whole of the history of traditional midwifery as it has the Mauritian society.

The second theme assumes two types of knowledge: biographical/personal and practical knowledge. These two types of knowledge are inextricably linked and identify an important epistemological position of traditional midwifery- women’s ways of knowing. For instance women’s experience of the process of childbirth provides a lived bodily experience that is not open to childless women and men. One of the crucial ways through which traditional midwifery establish its knowledge base is the claim of legitimacy through personal and practical experience.

The emphasis placed on and the importance of the socio-cultural context and practices cannot be ignored. Of special importance is the concept of local community and the collective orientated culture that shape the way in which knowledge is produced. The local community and community relationships give traditional midwifery its identity; it plays a significant role in socialising the learner-dais in the traditional midwifery system; in the preservation of their identity and culture. Bourdieu’s notion of habitus (1990) is particularly useful in understanding the socio-cultural context of knowledge production. I will return to examine this notion in chapter eleven. Finally in traditional midwifery, through the various rituals and traditions expounded in preceding chapters it is evident that the past is important; it continues to enter the present and informs the future. Unlike its scientific counterpart, knowledge has a long life span and appears to be unchanging. However religion appears to the guardianship of the sacred past and plays a significant role as transmitter of past into the present. It is a form of knowledge legitimation.
PART FOUR
INTRODUCTION TO PART FOUR

The cases studied provide us with two different positions that will constitute the analysis of midwifery knowledge to be undertaken in this final part. Here I want to return to the conceptual framework of this study to demonstrate those two different epistemological positions and pursue the analysis in accordance of the theoretical perspectives that make up this framework.

In part two I have sketched the broad contours of the development of midwifery as a field of practice in UK, reviewing, what I consider to be the main arguments for developing a knowledge base to guide its practice. Hence I am testing a historical development of midwifery epistemology. The evidence suggests that the development of UK midwifery is influenced by a number of factors embedded in modern and postmodern thinking. Modernity, to a large extent determined the horizons and directions of medical interests, systems of values and ways of interpreting and representing midwifery. It is in accordance with obstetric and other medical specialities. For this reason many types of knowledge has been lost or/and left unexplored.

In part three I have presented the development of midwifery practice in Mauritius. It differs from UK insofar that I am not testing a historical development. Instead I am focusing on the contemporary traditional midwifery. The empirical evidence suggests that traditional midwifery is informed by premodern thinking, which seeks the interpretation of everyday social reality. The concept of childbirth and midwifery takes on a different meaning. As stated elsewhere it presents a “rival theory” (Yin 1984) or contending worldview to the modern way of thinking, interpretation and representation of midwifery knowledge. It shows that midwifery straddles different domains/types of knowledge other than those made explicit in UK modern representation. I will also show that what is considered by critical/postmodernist theories to be futuristic, is a resurrection of past knowledge and past ways of constructing it. Mauritius offers valuable insight into past epistemological positions, which in my view is what is required to reconceptualise midwifery knowledge. I will be testing my empirical evidence with the premodern
theories expounded in the conceptual framework and the perspective of the domains of knowledge contained therein to justify this claim.
CHAPTER TEN

The Western Construct of Midwifery Knowledge - The Modern and Postmodern debate.

Introduction

Returning to the question of “how has midwifery knowledge developed?” it is now possible to consider the context, in which it evolved, was legitimated and utilised. In this chapter I take the inquiry beyond historical analysis to include the dialectics that have influenced the construct of midwifery knowledge and to show how it is linked with cultural transformation of society and societal value system.

Tracing the development of midwifery through the three discourses, that is, the ecclesiastical, political and medico-scientific suggested three fundamental moments marking the rise of medical knowledge and the foundation of midwifery epistemology from speculatively based midwifery knowledge (exemplified in the ecclesiastical discourse) to a modern empirically based midwifery. The theoretical investigation undertaken in part two shows that the development of midwifery spans a continuum of early modern to postmodern period.

In all three we confront differing conceptions of the reality of and epistemological positions relating to midwifery. The socio-philosophical theories (modernity theories, critical theory/ postmodern theories) discussed in chapter two suggest that the production of midwifery knowledge is influenced by the wider sociological conditions that have shaped the midwifery knowledge base. The process of medicalisation of birth, which epitomises modernity, involved a process whereby the social and everyday life aspect of midwifery and childbirth were legitimised by modern system that is based on rationalistic and empiristic approaches to knowledge. According to the perspective of critical theory and postmodernity, the western construct of midwifery knowledge based on the assumptions of modernity is problematic, insofar that it assumes that childbirth is predominantly biological. In the modern view, the practices surrounding childbirth have little to do with the social
and cultural environment in which they occur. As a consequence midwifery practice and its knowledge are seen to lie entirely within the framework set down by medicine. The legitimation of midwifery knowledge through the work of Foucault (1972, 1970, 1979, 1980), Lyotard (1984) and Habermas (1992) are addressed at this stage of my discourse.

**Contextualising the Western Midwifery Epistemological Debate**

In terms of its historical progression it is evident that the debate about midwifery centred on the necessity to make midwifery scientific. The socio-philosophical theories presented in chapter one engage us with the central questions of what making midwifery scientific entailed. They lead us to critically examine the processes involved in, and the consequences of the scientisation of midwifery knowledge, essentially the consequences of modernity. It is, therefore, essential to recognise that the debate is not only about making midwifery scientific, but also one that is immersed in the development of the nation state. As we discussed in chapter one, from a macro sociological viewpoint this involved the production of administrative and professional skills to meet the needs of contemporary society, which could be achieved through the development of new domains of knowledge (Lyotard 1984).

Consequently, the development of midwifery knowledge was influenced by wider sociological changes embodied in modern and postmodern thinking. Placing the debate of midwifery knowledge within the perspective of postmodernity/critical theory we find a deep distrust of existing structures of knowledge and the approaches that have guided its production and legitimation.

The discourse of modernity is not entirely new in the development of midwifery knowledge. It emanates from Aristotle’s writing who championed reason and rationality as the source of progress in knowledge development (O’Dowd and Phillips 1994)- a discourse that has pervaded the Enlightenment to the present. In the modernist view the development of knowledge was intended as goal-directed actions (Habermas 1984). As discussed in chapter one it is about perceived progress. The idea of it is rooted in the certainty that the development of science and technology
would enable human beings to gain mastery over nature and to liberate humanity from ignorance ultimately leading to happiness and well-being (Callinicos 1989; Steir 1991; Hamilton 1992). There was a sense of optimism with the Enlightenment Earlier work by Descartes (1637) suggested that mastery could only be achieved by human beings having knowledge – knowledge that is produced by a rationalistic approach. Thus, the aim of modernity was to redefine and replace all other forms of knowledge and provide it with a new meaning.

We shall see that western culture interpreted and legitimised midwifery knowledge through the ideology of progress, that is, through the legitimating framework of science. The modern interpretation and legitimation of midwifery and its relationship to knowledge production can be summed up under one main theme that enabled the cultural shift in epistemological contexts that midwifery witnessed during its course of development. I undertake the analysis of the contextual issues through two fundamental epistemological positions that laid the founding concepts of contemporary midwifery knowledge. Both positions rest on emancipatory interest as part of the assumptions of modernity.

**Contextual Issues**

In the course of the sixteenth to twentieth centuries the two fundamental epistemological positions were central to the development of the basic concepts of midwifery. They are:

- Religious assumptions.
- Scientific assumptions.

**Religious Assumptions**

The first type of legitimated midwifery knowledge was in the realm of religion. The imperative to create legitimate midwifery knowledge was in response to the Reformation (Parsons 1971), which located the governance of western society in the sphere of ecclesia. Thus midwifery knowledge is visibly linked to the rational decision and action of ecclesiastical leaders in socio-cultural reform. Central to the ecclesiastical arguments of knowledge legitimation, as discussed earlier, is this:
witchcraft was the dominant culture of childbirth and midwifery (Kramer and Sprenger 1928; Forbes 1962)- a major sociological phenomenon which not only described midwifery knowledge as detrimental to childbearing women and their infants but was also antithetical to the ideology of the Catholic church and Reformation (See chapter three). This argument is crucial to the contention that in the changing structures of consciousness the grounds for a new principle of reconstituting midwifery can be located. But what we do have here is revealed knowledge, which as we shall see was undermined by the Enlightenment.

In mediating the cultural dilemma, thus posed (essentially a crisis in the status of knowledge and in the validity of the ability of midwives) the ecclesiastical authority developed an epistemology, broadly construed, based on theological assumptions, linking midwifery with salvation of the soul and development of spiritual existence. According to Scheler (1980, p 80) religious knowledge (which falls in his third type)

Belongs to the community of the church: within such a community the only things worth knowing are those that lead to salvation; all other concerns appear trivia.

Scheler further points out that all knowledge is determined by a particular group’s ethos and what a group considers worth knowing is dictated by that group’s ethos. Hence, the church power defines its object (salvation of the soul) by reference to special knowledge reserved or extended to those who involved in the spiritual care of others. Indeed as we began to trace the development of midwifery knowledge through the analysis of its practice, we see just that.

Midwifery knowledge, as a type of religious revealed knowledge has received little attention in either midwifery or other literature. Therefore, hardly any data are available to offer a comprehensive explanation of what this epistemology entails beyond the perspective given below. Tentatively, religious knowledge constituted knowledge of rituals around the religious practices (which are exemplified in the rites of baptism and churching) expected of childbearing women and midwives. All other forms of knowledge allegedly based on witchcraft were forbidden. Hence midwifery knowledge became a representation of ecclesiastical values and culture. If we accept the argument of witchcraft expounded in chapter
three, then religious knowledge is emancipatory, in so far that it freed women and their infants from its detrimental effects. But the difficulty, it would seem, was that all knowledge was categorised as witchcraft, which imposed upon midwives and women one perspective of knowledge. Consequently it condemned any other forms of knowledge that underpinned the midwives practice. Furthermore most midwives began to interpret their role as passively receiving the structures of knowledge that was imposed upon them.

Here a parallel can also be drawn with Belenky et al's (1986) first two major epistemological positions —silence and received knowledge (see chapter one). It is clear that the development of midwifery knowledge was related to specific societal function, as shown earlier, this was: the establishment of moral rationality.

According to Ehrenreich and English (1973) and Honneger (1979) the association of midwifery with witchcraft is part of the modernising process of rationalisation. A similar point raised by Heinsohn and Steiger (1980) suggests that the ecclesiastical motive was more a case of rooting out female naturalness otherwise it would impede scientific and technologic development of modern times. Hence, we begin to see the permeation of the assumptions of modernity, in particular, the process of cultural differentiation. Here we see that midwifery knowledge was being created predominantly through the perspective of a patriarchal culture.

About the ecclesiastical interpretation and representation of midwifery knowledge we must ask: what did midwifery knowledge constitute before this stage of cultural change? How was it produced and legitimated? The answer lies partly in this: since personal experience of the childbearing process was a necessary criterion to practise midwifery (Donisson 1977) it is possible to extrapolate that the foundation of midwifery knowledge rested on the following:

- Personal knowledge.

- Practical knowledge.

Midwifery knowledge could not have come from literary sources because midwives did not have access to them. Even if such sources were made available, in
all probability midwives who, generally speaking, were non-literate at the time, would not have been able to make use of them. Since midwifery was principally

Women's entity of which they alone had special knowledge.

(Donisson 1977, p. 11)

It is clear that the origin of midwifery knowledge was grounded in women's biography. But there seems to be nothing in the literature that recalls or explains this form of knowledge. Suffice to say that midwifery knowledge emanated from practice and legitimated in practice.

However it is evident that the ecclesiastical discourse was part of the realisation of the project of modernity.

**Scientific Assumptions**

**The Implications of Scientific Knowledge:**

As was demonstrated in chapter five, by far the most comprehensive form of knowledge that exists in the western construct of midwifery is disciplinary, which is based on the expert system. Examples of this knowledge include biomedical and behavioural sciences, law, genetics and ethics. By putting Foucault's idea (1970) in context, the development of midwifery knowledge proceeded from knowledge or concepts borrowed from these disciplines. As was also discussed, advances in these disciplines have had far-reaching consequences for midwifery, particularly, in terms of the legitimation and utilisation of knowledge. In short these forms of knowledge control midwifery.

Central to the arguments for the development of knowledge in accord with the view described above is the political and medico-scientific adoption of the modernist philosophy that:

All peoples must have a right to science. If it the social subject is not already subject to scientific knowledge, it is because that has been forbidden by priest and tyrants.

(Lyotard 1984, p.21)
As we have seen in chapter one, Lyotard himself opposes this view. Explicit in this epistemological shift from religion to science is a fundamental socio-philosophical issue: the Enlightenment philosophers' disenchantment with religion, which was perceived to be epistemologically inferior (Scheler 1980), that is, it was nothing but superstition and dogma and as such was an obstacle to human progress, and by extension to midwifery. The view of the Enlightenment philosophers about science is somewhat illusionary. As Scheler (1980, p. 27) suggests:

Science is rooted in metaphysical and religious knowledge and can never pull free of its foundations.

As historical evidence of the development shows although the leaders of the development of midwifery increasingly sought to distance themselves from the religious precursor, they had in fact continued to build on the religious framework of emancipation. The Enlightenment vision of knowledge and of society as emancipatory has progressively led to the dominant secular framework of science (discussed in chapter five).

Habermas (1995) suggests that there are two processes through which modernisation of society could be addressed. They are the functional differentiation of the social system and the detraditionalisation of lifeworld. I want to unpack this idea as it relates to the development of midwifery knowledge.

The infiltration of the Enlightenment philosophy in midwifery can be observed in the growing separation of the church and the state, with the latter assuming responsibility for the welfare of women and their infants. It will be recalled that amongst the criticism levelled at midwifery, ignorance and superstition featured as the most compelling which pressed midwifery into a societal way of life, belonging to modern schools of thought. It will also be recalled that the medical criticism levelled at ecclesiastical epistemology is its one-dimensional view of knowledge, that is, its concern with religious matters only (Boorde, cited in Towler and Bramall 1986).

Let us examine the processes that enabled the epistemological shift. Although the process of decontextualisation has been gradual, one of the most significant considerations on the political and medical agenda was the creation of
institutions, which led to the displacement of the social space. Patterns of everyday life in which women and midwives were located and face-to-face communication as a means of imparting/sharing knowledge, were dismantled.

The Decontextualisation of Childbirth.

Although the decontextualisation of childbirth and the process of cultural transformation began with the ecclesiastical discourse and the involvement of medical—men in the construction of midwifery knowledge, the major impact is seen in the dislocation of spatial context within which birth occurred, happened, that is the complete hospitalisation of birth, instigated, legitimated and controlled by the state.

In a similar way to religion, which was seen as an obstruction to the development of science, midwives were distinguished as an impediment to the development of knowledge along the lines, the medical profession wished to develop it (Arney 1982). Thus Foucault’s idea of governmentality can be observed in the development of midwifery knowledge.

Based on the premise that modern medicine must be made available to all women (HMSO 1970), the dislocation of the social space (exemplified in the establishment of hospitals) in which birth occurred reflects the pervasiveness of the assumptions of modernity, at least the notion of universality. The growing significance of knowledge forces us to confront the effect of the decontextualisation of birth. According to Foucault (1972) it has had the following consequences:

- it has suspended the continuous accumulation of knowledge.
- it has interrupted its development.
- as well as forcing it to enter a new space, it has forced it to enter a new time.

Additionally, the relocation of birth into hospital, that is into medical space achieved the following: it emancipated medical professionals from territorial constraints of women’s exclusive space (which ecclesia had not disturbed) and rendered perspectives of knowledge to be had in that context defunct. Hence the project of modernity, that is the development of scientific knowledge could progress unhindered. As Scheler (1980, p 180) remarks:
Chapter Ten: The Modern Construct of Midwifery Knowledge -

One thing is certain and has been for a long time – cultures of knowledge especially those of positive science, are dependent, to high degrees, upon territories.

In examining interactions between medical professionals and the state through the development of midwifery since it became subject to scrutiny, we begin to see that the development of midwifery knowledge is enmeshed in a discourse of power external to reality of women; one that gave rise to medical science. As Foucault (1980, p. 91) observed

Power is always present, in any attempt to know; indeed power works its effect through its intimate interconnection with knowledge.

Thus midwifery knowledge began to develop from a perspective external to and independent of the realities of women as the knowing subjects (Habermas 1978).

Similar to

The new universities and research institutes created by the absolute estate in opposition to ecclesiastical organisation of knowledge brought with their new tenured chairs for specialised sciences also an entirely changed atmosphere (his italics) to the life of the sciences.

(Scheler 1980, p. 76)

The shifting of birth in hospital environment affected the development of midwifery knowledge. Akin to Foucault’s idea (1980) of governmentality, in which a range of mechanisms to allow different groups and discourse to regulate, control and constitute individuals, groups and society, is the reality of childbirth which was being redefined to fit in the context in which it then took place, that is consistent with political and medical ideology. Foucault (1972, p 162) further points out that:

Knowledge actively orders reality on the basis of the assumptions that make up the discursive formations within which the knower (the woman and midwife) is located.

In essence then, the creation of the modern institution, in so far as it has enabled all women to have access to modern medicine has also disembedded the mechanism that women had in place and distanced them from the local context of their “discursive formations”. Knowledge thus was being shaped by social
influences quite distant from them, which Foucault terms "non-discursive formations" (1972p 162). For instance economic practices and processes replaced the social relations that existed amongst women. In that respect modernity has been discontinuous, in that the everyday practice of midwifery was being shaped by the everyday practice of the institutions in which it was now located. (Foucault 1970, 1979).

I will return to Foucault's notion of discontinuity and its association to midwifery knowledge towards the end of this section. In the same way that the development of "proper scientific institutions" de-emphasised higher education (Lyotard 1984) so did the development of hospitals do to childbirth to control the production of knowledge.

Several social theorists have addressed the implications of decontextualisation on social reality. For instance the works of Giddens (1991) and Bauman (1998) are particularly significant to the examination of the context in which midwifery knowledge developed.

Further understanding of the implications of decontextualisation of the social reality of birth is given by Giddens (1991, p. 20-21)

The separating of time and space and their formation into standardised, "empty" dimensions cut through the connections between social activity and its "embedding" on the particularities of contexts of presence. Disembedded institutions greatly extend the scope of time-space distanciation and, to have this effect, depend upon coordination across time and space. This phenomenon serves to open up manifold possibilities of change by breaking free from the restraints of local habits and practices.

Disembedding, according to Giddens (1991, p. 21) is

Lifting out social relations from local contexts of interaction and their restructuring across indefinite spans of time-space.

Bauman (1998, p.106) places a similar emphasis and attests:

The deepest meaning of spatial separation was the banning and suspension of communication, and forcible estrangement. Estrangement is the core function of spatial separation. It reduces, thins down and compresses the view of the other individual qualities and circumstances
which tend to be vividly brought within sight of daily intercourse, seldom come into view when the intercourse is emaciated or prohibited altogether: typification takes place of personal familiarity, and the legal categories meant to reduce the variance and to allow it to be disregarded render the uniqueness of person and case irrelevant.

Therefore the establishment of hospitals and the medico-scientific rationality glimpsed at in chapters four and five, disengaged midwifery practice from spatially and temporally located activity. Thus the social relations between women, midwives and the culture of their locality were reconstituted across modernity's vista of space and time. Inevitably then previous mode of interaction could no longer be confined to the presence of women and midwives in a shared time and physical space. It became disembedded from such contexts and reconstituted on a universal level. Consequently this further led to an epistemological condition tantamount to Belenky et al (1986) notion of separate knowing.

Of special importance, however, is the link between scientific knowledge, progress, emancipation and social equality. It will be recalled that modern (Enlightenment) thinking was important in terms of its granting each individual the right to science (Lyotard 1984), thus emancipating them from the domination imposed by nature - a necessity of which the pathological dimension of childbirth and its association with high mortalities, discussed in chapters four and five indicated was paramount.

In terms of epistemological development, therefore, hospitalisation of childbirth must be understood as generating knowledge that can be used in the interest of prediction, control, and essentially generating knowledge about modern social life. But Habermas (1984) makes it clear that whilst scientific knowledge might have been necessary for social existence, it is insufficient to fully understand social phenomena. Similarly Lyotard (1984) argues that the perspective of local narrative, that it could be argued, was a way of explaining social phenomena lost its meaning as it gave way to metanarrative which represents the modern perspective of universality.

Another significant issue arising from the decontextualisation of birth relates to the proliferation of specialist, expert and technological knowledge. Undoubtedly
these specific forms of knowledge have been emancipatory, (see for example reproductive technology discussed in chapter five) on the basis that women may make choices about their care. These may involve opting for technological expertise. But although technological knowledge has offered possibilities that prior to modernity would not have been possible (see chapter five for reproductive technology as an example) it must also be recognised that it has appropriated and reconstituted the lived experience of childbirth embodied in the modern perspective of time and space. Thus knowledge production and legitimation relates to spatio-temporal activities which have been inescapably enmeshed in a process of discontinuation.

I now want to return to the concept of discontinuity to further explore the impact of modernity on the production and legitimation of midwifery knowledge. If we accept Foucault’s (1970) notion of discontinuity (see chapter one) which supports the cultural transformation thesis, the creation of institutions and contextualising birth in them holds more than what shifting it from one location to another entails. It involves a radical shift in our thinking about space and time and the relationship with the culture of a particular time, that is midwifery knowledge and the thinking about midwifery became divorced from its pre-Enlightenment culture. But we may argue that although, borrowing Foucault’s term (1970), midwifery epistemological field became fragmented or exploded in different directions, midwifery knowledge remains embedded in practice; it is the interpretation and representation of midwifery practice that took a different meaning according to the spatio-temporal context into which it is now situated. So the discontinuity is in the conceptualisation of practice. I want to draw more specifically on Foucault’s (1980,p. 112) concept as it relates to medicine. He writes:

In a science like medicine, up to the end of the eighteenth century one has a certain type of discourse whose gradual transformation, within a period of twenty-five or thirty years, broke not only with the ‘true’ (his parenthesis) propositions which it had hitherto been possible to formulate but also, more profoundly, with the ways of speaking and seeing, the whole ensemble of practices which served as supports for medical knowledge. These are not simply new discoveries; there is a whole new ‘regime’ (his parenthesis) in discourse and forms of knowledge.
By regime, Foucault means the politics of scientific statements. The important issue in the concept of discontinuity for Foucault further is the transformation of concepts which are accepted as scientifically true. As we look closely at the development of midwifery from the ecclesiastical to the medico-scientific discourses we see the extent to which this is true of midwifery knowledge. The concept of discontinuity therefore, evokes some concerns about what occupies the knowledge base that midwifery can call its own. If Foucault’s above idea is correct then even though the preecclesiastical concepts of midwifery were steeped in superstition (allegedly), it has to be considered as constituting a body of knowledge that belonged to midwifery in accordance with the culture of the time. Towler and Bramall (1986) and Biller (1986) have indicated that whilst the dominant culture prior to ecclesiastical involvement was entrenched in superstition, there was also indication of the use of naturopathic medicine- a perspective that was antithetical to science.

Despite resistance by some midwives, from the early stage of the cultural transformation to this day, generally speaking, midwives and women were/ are being acculturated to the scientific and technologic ways of understanding midwifery. Consider, then the implication on midwifery knowledge. Here a parallel can be drawn with Belenky et al’s (1986) findings on women’s ways of knowing- with particular reference with their notions of separate knowing. Separate knowing, according to Belenky et al (1986)) occurred when the socialisation process takes place in institutions where the values of the particular institutions are being inculcated. Consequently, midwives and women, by adhering to the medico-scientific androcentric culture (Lyotard 1984) which alienated them from the process of birth- “as it would evolve in their social reality, indeed became separate knowers”.

Thus Foucault draws our attention to an important element of knowledge in the construction and legitimation of midwifery knowledge: for him the contemporary forms of knowledge have become increasingly focused upon the biological dimension, thereby fragmenting the holistic nature of birth experience (1979), and permitting dissociation of consciousness, which I understand is his explanation of discontinuity (1970). Habermas’ analysis (1992, p. 71) of the
legitimation of knowledge concurs with Foucault, that as soon as knowledge was produced and legitimised within the positivist approach, the previous cultural traditions became

torn out of their interpretive systems that guarantee continuity and identity.

The legitimising force therefore becomes damage and undermined. In Habermas’ view (1978, p.72)

The dissolution of traditional lifeworlds is reflected in the decomposition of religious worldviews, of stratified orders of domination, and of those institutions which, by combining various functions, continue to characterise the society as a whole.

Thus the idea of progress as it has evolved in the production, legitimisation and utilisation of knowledge, reflects a definite and pervasive theoretical orientation underpinned by the assumptions of modernity. The argument of discontinuity therefore, as it applies to the decontextualisation of childbirth, suggests that the knowledge base of midwifery is not connected to its reality. As stated elsewhere it is fragmentary. As we discussed in chapter five, as midwifery knowledge has developed we have also witnessed the growth of disciplinary knowledge which has compartmentalised midwifery practice each having control on the domain of knowledge that has come to be accepted as midwifery. Thus Scheler’s (1980) view of the increase artificialisation of knowledge as it develops is a truism of midwifery epistemology. My question therefore is: is what is taken for midwifery knowledge can indeed legitimately be called as such? Is it not more appropriately obstetric knowledge?

As we have observed in chapter four and five the development of midwifery knowledge moved progressively from the perspective of medical science which interpreted if from the vantage point of biology, in which women became the object of medical science, and the development of disciplinary knowledge finds its root Foucault (1970). The development of knowledge be it disciplinary or otherwise is tied up with knowledge for action. For instance as we discussed in chapter five the development of knowledge was increasingly utilised for surveillance purposes,
particularly technological techniques (i.e. ultrasound techniques) which further facilitated the process of knowledge development about childbearing women. Thus ways of knowing are equated with ways of exercising power.

Invariably, then, development of midwifery knowledge from a Foucauldian perspective is linked with domination rather than emancipation and progress. So, therefore making scientific knowledge a basic right of every childbearing woman cannot be a matter of emancipation and progress as increasingly women have become dissatisfied with it on the basis of aligning childbirth with pathology in need of therapeutic efficiency (see, for example, Illich’s (1990) criticism of the use of analgesia). In his view the growth of specialist knowledge is linked to the emergence of subtle mechanisms of social control, and to the elision of a major chapter in the epistemology of midwifery.

The explosive growth in specialist knowledge (including technological knowledge) in the field of midwifery over the last few decades has been a significant factor in the increasing differentiation and fragmentation of modern culture. It is in fact the division of labour accompanied by the growth of speciality that determined the appearance of new domains of knowledge- knowledge from outside (Foucault 1970). To further demonstrate this point, Habermas (1995, p. 193) asserts that:

The complementary differentiation of an economic system and of a bureaucratic system of public administration that has a monopoly on force and is thus steered by power, serves as the great historical example of a line of development along which modern societies are gradually absorbed by their functionally specified subsystems.

This is well illustrated in the political discourse. Finally placing Scheler’s classification (1980) of knowledge in context, it is now possible to confirm that in the modernist approach the development of midwifery knowledge takes its root from the positivist and technological knowledge (see Scheler’s types of knowledge in chapter two).
Legitimation of Knowledge through Language.

Foucault (1970), Habermas (1987) (Lyotard (1984) and Jarvis (1992) draw our attention to the relation between language and knowledge, which they point out, forms a crucial part of legitimation. Critics of the medico-scientific discourse, particularly Jacobus et al (1990) and Illich (1990) have already raised the issue of linguistic representation created by doctors to express the medical perspective of childbirth. Indeed as we observed in chapter five, the linguistic paradigm created by medical science to communicate/ impart the knowledge generated by scientific methodology, aligns it entirely with scientific structures of meaning which is rooted in modernist assumptions. Additionally, Jacobus et al (1990) assert that professional authority and institutional structures are the principal constituents of the medical linguistic paradigm, which has not only alienated and still alienates women from the discourse of childbirth but also forces them into compliance. Existing communicative systems employed, consistent with Habermas' (1984) notion of lifeworld (see chapter one) where meanings were acquired and communicated mostly by oral means and understood by each other, were no longer relevant. An example of the above is found in the way women’s personal experience and knowledge of childbirth is documented. which is undoubtedly expressed in scientific terms.

Although coming from different perspectives, the works of Foucault (1970), Lyotard (19840 and Habermas (1984), collectively show that the scientific language adopted by medico-scientific discourse does not provide an adequate representation of the reality of childbirth and midwifery practice. In their view knowledge does not only consist of scientific reality but of the ‘discursive formations’ that within lifeworld (Habermas 1984) which in the pre-scientific culture occurred in women’s social space. In women’s lifeworld, existing forms of knowledge and communication were shared and understood by all members. Habermas (1984) raises our consciousness, that as sciences intrude into the realm of communication and assert control in intersubjective relations, which undoubtedly happened in midwifery, the result is the loss of meaning. To conclude the analysis of knowledge legitimation through linguistic representation, critical theorists engage us to be
critical of the dominant medico-scientific representation. Like Habermas, Foucault (1970) channels our attention to just that and challenges the construction of language through writing. Both Foucault and Habermas, albeit from different angles, raise our awareness to the problem of language in written form, because that form of communication is inaccessible to those that it is written about. For Habermas, language is limited to a cultural order, that is, the way a particular society thinks and speaks. It is clear in the context of western midwifery, language in the scientific context has established a cultural perspective that is not possible for other groups to use (women and midwives) except those who in the first instance created it, which further shows the cultural differentiation as midwifery has evolved through the premodern era (exemplified by the ecclesiastical discourse) to the modern era (exemplified by the political; and medico-scientific discourse).

Childbearing women were not involved in affecting the linguistic development, that is they were not involved in describing and formulating the (subjective) midwifery phenomenon according to their interpretation, which according to Foucault (1970) is the signifying function of language. In the Western culture, literature took the signifying function of language, and medical literature by extension to midwifery.

A further problem relating to the construction of language concerns matters of interpretation and representation. As we saw in chapters four and five, men, according to their interpretation, did all the writing about midwifery. Thus, here too Foucault's notion of power exemplified in medical dominant discourse is evident in midwifery. Through the notion of lifeworld and everyday practice Habermas has shown that language is limited to cultural order. Surely then the dissemination of knowledge involves a linguistic communication within social relations, and also appropriating practices crystallised in social contexts. Linguistic communications need to be multi-dimensional, our relation to one another are mediated by language. Thus the linguistic paradigm employed to communicate with women must be one that is regarded as joint endeavour. This further points the extent to which the linguistic representation of midwifery is by the scientific culture of modernity.
Chapter Ten: The Modern Construct of Midwifery Knowledge -

Methodological Issues

The final issue concerns the impact of modernity on methodological issues. As shown in chapter five the medico-scientific discourse claimed legitimacy through the positivistic philosophy. This philosophical orientation emphasises reason and rationality (Descartes 1637) as ways of legitimising knowledge. In the adoption of scientific methodology, which derives from the positivist schools of thought, the development of midwifery knowledge became enmeshed in the discourse of objectivity and value-neutrality. The power of this discourse established how the search ought to be conducted. What is clear, however, is that the political as well as the medico-scientific discourses have used conceptual systems, which depend on modern epistemological traditions.

As Foucault (1970), Lyotard (1984) and Habermas (1984, 1987) have pointed out scientific methodology can only be used for one type of knowledge and cannot represent the totality. In pursuing scientific methods as the only path to knowledge the medical profession as leaders of knowledge development in their times have neglected other approaches that did not fit into the scientific tradition. Lyotard’s (1984) notion of metanarrative, Foucault’s (1970) criticism of mathematical application to knowledge production and Habermas’ (1984) criticism of rationality concur that the sole application of scientific methodology is fallible on the basis that it conceals the context embeddedness of social phenomena and the perspective of knowledge to be had in the social realm of midwifery.

A similar notion also exists in the work of Bourdieu (1977, 1990) who shows that the problem with scientific approaches to the construction and legitimation of knowledge and its claim to objectivity is that it has established particular conditions on it, resulting in major discontinuities in the field of practice which is where its knowledge is embedded. He attests that the crux of the debate is a claim to legitimate domination. He proposes that theories of knowledge need to be adequate theories of practice. This requires, however, moving into a more profound consideration of the interrelationships between pragmational aspects of midwifery and the status of scientific knowledge.
Because it produces its science of the world against the implicit presuppositions of practical knowledge of the social world, objectivist knowledge is diverted from the construction of the theory of practical knowledge of the social world of which at least it produces the lack.

(Bourdieu 1977, p. 4)

**Conclusion**

As we have studied the development of midwifery knowledge it is evident that that is has been undergone a process of cultural transformation. Midwives and women alike have been acculturated into the scientific mode of thinking. The macrosociological perspectives confront us with some serious problems about the effects of modernity on the construction, legitimation and utilisation of midwifery knowledge. This forces us to raise further questions about knowledge, such as, what knowledge is important and relevant? How ought the search of knowledge be conducted? Both critical and postmodern theories in problematising the assumptions of modernity suggest that the modern approach (that is objectivism) is an inadequate intellectual orientation and recognise the importance of subjectivism. Thus they hold considerable potential for the development of a possible unified epistemology, since they contain a framework that facilitates apprehending reality as closely as possible. This therefore calls for understanding the subjectivist perspective of knowledge. In the next chapter I undertake the analysis of midwifery knowledge from the subjectivist perspective, and which the premodern might provide some clues.
CHAPTER ELEVEN

The Premodern Construct of Midwifery Knowledge

Introduction

This chapter undertakes the analysis of midwifery epistemology from the perspective of traditional midwifery. From a macro-sociological perspective, traditional midwifery fits into the context of premodernity. The data have been analysed in the light of the sociological theories presented in chapter one. The empirical findings presented in part three suggest that the premodern approach to knowledge production is pragmatic. It is embedded in religious assumptions and has not been subjected to the societal and political pressures for so long, insofar that knowledge has not been dissociated from the spatio-temporal continuum within which it is produced and utilised. Although progress in the midwifery spheres along scientific and technologic knowledge has been significant, it has not infringed or undermined religious beliefs and integration of religion in midwifery.

In lying outside the mould of positivism and diverse to its ethos and conventions, the premodern approach provides a different conception of midwifery knowledge, and a challenge to the dominant epistemological assumptions of modernity upon which contemporary midwifery knowledge is based. It facilitates the resurgence and unravelling of the forms/types of knowledge neglected by the project of modernity. In order to understand the epistemological basis of traditional midwifery one must first gain an appreciation of it from within, by exploring the arguments made within the culture to justify its knowledge claims. There are many issues that have emerged from the Mauritian case study. It is neither is it possible nor relevant to address them all in this discourse. Only those related to knowledge are addressed herewith. According to my analysis, the arguments relating to knowledge fall into four main areas. These are:

- Religious knowledge.
- Experiential Knowledge.
Chapter 11: The Premodern Construct of Midwifery Knowledge

- Context of knowledge production.
- Linguistic representation.

**Religious Knowledge**

Given the locus of the Mauritian culture it is not surprising that the religious-metaphysical worldview is the central justification for the knowledge claims of various subcultures. Firstly, as I have explained in the overview of Mauritius (see appendix two), religion and spirituality are profound and pervasive in the lives of the people. The core of religious knowledge encountered in this study comes from the Asian culture, which derives from the Eastern metaphysical gestalt and forms part of the ethos and formal doctrine of their religion. The Asian religions appear to have retained and integrated every aspect of religious and metaphysical knowledge into midwifery. Significantly Asian cultures did not experience the Enlightenment which was really only made possible by the Reformation. Scheler’s observation (1980,p.91) that:

> In all Asian cultures it was the ‘sage’ (his parenthesis) and a *metaphysical* (his italics) that won over religion as well as science.

This is undeniably the case in the Mauritian perspective of traditional midwifery. However, the relevance of religious practices in relation to childbirth and midwifery can be found in the teachings of other religions. For instance the book of Leviticus, found in biblical writings, provides evidence of the ceremonial laws that childbearing women were required to keep. The rite of purification is mentioned and, it stipulates a postpartum unclean period of forty days and details the requirements for the rite of sacrifice. Thus certain similarities in religious teachings exist in early Mauritian Christian and contemporary Asian cultures. However there are significant interpretive differences within these two cultures. Whilst in the Asian cultures, religious knowledge appears to be fixed and absolute, Christian emphasis seems to have shifted from a religious fixed worldview to a more secularised approach to childbirth and midwifery. But upon closer examination, religion still plays a significant role in the Christian culture. Looking at the religious sources of Christianity, one finds a philosophy consistent with later revelation in the New
Chapter 11: The Premodern Construct of Midwifery Knowledge

Testament. It is about knowledge for salvation. Indeed as Scheler (1980,p.27) has stressed:

It is knowledge by which the nucleus of our person seeks to partake in ultimate being and the very source of all things.

Thus the basis of the Christian epistemological position lays emphasis upon the spiritual life of the newborn, which is believed to be in a state of non-being until the rite of baptism has been performed - a rite which assures salvation of the soul. As we discussed in chapter nine, the significance of baptism is profound and concerns the integration of the baby in the social as well as the spiritual world. Thus the association of midwifery with religion to a lesser or greater extent is a manifestation of everyday life. Religion holds a mirror to life. Midwifery reflects life from the mirror of religion: there is therefore a reciprocal reflection - if not a structural similarity between them. Hence midwifery is beholden to religion and its basic metaphysics which are mirrored in its approach to practice and knowledge production and legitimation.

Secondly, one of the key issues in traditional midwifery knowledge is the belief that it is supernaturally sanctioned. It will be recalled that most dais claimed to have been called by God or the spirit. The crucial importance of this belief is that it leads to an inchoation of a perspective in premodern discourse which sees a kind of knowledge with claims to divine authority and revelation. It is a source of knowledge that sustains the complex roles and practices that dais are expected to fulfil. Additionally, existing traditional midwifery knowledge assigns a fairly central role to the interrelationship with God, the spirits and nature, which seems to suggest that at the heart of their epistemological position, is a wider sacred or divine reality. Here the notion of revealed knowledge can be observed, which in the modern context the Enlightenment undermined.

Hence the premodern discourse proclaims ‘universal laws’ which constitute both religious and natural laws and are the basis of traditional midwifery epistemology. These laws, which are expressed in the elaborate rituals described in chapter nine, are means through which the behaviour of childbearing women and the actions of the dais are regulated. Another dimension of spiritual significance in the
rituals is the number of days that the practices are carried out and certain laws observed. It will be recalled that the numbers seven, twelve and forty feature in almost all religious practices related to childbirth. Quite possibly these numbers may be a merely conventional number associated with the bio-physiological process of recuperation form the process of childbirth. But upon closer examination it appears to define a correspondence and a deeper meaning between the divine and the human. Although unrelated to Asian religion, there is evidence in biblical writings (for example in the book Leviticus, Numbers and Deuteronomy) that define the symbolic meanings of these specific days not only in relation to childbirth but also to other aspects of life.

The works of Habermas (1987) and Giddens (1991) have shown that religious cosmology, one of the defining features of premodern societies, is a way through which human life and its relationship with nature is interpreted. Indeed the dais and women’s perception of midwifery knowledge is located within such frame of reference, which subtends and contextualises a broader framework explaining the relationship of midwifery with nature. This relationship is expressed in the concepts of vulnerability, danger and liminality. Here there is a cosmology that represents nature as hostile to childbearing women: firstly, in the state of “hotness” and “coldness” (which poses a physical threat to childbearing women); secondly, in the malevolent forces; thirdly in the defiling state of childbearing.

Similar to the modern perspective, knowledge is utilised for prediction and control. The difference with traditional midwifery is that, it contains “symbolic templates” (Geertz 1973, pp.216-218) that follow predictable paths and control. For instance, the dietary regulations, use of earthen lamps, the flower method to monitor the progress of labour and the elaborate rituals are all tools of the symbolic templates, indicative of prediction and control. Two main thoughts emerge from this. Firstly, these “symbolic templates” show that, as well as being used for practical purposes, traditional midwifery knowledge connects the physical, the spiritual and the social. Midwifery knowledge, although equally prescriptive, is not fragmentary. This is consistent with the dais’ definition of midwifery, which it will be recalled, associates it with life itself. It is something that belongs to and deals with the whole
being of the woman as an embodied symbolic being in tune with the social, spiritual and natural world that she inhabits, that is, there are no boundaries between the social, physical and the spiritual. Thus, as the modernists claim that their representation of knowledge problematise the premodern, so does the religious-metaphysical representation of midwifery problematise the dominant positivist approach to knowledge construction and legitimation, which fragments our state of being into distinct parts and with distinct and separate functions. When we begin to deal with issues of religion and spirituality we should not be limited to, or constrained by rationality and reason alone. The epistemological basis of traditional midwifery extends far beyond the limits of reason and rationality and the ultimate form of knowledge promoted by the Enlightenment.

Premodern societies, exemplified by the Mauritian traditional midwifery system, have retained this ethos in every epistemological position. As Van Gennep’s study of Les Rites De Passage (1909, p.4) shows

Chez les demi-civilisés aucun acte n’est absolument indépendent du sacré. Tout changement dans la situation d’un individu y comporte des actions et des réactions entre le profane et le sacré, actions et réactions qui doivent être réglementées et surveillées afin que la société générale n’êprouve ni gêne ni dommage.

In semi-civilised worlds no one action is absolutely independent of the sacred. Every change in the situation of an individual constitutes actions and reactions between the profane and the sacred, actions and reactions that must be regulated and watched in order that society in general experiences neither difficulty nor damage.

There is a fundamental sense in which power and control, from a macrosociological perspective, defines the characteristic of knowledge across culture.

The Power of Religion in the construction of midwifery knowledge

Though not the source of modernity, the religious-metaphysical discourse also enjoys a powerful position in midwifery in that it controls how knowledge is utilised. In following Foucault, I argue that premodern societies equally control midwifery knowledge by positing external rules. These include the diverse rites expounded in chapter nine. According to Foucault (1970) the purpose of this control mechanism is largely institutional and aims at a conservation and perpetuation of
power. In the premodern scenario the notion of power is couched in the idea of the profane and the sacred and the ideas of rituals that mediate between these two opposing situations. The religious discourse of premodernity is bound by these discursive practices. Consequently, the notion that legitimation is concerned with the establishment of power and authority and securing obedience and order (Campbell, Luke and Thompson 1996) is equally evident in the premodern perspective of the midwifery epistemological debate.

However, the power relations here are not conflictual because women and dais subscribe to this worldview and are part of those micro-relations of power. Additionally the strength of traditional midwifery knowledge that sustains its power is that it is unchanging. Because of its unchanging structure/character traditional midwifery knowledge, as Giddens (1991) shows, serves as medium of trust. It gives stability, certainty and security.

Secondly, though not in the same context as modernity, it is possible to infer that traditional midwifery knowledge serves emancipatory interest, in so far that it allows dais and women to have control over nature.

*Experiential Knowledge.*

Experiential knowledge of dais assumes two types: biographical/personal and practical knowledge, that is the know-how (procedural knowledge) and knowledge that/what (propositional knowledge) (Scheffler 1983, Heller 1983). As already discussed their practical knowledge is also associated with understanding and controlling nature, obviously within the premodern cultural perspective.

*Biographical Knowledge/Personal Knowledge.*

The traditional midwifery system assigns an important role to personal knowledge. It identifies two fundamental issues:

- Personal human experience of the process of childbirth. Personal knowledge according to Polanyi (1958) is contained in the intuitive and procedural skills of the individual. Certainly this has relevance to our discussion about traditional/premodern midwifery epistemology.
Polanyi's argument about personal knowledge seems to suggest that it is tied up with is a kind of sensorimotor knowledge that is knowledge apprehended through our sensory experiences. But personal account in the present discussion is held at the level at which perception of midwifery knowledge is combined with patterns of thinking derived from the epistemic position that underpins it. In traditional midwifery knowledge we come across knowledge that is not simply held at the intuitive level but one that holds a rich complex of thoughts, beliefs and narratives.

- Age- Interconnected with the above- age brings two important epistemic positions of traditional midwifery- the notion of wisdom and expertise. These two combined are integrated to support their practice

Firstly human experience is multi-dimensional encompassing the biological, social and spiritual aspect of our whole being. It is a key element in the traditional midwifery knowledge. Amongst many scholars in the field of education, Brookfield (1987), Jarvis (1987) Usher, Bryant and Johnston (1997) have expanded the idea of experience as an important basis and resource for learning. Whilst important to the discussion of knowledge their works are not discussed here. Rather than a distinct method of learning, personal experience is discussed in relation to knowledge production, as the dais perceive it. It will be recalled that most dais are either semi-literate or non-literate. Their knowledge does not come from literary sources, nor do they access such sources. One of the sources of their knowledge comes from personal experience of having given birth, which every dai must have undergone. Such experience provides an inner orientation, that can only be had from being a woman (subjective knowing). A powerful message lies in the personal experience of childbirth. In my view this is the basis of understanding of physiological knowledge which comes through experiential “in vivo” bodily orientation. What I am really saying here is that textbook knowledge is not the only source for acquiring physiological knowledge, which undoubtedly is artificial but there is a natural way of learning about it. An example of this is found in most of my excerpts about dais’
biography and their ability to articulate with precision the physiological knowledge
within their mode of calling in traditional socialisation of mother. As a paradox
however, this raises the question: should midwives be always mothers? I will return
to this point in the next chapter where I broach the implications for the curricula.

The significance of knowledge within the notion of “wholeness” is reflected
in an extreme process of acculturation which some dais elect to experience in order
to enter and habituate themselves to the cultural milieu of the women who they are
called upon to serve by virtue of their personal knowledge about the social and
spiritual dimensions of other subcultures (See chapter nine– narrative one). This
suggests that some dais/traditional midwifery take account of the relationship
between individuals’ lives and their social reality in order to respond to the diversity
of cultural and social needs that they may encounter in practice.

From the Mauritian perspective of premodernity, therefore, childbirth is
grounded exclusively in the arena of women’s lifeworld (Habermas 1987) from
within which childbearing women come to understand one another about the
biological, social and spiritual processes of childbearing. It is about interpersonal
relationships. The basis of dais practice as we saw in chapter nine, in particular
during labour, dais, childbearing women and the kin enter into interpersonal
relationships with one another, and they do so as actors to a network of normative
expectations. Thus, to use Habermas’ term (1995) biological knowledge becomes a
significant dimension of the normative (Luke 1996) context, within which dais and
childbearing women’s life world is intersubjectively shared. It is knowledge that has
relevance. It seems that childbirth as well as being intimately connected with the
social construct of being a woman and arguably, a mother, brings out another
important notion about personal/biographical knowledge that may be used to further
explicate the embededness of the social process involved in knowledge production
the notion of personhood. Although it is not the place of my study to embark on an
in-depth examination of personhood, I believe it is of some relevance here in
shedding further light on the state of being and or our capabilities of reason and
rationality beyond the modernist/scientific explanation. About personhood Heller
(1983, p 36) writes:
Chapter 11: The Premodern Construct of Midwifery Knowledge

In everyday life the person objectivizes himself in many forms. He shapes his world and in this way he shapes himself...Everyday life takes place in and relates to the immediate environment of a person...every human being is a particular person who comes into the world equipped with given set of qualities, capabilities and aptitudes. From the person's point of view, the qualities he is born with as natural gifts.

I am aware that Heller does not particularly refer to women, neither do I assume that the "qualities, aptitudes, capabilities" are necessarily biological; nor are they solely intrinsic to women's childbearing capabilities. Indeed the "qualities, aptitudes and capabilities" she refers may be largely products of human mode of socialisation and culture. The reason why I have recalled Heller's critical observation is not only to emphasise the dais' view that women are equipped with natural propensities to handle the biological and the social processes of childbirth but to demonstrate also that there is a reciprocal flow of kinetic forces between the environment, (essentially the powers of nature) and the social, and biological processes inherent in the woman as the child bearer. Undoubtedly as we saw in chapters eight and nine dais and women sacralise the forces of nature and the artifacts that they use to control these forces, and connect them to the natural world in a deeper way that we have come to understand. Humankind is not only biological but also social, as well as spiritual, beings.

Let me try to unpack this point as they relate to knowledge construction. Employing the perspective of biography helps us to begin to see the many directions in which midwifery knowledge flows. This is similar to the point illustrated in the notion of lifeworld raised by Habermas and local narratives raised by Lyotard.

Another perspective on women's knowledge suggests that it is particularistic and constitutes everyday knowledge (Heller 1983). As she attests, everyday knowledge which women appropriate is quite different from that incumbent on men. More importantly within the Mauritian context, it is a different knowledge that is incumbent on childless women as well. This everyday knowledge, as mentioned earlier, is to do with what women know through their bodies and partly through the social processes of childbearing. Personal knowledge, thus, serves to provide shared meaning (Habermas 1987). This perspective is somewhat similar to Belenky et al's
(1986) view of subjective and constructed knowledge which they describe as follows:

- Subjective knowledge - a perspective from which truth and knowledge are conceived of as a personal, and subjectively known.

- Constructed knowledge - a position in which women view all knowledge as contextual, and experience themselves as creators of knowledge. This does not appear to be conscious effort on the dais' part. It is just circumstantial.

To further illustrate this point I want to cite Freire's notion (1972) of pragmatism which suggests that approach to knowledge construction involves a dialogical relationship between knower and known. If as Freire (1972) further suggests that all knowing beings with experience which is the actuality of lived experience (that is the biological social and spiritual), then dialogue can only occur among women and dais who have themselves borne children. Beyond the beliefs that childless women have the potential to cause harm, what the dais are actually telling us, is that knowledge is not something that can be constructed independent of its experiential reality that is by using the criteria of positivist methodology. Here we have a very significant issue pertaining to knowledge development. If we consider midwifery as a field in its own right then its knowledge must also come from within as opposed to disciplinary knowledge which comes from outside women's knowing. Biographical knowledge in the context of this study suggests that what lies outside it can only be artificial. So then the person who has not experienced childbirth, in a sense, has artificial knowledge when discussing midwifery practice.

It will be recalled that Scheler (1980) states that as knowledge has developed it has occurred with increased artificiality (albeit in the context of scientific and technological knowledge). So to allow women who lacked personal knowledge of the process of childbirth to become a dai would be seen as tantamount to dilution or artificialisation of knowledge observed in the modern epistemological stance, that is, as ascribed to the modern view of those who try to avoid any dilution or artificialisation of the traditional knowledge base.
Thus when the dais claimed personal experience of childbirth to confer legitimacy on their knowledge, it involves the interpretation of the totality of that process, and the way in which this process is mediated by culture and their understanding of how to make judgements and perform in practice. Therefore we see one aspect of knowledge that constitutes more than theoretical knowledge, and one that involves the subjectivist perspective which can only be had by having first hand experience of birth- knowledge that orientates to the self rather than away from the self. It is this self knowledge or self consciousness, as Hegel (1996) points out, that permits us to understand the basic structures of midwifery reality, and enables us to get beneath the perspective of knowledge presented through the assumptions of modernity. In a sense the dais are reflective practitioners or even more they are practitioner-researchers (Jarvis 1999).

The account of personal knowledge presented so far suggests that traditional midwifery knowledge of the dais must include some account of themselves if they are to assist the women in their care, fully. By the mere fact that dais raise the point that in order to assist women in the birthing process they need to themselves know what it is like suggests that they are self-conscious about their knowledge system. As Giddens (1991) and Alvesson and Skoldberg (2000) point out, all human action involves self-reflexivity, which is a conscious and purposive guiding of activity within social contexts. I showed in chapter two the very essence of pragmatism is in its reflexive nature. The problem with reflexivity in traditional midwifery knowledge in Giddens' sense (1991) is that it is largely limited to the interpretation and reinterpretation of the past (Giddens 1991). Nonetheless it is authoritative knowledge that Jordan (1993, p. 154) defines as follows:

Authoritative knowledge is knowledge that within a community is considered legitimate, consequential, official, worthy of discussion and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand.

**Age and Wisdom.**

There is a second dimension that has to be incorporated into the discussion about personal knowledge: age and its relationship to knowledge. To some extent this has been addressed in chapter seven. Aristotle viewed wisdom as the most
finished form of knowledge (Miller 1995). It will be recalled that most dais are
grown into women who have passed childbearing age and as we saw in chapter eight, their
knowledge therefore is also shaped by the years of experience they have had in their
capacity as mothers. I have shown in chapter eight older dais are held to possess
superior knowledge. What emerges here is the notion of wisdom as a factor in the

Wisdom is in some way the store of knowledge, opinions, and insights
 gained, often through long years of life. Wisdom often implies being
able to provide reasons for why things are the way they are, and in this
sense it is metaphysical and presociological.

Indeed, according to the premodern discourse wisdom warrant legitimacy
because of the knowledge skills that are accrued over the years. It is also the basis
upon which expertise is founded. This is expressed in the number of years it takes
for a dai to acquire the skills and knowledge that within the traditional perspective is
considered necessary to practise midwifery.

Polanyi (1958), writing about wisdom, maintains that there are intellectual
skills inherent in the term. However the positivist schools of thought contend that
because of its subjective nature wisdom cannot be claimed as an absolute
authoritative foundation on which to base scientific knowledge (Miller 1998), that is
objectively derived. The argument here is not so much about the subjectivity/
objectivity dichotomy but about the assumptions upon which schools of thought are
based which in turn are more of a cultural issue and the temporal location of culture.
Furthermore it could be said that wisdom is a social, construct, insofar that it takes its
meaning only within the socio-cultural framework of traditional midwifery.

This is expounded further under the social context of knowledge production.

**Practical Knowledge**

A third conception points to the proposition that midwifery knowledge come
from dais' practical experience, their know-how of doing the job. It seems artificial
to deal with practical knowledge as a separate entity because it is inextricably linked
with their personal knowledge which, as we discussed, provides them with a deep
understanding of childbirth. The general hypothesis here is that dais create for
themselves a sense of what the skills required for midwifery practice is about. They do this by participating in sets of meanings constructed, interpreted and deployed throughout personal knowledge, and with the relationship with other women undergoing the experience of childbirth. Additionally the practical knowledge base of traditional midwifery includes a repertoire of knowledge which in the typology of Scheler's classification straddles the first types seen in use in daily practice. But when we return to the complexity of traditional midwifery practice and its knowledges that are brought to bear on that practice we find that practical knowledge is multifaceted—indeed it is meta-knowledge.

**The Context of Knowledge Production.**

Perhaps one of the most significant factors in the epistemological orientation of traditional midwifery is the context in which it operates. Within the social theories about premmodernity, expressed in chapter one, the context is described from two different but inextricably linked angles: space and time. There is a fundamental contrast with the modern construct of midwifery in that traditional midwifery is structured in time-space “zone” that has not yet been fully affected by distanciated time-space relations. Hence the childbirth practices and midwifery knowledge of traditional midwifery system discussed in chapters nine and ten remain embedded and continuous in spatio-temporal relations.

In contrast to the notion of discontinuity advanced by Foucault, we see here the notion of continuity, in so far that the context in which traditional midwifery knowledge is produced and utilised, allows for cultural contents to retain their imperative power, their continuity of a history through which individuals identify themselves, giving a sense of cultural permanence (Foucault 1970, Habermas 1978, Bourdieu 1990; Giddens 1991, Luke 1996). It was stated in chapter one that the local community and tradition itself is the medium that enable dais to perpetuate the normative frame of practice and knowledge production and reproduction. It is a frame of reference that looks back to the past where knowledge has its origin.

Encompassed in the notion of habitus (Bourdieu 1990) is further explanation about the relation between time and space as it relates to traditional midwifery. As
well as being part of women’s biography (which has been elaborated elsewhere) it is
also part of the collective history of the local community and a collectively
orientated culture, handed down by means of tradition, in which, it will be recalled,

neither the “past” nor the “future” is discrete phenomenon, separated
from the “continuous present”. Past time is incorporated into the present
practices, such that the horizon of the future curves back to interact with
what went before.

(Giddens 1991, p.102)

In essence the knowledge production, according to the premodern
perspective is hermeneutically derived (Luke 1996) and involves a dialectical
relationship which as Benson (1983, p. 334) suggests

Shaped by its context and by the way in which knowledge producers are
inserted into the social world. The producers of social knowledge react
to the real world but not in a merely passive way. Rather, through their
practices, shared within knowledge communities they actively shape the
knowledge they generate ...The practices through which knowledge is
generated are, like other human practices, developed in particular social
contexts and are partially shaped by those contexts.

In the context of traditional midwifery the local community performs an
essential role in so far that it provides a stable socio-cultural milieu which gives its
members a sense of certainty and security (Giddens 1991; Beck 1992). Dais display
this sense of certainty and security because in their local space, all the religious
rituals can be carried out unhindered. As we discussed in chapter nine estrangement
of childbirth events from local contexts disrupts the sense of security and certainty
fostered by the community. In so doing it also disrupts the interpretive process by
which understanding of reality of childbirth, midwifery practice is reached. Beck
(1992) has argued that modernity has destabilised the stable socio-cultural milieu
which once provided a sense of substantial protection, and to this I will add, the
context for perpetuating the ethos of midwifery culture.
Chapter 11: The Premodern Construct of Midwifery Knowledge

Linguistic Representation

As we find, critical theory and postmodern critique operate as a major form of de-legitimation. In the modern perspective it contributes to a loss of confidence in linguistic paradigm created by medical science because it detracts from the ‘discursive formations’ (Foucault 1972) within lifeworld (Habermas 1987). In this final section I turn to the linguistic system that dais employed to communicate as well as accumulate knowledge, which Scheler (1980, p.76) points out:

Every type of knowledge develops its own language and style through which it is formulated, whereby religion and philosophy are necessarily more attached to natural folk-language than are the sciences, which—especially mathematics and the natural sciences—develop purely artificial terminologies.

Here I want to return to Habermas’ notion of lifeworld in which everyday practice, communication and shared meanings occur. Epitomising premodernity, within the dais’ lifeworld, the linguistic paradigm is oral and consists of two main forms which are not necessarily specific to midwifery but are specific to artifacts and metaphors, and are loaded with symbolic significance. They have profound influence on the way knowledge about midwifery is acquired. The dais linguistic system has its roots in religious-metaphysical beliefs that are embedded in their own cultural relationship. To illustrate this point I want to draw on two metaphors— the ‘flower’ and the ‘house’— which mediate the woman’s personal experience of childbirth and dais’ practical experience of doing the job. As well as constituting religious significance these metaphors/artifacts conjure up images of the internal bio-physiological environment and processes involved in childbearing.

The “Flower” Metaphor

The “Flower” is used both as a metaphor and an artifact. Its use and some of the concepts that emerge from this metaphor have already been addressed in chapter nine. In this section I will discuss its significance in relation to the spiritual context in order to grasp the meanings that are associated with the knowledge base of midwifery. As an artifact the “flower” mediates to indicate the physiological transformation that occurs during the process of birth. It is a sacralised object. It
symbolises integration between the power of nature and the power inherent in the childbearing women.

The second usage of the “flower” in the premodern linguistic terminology relates to the placenta. In fact the term placenta does not exist in dais’ language. Interpreting the placenta as a “flower” the premodern construct brings a rich set of meanings and implications. The “flower” (as we discussed in chapter nine) symbolises life and the placenta is the giver of life- a life/ a being in its own right. The symbolic equivalence of the placenta in the premodern linguistic construct purveys a social and spiritual perspective. This is exemplified in the rituals and practices surrounding the interment of the placenta (See chapter nine). It is hard to conceive of the placenta as anything other than a biological organ, performing a biological function. The most significant difference between the modern and the premodern constructs is simply that the former expresses, solely, the complexity of its biological reality- that is an organ that mediates between maternal and fetal spaces to sustain the baby’s intrauterine development and survival. Equally significantly the norms and values upon which the placenta is built in the modern construct is culturally bound to the preoccupations and priorities of medico-scientific discourse in which the placenta became an object for research that can be used to advance medico-scientific knowledge. The modernist interpretation and representation emphasises, yet again a biological construct and obviates the spiritual and social meaning premernity conveys.

The “House” Metaphor

Another metaphor in the premodern linguistic construct, which lay strong emphasis on the social meaning of midwifery knowledge, is the “house”. It is a term that dais employ which means the uterus. The terms uterus or womb as they feature in the modern linguistic construct carries no significance or meaning whatsoever in the dais language. Thinking of the uterus as a house focuses the attention of the dais and women on the environment in which the baby is nurtured. It will be recalled that pregnant women are held responsible for the healthy development of their unborn infants and are behoved to adhere to certain practices. These have been dealt with extensively in chapter nine. To my mind the “house “ metaphor brings in a rich
perspective of the premodern cultural conception of midwifery knowledge. Similar to the placenta we see, in the metaphor of the house, a social meaning that is not made explicit in the modern construct.

I used those two metaphors to emphasise the capacity of language to represent accurately the epistemological world of midwifery. As we move in the context of critical theory and postmodernity, the relationship of language and the production and legitimation of knowledge becomes critical. Language is treated as the chief means through which knowledge is communicated. In the modern construct of midwifery it is done through words, whether this be in textbooks or research articles. Habermas (1987) has pointed out that when science intrudes into the realm of communication and asserts control in intersubjective relations, the result is loss of meaning.

**Conclusion**

Where this chapter has led us is into an analysis of the development of midwifery knowledge and thought about redressing the legitimation and representational crisis that resulted from the assumptions of modernity. There is strong evidence, from a sociological as well as philosophical perspective that there cannot be a singular view of an approach or social process to knowledge. The premodern perspective shows that there are complex processes involved in the development of midwifery knowledge.
CHAPTER TWELVE

SUMMARY AND CONCLUSION

Introduction

Having now examined the modern and premodern perspectives of midwifery, I feel the need to reconceptualise the whole idea of the development of midwifery knowledge. From the examination of the two case studies it is evident that midwifery knowledge emanates from practice. It is a social construct, culture bound and embedded in historical contexts, that is, midwifery knowledge is sociologically conditioned by the structure of society at a given point in its stage of evolution. From a macro-sociological perspective, this study has shown that midwifery knowledge is based on two contending sets of assumptions that define the culture of the two cases studied. These are: philosophical and religious assumptions. It is the two sets of assumptions that control the social processes whereby knowledge is produced legitimised and utilised. It is my view that we must keep these two tensions in balance in order to realise the potential of midwifery knowledge. However the dominant distinction in terms of knowledge between the philosophical and religious assumptions are the scientific and non-scientific ways of knowing.

It is evident that the modern discourse has set in motion a series of changes affecting midwifery practice and its epistemological base. These series of changes began from what was observed, in and about practice, which progressively led to knowledge bases that were derived from positivistic methodology. In it women became the object of scientific methodologies that postulate that knowledge is objective and value-free. Hence we have seen the objectification of women in the sense that they had to conform to the modern definition of childbirth. Midwifery practice/knowledge has become objectified in the same way, in the sense that the social system in which it was located was functionally differentiated. If we return particularly to the political and medico-scientific discourses we see that midwives' skills and knowledge were altered through the application of new skills and new knowledge. Consequently the field of midwifery knowledge was narrowed. As the
discussion evolved we saw that this was to do with the development of the nation state. Such approach admits no possibility that knowledge may be generated between women and their experiences of childbirth.

Within the Western context, the principles of positivism have set the agenda for the production, legitimisation and utilisation of knowledge. It has reflected a definite and pervasive orientation of midwifery. Having considered the arguments raised by post-modern schools of thought and critical theorists, although coming from different perspectives, all indicate the fallibility of science and endeavour to deconstruct the dominant episteme of modern midwifery, and suggest that we need to revisit all the issues between "scientific" and non-scientific ways of knowing. However other than enabling us to problematise situations they do not offer any way forward except by suggesting that we return to the anthropologisation of knowledge (Foucault 1970) and the utilisation of local narratives (Lyotard 1984) as they relate to women's lifeworlds (Habermas 1987). My interpretation of Foucault's notion of anthropologisation and Lyotard's local narratives simply suggest that we need to resituate the woman as the knowing subject at the centre of knowledge production.

The problems of medico-scientific discourse based on the assumptions of modernity, become evident: they are, representational and legitimization. Embedded in critical theory and the discourse of postmodernity, these crises are associated with the consequences of cultural transformations and the leaders involved in actualising such transformation. The critical and postmodern theories make two key and problematic assumptions about contemporary midwifery knowledge. The first presumes that contemporary midwifery knowledge cannot be called as such because it does not capture women's experience and knowledge as they are expressed by them and in their socio-temporal context. The second is about legitimation, which asks questions about the criteria used for developing midwifery knowledge. Both problems are associated with the social processes involved in the development of knowledge and indicate why those two crises of knowledge exist.

Midwifery knowledge has been created out of interpretation and representation of particular situation created by the medical profession (which is based on the philosophy of modernity) rather than including the different forms of
knowledge based on values held within different perspectives— for instance the dismissal of all pre-ecclesiastical/ pre-Enlightenment forms of knowledge as witchcraft. Whilst I acknowledge that witchcraft knowledge may have existed, I also believe that there were other forms of knowledge. It could be summed up as dilution of all forms of knowledge inherent in practice and its replacement with medico-scientific know-how as the logocentric system of midwifery; essentially it stripped midwives and women of reasoning faculties. There is no doubt that modernity, reflected in the medico-scientific discourse overlooked aspects of everyday life, in order to secure control over midwifery practice and the development of its knowledge base. The medical indifference to aspects of everyday life, it would seem, did not have any immediate bearing on the medical field or to objective knowledge.

Following Foucault’s argument (1980), obstetrics was enabled to control the midwifery discourse by positing and imposing external rules to its original position, couched in the idea of safety. It did so also by the rules of exclusion (Witz 1993); this was partly based on the notion of performativity- ‘medical men’ were recognised as knowing better than ‘ignorant midwives’ (Mowbray 1732, cited Cutter and Viets 1964). The assumption was that theory always understands practice.

The rule of exclusion is closely related to the direction medico-scientific discourse would take to develop midwifery knowledge, and it reveals the constraint placed upon all other forms of midwifery discourse as well as the development of an amalgam of practice that has come to occupy a major position in modern midwifery. Clearly if knowledge is produced almost exclusively from the position of objectivism, a deficient form of knowledge is derived (Foucault 1970, 1980; Lyotard 1984, Habermas 1987). Such knowledge Bourdieu (1977; 1990) asserts is detached from practice. Midwives too participate in, and reproduce the dominant epistemological position of the modern construct of midwifery, because the structure of midwifery lends itself to that kind of participation, that is the structure of thought and knowledge that orders relationships between midwives, women, medical and medical-related specialities (Wagner 1994). Midwifery practice, although it continues to operate in the arena of social interaction, has boundaries that have been created by modernity. As we have seen in part one, the process of knowledge
production by the application of strict rules and objectification of subject of knowledge, (that is childbearing women), developed independently of women and midwives. This altered how interaction took place. Foucault (1970, 1980) and Lyotard (1984) have shown that the tendency towards objectification is associated with the predominance of positivistic approaches to the production of knowledge. Although the necessity to develop a scientific knowledge base was a concern to improve performativity, the link between the social processes, practice and knowledge was not forged.

The assumptions that this is the way that knowledge, which will improve practice, should be produced are part of a process that led midwifery practice to become a scientific and technological process. As midwifery has evolved, we have and continue to witness more technological knowledge being produced, and the reliance of technological knowledge to inform practice becoming the norm.

It is my contention that the most serious deficiency of the modern construct of midwifery knowledge which assigns a central role to scientific and technological knowledge is its undifferentiated treatment of the key factor in knowledge production: experience (Dewey 1938; Rorty 1966; Freire 1972; James 1995). It will be recalled that Kant (1996) claimed that all human being are endowed with the faculty of reason, an attribute/ tool allows us to make individuals decision and choices.

The criticism of modern assumptions, as depicted in women's increasing dissatisfaction with the scientific and technological approach, is that it has not matched other forms of knowledge by equal treatment, that is with the same emphasis placed on scientifically derived knowledge. In so doing it has nullified important socio-cultural practices and forms of knowledge that are embedded and embodied in everyday life. Since midwifery in the modern context is governed by medicine I would argue that what is understood to be midwifery is in fact a branch of medicine, to be more precise, obstetrics. Thus our knowledge of midwifery remains not very sophisticated and comprehensive.

The premodern discourse of midwifery has uncovered a multiplicity of practices and forms of knowledge that describe midwifery purely in social and
cultural terms. These practices and knowledge, in my view, are fundamental to what constitutes midwifery knowledge as differentiated knowledge and ways of knowing removed from the medical. It shows how midwifery straddles the different forms of knowledge that to a large extent have been missing, if not elided in modern midwifery knowledge. It is clear from the premodern discourse that midwifery knowledge is constructed in and through practice and is entirely pragmatic. It presents a challenge against the modernist discourse in which knowledge is produced and legitimised almost exclusively from positivistic modality. In the premodern discourse women are involved in the production of knowledge.

However I recognise that knowledge is contextual and no one discourse can fully incorporate the diversity of needs that arise from cultural, spatial and temporal variations. The biomedical sciences/ knowledge constituting the modern discourse has a place. To leave aside the modern discourse in favour of the premodern would thus weaken the service offered to childbearing women. We need to take account of the strength and weaknesses of both discourses. Nonetheless I feel that we need to understand the complexity, and the ways in which different types of knowledge are developed. This is crucial to our efforts to reconceptualise midwifery knowledge which needs to borrow from the concepts inherent in the premodern ways of knowing.

There will always be women who will choose their own “way” of giving birth, and this may be the medico-scientific way or within their own natural social context exemplified in the premodern discourse. Therefore I will suggest a framework that will demonstrate a dialogical approach to serve the needs of women whichever paradigm they select. Then we can go about the task of reconceptualising midwifery practice and knowledge.

My second conclusion concerns the production and legitimisation of knowledge. This has to be research based but here we need to consider what type of research should be used as well as the role of the researcher. This latter has to be done, as we shall see, directly upon, and drawn out from the social and cultural context rather than imposed in a positivistic manner “from above”. Hence we ought to be refocusing on the practical context rather than the purely theoretical one. But
we also need to go beyond what we understand practice to be and the forms of knowledge inherent in that practice. The empirical investigation done in the premodern context of the Mauritian midwifery system has provided us with insights into the wider perspective which encapsulates aspects of everyday life, whereas the UK scene which takes place in the hospital context seems to narrow our view of practice by neglecting socio-cultural aspect of the experience of the birth process. In other words what I am really stating here is that the woman is at the centre of all midwifery knowledge production and hence must be involved in a significant way. Our research procedures then must take into consideration this centrality of the woman unlike the positivistic approach where the woman is dissociated from her very state of being and relegated to being a number in a file.

The final part of the argument will deal with the implications of the above conclusions for midwifery curricula. From being based in women's social space to the practical context of the birthing room, midwifery curricula now finds itself in the academic setting of universities and hence a cultural transformation has taken place for all midwives concerned; this detracts again from the social context. More often than not, hard evidence is being sought in technological domains rather than through direct contact with the women themselves, What is required is some kind of fluidity between various frameworks, though, keeping in mind the centrality of the woman experiencing the birth process. A serious consideration of the social context of learning must be undertaken, thus calling for a revision of the social (practical context of learning), the midwife educator's role, and the midwife practitioners who serve as mentors to learner-midwives in the production of knowledge. All this will inevitably lead to midwifery knowledge being firmly rooted in the realities of everyday life.

_Midwifery Knowledge Reconceptualised._

Generating a consensus about what constitutes the domains of midwifery knowledge is essential. Any attempt to reconceptualise midwifery knowledge should take into account the relationship between culture and knowledge. This study bases midwifery on two sets of assumptions that reflect the macro sociological processes of cultural transformation: the philosophical and religious. The reconceptualisation
therefore, must clearly make adequate representation about the relationship between the macro sociological interactions. Croissant (1998, p. 167) suggests:

Theories of knowledge need to be adequate theories of culture, assuming neither inherent stability nor instability, and not succumbing to surface illusions of homogeneity or hegemony.

The proposed conceptual framework aims to facilitate the transcendence of the ideas/concepts derived from the two case studies. It is based on these two sets of assumptions, which assert that there is a complex of concepts that can be used to resolve the difference that exists between scientific, and non-scientific ways of knowing, essentially suggesting that we need to shift the boundaries that have been placed around midwifery and finally that we need to rethink our paradigms to suit the culture in which we live.

It acknowledges that childbirth and midwifery have biological meanings but also consist of social as well as spiritual meanings. As human beings we are not only rational beings but also spiritual ones. What I am suggesting here is not necessarily new but simply to asserting what needs to be recaptured, revised and prioritised. The notion of spirituality embedded in religious assumptions has been an issue of the epistemological debate since the inception of scientific thinking. As I have stated elsewhere in this study, Hegel (1996) has argued that knowledge cannot be understood outside the spiritual context.

The premodern discourse shows that, besides the scientific, there are other socio-cultural practices that are important in the production of midwifery knowledge. Thus our understanding needs to be informed by these social practices. As our understanding and knowledge of midwifery has been changed through the clinical gaze (Foucault 1973), which circumscribed childbirth by the pathological phenomena discussed in chapter five, we need to develop midwifery by extending our field of visibility to include the social and anthropological dimensions; encompassed in religious assumptions.

Philosophical Assumptions.

The philosophical assumptions include scientific ways of knowing and the external factors that have influenced the epistemology of midwifery, which centre on
Enlightenment philosophy, upon which the assumptions of modernity is based. It is almost paradoxical to suggest the inclusion of an approach to midwifery knowledge construction that has been produced and canonised almost entirely by the biological perspective and mostly male dominated and in which homogeneity and hegemony, spatial and temporal decontextualisation and scientific worldview imposed (Foucault 1980) themselves on midwifery. Indeed scientific and disciplinary knowledge, which developed out the Enlightenment philosophy that emphasised their reason and rationality, are important. I want to make it quite clear that the justification for including scientific assumptions is that we have to accept that modern culture through the development of scientific and technological knowledge has so engendered an entirely new way of thinking about the experience of childbirth, midwifery practice and midwifery knowledge that it would be impossible and inappropriate to deny or dismiss its place in the conduct of childbirth. Another justification for including scientific assumptions is out of recognition of cultural differences and the respect of choice by women who may require scientific and technological knowledge to assist them through the birth process. The emphasis of this orientation is on meeting the needs of individuals who subscribe to and midwives who practise in an environment which projects and is projected by the scientific paradigm.

There will always be women who either because of reproductive problems or by choice may wish to avail themselves of this service. In some instances reproductive technologies may benefit women. Thus childbirth will remain partly medical issues. The core knowledge the first part of this framework includes under philosophical assumptions is thus biological knowledge/ biomedical sciences.

However if we accept that there are ways of knowing that cannot be generated through objectification (positivism) and if we also accept the premodern definition given by the Mauritian dais, that equates midwifery with life, then the portrayal of midwifery practice as a purely scientific and technological process can only be a partial representation. This combined with the universalistic approach and the dominant text/discourse of medicine mediated through Foucault, Lyotard, Habermas should be redressed in order that midwifery, which has been on the margins, can be rendered visible.
Chapter Twelve: Midwifery reconceptualised: Implications for Midwifery Curricula

Religious-metaphysical Assumptions

I now move on to my second proposition, which suggests that religious-metaphysical assumptions should become part of the epistemological base of midwifery. Within the premodern perspective midwifery is about life itself. The historical as well empirical evidence reviewed in accordance with the above perspective provide a strong rationale for the importance of knowledge based on religious assumptions. We have seen in part three that there is a complex of knowledges that can be summed up as experiential knowledge. To my mind the essence of experiential knowledge is captured in women’s biography, it goes beyond just giving birth safely but includes the social factors of everyday life, the synthesis of the religious, spiritual, mythical and lay medical knowledge that it encompasses.

These factors provide an expanded context for understanding midwifery practice and knowledge. Everyday life in the light of the discussion of this study, as yet does not explicitly form part of midwifery knowledge but if we accept the dais’ definition of midwifery, which is about life itself, then these are important elements that need to be used to shape midwifery knowledge. In attempting to understand and incorporate everyday life in the construction of knowledge, it is essential to recognise that it differs according to cultural background and context, but the main point in this approach to midwifery is that it centres on women and their perception of the reality of childbirth and the ways of knowing that are encompassed within the religious-metaphysical ways of knowing.

However the integration of both sets of philosophical and religious assumptions calls for a space-time shift. Here I do not just mean changing the spatial contexts in which birth takes place, although this is important and will be addressed later in this chapter. It also calls for a shift in our thinking about midwifery knowledge, about the significance of the macro and micro-sociological relations in the construction of knowledge. Midwifery has a specific culture. My understanding of it within the two cases that I have studied is based on local diversity. Once it became subsumed in the universal culture of medical space, this local diversity was lost. If we return to the development of midwifery knowledge in the UK we find that the local aspect of knowledge rested on religious-metaphysical assumptions. This
leads to my second conclusion, which is about the production and legitimisation of knowledge, which essentially is about research legitimacy.

**Production and Legitimation of Knowledge**

One of the most crucial ways to establish a body of knowledge is to claim legitimacy through research. However we have seen in the arguments posited in this study that scientific methodology entrenched in the positivist schools of thought can only represent one aspect of knowledge. When we begin to think about midwifery knowledge from the viewpoint of pragmatic school of thought we are forced to embrace several epistemological positions that have become evidence in the premodern discourse. It would also mean breaking down the boundaries placed on research and methodological approaches that generate 'reliable' knowledge. If we accept Rorty’s view (1966) that knowledge production should be concerned with cultural practices we must also accept that knowledge is dependent on several factors; the childbearing woman is the knower and should be actively involved in the construction to constitute knowledge. I acknowledge that pragmatism has always been a way of legitimating knowledge but in the context of my argument I refer to subjective pragmatism, the element which the Enlightenment marginalised.

Another important element in research is the social setting within which the cultural practices take place. We saw in chapter two that social settings are complex and made up of individuals with different perspectives. Hence our goal is to seek to understand the complexity from the perspective of women. This would allow for lay knowledge and other forms of knowledge that constitute her biography and have been elided to be incorporated in midwifery epistemology. This shift will create spaces for practices and research within an equal partnership with not only medical personnel but also with other health professionals as opposed to the dominance hitherto imposed upon it by an androcentric worldview.
Chapter Twelve: Midwifery reconceptualised: Implications for Midwifery Curricula

Conclusion

Knowledge is not fixed and there should therefore not be any closure. There has to be dialogue between modern and premodern ways of knowing. This can best be explained by using Bauman’s (2000, p. 3) metaphor of fluidity

Fluids travel easily. They ‘flow’, ‘spill’, ‘run out’, ‘splash’, ‘pour over’, ‘leak’, ‘flood’, ‘spray’, ‘drip’. ‘Seep’, ‘ooze’, unlike solids they are not easily stopped- they pass around some obstacles, dissolve some others and bore or soak their way through others still. From the meeting with solids, they emerge unscathed while the solids they have met, if they stay solids, are changed- get moist or drenched.

Considering midwifery practice and knowledge in the notion of fluidity would not only enable midwives to rethink the epistemological base of midwifery but would enable an integration of a wider knowledge base, which they may use to serve women according to their preferences and to demonstrate the situation. In that sense women as well as midwives will be free from the pervasive cultural hegemony, since midwifery became a political and medical concern as entrenched in the ethos of modernity. Women may regain control and power over a process that was originally their domain. Additionally this may also enable the medical professionals to shift their views about midwifery.

However it is only when we have broken with the restricting structures of modernity can we begin to address the issues that are being discussed in this thesis. Breaking with the structures of modernity, can only be done, to use Bauman’s term (2000, p. 3)

By melting the solids, that is dissolving, whatever persists over time and is negligent of its passage or immune to its flow.

This calls for a major shift from the dominant ideology of positivism imposed by modernity (medicine). I want to reiterate that by suggesting a major shift from positivism, I do not mean that we do away with all “solids”. Indeed as I have discussed before we need to have a service that is suited to women’s needs and in accordance to their choice. In the light of the insight obtained from my empirical evidence and in accord with critical theorists/postmodernist perspective, what I am suggesting here that we should consider the need to create ground for new “solids”,

275
that is, to redress the imbalance of the modern representation of midwifery and its epistemological bases.

Through this study we have seen that midwifery knowledge based on the assumptions of modernity has been problematic. Therefore we can no longer passively accept what does not adequately represent our epistemology. Returning to philosophical basis of modernity we see that the first "solids" to be melted was indeed the religious-metaphysical foundation of midwifery knowledge. This process of modernisation thus has meant shedding the religious-metaphysical path to knowledge which stood in the way of reason and rationality. In modern culture the religious-metaphysical has been stunted. Breaking from the structures of modernity, calls for more than political acuity and involvement, but also for earnest examination of what midwifery is about and how can we, as midwives shift from our adoption of the modernist mentality. We may consider borrowing ideas from the dais approach to midwifery practice. Since acculturisation to the modern culture involves the adoption of an "alien" culture it therefore presupposes the pre-existence of an "indigenous" culture, knowledge and practice. Traditional midwifery even though is not steeped in bio-medical sciences of modernity, ought not to be dismissed as not constituting a body of knowledge and therefore not the have an impact on midwifery epistemological development. The scientific basis of midwifery is a dilution of knowledge from other sources. This study has shown that midwifery has other roots and epistemological positions. We should consider the use of other sources and forms of knowledge to develop our knowledge base.

As the data in chapters eight and nine show, dais functioning within their interpretive framework (which it will be recalled is based on their biographical and practical knowledge, with religion and metaphysics being the overarching framework) are confident and competent to the point of even challenging and being critical of other interpretive paradigms. This is clearly expressed in an encounter with a dai’s interrogation of my practice relating to the problem of retroverted uterus (see chapter nine page 191-192). I recognise that the biographical knowledge raises pertinent issues about access to midwifery practice. Indeed, as we discussed in chapter seven, dais, in allowing only women with previous experience of the
childbirth process in practice create inequality. They exercise power over recruits into the field of traditional midwifery practice. But the debate about knowledge, here, is that dais use their personal experience of childbirth to formulate meaning. In so doing they are interpolated in positions of identification at the centre of traditional midwifery discourse. Dais are powerful because they make utterances from a position of authority which has been conferred to them through revealed knowledge and on the basis of their parity or more precisely their multiparous status (parity is a term that defines the number of pregnancy a woman has had). By exercising their power dais are able to interpolate their personal experiences and views into the public domain for the conduct and control of the childbearing process.

Similarly we might adopt an approach where midwives become the forefront of midwifery by utilising their practical knowledge. Developing the practitioner-researcher approach (Jarvis 1999) is a way midwives, like the dais, may not only regain control over midwifery practice but also differentiate it from obstetrics and develop a paradigm that represents midwifery. The opening quote of this study stated this:

There is perhaps no better way to gauge the development of a field than to critically examine its body of knowledge

(Brocket 1991,p. 121)

This study began with an in-depth analysis of the historical development of midwifery practice so as to contextualise the development of knowledge. Sustained by the analysis of the modern midwifery, I would call what we accept as midwifery knowledge in question. In my personal view it is indeed obstetric knowledge. The premodern perspective exemplified in the Mauritian case study poses a challenge or a rival theory (Yin 1994) to the modern representation of midwifery knowledge. I now know from the dais that midwifery knowledge is far more complex and far more sophisticated that we have come to understand it. However I am also aware that there may be forms or types of knowledge that we may never know.

Le Coeur a ses raisons que la raison ne peut connaître

(The heart has its reasons that reason cannot understand)

(Pascale 1623-1662).
CHAPTER THIRTEEN

Implications for Midwifery Curricula

Introduction

I know that this study has not been able to address midwifery curricula in any depth. Therefore from the outset I want to state that there is a need to take this research further into the area of knowledge and the curriculum. As I stated in chapter two the aim of my research, endeavouring to understand the nature and development of midwifery knowledge was the main focus. However the analysis of midwifery knowledge presented in this thesis and the conclusions arrived here have implications for midwifery curricula that cannot be ignored. But firstly we need to understand the context of contemporary midwifery education in order to situate the arguments. Therefore this chapter opens with a brief discussion of the cultural transformation of midwifery education. Looking at the implications of knowledge and the curricula then follows it.

The Cultural Transformation of Midwifery Education

Questions about the cultural transformation of midwifery education too are not new. Examples of the questions that are being raised relate to crisis in progress (Henderson 1997). When we place the examination of midwifery education within the conceptual framework discussed in chapter one we see that it too endured similar consequences as the field of practice. The cultural transformation is linked up with the functional differentiation of the societal system, the detraditionalisation of lifeworld (Habermas 1995) and a process of discontinuation (Foucault 1970).

In terms of its historical progression it is evident that the debate about midwifery education centred on the necessity to shift it from its practical/pragmatic orientation to an academic "lifeworld". As early as the eighteenth century we began to observe the shift in the culture of education. It will be recalled that Smellie in 1752 (cited in Radcliffe 1967), in suggesting that contrived environment for education is necessary, started the process of cultural differentiation within the field of education. As I stated elsewhere, from being based in women's social space, midwifery education moved to the practical context of the birthing room located within medical space. This is, as it
may, suffice to say that midwifery education remained contextualised and practice remained the field of learning. For most part of their learning learner-midwives had direct contact with childbearing women themselves but as midwifery education became disembedded from its local context, so did learner-midwives become separated from the reality of practice as field of learning. We need to note, therefore, the disembedding and fragmentation that was brought by such transformation.

Although the process of cultural transformation began in the eighteenth century, similar to the decontextualisation of practice, the major impact is seen in the displacement of the spatial context of midwifery education. The significant change, which occurred in the last decade or so, has been the relocation of midwifery education from National Health Service control to Institution of Higher Education, following the Briggs recommendation (Briggs 1972). The merger into Higher Education has led to the development and growth of graduate programmes, which have differed in emphases from a practical orientation, located within the space of maternity hospitals to one that is now entrenched in the academic setting of universities. Here the notion of progress, embedded in the assumptions of modernity can be observed. However I do not dispute the necessity for progress. Indeed midwifery education needs to move along with societal changes which, transposing Lyotard’s idea (1984) of performativity, in part is to do with the need for professional skills necessary for the stability of the profession. It is unarguable that we need to develop an intellectual workforce consistent with contemporary intellectual movements. My intention in addressing the implications of this study and its conclusions for midwifery curricula, is to urge midwifery educators as programme planners and curriculum developers to consider the important aspects of midwifery education, the context within which it takes place, the assumptions which underpin the curriculum and the values that are used to inculcate and acculturate learners.

**The decontextualisation of midwifery education**

A parallel can be drawn with the decontextualisation of birth. Here I want to recall Foucault’s notion of discontinuity (1970), Scheler’s concept of artificialisation (1980) and Habermas’ idea of detraditionalisation (1995) discussed in chapter ten to suggest that midwifery education too has witnessed many discontinuities. As it happened with the location of practice in hospital settings in the 1970’s, similar consequences have
been observed in midwifery education. Barnett (1994, p. 142) makes the following remark:

Historically midwifery is an essentially human practice...the key aspects of knowing are embedded in human action and are transmitted to new recruits to the profession through the practical example set by those experienced in the field.

It is possible to infer that in just the same way as the development of midwifery knowledge has increased with artificiality so have the context of learning and the learners’ acquisition of knowledge. However the process of artificialising midwifery education or more aptly practice as a field of learning was recognised and challenged by Sarah Stone, one of the prominent midwives of the eighteenth century (See chapter five). The dissemination of knowledge has changed according to the changing nature and structure of practice and with it the priorities of education has altered.

We have, and continue to witness a cultural transformation. Here too if we apply the notions of discontinuity, artificialisation and detraditionalisation to midwifery education, we see that shifting it to the academic setting of higher of education holds more than just spatial relocation. Similar to what we have observed in the cultural transformation of practice, it has involved a shift in our thinking about the culture of our profession and the ways in which we socialise our learner-midwives into the profession. Generally speaking learner-midwives are being acculturated to the academic culture of universities. Learners acculturated into the academic culture are bound to develop a different perspective of midwifery which in turn will influence their conceptualisation of midwifery knowledge and how it is utilised in practice.

Here Belenky et al’s (1986) notion of separate knowing becomes also significant insofar that learner-midwives are being inculcated with the values of the institutions in which the socialisation into the midwifery profession takes place. Belenky’s et al (1986) observation of separate knowing being the opposite of subjectivism, is a depiction of the culture of contemporary education. I stated elsewhere that more often than not knowledge is being sought from literary sources and technological domains, rather than through direct contact with women and midwives practitioners. Placing primacy on academia adds further emphasis to that approach and distanciates learner-midwives further from the reality of the practice that we are preparing them for, that is seeking to understand knowledge from childbearing women’s biography.
Chapter Thirteen: Implications for Midwifery Curricula

What can we learn from the dais' approach to the socialisation of their learners to practice and the acquisition of knowledge? We have seen in the premodern culture that knowledge is transformed from something that exists within the person (personal experience of childbirth and the associated social practices) and between persons. It was also made evident in previous chapters that midwifery knowledge is not an aggregate of isolated elements, but a configuration or network of relationships of which learners inevitably become a part; therefore they must be able to make sense of those relationships and their position in the midwifery epistemological debate. There is a sense in which dialogue serves as a key organising factor or strategy for enabling learner-midwives to access knowledge that is inherent in women's ways of knowing as their lifeworld situation. This knowledge can then be utilised in addition to scientific and technologically derived knowledge. It will be recalled that according to Foucault (1970), Lyotard (1984) and Habermas (1984, 1987, 1995) that scientific knowledge and ways of knowing are the only valid kind of knowledge. Carr (1989) further endorses this view by pointing out that knowledge must be transformed from something that exists within the person and between persons to something that exists between literary sources. The link between theses sources needs to be made.

Adopting Dewey's' (1985) notion that theory (scientific knowledge) be treated as hypothesis that needs to be tested in practice I would even suggest we inculcate our students to interrogate scientific and technological knowledge with what actually happens in practice. When as educators of midwives we begin to think about knowledge from the vantage point of practice we are forced to embrace several considerations that have become evident in the premodern discourse. An example of this would be placing primacy on practice as the field of learning, whilst promoting the intellectuals skills that are required to undertake the task of producing knowledge from practice.

Knowledge and the curricula

We have observed that the whole debate about the evolution of midwifery knowledge is about cultural transformation. This has been argued from various perspectives, such as historical, socio-philosophical and to a lesser extent feminist, which show that midwifery curricula must reflect the culture by which society is influenced. Lawton's (1975) model suggests curriculum must be a selection from culture and the
kind of pressures in society that should influence our development of the curriculum. As we have observed the whole debate vis-à-vis the evolution about midwifery knowledge is about cultural transformation.

Many contemporary midwifery curricula adopt Lawton’s idea of culture. In his analysis of culture and its relationship to the curriculum Lawton (1975) further points out the various factors that have influenced societal and cultural transformation and are significant to curriculum development. These are:

- Destruction of traditional ways of life.
- Changes in the work relationship.
- The growth of a conflict view of society.

These factors resonate with the argument posited by critical and postmodernist theorists. However Lawton’s view, although it alludes to the importance of sub-cultural differences, it equally refers to the different classes within a homogeneous society. Whilst being significant for the context and the time that he wrote, Lawton’s definition is deficient. We increasingly live in a heterogeneous society in which there is a diversity of cultures, representing modern and premodern ways of thinking. Learner-midwives are confronted with such diverse cultures and their concomitant pressures in their everyday practice. Hence to develop Lawton’s view further, these are the kind of pressures in contemporary society that should influence the development of our curriculum. My observation about curriculum development in the capacity of programme planner shows that there has been a tendency to circumnavigate the professional culture instead of embracing the wider macro and micro-cultural relations of the given society. Curriculum needs to reflect these relations. Friere (1994) points out that there is a need to understand the dialectics between cultures and to respect the types of knowledge that arise from them. Here I want to recall Croissant’s (1998, p. 167) assertion that:

Theories of knowledge need to be adequate theories of culture, assuming neither inherent stability nor instability, and not succumbing to surface illusions of homogeneity or hegemony.

Within a broader socio-philosophical framework I would maintain that the curriculum must integrate the modern scientific and premodern religious-metaphysical assumptions. The justification for this position rests firstly, on my adoption of the definition of midwifery offered by traditional midwives because it is about life itself. As
humans we are rational as well as spiritual beings. Secondly, as we have observed in the development of the arguments in this thesis these two different assumptions ask different questions about knowledge. It is only when we begin to orientate our learner-midwives to search for answers from different perspectives or epistemological positions, can we then enable them to unravel the complexity of midwifery knowledge and prepare them to function and serve society from a holistic broad-knowledge base that subdues the concrete foundations of theoretical isolationism and hegemony with ease of Bauman’s (2000) notion of fluidity.

**Midwifery Practice as a Field of Learning**

Through Bourdieu’s notion of habitus (1977; 1990) we have seen that there exists a relationship between knowledge and practice, and in the dais situation, in addition to personal experience all knowledge is derived from practice. In modern midwifery practice, the field of learning is bound specifically by medico-scientific culture, which inculcates socially differentiated forms of thought and engenders different dispositions and beliefs from the type of thoughts that are reflected in dais’ practice and knowledge production. I acknowledge that the dais insistence on personal experience of childbirth as a basis of midwifery knowledge is problematic, however, as postulated by critical theorists it is important that when inquiring about knowledge learner-midwives seek to enter into dialogue with women to understand it from the point of view of women’s biography and not mainly from the interpretation of literary texts.

There are numerous approaches to knowledge acquisition as it features in midwifery curricula. An example of this is evidence-based curriculum, which adopts the principle of problem-based learning (Freire 1972; Barrows 1998). The source of evidence ought to be made clear. Based on my experience of evidence-based curriculum, learner-midwives, in their search for knowledge tend to gravitate towards technological and literary sources rather seeking the evidence from women and midwives, thereby creating and recreating the same forms of knowledge. How do we address this problem? The answer lies partly in the adoption of the dais’ socialisation of their learners in practice. In the dais’ “curriculum” practice is “THE” field of learning. There is no differentiation between knowledge and practice. Learning takes place in the reality of everyday life not in a contrived situation. Given the entrenchment of midwifery education in university setting it would be illogical to suggest the complete adoption of
the dais system. In addition to providing our learner-midwives with the intellectual skills that they can utilise to generate knowledge from practice, we need to review how we orientate them to practice setting, how do we make the childbearing woman the focus of knowledge production. To continue to place primacy and emphasise knowledge acquisition from literary sources be it research-based or from expert opinion, in my view, would be reproducing the values of modernity- at least the notion of reason and rationality. The midwifery curriculum should keep literary and non-literary sources in balance.

The knowledge gained from studying women’s biography and from practice needs to be given the same status as scientifically derived knowledge. Learner-midwives must be able to gain knowledge that is not centred on texts as the main sources. Here I want to emphasise Lyotard’s narrative as a way of enabling this process. The use of women’s narrative has already been advocated by Kirkham (1996) as a way of redressing medical appeal to meta-narrative.

What does generating knowledge from practice entail?

The thesis of this study is that midwifery is a field where a multiplicity of forces is articulated to create its practice and its knowledge base. As the arguments have evolved we have observed more and more that we need to seriously consider generating knowledge from practice as well as other sources identified earlier. We have seen that the knowledge base of midwifery is in fact meta-knowledge and the acquisition of knowledge embedded in practice as seen in the dais’ acculturation, in my view, is a meta-cognitive process. A final approach to facilitating knowledge production from practice would necessarily call for a rethink of what practice is about and the role of the midwife teacher in facilitating learning. Does the modern culture of academia detract from the richness of pragmatically derived knowledge? The question about academia, which essentially deals with the acquisition of knowledge in the classroom, entails more than a straightforward question about knowledge production and acquisition. It recognises that similar to the shifting of birth into medical space, it is about political processes involving inclusion and exclusion; that is what knowledge is about-articulating the values and beliefs inherent in the curriculum and making choices of what is left out. Thus the dominant culture of the institutions in which midwifery education is located decides what is included in the curriculum. Here too we begin to see the
emergence of a crisis in representation in so far that a partial representation may be had. In the dais' “curriculum” as shown in my empirical evidence a total picture is obtained—the biological, social and spiritual.

The domain practice has been the subject of intense study. Schon (1991) has demonstrated the extent to which professional education, by extension midwifery, undervalues the knowledge inherent in practice and grants privilege status to intellectual scientific rational knowledge. The key point expressed in his work is about the significance of practice and its potential contribution to knowledge construction. But there is a gulf in Schon’s attempt to produce an epistemology of practice since he does not expound the value of everyday life experiences that are explicated by the premodern perspective of midwifery. These are important issues, which should be considered when planning learning activities that aim at generating knowledge.

Conclusion

As midwifery education becomes more and more embodied and embedded in the culture of higher education, it is getting further removed from the pragmatic orientation of midwifery. Many important skills are now taught by simulation in an artificially contrived environment, which learner-midwives then utilise when they are in practice. Essentially then primacy is placed on academia as opposed to practice. It has not been impossible within the remit of this study to examine fully, midwifery curricula in relation to cultural transformation that it underwent as it moved into the academic arena. However it is possible to infer the academic setting of universities has the atmosphere conducive for the assumptions of modernity on the construction and legitimation of midwifery knowledge. It is equally problematic insofar that it remains a partial representation of the curriculum. Similarly, we should be using a similar framework employed to examine the development of midwifery curricula.
CHAPTER FOURTEEN

Epilogue

Introduction

A closure to this thesis is clearly not possible. This is because, having spent most of the study attempting to answer the question “how has midwifery knowledge developed?” I now find myself left with more questions that compel further inquiry. However I will end this phase of my search for an understanding of midwifery knowledge by addressing the implications of my discussion. Future areas for research will be raised as the final conclusion.

I want to return to the conceptual framework of the study, which it will be recalled constitutes three different moments in the socio-cultural evolution of society. We have seen through this study the impact of cultural transformation on midwifery. The research approach, which used a combination of critical/postmodernist theories has permitted me to go beyond the surface meaning to provide the phenomenon of midwifery epistemology with content and deeper meaning; to problematise and challenge the dominance of the positivist view of knowledge and its assumptions that scientific methodology is the only path to knowledge (Foucault 1979, Lyotard 1984, Habermas 1981). They have also made it possible to understand how dominant ideologies have come to occupy the centre of midwifery epistemological orientation.

About The Reconceptualisation of Midwifery Knowledge

Stemming from the socio-philosophical perspective we now know that there cannot be a single unit that comprises midwifery knowledge but a complex of knowledges. Additionally we have seen that there can neither be a single dominant path to knowledge nor can there be a dominant ideology. This study proposes that the construction/ legitimation of midwifery should be based on philosophical and religious-metaphysical assumptions as these articulate a complex of concepts significant to the midwifery epistemology. Accepting this proposal would entail accepting a different concept of knowledge and different forms of knowledge which
are beyond the grasp of rationality and reason. It would also require acknowledging other paths to knowledge construction and legitimation. In practical terms this means that midwifery knowledge should not be controlled solely by disciplinary knowledge and knowledge production, legitimation, utilisation and transmission should not be regarded as the absolute province of those considered as experts. Consequently it might be necessary that collectively, as a profession, and as individuals, for midwife practitioners and midwife educators to engage in a process of deconstructing the dominant ideology of positivism-based knowledge. Deconstructionism is a concept that is associated with postmodernism and is connected with various discourses of philosophical, political, literary and intellectual positions. In the sense used here, is an exercise that necessitates critical examination of one's existing paradigm in terms of its significance, meaning and knowledge claims. It offers a vital strategy for moving beyond the claims of various methodologies, to see how each is constructed. We may perhaps recognise that knowledge advances not just through tearing down systems but also through building new ones as Bauman's (2000) notion of fluidity indicates. In order to drive the production forward we might to transcend these two sets of assumptions.

Since the Enlightenment, the idea of religion and the spiritual has been seen as the cause of obstruction to the progress of the scientific knowledge development. It will be recalled that the Enlightenment dismantled religion as the dominant discourse. It defended the need to secularise midwifery and childbirth in order to allow research to progress. It will be recalled that religious-spiritual organisation of society and ways of legitimising knowledge are a feature of premodernity. Yet the arguments posited in this study, sustained by critical and postmodernist theories, suggest that we reopen the dialogue with premodern ways of legitimation of knowledge, a space that was previously closed by the totalising secular discourse of the Enlightenment.

A return to the premodern ways of knowing would necessarily mean that we break with the secularising structure of modernity, engage into a deeper understanding of the religious-spiritual component of midwifery knowledge and utilise it as appropriate. I acknowledge that this may be a very sensitive issue in the sense that some professionals may hold a perspective that is antithetical to the...
religious-spiritual worldview, but if we accept the holistic nature of midwifery and Hegel’s (1996) assertion that knowledge cannot be understood outside the realm of spirituality, then it is inescapable that our conceptualisation of midwifery gives equal recognition to religion and spirituality. We have seen that within the religious-spiritual interpretive framework, dais and childbearing women engage deeply with the social biological and spiritual aspect of life. A serious consideration of the fundamental concepts that we now have is required to fully expand the partial representation or more aptly to reconstruct midwifery knowledge. Religion and spirituality have been given little attention in the midwifery epistemological debate (at least to my knowledge) and there is generally a lack of research about this. It may simply be because our thinking about midwifery knowledge has been so entrenched in the assumptions that have engulfed modern midwifery. Yet if we accept Habermas’ notion of emancipation which extends beyond the modernist view of mankind’s mastery over nature to emancipation from domination of power relations amongst members of any given society, group or individuals, then we must intensify our efforts to recapture the spiritual culture that is embedded and embodied in the premodern perspective of midwifery epistemology. By having a concept of midwifery which incorporates the modern and the premodern, that is, the scientific and the religious-spiritual we can begin to think through an epistemological base to reflect the pluralism that surrounding it. Attending to the spiritual dimension of midwifery knowledge would be acknowledging at least two fundamental issues: the “wholeness” of midwifery and the centrality of the woman as the knowing subject.

About Legitimation of Knowledge

Acknowledging other paths to knowledge similarly calls for deconstructing the modernist approach to its production and legitimation. It concerns research approach. In the process of modernisation, midwifery has tended to adopt the positivistic epistemological orientation to research. If we consider the stance of pragmatism taken in this study, which emphasised the subjective nature of experience, then our approach to knowledge construction must give validity to those methods that seek knowledge from the subjective perspective of the knower, that is the childbearing women. The idea here is not to undermine or argue against
scientific approaches but to adopt a more differentiated understanding of knowledge legitimation as it transpires among alternative practices of inquiry. It will be recalled that within the modernist frame there are research methodologies (for example, experimentation, randomised controlled trials, that is, scientific methodology) to generate and legitimise knowledge. Under postmodernism scientific methodology loses its status as the principal authority of knowledge claims and legitimation. Thus it is limited to verify or justify a theoretical position within a limited range of culturally embedded assumptions. As we have seen in this study, these are the assumptions of modernity.

If we consider the arguments posited by critical and postmodernist theorists, and their scepticism in the grand narrative of science we are led to question the knowledge claims derived by scientific methodology. Critical/postmodernist theorists shift the emphasis to local narratives and everyday reality and, suggest research methods that provide alternative interpretations to the ‘objectivity’ stance of the scientific. Methodological multiplism is an approach that has been advocated by many critics of positivist methodology and offers a broader context than empirical research advocated by quantitative and qualitative methodologies.

Adopting methodological multiplism calls for the integration of a broader philosophical base to research to redress that imbalance caused by the discourse of modernity. In so doing we will be able to bring to the fore the other types of knowledge that have been marginalised by the Enlightenment. Methodological multiplism also calls for involvement of those being researched as co-researcher instead of being passive subject/s of research. The concern here is also to do with who controls research, and who makes the decision about what methodology is valid and how data are collected, interpreted and represented.

Jarvis (1999, p 165) made the point that

Traditionally research has been associated with the empirical and the scientific, a realm of high-status knowledge, and researchers were automatically treated as people from the upper echelons of the learned society.

It is clear, in midwifery that research methodology has been imposed “from above”. This perspective needs to be called into question. If we pursue Habermas’
(1978) notion of emancipation and Foucault’s (1970) idea of anthropologisation of knowledge, then our research should recognise that elements other than and not only the researchers’ own ends or epistemological orientation are central. An example contextual to midwifery includes the acknowledgement that childbearing women play an active role in the production of knowledge, that is, they should be at the centre of knowledge production. Placing the woman at the centre of knowledge production involves obtaining and giving validity to subjectivity. Research endeavour built around a partnership with women and professionals will enable all parties concerned to pose research questions that may be more relevant to the reality of childbirth experience. Developing partnership in research has implications for knowledge legitimation in a number of ways. Firstly, midwifery knowledge has been created predominantly through the perspective of a patriarchal culture, which not only determined what knowledge is important but also how the search for knowledge ought to be conducted, utilised and imparted. According to the critics of the scientific domination of midwifery knowledge, there is a demand to break the rule of exclusion created by patriarchy, as there is a demand for other perspectives and representation that would offer a range of discursive enunciations (Foucault 1972) on the approach to knowledge construction, the way it is utilised and imparted.

My understanding of the critical and postmodern theories discussed in chapter one suggests, that the partnership approach to research calls for a shift in the positivist epistemological orientation which was imposed by medical patriarchy, essentially breaking down restricting structures of modernity. From the insight gained into the premodern approach to knowledge production this is also to do with the context-embeddedness of socio-cultural aspect of midwifery. Another consideration in the legitimation of knowledge is the issue of interpretation and representation. Secondly, conducting research in partnership with childbearing women as knowing subjects will entail accepting their interpretation. As Usher, Bryant and Johnston (1997) and Jarvis (1999) assert, the researcher does not manipulate the data or control the situation but sets about developing understanding through dialogue. In essence then the researcher becomes a learner in the research
process. He/she learns from the subject being researched instead of learning about the researched.

In past research, the researcher has interpreted findings; as such it has articulated the perspective of the researcher. If we adopt the stance of critical/postmodernist arguments about subjective pragmatism, then this calls for allowing multiperspectives to speak of their own meanings. In turn this will involve transcending the set rules and procedures laid down in the positivist tradition. Only then, can we avoid the kind of representational and legitimation crisis caused by modernity. However we have to accept that there is knowledge that we may never know and therefore may be unresearchable.

**About the Curriculum**

To a large extent the implications of my discussion have been addressed in chapter thirteen in which several notions were put forward. Here, I simply want to return to the idea of curriculum as a selection from culture and the need to rethink the curriculum within a shifting field of social and cultural forces. In terms of culture as well as life in general we live in a world of multirealities. The curriculum should be linked to the world in such a way that it becomes more relevant to societal life. This takes us back to the social context of learning, which as we discussed is entrenched in academic culture of universities. We need to maintain the academic culture. There needs to be an articulation between academia and the reality of practice, if midwifery is to differentiate its epistemology from the obstetrical orientation.

**Reflection on the Study**

In this section I address the strengths and limitations of my study.

**Strengths and usefulness of this Research**

This Study has a number of strengths. Firstly it is useful in that offers a theoretical framework that could enable us to understand the development of midwifery knowledge across different, societies, cultures and eras. The vast literature that I used and my understanding of it enabled me to develop a robust
framework that brings together a synthesis of sociological and philosophical theories, about dominant discourse, relativity of knowledge and cultural transformations. It has offered an insight into the forces and the processes that have impacted upon the development of the different epistemological positioning midwifery. If we accept that midwifery is a social construct, and if knowledge is relative and something defined by cultures and societies within their spatio-temporal context, then the notion of universal objective knowledge becomes problematic. In that perspective, the dominant discourse of positivism since the Enlightenment loses its supremacy. The analysis of the development of midwifery knowledge has shown that the process is linked to the discursive practices of the societies and culture in context of space and time. Therefore the theoretical framework that this study produced, which is based on the interrelations between modernity, postmodernity and premodernity, could also provide midwifery professionals with radical orientations in their endeavour to rethink and rewrite their paradigm if it is their desire to do so.

Secondly although the empirical part of my research is far from the western ideological orientation; nonetheless it has unveiled a wealth of knowledge that has not only expanded our grasps of what the midwifery epistemology could entail but also just how complex and sophisticated it is. Additionally the theoretical framework could enhance new discursive spaces, where pre-Enlightenment practices and knowledge would have lost their validity.

Thirdly by using a combined methodological approach, it has opened the modern assumption about research to evaluation and exposed its fallibility. It has examined the different dimensions of representations, particularly showing that the modern perspective of midwifery knowledge is only a partial representation. In keeping with the thinking inherent in the conceptual framework, with particular reference to critical theory this study shows that no dominant discourse should enjoy the privilege of being at the centre, whereas others remain on the margin. In that respect this research is emancipatory. It provides the conceptual tools for that process.
Fourthly it has potential for Mauritius. As demonstrated in appendix two, Mauritius is in the process of cultural transformation, which involves the permeation of modernity. During this research I realised that I was capturing very valid knowledge about the premodern perspective of midwifery. The discussion with the chief executive of the Institute of Research, who also acknowledge the validity of premodern knowledge and ways of knowing as being the bedrock of midwifery epistemology, indicated that whilst the premodern still exist we should record it. As the ideology of modernity permeates the Mauritian culture it runs the risk of losing valuable premodern knowledge and with it, the original meaning of midwifery knowledge as it is represented by the discourse of premordernity. The empirical aspect of this research has raised the awareness of the significance and potential of local knowledge. It could be argued that it constitutes an important aspect in the epistemological base of midwifery. The way in which Mauritian obstetricians and midwives straddle the modern and premodern perspective, that is, the way they integrate local/cultural knowledge and scientific knowledge was particularly insightful about ways of entering into dialogue with scientific and non-scientific ways of knowing. In that respect it will be of value to Mauritius.

Finally this study has a major impact upon my thinking about the construct of midwifery and what each culture contributes to it. It has enabled me to go beyond the surface meanings of the midwifery epistemological phenomenon (that is the unquestioned beliefs and values upon which my taken for granted assumptions of midwifery knowledge rest) to reconcile the dissonance in my professional acculturation and my taken for granted assumptions about midwifery knowledge. I was impressed by the dais confidence in their interpretive paradigm, their pragmatic orientation to knowledge construction and ways of legitimating it. But the turning point in my conceptualisation of midwifery has been the dais’ definition of midwifery which it will be recalled is

*It begins with conception of the baby and ends when the child, as person is ready to depart from life. It is about the beginning and ending of life itself.*

(Field notes July 1996)
That a “case study is both the process of learning about the case and the product of our learning” (Stake 1998, p.87) has been a reality in my experience as a researcher. I have great respect for the dais who have taught me so much about their perspective of midwifery practice and about what counts for midwifery knowledge. They have enriched my understanding and knowledge of midwifery.

**Limitations of My Research**

There are a number of limitations to this study. These are addressed under two main sections: the conceptual framework and the research methodology which includes the prescriptive nature of the conclusions and the recommendations.

**About the Conceptual framework**

The conceptual framework focused on the particular works of Lyotard, Foucault, Habermas, Scheler and Giddens. There are other socio-philosophical theories that are equally important and would have enhanced the validity of this study. For instance the work of Jacques Derrida on deconstructionism and linguistic construction would have added to the perspective offered by Lyotard, Foucault and Habermas. Amongst other Scholars are Illich, Oakley, Jordan, Kitzinger and latterly Davis-Floyd who have provided great insights in the sociological and anthropological perspective of midwifery. The remit of this study has not permitted me to embrace fully the concepts implicit in their works. This is mainly a question of choice of focus. Their works are of great importance and will form the basis for future studies of the epistemology of midwifery that I intend pursuing.

This study placed much emphasis on the historical perspective of midwifery in UK. History is important for me on two counts. First, as I stated in the preface there were questions in mind about what midwifery knowledge actually entailed and what were the processes involved in defining midwifery knowledge as we have come to understand it in the west. Consequently it became a process in the research so that I could seek to identify its distinctive problems in order to construct coherences about midwifery knowledge that, for me, lacked coherence, namely the actualities of social phenomena. This was principally to enable me to understand what was happening, as context specific, in UK. Second, influenced by the ideology
of critical theory which inspires broader consideration of social and historical contexts (indeed some authors such as Denzin and Lincoln 1994, Angus 1994 point out that within this tradition, the relationship between the object for research and the whole social and historical context is a key criterion), I became too involved in history and perhaps placed its analysis on a macro-historical plane. I spent too much time on it. Consequently it detracted from enabling me to develop the premodern ideas inherent in the empirical research more fully and to give a better balance between the modern and premodern dimensions of the representation of midwifery that I might have wanted to do.

**About the research methodology and the prescriptive nature of the conclusions and recommendations.**

From a methodological standpoint there are a number of criticisms. The main and perhaps the most significant of these is that having done in-depth research into the different epistemological positions I have tended to generalise the findings of the research and be prescriptive in the conclusions and recommendations. Because of the nature of my research, my cultural background and ideological orientation my own values have been evident throughout this thesis. Clearly, as I pointed out in chapter one, in the same way that those who were involved in the modern epistemological base of midwifery have their own values, so do my own values feature somewhat strongly in my conclusions and recommendations. The difficulty as I perceive it lies with data interpretation and representation. The listening of the tapes, reading and cross-referencing the transcribed texts could have been influenced by my own ideological orientation in such a way that there might have been certain things that stood out (such as religious beliefs and practices). Consequently my own ideology may have constrained my interpretation. Clearly a researcher who did not have my cultural background or share my ideological orientation could have read the data differently.

A way of improving upon the analysis of the findings and the prescriptive nature of the conclusions and recommendations could include two or three researchers who have a different ideological orientation to listen to the tape and read the texts. On the basis of differences between researchers ideological orientation and
attempts to discern other people’s meanings of their lifeworlds, different criteria may have been used to identify the categories for analysis. It may also have allowed me to draw on diverse interpretive schema. Thus different knowledge or perspective of knowledge about the midwifery phenomenon may have been produced.

In the present study it has been difficult to achieve that. First, the funding available precluded the involvement of more researchers. The second issue concerns the language in which the data were predominantly tape-recorded. It will be recalled in the methods that the discussions/dialogue with my informants, particular with the dais (the main informants), were in French and Creole. It therefore would have been almost impossible to have a team of researchers to corroborate my reading, further inform my interpretation of the data, and given me the space to delve deeply into the different current of thoughts that premodern midwifery has to offer.

During the progress of my research greater insight were obtained about the ideological orientation I employed. In a public address to graduate and undergraduate midwives I discovered the extent to which I was becoming an advocate of the premodern epistemological orientation. Though at the outset, and for sometime during the research I was an outsider I had in fact become very much a part of the premodern midwifery and ways of thinking. As I broached the subject of premodern midwifery, which still exists in Mauritius, I found that that a vast amount of midwives had limited insight and knowledge about it. As an “outsider” I had not only obtained a sense of what went on in the premodern midwifery world but also advocating it and suggesting its inclusion in the midwifery curriculum.

As stated in the preface I do not dismiss the modern (scientific) perspective of midwifery knowledge in favour of other knowledges. What I intended to do intended in this study was to problematise and challenge the dominance of the positivist view of knowledge and its assumptions that scientific methodology is the only path to knowledge as the positivist school of thought implies. In so doing I had become so entrenched in my own ideological orientation which influenced my interpretation. In that sense it became easy for me to generalise, when clearly the intention was to arrive at some consensus of what midwifery knowledge actually
entail. There is a need to equally problematise the assumptions which premodern midwifery is based.

There are other methodological limitations in the empirical enquiry. The findings of the traditional perspective of midwifery in the Mauritian Case Study are limited to interview statements. Clearly direct observation of the dais’ practice would have yielded further insights in their know-how. Hence the conclusions and recommendations of this study should be viewed in the light of the above discussion.

**Future Research**

This study points to several other issues that have not been explored in this research, that could be addressed in future research to enhance our understanding of the complex nature of midwifery practice and knowledge. As stated at the outset of the epilogue, this study has raised more questions that compel further inquiry. These are as follows:

Firstly, if midwifery, as the premodern interpretation indicates, is about life what is the relationship between midwifery and life? Prior to my engagement with traditional midwifery, the association of midwifery with life revolved around the biological development of the baby and his/her subsequent birth. From the perspective of biomedical sciences this is clear, but at the same time it is also a limited view. The insight gained from the premodern perspective shows that there is a far deeper meaning that calls for a more in-depth inquiry.

Secondly, the dais’ notion that all midwives must be mothers in order to understand what childbirth is about and to know how to care for childbearing women, begs at least two important epistemological questions- are there implications for the midwife who is a non-mother? What makes a midwife not a mother? Throughout my experience as a midwife, women have repeatedly asked and continue to ask, what, in my view is a pertinent question- *have you any children?* It is a question that I attached little significance to until the dais challenged my status as a non-mother. There is a sense in which this question suggests that women are seeking to identify with women who know what the process of childbearing, from a personal standpoint is about. This seems to resonate with Habermas’ (1987) notion
of lifeworld and Bourdieu’s (1977; 1990) notion of collective habitus. To my mind it is a dimension that warrants further inquiry.

Thirdly, this study alludes that the modern representation has narrowed the field of practice. When we consider the perspective offered by Bourdieu (1977; 1990) we see the extent to which this is true. However this leads me now to ask, what is the nature of practice? I feel that it is necessary to undertake an examination of practice as a discrete entity.

Fourthly it has been impossible within the remit of this study to examine knowledge and the curricula in great depth, but once we begin to assimilate the cultural perspective of knowledge gained in the Mauritian case study we see the necessity to move beyond curricular issues to address the anthropology of midwifery education. I know that similar views related to the wider aspect of education have been expressed and research in this area have begun (Judden-Tuppakka 1999) A collaboration with this already launched research is well worth pursuing to further strengthen the position of midwifery as it is poised to redefine or establish its epistemological base.

Fifthly it might be useful to investigate further into the use of alternative remedies, that dais employ to treat with pathological conditions of pregnancy such as preeclampsia. Perhaps looking for ways where we can make connections between the properties of the naturopathic remedies and the bio-physiological and chemical response might foster further development of midwifery.

A final area research constitutes the realm of sociology and philosophy of midwifery. For instance there is sociology as there is a philosophy of education. Can there be such a thing as a sociology and a philosophy of midwifery knowledge?

**Finally**

In concluding I want to return to the thesis of this study. Midwifery is a social construct. It is a field where a multiplicity of forces is articulated to create its knowledge base that is culture-bound and embedded in historical context. Through the process of modernisation important domains of knowledge have been suppressed. What we have today is a dilution of its original meaning. The aspect of
everyday life, the socio-cultural knowledge that once embraced midwifery, has been decontextualised and given a new meaning, which reflects the pervasive scientific worldview. Midwifery is far richer and complex than the modern representation of it. It is more than just giving birth safely and normally. It transcends scientific boundaries; it is about lifeworlds, culture and values, and how each society construes it. We live in an analytically challenging world. Midwifery can no longer accept the dominant rationality of scientism as the main explanation of midwifery knowledge and as the basis for the curriculum.

As the background states, this study recognise that there are other views on midwifery knowledge as there are different positions that are adopted regarding its legitimization. This thesis is only one way of looking at it.
Dear Mr Gopal

May I first of all introduce myself to you. I am a Mauritian currently living in the United Kingdom. I undertook, my basic and continuing professional education in Nursing and Midwifery in the UK. I am employed as a senior lecturer by the Wolfson Institute of Health Sciences, Thames Valley University.

Presently I am reading for a Doctor of Philosophy degree in education at the university of Surrey. My thesis broadly relates to the construction of midwifery knowledge and its relationship to the curriculum within an international frame of reference. I am seeking the Ministry’s permission to conduct my fieldwork in Mauritius. I would like to visit the Regional Maternity Hospitals and the appropriate Area Health Centres. Part of my research plan includes observing nurse-midwives and midwives in practice. This activity will be followed by individual interviews.
I would also like to interview the traditional midwives. I will be grateful if you would allow me to access the register to obtain their contact addresses. I plan to travel to Mauritius to carry out my fieldwork at the end of June and will stay for a period of three months. I will incur all expenses. Nearer the time I will send you an outline of my research proposal. I enclose a letter from the supervisor of my research, Professor Peter Jarvis, in evidence of my proposed work.

On completion of my work I will be happy and willing to share the findings of my work with all concerned. Thank you for your support

Yours Respectfully

Miss H.Comerasamy
Senior Lecturer
Wolfson Institute of Health Sciences
APPENDIX 1B

Dr J.C. Mohith  
Executive Director  
Mauritius Institute of Health  
Powder Mill  
Pamplemousses  
Mauritius

15th February 1996

Dear Dr Mohith,

May I first of all introduce myself to you. I am a Mauritian currently living in the United Kingdom. I undertook my basic and continuing professional education in Nursing and Midwifery in the U.K. I am employed as a senior lecturer by the Wolfson Institute of Health Sciences, Thames Valley University.

Presently I am reading for a Doctor of Philosophy degree in education at the university of Surrey. My thesis broadly relates to the construction of midwifery knowledge and its relationship to the curriculum within an international frame of reference. I have sought permission from the Ministry of Health to visit the regional Maternity Hospital and appropriate health centres where midwifery education is involved. To this end I am seeking the assistance and support of the Mauritius of Health.

I plan to travel to Mauritius to carry out my fieldwork at the end of June and will stay for a period of three months. I will incur all the expenses. Nearer the time I will send you an outline of my research if you
require it. I enclose a copy of the letter from the supervisor of my research, Professor Peter Jarvis, in evidence of my proposed work.

On completion of my work I will be very happy and willing to share the findings with all concerned. Thank you for your support in this endeavour.

Yours Respectfully

Huguette Comerasamy
Senior Lecturer
Wolfson Institute of Health Sciences
Thames Valley University
London
APPENDIX 1C

MINISTRY OF HEALTH

My Ref: 19414/84 v4

From: Ag. Permanent Secretary, Ministry of Health 2nd July 1996

To: Regional Nursing Administrators

Through: Regional Health Director, Dr A.G Jeetoo Hospital
Victoria Hospital
S.S.R.N Hospital
J.Nehru Hospital

Subject: Research in Midwifery Education

Miss H. Comerasamy who is reading for a Doctorate in Educational Studies in United Kingdom is presently in Mauritius and is preparing a thesis on international perspective in midwifery education for her PhD.

2. She has been, in this connection, authorised by the Ministry to conduct her research work in our health set up.

3. It would be appreciated if you could extend your support in her endeavour.

4. Her programme is as follows:

(a) Meeting tutorial personnel, particularly Midwife Educators- Schools of Nursing.

(b) Visiting maternity units and meeting Nurses/Midwives of S.S.R.N, Victoria Hospital, J.Nehru Hospital and Dr A.G Jeetoo Hospital.

(c) Lecture- to pupil and student midwives.

(d) Meeting with/working session Nursing Staff of the following Area Health Centres:

(i) Lady Ramgoolam Area Health Centre
Appendix 1 - Correspondence

(ii) Dr Bouloux AHC- Cassis
(iii) Dr Quenum AHC-St Pierre
(iv) Rose Belle AHC
(v) Triolet AHC
(vi) Castel AHC

5. Meeting with Executive Director, Mauritius Institute of Health.

6 Working sessions with Officer-in-Chief/ Deputy Nursing Officer-in-Chief.

Time Schedule will be flexible.

7 Thank you for your help and support.

N.Gopal

Nursing Officer-in-Chief

For AG. Permanent Secretary.
Miss Huguette Comerasamy
PhD candidate,
4 Greenpark Court
Bridgewater Road
Wembley
Middlesex HA0 1YF

Dear Madam,

Thank you for your letter of the 15th February.

I am pleased to learn that you plan to travel to Mauritius by the end of June this year in connection with your study on midwifery education and practice. The Institute will be happy to provide assistance and support in your research work.

Looking forward to meet you soon.

Yours Sincerely

Dr. J.C. Mohith
Executive Director
Appendix Two: Overview of Mauritius

Appendix 2

An overview of Mauritius- conceptualising the empirical investigation.

Introduction

This chapter sets the background against which the arguments posited in part one of the study could be recontextualised. It gives the sociocultural perspective of Mauritius. Understanding the origins of the Mauritian midwifery practice and its epistemological base requires a view of the Mauritian society as a whole of how it has evolved.

Mauritius, a diminutive island born out of a volcano, is situated in the Indian Ocean. It lies approximately five hundred miles off the east coast of Madagascar. It has a land area of seven hundred and twenty square miles. Topographically, it is roughly oval in shape and rises from the coast to the central plateau which elevates about six hundred metres above sea level (Toussaint 1977; Meade 1961). Mauritius is ringed with coral reefs which protect the island against the ocean swell. Because Mauritius lies in the tropical zone it is vulnerable to cyclones- a natural phenomenon that is potentially damaging to the environment and the economy of the island.

Mauritius has a number of island dependencies; as such it is known as the State of Mauritius. In comparison to some other parts of the world, Mauritius is a relatively young state, aged around five centuries. These times have marked many significant political as well as sociological transformations- from European governance to Mauritian autonomy and democracy. The knowledge of its existence emerged in the sixteenth century, although some literature shows that Arab and Malay soldiers first discovered the island. Since they were mainly traders and the island was uninhabited, they took no interest in taking occupancy (Addison and Hazareesingh 1989; Toussaint 1977; Armitage 1990; Appiah and Patrick 1991). The French followed by the British settlement began to transform Mauritius into a modern state.
Appendix Two: Overview of Mauritius

Mauritius- a sociological perspective.

Mauritius is at interesting stage of development- an intersection of premodernism and modernism. Whilst the development of modern institutions is rapidly taking place, Mauritius has not made a break with tradition which remains important, especially in the field of religion. It has crystallised a system whereby people live their lives; it permeates every aspect of Mauritian lives. The cultural transmission therefore remains situated and contextualised. In Mauritius the secular and religious/spiritual are equally profound and pervasive in the lives of the people. Progress in political and economic spheres has been significant but the secular has not infracted or undermined their religious beliefs. The impact of religion and tradition is seen in the various religious festivals which transcend all levels of intellectuality. Such orientation emanates from the ethnological development of Mauritius.

The Ethnology and Culture of Mauritius.

In order to understand fully the ethnology and culture of Mauritius it is necessary to engage it in the discourse of colonialism and colonial ideology. Its history shows that Mauritius underwent several stages of colonialisation, through which it became linked with the Western nation-state colonial system. The process of colonialisation began with the Dutch occupancy of the island in the late sixteenth century. They introduced slave trading in Mauritius mainly for agricultural work. After almost a century of residence the Dutch abandoned their settlement in the seventeenth century. Within the same era, Mauritius became the territorial possession of the French who similarly brought with them slaves from Madagascar and Africa to provide the labour force of the island. The difficult living conditions imposed by the slave social system led enslaved men and women to escape and seek refuge on the coastline which was densely covered by forest; thus the likelihood of being found was remote (Kalla 1993; Noel 1993). Consequently, a different segment of society was formed - a new community of African people who were able to preserve their cultural heritage and to express their culture in their everyday life. All
that remains of African culture and knowledge is found in African music— the sega which is the folklore music of the island.

The French governance of Mauritius ended in the early eighteenth century following British invasion and successful conquest of the island. Slave trading continued until the early nineteenth century. The end of slavery signalled a dramatic change; it did not only impact the labour force, but provided a sense of cultural freedom (Benoit 1995; Manick 1989). Emancipation from slavery enabled former slave workers to set up homes elsewhere on the island; consequently the labour force for continued development in agricultural production, the central focus of the Mauritian economy, suffered a sharp decline—a transitory problem that was solved by the importation of labourers (bound by indenture) from the sub-continent of India who brought with them their culture, value system and knowledge. Thus Mauritius began to evolve as a culturally diverse society reflecting Western, African and Eastern influences—Indeed this is what gives the Mauritian society its characteristic identity.

The ethnic composition of Mauritius

In the ethnic composition of Mauritius, we distinguish five heterogeneous communities—the Euro-Mauritians, the coloureds, (these two groups are collectively referred to as the general population), the Hindo-Mauritians, the Moslems and the Chinese. Each group traces its origin to the French, English, African, Indian and Chinese settlers and accordingly derives its own culture, language and philosophy of life. The Euro-Mauritians comprise the descendants of mostly French settlers. The coloured community (which has a rather complicated genealogy) describes a group of people of mixed ethnic origin, such as those of European and African descent, African and Indian, Chinese and Indian. Thus they are commonly known as Creoles (Fanchette 1972; Manick 1979; Maudar 1979; Addison and Hazareesing 1989; Selvon 1991). In contrast, the Hindo-Mauritian community (which comprises 67% of the population and has political and bureaucratic control in the island) is subdivided into at least four different groups—the Marathis, Hindus, Tamils and Telegus. Similarly the Moslem community is formed by the following groups—the Shias, Sunnis and Ahmadi. This is what constitutes the population of Mauritius.
which amounts to 1.13 million. Forty five percent of the population is classified as urban, fifteen percent as semi-urban and forty percent as rural. (Appiah and Patrick 1991; Sparks 1998).

Whilst the urban population appears to reflect the western style of living, they share a common and important feature- they live in communities. Community and community relationships give the Mauritian people their identity and culture; it plays a significant role in socialising its members into their social system; in the preservation of their identity and culture; and in creating their socio-spatial identities. Bourdieu's (1990) notion of 'habitus' is particularly significant in explaining how communities function to acculturate their members into the respective social system and to preserve their culture. In a sense communities operate as sites of cultural production, hence the transaction between the past and present is apparent. Cultural values in action can be observed in religious observance and performance of associated rituals. They are expressed in everyday life, including practices surrounding childbirth. The idea of community is expanded in the next two sections

Social variations and their relevance to midwifery practice.

The social variations of the Hindu community requires further explanation so that their relationship to midwifery practice, in particular traditional midwifery practice can be contextualised. Operating on a similar line of social stratification, the caste system explains the social structure of the Hindo-Mauritian community. The origin of the caste system itself is obscure, but has been fundamental to the history of Indian civilisation. Amongst differing theories, the concept of caste explains a system that is entrenched in the belief of Brahma as a deity. Accordingly, four castes emerged from Brahma which dictated the social position/ status of the people in Indian society. On the one side of the spectrum, the highest is the Brahmin who were assigned special powers of divinity and they emerged quite distinctly as priesthood, royalty, and teachers, whilst the lower end consists of those assigned to serve the higher castes (Baker 1990). This reflects a clear-cut division of labour. A system of hierarchy can be observed to dominate caste thinking. Additionally Baker (1990) describes the caste system as follows: strict ranking of families, endogamy, instructing one's own offspring in one's own technical skills, customs over the
consumption of food and drink, customs of dress, concepts regarding the notion of pollution, the performance of rituals, the way in which each group conducts themselves within their own community and finally the extent to which one can socialise outside one's caste. Although to some extent some of the features of the caste system are apparent in the Mauritian Hindu community, the most significant ones in the context to midwifery relates to the notion of pollution which is explained in chapter seven.

Integral to Mauritian ethnicity is religion and religiosity. Religion forms a fundamental part of Mauritian lives- in itself the very essence of mauritianism. Indeed there are inseparable relationships between religion and people's everyday lives. Broadly speaking, the types of religion in Mauritius can be classified as: Christianity, Hinduism, Islam and Buddhism which obviously have different orientations that are too complex to be examined in this study. Christianity encapsulates an array of denominations of which Catholicism is the most dominant. Amongst the others are Seventh Day Adventism, Pentecostalism, and Protestantism. The latter, being mainly the religion of those Europeans who have immigrated to Mauritius. Hinduism, a religion as well as a philosophy, exemplifies a complexity of religions. Examples of those religions are the Sanatanist, Arya Samajist, Arya Ravi Ved, Arya Rajput, Satya Sai Baba, Hare Krishna movement, Shivatis, Chinmaya, Brahma Kumari, Rama Krishna mission and the Divine life society. Such variations in the Hindu religions reflect developments within the Hindu tradition itself (Whaling 1987). Within Hinduism, an element of totemism can be observed. Additionally for many Hindus Mauritius itself is a sacred land, with symbolic holy places in some parts of the island, sacred natural places, an idea imported from India - such as 'Grand Bassin' a natural lake is a site of yearly pilgrimage. Some of the Indian religious movements represent neo-Hinduism. Islam comprises three different sects while the Chinese community mainly holds beliefs in Buddhism. Ethnic boundaries are distinguished by religion (Selvon 1991).

Language

Mauritius is linguistically diverse. There are approximately twelve languages that are spoken by Mauritians. These include English, French, Hindi, Marathi,
Telegu, Tamil, Gujurati, Urdu, Mandarin, Hakka, Cantonese, Bojpuri and Creole (the latter is understood by all the population, it is widely employed in everyday ordinary communication). As with the ethnic composition of complex determination, substantial differences exist between these languages. They not only form an important part of each group's collective identity and culture, but serve to keep the authenticity of its traditions and values embedded in each culture. Essentially language in this context is used as a means to convey meaningful understanding and empowerment of each respective culture.

Although English is the official language, French remains the dominant European language of the island. (After nearly two centuries of British governance, France remains the Mauritian metropole) The Malagasy and African slaves, in an endeavour to establish effective communication between themselves created Lingua Franca or Patois, also known as creole. Having been subordinate to all other legitimate languages, Creole, in the late 80's received legitimacy as a language in its own right. Because it was the only language that evolved in the Island it became a symbol of nationalism. However the legitimisation was more of a political expression than nationalism. It became an important discourse of a political movement that drew on the socio-historical perspective of Creole with the aim of creating a unique Mauritian Culture (World Survey 1987; Shillington 1991). In the present situation each ethnic group remains strongly connected with its linguistic ties and what this represents for the group; therefore the nature of socialisation and the boundaries of each societal community remain firmly rooted.

Significance of symbols and rituals.

As sociological analysis demonstrates religion involves a set of symbols linked to rituals (Giddens 1993). Furthermore, symbols and rituals are loaded in meaning and significance as will be discussed in chapter nine. Because religion plays a central part in Mauritian lives, religious symbols and rituals are expressed in everyday life and carry with them much moral and ethical significance. As Giddens (1993) points out, religious symbols and rituals are often integrated with the material and artistic culture of the society- in particular music, dance and paintings. This cannot be more overt in the Mauritian society- a facet that particularly characterises
Hinduism and Islam. However, because of the diversity of religions found in Mauritius, understandably the associated rituals are also very diverse. The performance of religious rituals is a public as well as private matter. Performance of religious rituals in public, which involves some most complex processions to sacred places of worship, is a common phenomenon in Mauritius. Rituals and symbols are means whereby the cleansing of body and soul could be attained. This is reflected in certain social practices, such as abstinence from certain foods, forbiddance to attend places of worship when the body is in an unclean state (as in menstruation, because menstrual blood is considered unclean).

The Mauritian society in perspective

Despite rapid social changes, religion remains a powerful institution that is seemingly unshakeable. The important point in the sociological analysis of ethnicity is the reflection of traditional values, the system of meaning that accompanies each religious orientation. Viewed from this perspective, Mauritius has retained a strong element of traditionalism. From a broader sociological perspective Mauritius therefore still functions as a premodern society. The idea of premodernism, from the context of religion and religiosity is extremely important for a critical analysis of midwifery practice and the development and understanding of midwifery knowledge. It is also important in any attempt to deconstruct and reappropriate midwifery practice and its knowledge as it is reflected in the Western construct of midwifery- an idea that will be expounded in chapter twelve. The diversity of ethnicity and the diverse cultures that it encapsulates is extremely important to understanding the broadest view of midwifery practice and its epistemological base. However, as the next section demonstrates Mauritius, is also undergoing major changes that are based on the tenets of modernisation.

Mauritius in the global society- the process and impact of modernisation

The modernisation of Mauritius can be observed in the following areas: economic development, advances in technology and communication, international travel and scientific development. Mauritius' position in global society can be explained primarily in economic terms. The World Bank classifies Mauritius as
'upper middle income economy' (Sparks 1998; Mistry 1999). Until late in the century, the Mauritian economy operated almost exclusively through agriculture and dominated the rest of the third and developing worlds in the export of its produce (mainly sugar) in the global market. However, political independence from British governance in the late 1960's set in motion a rapid sequence of events in economic development, which began to change the processes of agricultural production.

The 1970's witnessed a rapid growth in development of industries - a development that entailed investment in costly technology. Technological development particularly related to agricultural technologies was also supported by research institutions and scientists in the industrialised countries who carried out relevant research. Thus, the values of modernisation reflected in the Enlightenment, as, Jarvis (1996) asserts, once imported by colonialisation, was being reinforced through technological development (neo-colonisation). Undoubtedly technological forces are intertwined, with each other, especially insofar as technological developments impact the scale of operations and efficiency of production. Additionally, in the last decade or so many transnational companies have shifted their production operations to Mauritius which, combined with national development, have altered the economic and social structure - the labour force included men and women alike on a much wider scale. The unemployment rate fell to zero (Sparks 1998) - a remarkable achievement for a relatively small island, in a relatively short period of time. Consequently, alteration in the pattern of social as well as economic life could be observed. In addition transnational companies have also introduced an international labour force in the island imported from the Philippines, Sri Lanka and China to further increase the production rate.

**The impact of technology.**

As the twentieth century progressed, technological developments, in relation to economic performance, have become more marked. Employers were faced with the necessity to improve the skills, knowledge and capabilities of their human resources. Such manpower development was achieved through learning on the job - no formal provision for education was made.
Technological advances can be observed in communication system. On one hand improved communications have facilitated the development of international business operations, but on the other, has fostered greater awareness of and exposure to events and life style in other countries, particularly the West. This has led to a gradual radicalisation of the socio-cultural system and the pattern of social life in Mauritius. The processes involved in the development of the Mauritian economic system reflects the Western ideology, at least in progress, which is one of the characteristics of modernity as defined by Hamilton (1992). The major difference, however, is time: whilst it took the west almost a century to shift from a premodern economic structure, it took Mauritius an alarmingly rapid fifty years to begin the modernisation process.

The influence of globalisation on other spheres

Globalisation, "the process by which the peoples of the world are incorporated into a single world society, global society" (Albrow 1990,p.9), is becoming evident in almost every domain of the Mauritian organisational structure. In the realm of Health and Education, Mauritius is linked with different universities in the United Kingdom, France, United States of America, Australia, Africa, India and Russia. International travel is becoming increasingly apparent. Researchers, as well as students, travel to and from Mauritius either on exchange visits or to conduct research, either individually or collaboratively. Moreover, the number of students pursuing university level studies overseas is escalating. Inevitably as people travel they interact, adopt and adapt to different cultures; they begin to reconstruct their lifeworld. As they do so the context begins to shift. Thus, international travel, has posed a gradual threat to the socio-cultural identity and value system of Mauritius. Furthermore Mauritius is now competing in a more dynamic, rapidly globalising market which is dominated by information technology and knowledge-based service industries. The process of modernisation is further accelerated by modern communication in information technology which is having significant impact on time and space.

The modernisation process illustrated in the economic system has had a major influence on the transformation of Mauritius since its accession to
Appendix Two: Overview of Mauritius

independence. Undoubtedly this island-state has accomplished much in the economic as well as in other structural domains, such as education and health. Performance in improving social indicators and achieving increased income is remarkable. Additionally the result of improved economic performance has lead to urbanisation on a large scale.

Although, by its nature, globalisation processes weaken the power of nation states to retain their culture (Hasley and others 1999), Mauritius exhibits characteristics of modern as well as premodern culture. There is a blend of the global and the local, a process which Robertson (1995) calls “glocalisation”. Essentially glocalisation is about the retention of local diversity and its spatio-temporal significance. For Hanerz (1990, p 250) local diversity is a "principle that allows all locals to stick to their respective cultures" As will be shown in chapters eight and nine traditional and local activities form a major part of Mauritian Premodern Midwifery, which differentiates from the formal government-led midwifery.

The Education System And the Socialisation Process

The Educational system in Mauritius is inevitably affected by its history and socio-economic conditions. It aimed to bring about transformative actions that would not only benefit its citizens but also the economic status of the country as a whole. The following quote expresses the government's purpose of education:

Education will be called upon to play an important role in achieving the plan target of economic growth with equity, taking into consideration the social dimensions of development process. The provision of equal educational opportunity is one of the surest ways of ensuring that all Mauritians can develop to their full potential

(National Development For Education 1995 P10)

Education, characterised by intense competition, forms an integral part of Mauritian culture. As Meade (1961), points out, this intense competition is a feature of Mauritian Education which starts from a child's earliest years to the end of social life and is itself a reflection of Mauritian life as a whole. It is a key factor that can hardly be ignored by parents and their children if they are to do well in the academic domain. Consequently this leads parents to engage their children in extra curricular
coaching- a distinctive private scheme set up by teachers to enhance children's academic capabilities. The implications of this, is that the less economically privileged may be unable to afford the cost imposed by private extra curricular coaching thereby causing disparity in children's ability to achieve well.

The Structure of The Educational System

The structure of the Education system in Mauritius, as it stands today, comprises four levels. These are pre-primary, primary, secondary and tertiary.

Pre-primary Level

Pre-primary education or Ecolle Maternelle as it is most commonly known, admits children between the ages of three and five. It does not form part of the formal organisational structure of the Education system. It is only available through private agencies; as such it is optional. Although not accountable to the Ministry of Education, all pre-primary schools must be respectively registered (Selvon1991). In addition to developing basic skills of literacy and numeracy, pre-primary schools nurture necessary interactive and social skills for later school life. It is generally regarded by the public as a fundamental part of the whole educational process. Thus for most parents it is important to engage their children in learning activities at an early age.

Primary Level and Secondary

The formal system begins with primary education. It admits children from the age of five and lasts for five years. In order to progress to secondary level education each child must successfully complete the national examination set up by the Ministry of Education (MOE 1995). Secondary level education leads to certification at general and advanced level (which is known as School Certificate and Higher School Certificate examinable by the university of Cambridge). The latter is a prerequisite for tertiary education.

Tertiary Level

Currently there are four autonomous institutions which provide education at tertiary level. These are Mauritius College of the Air (established in 1971 it serves as a medium for distance education); the Mahatma Ghandi Institute -a centre for
Appendix Two: Overview of Mauritius

cultural activities and education, it specialises in oriental languages. The third, Mauritius Institute of Education, founded in 1974, is responsible for education of teachers. It is also the national centre for curriculum development. Fourthly, the University of Mauritius (the only university in the country) provides a wide range of courses, all of which are orientated toward high status employment (MOE 1995). Due to limited access, a vast number of school leavers undertake tertiary level education overseas. Because education at all levels occupies such an integral part of Mauritian lives, parents go to great lengths to finance their children to attend university elsewhere if they do not gain entry to the national university. Currently tertiary education is limited to young adults. Education, like economic standing, represents the status of each citizen- this is partly a French colonial legacy.

Conclusion

In this brief I have given, I have given an overview of Mauritius as an island and highlighted the social changes that it has witnessed since colonisation by the different Western nation states. I consider this information important because it sets the background against which the development of midwifery practice and its knowledge base can be examined and understood. Mauritius is undoubtedly well into the process of modernisation. The chief indicator of modernity is industrialisation, which has significantly affected the political, economic and social development of the island. A large component of premodernity still remains. This can be seen in the various aspects of religious rituals observed by each ethnic group. Religion remains an authoritative discourse. In terms of cultural development premodern and modern values appear to co-exist. In the next chapters I examine the influence of social changes on the development of midwifery.
APPENDIX THREE

Samples Of Transcripts Of Interviews

Transcript 1-

Date of Interview: 25th June 1996

Time of Interview: 15.00-16.00 hrs

Place of Interview: Interviewee’s Residence

Interviewer: Huguette Comerasamy

Interviewee: Ex-hospital Maid (27 years of service)

Ethnic Background: Creole

Religion: Christian

Age: 60 Yrs

In Attendance: Interview’s Daughter-in-law

Introduction

Good afternoon. First of all let me thank you for agreeing to talk to me about the work you used to do sometime ago assisting women to give birth. But first I just want to tell you a little bit about myself and explain the reason why I am here. Then together we can decide how we to proceed.

As you know I was born and went to school in Mauritius. In fact I come from the west part, in Medine, district of Black River. I now live and work in London. I went there some years ago to learn how to become a nurse and a midwife. Today I work as a midwife and midwife teacher. In 1992 I came back to do some studies about how midwives are taught.
When I was talking to some midwives at Dr Ramgoolam Area Health Centre I was introduced to a dai who told me a little bit about her way of doing midwifery work. I was very interested to know more but there was little time left before I was due to return to London. So, that is why I have come back home to learn about midwifery from you. I will be in Mauritius for three months and will be travelling all over the island to see and talk to other dais. Fell free to ask me any questions that you may wish to do. If there is any ting that I say and you want further explanation or clarification do not hesitate to do so. Also because I would like to listen and talk with you I would like your permission to tape our conversation. I want to assure you that no one will have access to it except me and neither will your personal information appear on it. If you do want me to use the tape that is fine- would then allow me to take notes? Just before you start how should we go about having this talk.

**Interviewee:**

You Know as you like How to start! Preferably you start. But let me tell you, it is you who want to know so you ask me what you want to know and then I will see if I can answer you or not. Because you know, here (meaning in this country) you must be careful what you say and how you say it. You understand what I am trying to tell you.

**Interviewer:**

Very well I am happy to start. Just one thing before we start. How do you feel about my using a tape recorder?

**Interviewee:**

If, as you say you are the only one that will use it, then it is ok. You will make sure though that you do not write my name on it.

**Interviewer:**
I assure you that I will keep all that you have say confidential. You know I just want to know did you learn to assist women give birth and what of work did it involved?

**Interviewee:**

You know let me tell you first, I have five children myself, so I have that experience to know what to tell the women. Also long ago in the hospital there were few nurses and midwives, especially at night. Sometimes there was only one nurse for the whole labour ward and there were many women who came to have their babies. Sometimes four five women will be in the labour ward at a time. When the women began to give birth I helped the nurse, I watched the way she did it and I learnt that way, whether it was the baby’s head coming out first or the baby’s buttocks or feet, sometimes you see the baby’s face coming out first, you see all this I have seen and know what to do. Now it was all right when there was only one woman giving birth, but sometimes two or three. Very often whilst the midwife was attending to one woman, another would start giving birth. Often times the doctor was somewhere else in the hospital and besides there was not as many as there are today. It was quicker to get on with it yourself. You could not leave the woman to borne the baby by herself. The women were afraid, they kept on screaming and screaming for sister please the baby is coming, come and help me, help me, I want push, I want to push. So we had to go instead, and by the time the sister came we had already deliver the baby. The midwives knew they could count on us. The doctors too were pleased with us. You see this is how it was in those days.

**Interviewer:**

May I ask you to tell me a little bit more about how did you learn by yourself? I know you said you watched what the midwives helping women giving birth, but how did you learn to assist women giving birth by yourself?

**Interviewee:**

How can I explain to you? You see as I came to see the women when they called, sometimes as I approached I saw that the baby’s head was already out – what to do! I just held the baby’s head and take the rest of the body out and I succeeded. I tell you, long ago there were no gloves, you had to just do it with bare hands not like today they have all kinds of gloves. Now if you see that baby, he is twenty-two years old and going
to university, so I did it right. And now let me tell you, I have done many more. Almost all those youngsters in the village are my children, at least about twenty of them. Did you know that when you help a woman give birth you become the second mother that is why I am telling you that I have. I am the mama of many in this village.

Now that is not all. After the baby is born, you must cut the umbilical cord and then you can take the placenta out, and all that I learnt by watching the midwife. I know how to measure before cutting- about four-finger breadth. Then you must do the nursing of the mother and her baby (Nursing is the term employed to define the postnatal care of the mother and baby). You had to give the mother her bath first, clean her down below and put her dressing (meaning sanitary pad) and then help her put clean clothe on. Afterwards you bathe the baby and you must make sure that you remove all the dirt from the baby’s hair because you know certain religion believe that this is dirt and in any case the baby’s first hair itself is considered dirty even though all the blood and everything that comes from the woman when she gives birth, You are a midwife you know what I mean. Me personally I do not believe in these things but you must respect what other people believe, so you do it as best as you can to please them. Now I forget to tell you, you must also do the baby’s umbilicus- and dress the wound. What you do you put small gauze on it to make sure it stays clean. You know when people began to know that I can do this work, they would call me to do it in their own home, so this is why now I continue to do it when they call me.

**Interviewer:**

You know this is really great. May I go back a few steps and asked you a little bit more about how you assist women giving birth. I am fascinated by the way you described how some babies are born especially those baby’s who come out by their feet or bottom or the face. Have you ever had to assist any of those?

**Interviewee:**

Ah! What I can tell you, of course. I have certainly done so many who have come by feet and bottom first.

**Interviewer:**

I would really like to know how you did them. Would you mind telling me?
Interviewee:

Of course. When you see the little feet coming, you wait and see which one comes out first and then you grab and pull on it and then the second one. Sometime both come out together. When the feet have come out you let the woman push the rest of the body out. If the body does not come out you garb the feet and you pull. But you must be careful how you pull. I have seen how the midwives do it. They do it gently so I also do the same. Then you pull the arms out. Sometimes the baby’s arms remain high so you have to put your hand in the woman’s’ passage to bring them down. (A demonstration resembling the loveset manoeuvre was done to explain the procedure). These are the biggest problem; once you have done this you hold the bay and let the woman push the head out herself. Now another thing I want to tell you. There is also the spirit that tells me what to do.

Now I am going to recount another thing. As long as the baby is bring born by the head, by the bottom, by the feet, that is fine, but what are you going to do if the face appear first. All this you have to know. Do you think this work is easy? Eh Eh! Sometime it is very difficult, even the midwives say, eh that one is difficult.

Interviewer:

I am sure. But tell me why it is difficult and how did you deal with difficulties?

Interviewee:

But you know, as I told you, there is a spirit that tells you what to do. So you are not afraid. You just have to listen and do how the spirit guides you. The bay that comes face first- what you do is this- first you put a finger in the baby’s mouth and then you lower the baby’s mouth down. In that way the baby’s head will come down easy. But if you do not all this you are stuck. The baby will come anyhow, it is the mother that will get hurt, she will be torn badly, then later there will be problem, how will her husband accept her. You see what I mean when I say that this work is difficult.
Interviewer:

Indeed. I want to ask you another questions, if I may. You said long ago there very few midwives and the domestics helped women giving birth when they were on duty in the hospital, but when did this all change?

Interviewee:

Aaah!! What are you asking me now? You know in times gone by nobody minded what you do. To begin with this work this work was done mainly. Most women gave birth at home. But when women came to hospital the midwives did it. So when we were called to help no body cause problem. Now how can you do this, in the hospital no way! Let me tell you. Long ago there were very few people, so it was all right. Now you must also think that the population was increasing. Little by little the youngster began to go in other countries, like India, France, England, even Russia to learn to become doctors. When they came back, they took over our work. But also the government began to teach many more midwives. Where there was only one nurse, midwife in night duty, now there are eight. As from then they no longer needed us. But you know that is why I do this work for women who call me when they are having their baby at home. Long ago there was only one doctor now there are so many, and everything has become so complicated. Nobody cause any problem now you have to be so careful because every body makes trouble (meaning lots of complaints). Long ago when a women had her baby in the house we did everything by ourselves, and yet the hospital was only two steps from away. Now we cannot do it that way, you have to go to hospital for everything.

Interviewer:

I have been so fascinated by all the things you have told me today. There are so many things that I would like to know about midwifery. Let me give you some examples: why do we have to give birth hospital now? How we come about? How can we preserve the things that we knew before we began to learn them in the hospital? How did the women who did this work before there was any hospital learnt it? I tell you there are so many things that in my view should not forget and lose. May I come back at a later date before I return to London to talk to you again? You do not have to give me an answer now. Take your time to think about it. If this si ok with you I will give you a call on Monday to book another appointment Let me also leave my telephone number with
you, if you want to call me before then. I would like to thank you for your time and all the information that you have shared with me. Once again thank you.
Transcript 2

Date of Interview: Wednesday 10th July 1996

Time of Interview: 14.00-15.00 hrs

Place of Interview: Interviewee's Residence

Interviewer: Huguette Comerasamy

Interviewee: Dais (10 years of service)

Ethnic Background: Hindu

Religion: Hindu

Age: 52 Yrs.

In attendance: Many members of her family

Introduction:

Namascar (Good afternoon). I believe you are a dai and that you go to different parts of the capital city to assist women giving birth.

Interviewee: Yes I do.

Interviewer: Brilliant! Ok let me just tell you a little bit about myself and why I have come to talk to you. Do you know Medine in Black River district?

Interviewee: Yes, it is in the west part of the island, isn’t it? It is not so far from here.

Interviewer:

Correct. I was born there and went to primary school there too. When I finished all my education I went to England to study nursing and the midwifery. That was some time ago. Now I live and work there. In fact I am a teacher of midwifery. Any way enough about me, how about you? Have you always live in Port Louis?

Interviewee:

Yes. I was born in Paille and then when I got married I came with my husband to live here in Cite La Cure and I have been here since. Let me see, it will be nearly thirty-
six years. I am use to this place now and I am happy. All my children are also big now, so no problem.

**Interviewer:**

Thank you for sharing this information with me. I now want to tell you about the work that I am doing. I am currently in Mauritius for three months doing research about midwifery. I will be going all over the island to talk to other dais like yourself to learn your way of learning about midwifery and about how you assist women giving birth. I have also visited two main hospitals and some Area Health Centres and will be visiting some others whilst I am here.

Before we start I would like your permission to tape our discussion. I assure you that all the information will be for my use only, nobody will have access to it and I will certainly make sure that you details do not appear on the tape. During our discussion feel free to ask me any thing you may wish to know about my practice as a midwife working in London.

You know I find it is interesting that there are so many dais still doing this work especially when increasingly women seem to go to hospital to give birth. Tell what made you chose to do this work?

**Interviewee:**

How can tell you! You know I was thirty-five years old when I began to learn how to do this work. There was another dai, she was my mother-in-law, I learned from her. Each time she went to attend a birth, like my sisters, sisters-in-law when they were having their babies, I went with her and I helped her. When she became old she let me do the births and watched me. She stopped doing the births; she made me do them instead. She taught me what to look for, how to examine the woman passage, what the measurements are. In that way I knew what to do. She also taught how the baby will come out, either by the head, or by the feet. For example, if the baby’s house is still high this mean that then baby will come by feet because the baby’s head is up instead of down.

**Interviewer:**

If the baby is coming feet first how then do you assist the women to give birth?
Interviewee:

But you wait. You will know, when the woman’s passage is open then she will give birth. But the way the woman behave, the noise she makes will tell you she is ready. But you also have to say your prayer silently so that the God will be with you. In our practice this is important. When you go and see other dais they will also tell you the same thing. How can I explain this to you? Have you had any children?

Interviewer:

No. My experience of childbirth is purely from assisting other women giving birth.

Interviewee:

You see, this part you will never understand. When you have had children, the sensation that comes when the baby is coming, even by the head or feet first you know, your body tells you what it is. This knowledge is an intelligence you only get when you yourself have gone through that journey. Then when you are helping other women giving birth you know what is like. You can tell them what to expect and they will trust you because they know that you know what you are talking about. If they make too much of a fuss you can tell them off too.

Interviewer

Can I just ask interrupt you for a moment and you about something you said just now about your practice?

Interviewee

Yes you can. What do you want to ask?

Interviewer

You said that you have to say a prayer. I am so interested to find out why this is so important? Is it not sufficient that first of all through your experience of giving birth and what the older dai taught you to do your work?
Appendix Three: Samples of Transcripts

**Interviewee**

But no. How can I tell you this? You see I agree with what you said that when you have had a baby you gain the intelligence of what to do and that true what the dai taught me is also important. But you also must remember that first you get a calling form the God. If you do not have that calling and you start this work by yourself likes some women do, You know like those who learn when they were maids in hospital. But when God calls you, you must acknowledge that He will give you knowledge so you must say a prayer. In that way you know that the woman and her baby will be ok. That also you will not understand unless you have been called yourself.

**Interviewer**

Ok you are telling me this but other dais say that this work is dirty and so if they do it they will become dirty and will not be able to pray and sell milk form their dairy farm. How can this be?

**Interviewee.**

Listen. I will explain it to you. You see this work that we do, it is true it is dirty. But there are things that you need to do before you go and when you come back. When you came to my house just now you saw the God in the shrine in the front of my house. This is one of many gods that we serve. There are systems that I have to do. Before the house I must say a prayer to that god first. Then when I come back from doing my work I cannot enter the house, first I must clean myself. I stopped by the shower room that is situated outside the house; I will show it to you when you go. I must take all my dirty clothe, wash them there. You must not bring nay of it in the house. Then when I have cleaned myself I can enter my house. When I come in I have to stop by the shrine and say another prayer. Then you become normal again. You can do everything as normal. In that sense you have nothing to fear. If you ask other dais, they will all tell you that. Now I want to tell you another thing, when you go to the woman’s house you enter by the front door, but you come out you live by the back door. This is our custom. In that way you do not offend any one.

**Interviewer:**

This is very interesting. What else do you do as a dai?
Interviewee:

Oh there is a lot. But you know nowadays everything is changing. Before all the women were giving birth at home now all them want to go to hospital Only a few of them are asking me to help them have their baby at home. It seem that they are afraid. They have out it in their head that it is better to have their baby in hospital. It is their choice. But I am going to tell you hospital is no good. There are lost of things that they do that are not right. They are quick to cut the women down below. This cause problem later. You know what I mean? Don’t you. How are they going to do? It will pose problem about sexual relationship alter. A lot of women have told me that. This is how I know.

Interviewer:

Ok. Then if most women are giving birth in hospital, tell me what else do you do?

Interviewer

Mamzellle! (this is a creole term literally meaning miss). There is lot more to our work. Now women even they go to have their baby in hospital they see us during pregnancy. First they come and ask us to do massage. This important. When you do massage the baby will stay in the right position in the baby’s house. Also the women. Will have a better labour because the muscle is supple and then they will also regain their figure quickly. We continue to do that massage after the baby is born for both the mother and the baby. But when the baby is born we use different technique. When the women are still pregnant we just use oil, either olive or whatever the woman can afford. But after birth we also use heat. When we have finished giving the woman her bathe. We first of all light a coal fire and she must stand astride on the fire. You see in that her inside will get warm. The wound that is caused by the *flower* will heal quickly and the all the dirty blood will also come out quickly. Without that she may catch a cold and get infection. After a time of about five to ten minutes then we massage the woman’s tummy and apply heat. Again this is to help her get rid of all the dirt. We also massage the bay with oil as well. But for the baby this is to make sure that he grows strong and then if the head is deformed during birth, you know sometime s this happen, then you need to get it back into shape. In that way the ugliness will go and the bay will not have headache.
Interviewer:

For how long do you do those massages?

Interviewee:

Normally for about six days.

Interviewer:

You know when I talked they told me there are a lot of systems that some people have to do mostly after the birth. What kind of systems are they? Do you think that these things are important even today?

Interviewee:

Of course there are many systems that have to be done? In our culture and religion these system are important. But regarding this there is lot to tell. Where do you want me to start?

Interviewer

You start where you like.

Interviewee:

Well. I think I start with labour first. You see when a woman starts the pain of labour; in our culture she is already impure. She must stay in the room and not come out. Normally her mother-in-law and her sister stay with her. Now the woman must take all the jewellery especially any ring necklace and she must also remove any hair slides and unplait her hair and wear lose clothing. If she does not do these then the baby will not come out because any constricting thing for us mean that labour will be obstructed. She must not stay in front of the door either and no one else must stay in front of the door. All the passages in the house must be kept free of any obstruction. Any what this is what we believe. A lot of people might say differently. Now another thing I want to tell you, we bring a flower with us. You know us dais we use this flower to know how the woman is doing in labour. This flower you know it is sacred. We use it only when we assist the woman in labour and after the woman has given birth we put it away for the next time.

Interviewer:

The flower that you mentioned just now. Can it be any flower? What is it called?
Interviewee:

Oh. No. You can’t use any flower. It is a special one. But I cant’ tell you the name. You see the flower is special because the gods like it therefore it has special powers. But before you use it for the power to be released you have to say a prayer first. If you do not say the prayer it will not work. Another thing you cannot use any colour as well you must either use yellow or white.

Interviewer:

Why only these two colours when there are so many other beautiful colours?

Interviewee:

Yes sure but as I told you already this is to do with our beliefs. The gods like them an only the two colours must be used and you will find if you ask other days that mostly the Hindus will use yellow. The Moslem women use the white colour. But I am telling you this midwives in hospital us it too. Will you be talking to them as well?

Interviewer:

Yes I will.

Interviewee:

Ask them and they will tell you so.

Interviewer:

Would you mind if I ask you a little more about it? I am so fascinated by what you have been telling me. Where do you put the flower and how does it work?

Interviewee:

Ah. How can I explain? You see when you arrive at the woman’s house. You ask for a little vase and then you put some water in it and then you place then flower in and leave it on a table in the corner of the room or by the woman’s bed. But as I said and I am saying again, you must say a prayer. Then the flower begins to open little by little. In that way you know that her passage is opening as well. When the flower is fully open you know that the baby is ready to come.
Interviewer:

When the flower is fully open and the baby is ready to come what do you do next?

Interviewee

Then we ask her to push. Most of the time the woman herself will start making that noise. You know the one that you start making when the baby’s head is wanting to come out. Oh I forget you have not had that experience so you would not know.

Interviewer:

You think so. But I you I do. I do precisely because I listen to what the women tell me and I observe. When they are ready to give birth, yes you are right they do a make a different noise. And if you observe how they behave you will also find that it is different too.

Interviewee:

Ai yo! Ah Ah! (This is an expression of surprise which was followed by laughter) mamzelle, you do know.

Interviewer:

Of course. Any way I am intrigued to know what happens to the flower. Please tell me more.

Interviewee;

So you want to know more. Ok. You see when the woman starts to push the baby out and when the baby is born the flower will shut by itself. Then after everything is over we just put it away for the next time. We warped it up and take it back home. We keep it safely in a special place.

Interviewer:

What happens if the flower does not open?

Interviewee:

Ah! But then we know that the woman is in danger. Then we have to take the woman to hospital. There are times that it does not open or it opens very very slowly. Usually the flower opens fully in about twelve hours sometimes less. Sometimes it dose
Appendix Three: Samples of Transcripts

not open at all. But you must also make sure that there is no obstruction anywhere in the house. If there is then the flower will not open because the passages are not clear then how will the woman’s passage be open, But all this! Should not think about?

Interviewer:

How fascinating. Now tell me what happens to the other flower, the placenta. How do get it out?

Interviewee:

It comes by itself or the woman will push it out herself?

Interviewer:

What do you with afterwards? How do you get rid of it?

Interviewee:

Ah Yo mamzelle. What are you saying! You don’t get rid of it. That flower (the placenta) it is a life. There are systems that we must do. Otherwise there will be trouble for the woman or her baby or both. Firstly when the baby has just been born you do not cut the umbilical cord you have to wait until the flower dies? This you will know when the baby’s umbilical cord stops beating, then only you can cut it. You did not know that! In our way culture we believe that the flower is another life. It is the flower that gives the baby its life. One life must die first before the other one can it fully? You understand now.

You also ask what do we do with afterwards. Well what do you do when some one dies? You have to bury them. We do the same with the flower (placenta).

Interviewer:

Oh sure. I like the way you say that the flower must be buried. But let me ask you about something else you said just now that there are systems and there will be danger of you do not do them What kind of danger?

Interviewee:

You know. There are many things. First you must make sure that you bury it in a well-hidden place out of sight. Usually it is done under the mango tree. When you have buried it you need to place a little lamp you know those little earthen lamp. You light the
flame and say a prayer and then leave it. Everyday you must take food there for at least seven days and then is ok to stop. In our beliefs you must keep the spirit of the flower happy so that no harm will come to the baby or the mother. Now there is another thing. That lamp that we place there, its flame will keep any bad influence away or people with bad intentions will also be kept away. It is protection to the woman and her baby. Now what else do you want me to tell you?

Interviewer.

Ok I think that you have given me a lot to think about for now. Thank you very much. Would you mind if I come back and talk to you again?

Interviewee.

Yes sure

Interviewer:

Is convenient to do so now.

Interviewee:

Yes, as you please.

Interviewer:

Ok. How about next Tuesday and at the same time? Is this convenient to you?

Interviewee:

Yes.

Interviewer:

I will give you a call to confirm it. Once again thank you for you for sharing your time and your knowledge with me. See you next Tuesday all being well.
Transcript 3

Date of Interview: Monday 3rd September 1996

Time of Interview: 10.00 am- 11.00 am

Place: Victoria Regional Hospital

Interviewer: Huguette Comerasamy

Interviewee: Nurse-Midwife (25 Years of service)

Ethnic Background: Moslem

Religion: Moslem

Age: Not disclosed

In Attendance: Midwife Teacher

Introduction.

First of all may I say thank you for taking time to talk to me. As you know from the Ministry of Health’s’ correspondence I am a midwife teacher who is currently doing research into midwifery. I have been in the country for almost three months now and I am almost at the end of my fieldwork. I am looking into what midwifery knowledge really is, how do we use it in our practice and how do we teach it? I would just like to have a discussion with you about your views on this subject. This is the second time that I have come to do research work in Mauritius. Let me just start with a discussion on what is midwifery education and practice entail here.

Interviewee:

Well there used to be two types of training programme, as you probably know. The one-year programme for midwives and eighteen months for nurse-midwives. Most of the midwives work in the community that is in Area Health Centres like this one. You will see that nurse-midwives staff the hospitals only. I guess this is because our training prepares us to work in these different environments.

Interviewer:

What dose you practice as a midwife entail?
Interviewee:

Well we do everything, from antenatal right through to postnatal care. Mostly, during the antenatal period the gynaecologist examines the women. We tend to assist them in doing the general observations, such as weight, BP, urinalysis. Of course we do antenatal examinations as well and give advice practices such as nutrition, breastfeeding. In labour it is a different thing altogether. There the nurse-midwives are more involved. We do have a gynaecologist that is usually on call but on the whole we tend to assume responsibility for all women in labour. But obviously when there is a need to call the gynaecologist we do so. This is usually when there are deviations from normal. Such delay in labour and there is a need for augmentation of labour or instrumental delivery or anything else that require medical assistance.

Interviewer:

This is great. But tell me what other remit do nurse-midwives regarding antenatal care. For instance do you do breech birth, repair episiotomy ands such like?

Interviewee:

Yes sure. When we perform an episio (episiotomy) we also do the repair. But it is not only to with episio; if the woman sustains a laceration we repair it as well. As for breech birth, yes most of the time we do them ourselves.

Interviewer:

Who taught you how to do breech births?

Interviewee:

We learn the theory in school. But the practice I learnt from the older midwives who did their training solely on the ward, long before there was a school of nursing. They were good at everything. Even the RMO’S (Resident Medical Officer- a term equivalent to Senior House Officer) learnt from them.

Interviewer:

Thank you. This is great. Let me just ask you ask a questions tat I have asked for so many times. Other than the definition we have in the textbook what do think midwifery is?
Interviewee:

Oh, I guess it is about pregnancy, labour postnatal and the care that we give to women. So that would involve all the care we give to women at any stage in their pregnancy, labour and after they have given birth. This is a tough one. I do not know whether I have answered this one well.

Interviewer:

Oh you are doing fine. You know I am so interested also to find out midwives about what midwifery knowledge is. What are your views about?

Interviewee:

Now you are putting me to the test. I thought the last question was tough but this one is tricky. How do I answer that one? Give a moment to think through that one.

Interviewer:

Take your time. Most of the midwives that I have to about this reacted in the same way. Feel free to express your view however you see fit.

Interviewee:

I guess it is all the knowledge that we learnt on schools about physiology of pregnancy and labour, postnatal and the changes that occur in the woman’s body during these processes. But you know once we have qualified form school, and obtained our license to practice we do not go back to school again. Some years ago the school started a refresher course of all midwives but we have not heard anything for a long time so we do not know what has happened to this idea. But after a while when you become experienced you develop your own and you just get on with work.

Interviewer:

Can I just follow through an idea that you just raised a minute ago?

Interviewee:

Oh am I getting myself in deep water now.
Interviewer:

Oh no, not at all. I just want to explore your ideas further with you. If I ask you to describe what you mean by developing your own and to classify it like we have done with anatomy and physiology what would they be.

Interviewee:

You know when I agree to talk with you I thought this was going to be easy. I did not know that you would be putting me through the test. I left school a long time ago you know.

Interviewer:

Oh no, I am certainly not putting you to the test. On the contrary think you are bringing up some every important issue about knowledge. This is the reason why I want to find out more.

Interviewee:

Oh, ok. But I still find it difficult. I will try my best. How can I best describe what I mean? Putting it this way, when you are doing something day in and day out you begin to learn more about the women and more about your practice. You no longer do exactly how you were taught in school. You develop your own way and you begin to discover what works and what does not. I can’t really describe it to you. It is something that you develop as you go along. You know what I am trying to say.

Interviewer:

This is great. You know I just want to pursue something different now if I may. As you know I have been talking to many dais from as far as the Northern part of Mauritius, Port Louis and Curepipe to find out about their ways of practising midwifery. What do you think about those women practising midwifery?

Interviewee:

I think they have a place but the have need to be trained. Very often the have to transfer the women to hospital. This mostly due to prolonged first stage of labour. Sometimes women incur bad perineal lacerations. We see quite a few of these cases when we are rostered ion Casualty because the repairs are done there. But you know women continue to avail of their services because of the all the religious practices. Some
women are so strict about the observance of the religious practices that they would not allow anything to get in their way of observing them. You see when they come in hospital, they will not be able to do them whereas if they stay at home, they are free to do what needs to be done. The dais have to respect the woman’s religion. The dais have a lot of knowledge about the religious practices. They also do massage very well. Many women go to them even professional ones to have massage during pregnancy and after birth. There is another thing about them. Most people believe that they are called from God to do this job, so they trust them and their knowledge. They are known in their community for so long and if they have a good reputation, people would trust them even more. Sometimes the women would get a second opinion from them. I remember a particular case. A young primiparous, 38 weeks pregnant was booked for a caesarean section because at the time of antenatal examination at the AHC, the fetal head was still not engaged and in fact was very high. At the appointed time the woman did not arrive for her caesarean section. She turned up in labour the following night. As the nurse-midwife admitting her, I soon realised that she was a complicated case and I alerted the RMO immediately. Whilst we began to get the operation ready, the woman began to push, the baby’s head was visible, and she gave birth normally to a live male infant within half an hour of arrival to labour ward. We later ask her why she had not turn up when she was asked to, knowing she required a caesarean section. She said “I know, but when I left the clinic I went to see the dai, she felt my tummy and then gave me an examination down below. She said it was true that my baby’s head had not entered. My passage yet (Meaning the pelvis), but the baby was only small and that once I start labour pain it will go in alright and that I will be able to give birth normally and that I do not need a caesarean operation. There are many cases like these and that is why I say to you that they have a place.

Interviewer:

How do you reconcile the fact that some women take advice from the dais and act upon them accordingly rather than listen to the voice of the doctor or the nurse-midwife/midwife?
Interviewee:

Of course we do not like it. But if that is what women want to do we can't stop them. They make their decision and if anything goes wrong then it is their responsibility. You have to respect their choice.

Interviewer:

You know the dais told me something very interesting about how they monitor the progress of labour. They use a dry flower, which apparently opens up as the women cervix begins to dilate and it tells them that all is going well. Have you ever seen heard or come across this before.

Interviewee:

They have told you that! Did they show it to you?

Interviewer:

No. They said it is a secret.

Interviewee:

I did not think they would. You see there is truth in it. Yes I have seen it. Apparently it is a special flower believed by some people to be sacred and have special powers. Some nurse-midwives also use it in the ward even, but only for the women who share the same religious belief. Yes I have seen the flower opening and the women wanting to push. When it is fully opened. You will not be able to understand it unless you hold the same religious belief. In our religion we believe in the power of the flower. But at the end of the day you can't compare the dais practice with ours. They have a different view altogether.

But you know in hospital you have to be careful how you use all those things like the flower because it is communal area. At home it is different, the woman is in her private space. So that is the reason why some women prefer to give birth in their own home. There are a lot of things about the dais and the things that they do.

Interviewer:

Oh yes I do agree. Having spent time talking to them I have learnt a lot about their version of midwifery, especially the aspect of systems. I would never have thought that these women and their practice still exist in our country. Just as well I personally
that I have a lot more to learn from them. Any way I realise that our time is drawing to a close. I would like to thank you very much for taking time to talk to me and to share your knowledge. I plan to return to Mauritius on completion of this study to share the findings with you all. I would invite all of you who have participated to come. Once I organise it with the Ministry I will let you know. Once again thank you.
Appendix Three: Samples of Transcripts

Transcript 4

Date of Interview: Thursday 1st August 1996

Time of Interview: 11.00am-11.45 am

Place of Interview: Mauritius Institute of Health

Interviewer: Huguette Comerasamy

Interviewee: Executive Director, Mauritius Institute of Health

Ethnic Background: Hindu

Religion: Hindu

Age: Not asked

In Attendance: No one

Introduction:

Thank you for agreeing to see me and to talk to me about the role of the Institute in Midwifery matters. As I stated in my correspondence the subject of my research is midwifery knowledge and it is this connection that I seek your views. What I am really interested in is the traditional perspective of midwifery knowledge. I have already interviewed a number of dais and obtain their perspective of midwifery and the remit of their practice. I have some topic areas that I would, like to address with you. First of all may I start by asking you form a medical perspective what do you see as constituting midwifery knowledge.

Interviewee:

May I say first of all how delighted I am to see some one like yourself who have studied midwifery in the western context return to the homeland to seek to understand the lay perspective of midwifery. Mauritius is undergoing major changes and is in a state of transition in every aspect, financially, culturally and politically. There are many people who are interested in Mauritius. Mauritius as you know is a multicultural country. How will the changes affect certain cultures?

Let us now see how the changes will affect maternity services. Today majority of births take place in hospital. Birth, a natural, social process has been institutionalised.
Many practices that concerned childbirth, here I refer to the social and religious practices that once were the norm have been eroded by the institutionalisation of birth. But we will be returning to homebirth. There are many reasons for this cultural change. There are cultural changes. We need to recapture the cultural aspect of births and not only that but reestablish its identity. You see hospitalisation has meant a complete devaluation of cultural practices and cultural knowledge. I am certain that you have received a good insight about cultural knowledge from the dais because it is in that area that they specialise. The dais have been and continue to be marginalised, when you consider that most of the prominent people in this country have been born by dais. So in shunning their practice and their knowledge what are we in fact saying? This needs close examination. Are we not renouncing the practitioners who in the first instance assisted us to life itself? When you look at this closely what has really happened we have rejected our own culture in preference of someone else’s. Evidently it is Europe’s culture. I want to use another illustration- take to case of breastfeeding as an example. The culture of artificial feeding has crept in our society with great rapidity for the financial gain of milk manufacturers. Women are having their babies nourished by some artificial form of nutrition when the value ought to be placed on breastfeeding. That is where the culture of the dais comes in, their knowledge relates to recognising the merit of the natural. We are working towards re-instating the culture of breastfeeding.

**Interviewer:**

May I return to ask you how what envisage cultural transition phase that Mauritius is in right now affecting midwifery in particular?

**Interviewee:**

Clearly this will affect the whole maternity structure, from strategic to operational level. There has to be a change in mentality. I am sure in your capacity you know that this is not always easy to get people to accept change readily. Education will have to play a major role here. When I spoke about culture just now, I also meant a change in the professional culture. Let us return to the dais. It is imperative that we consider the knowledge inherent in their practice. You must have found out by now that these women are not ordinary women. For them become dais, by that I mean the ones who are real dais not the ex-hospital maids, although I do not discredit the latter by any means, they have had a special, calling. This gives a cultural perspective specific to
traditional midwife. These women are endowed with power from above. We must not renounce this fact. You see the dais have a different philosophy in just the same way as the doctors and nurse-midwives do. Dais view things form a religious viewpoint whereas the professionals approach midwifery form a scientific stance. Women as well as society in general as been led to accept the value of science. This cannot continue because in accepting the value of science we have and continue to erode our very state of being and our cultural identity. Undoubtedly scientific knowledge has a part to play in the affairs of midwifery but it is not the main source. This is the price you have to pay when you adopt another cultural perspective without fully examining the value of your own.

**Interviewer:**

But would you not then be rejecting new knowledge in favour of the old? Surely as society as evolves and new knowledge comes to light, changes will inevitably occur. Would it not be a sort of cultural imperialism if we dictate what should be done?

**Interviewee:**

Good point. My argument is not so much about imposing culture. This has already been done a long time ago by the permeation of different cultures in our land. Let me return to the point of breastfeeding- how did we become imbued in the view that we must feed our children on cow’s milk. How did we get the births must be institutionalised? My argument is therefore to stop and look at how far down the line of institutionalisation we have gone and consider the effect on culture. Indeed we have to accept new knowledge but we must also not reject the old. We must preserve our identity. In the context of midwifery, we have only a few dais left and the practice are rapidly disappearing.

These women hold valuable knowledge that with the reform of midwifery and the adoption of the western system have been forgotten. The cultural knowledge that once formed the bedrock of midwifery and give it meaning must be recaptured. So when you sated that your study entailed looking at traditional midwifery practice I was delighted that at last we have some one who is taking interest in resurrecting that part of midwifery.
Interviewer:

Let me ask one more thing. From a strategic point of view how do you envisage the incorporation of the cultural values that we have just been discussing? The demise of traditional midwifery and its knowledge, is not just a local or national impetus, we are influenced by the WHO and UNICEF as well.

Interviewee:

Indeed. We certainly need to work with the WHO and UNICEF initiatives, in accordance with how it fits with our culture. Accepting WHO and UNICEF initiatives does not mean demise of our own culture and perspectives. We need to establish a firmer collaboration with professional and dais. At the moment the dais are not by any means recognised. Having them reporting to the AHC each time they attend a woman in labour is insufficient. Having them follow a training programme which at present is haphazard, is insufficient. We need to build on their existing knowledge and practice and provide opportunity for them to share their knowledge with us, rather than inculcating them with professional culture. Now there are implications here. What we are really saying is that the professionals, not only nurse-midwives and midwives doctors have to recognise and acknowledge first that the dais have expertise tantamount to them. Now this will involve a major shift in culture and way of looking at midwifery. That is why I stated earlier on, how would certain cultures react to the changes that will occur. Some of the cultural issue are very sensitive ones, especially when it comes to upholding religious practices. The question remains how do you get all those who at the forefront of midwifery practice to transcends religious barriers. This is major task. Any way if we are to return to recapture the culture of midwifery we are inevitably face with that task of resurrecting theses values and incorporate them in a very significant in every aspect of life. We shall, events. Any way I look forward to reading you work. Good luck.

Interviewer:

Many thanks for your contribution. I will certainly return to Mauritius on the completion of my work and share my findings with all those who have been willing to participate in my research and most importantly share their knowledge with me.
REFERENCES


Andrews, M.M; Hanson, P.A (1998), Transcultural Concepts in Nursing Care Philadelphia: Lippincott


Bogdan, R.C & Biklen (1982), Qualitative research in education. Boston: Allyn and Bacon


References


Croissant, J. (1998), "Criteria for a theory of Knowledge". In A. Sica (Ed); what is Social theory. Massachusetts: Blackwell

Cronbach, L.J (1975), "Beyond the two Disciplines of Scientific Psychology". American Psychologist February 1975, 116-127


Davies-Floyd, R. (1992), Birth as an American Rite of Passage. Berkeley: University of California Press

Davies-Floyd, R.E, St John, G (1998), from doctor to healer. The transformative journey. New Brunswick: Rutgers University Press
Davies-Flyod, R.E and Cosminsky, S, (Ed) (1999), Postmodern Midwifery. A Special Issue of Medical Anthropology. Unpublished material (Personal communication with Davies-Flyod)


Dewey, J. (1933), How we think. Boston: Capricorn Books


Donnison, J (1977), Midwives and Medical Men. New Barnet: Historical Publications Ltd


References

Fanchette, R. (1972), L’île Maurice-Mauritius. Mauritius: Mauritius Tourist Ltd


Foucault, M. (1972), The Archaeology of Knowledge. Tavistock Publications


Foucault, M (1979), and Discipline and punish: The birth of the prison. New York: Pantheon


Frankfort-Nachmias, C and Nachmias, D 1992), Research Methods in the Social Sciences, London: Edward Arnold


Gordon, J.E. (1970), "Nurses and Nursing in Britain 2: The Saxon Centuries". Midwife and Health Visitor, July Vol 2


Hanerz, U. (1990), ”Cosmopolitan and locals in world culture”, In Featrestone, M. (Ed); Global Culture. London: Sage Publication


Heagerty-Broolce, V. (1990), Class, Gender and Professionalisation: The Struggle for British Midwifery 1900-1936.D-Phil Thesis, RCM Data Base


Heinsohn, G and Steiger, O. (1982), The Elimination of Medieval Birth Control the witch Trials of Early Modern times. International Journal of Women’s Studies, 5 (3) 193-214


HMSO (1936), The Midwives Act 1936. London; HMSO Office


Honneger, C (1979), Comment on Garrett's 'Women and Witches'. Signs 4 (4)


355
Jarvis, P. (1983), Professional Education. London: Croom Helm


Kitzinger, S. (1992), Ourselves as Mothers. The Universal Experience of Motherhood London: Transworld Publishers

Lawton, D (1975), Class, Culture and the Curriculum. London: Routledge and Kegan Paul


References


Midwives Act (1902) London: Eyre and Spottiswoode. For the King’s Printer of Acts of Parliament


358


MOH (1955), Report of the committee of Enquiry into the cost of the National Health Service (Chairman, C Guillebaud), London: HMSO

MOH (1959), Report of the Maternity Services Committee (Chairman Earl of Cranbrook, London: HMSO

MOH (1970), Domiciliary Midwifery and Maternity and Maternity Bed Needs: the report of the Standing Maternity and Midwifery Advisory Committee (Sub-Committee Chairman J.Peel), London: HMSO


Nihell, N. (1760), A treatise on the art of midwifery. London


359
References


Radcliffe, W (1967), Milestones in Midwifery. Bristol: John Wright & Son Ltd


References


References


Tritmus (1962)


Towler, J and Bramall, J. (1986), Midwives in History and Society. London: Croom Helm


Tritten, J. (1999), The Development of a Global Midwifery


References


Wildwood, C (1998), The Encyclopaedia of Healing Plants. London: Judy Piatkis Publisher

364
References


Witz, A (1992), Professions and Patriarchy. London: Routledge


Marks, L. (1996), Metropolitan Maternity. Amsterdam: Rodopi
Bibliography


APPENDIX 1D

MAURITIUS INSTITUTE OF HEALTH
POWDER MILL- PAMPLEMOUSSES
MAURITIUS

R/95/MRU/COLL.3

28th February 1996

Miss Huguette Comerasamy
PhD candidate,
4 Greenpark Court
Bridgewater Road
Wembley
Middlesex HA0 1YF

Dear Madam,

Thank you for your letter of the 15th February.

I am pleased to learn that you plan to travel to Mauritius by the end of June this year in connection with your study on midwifery education and practice. The Institute will be happy to provide assistance and support in your research work.

Looking forward to meet you soon.

Yours Sincerely

Dr. J.C. Mohith
Executive Director