Exploring Symbolic Exchanges in Childbirth:

Cultural Implications for Midwifery Education and Practice

Volume II

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Chapter 11

Cultural Implications for Midwifery Education and Practice

It is increasingly important that the midwifery curriculum is grounded within an understanding of social and economic history of our times and the salience of markets, privatisation and globalisation. Formal education does not function in a vacuum and a curriculum is always performed in a physical, social and cultural context that is subject to both internal and external forces as described in the preceding chapters. Curriculum is thus contextually shaped and globally influenced.

Midwifery education is defined as the study of childbirth and midwifery issues aimed at developing the theoretical, conceptual and practical framework of, and for, the education of practitioners of midwifery. In the past few years the shift toward delivering the midwifery curriculum in or affiliated to universities is part of a general shift in the changing role of higher education worldwide. There are eight key concerns that impact upon and shape the nature of midwifery education and the curriculum to varying degrees in all five case study countries, namely Ghana, Malawi, America and England. These are:
Global interconnectedness: Local reframing

- **Women's issues**: status - degree of power and authority; choice; control, needs and wants; wealth-poverty; health
- **The communication revolution**: mass media; World Wide Web and Internet; availability and easy access to information for self-diagnosis
- **Economics & marketplace**: global corporations - competition; mobility of work force
- **The knowledge explosion**: scientific and technological developments; emphasis on research & evidence-based practice; specialisation
- **Ecological imperatives**: planetary resources and hazards; pollution
- **Increasing pluralism**: shift from community based focus to individual focus;
- **Search for meaning**: personal achievements; cultural alignment to particular cultural types
- **Societal changes**: toward increasing litigation; desire for the exotic; desire for modernity; risk society

These factors have been examined in the preceding chapters and so are not rehearsed again here. Instead, the following questions are addressed.

What are the cultural implications for midwifery education?

What does this mean for the development of educational programmes for midwives globally?
Cultural Implications of Modernity for the Education and Training of Midwifery Practitioners

Modernity and education have developed simultaneously, acting on and reacting to each other. The technological development that ushered in the modern age created the demand for high levels of education; education, in turn, has trained people not only to use technology but also to go on and develop new and higher forms of it. Thus, modernity's technical foundation both creates and depends on advanced systems of education, which in turn, create and depend on technology.

As societies develop and change under the impact of globalisation and new knowledge becomes available, the content of education likewise changes. In the modern world the greatest advantage a nation or individual can possess is access to and participation in symbolic-analytic services. Symbolic-analytic services are problem solving, problem-identifying, and strategic brokering activities in which symbols - data, words, and visual representations - are manipulated. As Reich explained, symbolic analysts:

simplify reality into abstract images that can be rearranged, juggled, experimented with, communicated to other specialist, and then, eventually transformed back into reality. The manipulations are done with analytic tools, sharpened by experience. The tools may be mathematical, algorithms, legal arguments, financial gimmicks, scientific principles, psychological insights
about how to persuade or amuse, systems of induction or deduction, or any other set of techniques for doing conceptual puzzles. (Reich, 1991:178)

This type of work is performed in a variety of occupations in science, engineering, law, public relations, management, energy, architecture, agriculture, marketing, the media, higher education, and elsewhere. Practitioners in these fields find ways of increasing efficiency, yield greater resources, save time, or create something new altogether. While most countries, including America, tend to teach a prescribed standardised curriculum, Reich found that the best students in America were better prepared for symbolic analysis than in any other country in the world. Although in mathematics and science American high school students often lag behind their counterparts in Japan, South Korea, Great Britain and Germany.

Embryonic symbolic analysts learn to construct meanings for themselves; provide their own interpretations; organise information; and identify new solutions, problems, and choices. This entails, states Reich (1991:229), refining four basic skills:

- abstraction,
- system thinking
- experimentation
- collaboration.

Abstraction is the ability to take disorganised information, integrate and assimilate it, and shape it into a workable and perhaps original pattern. Students are not given pre-
digested information nor are they required to commit it to memory in order to become adept at abstraction; rather they learn to interpret data and give meaning to it themselves. To promote this process the curriculum needs to be fluid and interactive.

Instead of emphasising the transmission of information, the focus is on judgement and interpretation. The student is taught to get behind the data - to ask why certain facts have been selected, why they are assumed to be important, how they were deduced, and how they might be contradicted. The student learns to examine reality from many angles, in different lights, and thus to visualise new possibilities and choices. The symbolic-analytic mind is trained to be sceptical, curious, and creative. (Reich, 1991)

Another characteristic of symbolic analysis is system thinking. This is an extension of abstraction in that it involves the ability to visualise how the various components of an object, issue, or problem are linked together. Thus the symbolic-analyst tries to discern "larger causes, consequences, and relationships" (Reich 1991:231). In system thinking, students are taught not to immediately solve problems that are presented to them, but to examine why the problem arises and how it is connected to other problems. Solutions can therefore be more effectively determined, as they are based on a consideration of a broad range of possible variables, influences and outcomes.

System thinking and abstraction are learned through experimentation; students test and explore various possibilities or outcomes, noting similarities and differences, in seeking the best possibility or outcome for a particular situation. Finally, notes Reich, there is
the capacity for collaboration, or the ability to communicate abstract concepts, to negotiate needs, to seek and accept criticism from peers, and to work as part of a group. In this model learning does not cease on graduation, but continues on the job since much of the work symbolic analysts engage in is oriented toward creative problem solving and gaining new insights.

America does not have a monopoly on symbolic analysts; however, the direction of the most modern forms of education across the globe appears to be toward producing more symbolic analysts. Modernity rests on advanced educational systems, and the social change it produces is based on the production of new knowledge. Thus modernity and education are invariably linked; one builds on the other. In all societies education has become increasingly important. Advanced nations, in particular, have found that ever-larger proportions of their population are employed in jobs that require well-educated workers.

In the past, such mechanistic interpretations of human behaviour, promoted by sensualism, associationism and behaviourism, have compartmentalised human activities, and consequently have led to the development of separate sciences, such as biology, psychology, and sociology. Implied in these approaches is the tendency to segregate parts and components analytically. Little attention was given – and little success was achieved – in putting the pieces together again. The main task of science was seen as breaking Humpty Dumpty apart (Riegel, 1978:15).
Modern midwifery theory and practice have been rooted in the biological sciences and the enhanced understanding of these has had a major impact upon the organisation and delivery of midwifery and obstetric care.

*Midwifery education and practice: socio-cultural determinants*

Midwifery education and practice has, until latterly, been more or less confined within the boundaries of the national context. Granted there has been sharing across boundaries and the influence of the World Health Organisation and the International Confederation of Midwives cannot be denied. But generally speaking, apart from the influence of midwifery consultants, under the auspices of such global agencies, on the developing world, there has been little interconnection between midwifery programmes of study. The formal, organised midwifery curriculum has generally been influenced in the main, by local and national considerations and by statutory requirements. In the West, under the influence of science and technology we have seen an increasing industrialisation of childbirth along with increased instrumentalism that has, in effect, created a distance between midwives and the women they attend (figure 11.1).

One of the prime effects of this distancing has been to deprive midwives and women from developing and understanding the ways in which women's bodies work. Midwives working in the hospital context no longer have time to devote to a single woman throughout her labour and delivery to generate a personal theory of the interconnectedness between the woman's body and that of her unborn child.
Figure 11.1  Culture and the Curriculum

Under the conditions of globalization there is a counter mechanism at work

Global communication systems are putting midwives and women in touch globally

Challenging medical model of body and childbirth

Formation of global diaspora of midwives – imagined community developing

Allowing sharing of values and ideas – observations about birth

Generating global data

Recreating and creating knowledge and personal theories

Modernity

Move in values from knowledge of tradition to knowledge of effects – knowledge of technology

Breakdown of communities and support structures

Distancing of women and midwives from knowledge of natural processes

Leading to closing and narrowing of focus in medical model of childbirth

Increased instrumentalism

Industrialisation of childbirth

Creation of a Global Formal Curriculum

Organised Model

Organisations control activities and knowledge of women and midwives

Dis-organised Model

Dis-organisation model – knowledge and activities are controlled by women and midwives but they have to act outside accepted formal structures and so represent danger to established model of education and practice
Most of the nascent midwife’s knowledge comes instead from de-contextualised theory leading to a narrowing of focus and a closing of the mind (figure 11.2) which may be influenced by experiences of horizontal violence (see McCall, 1996; Leap, 1997). We are experiencing a shift in values from knowledge of tradition to knowledge of effects and knowledge of technology along with the breakdown in community and support structures. As the medical model of childbirth is transmitted globally, these effects will multiply as health institutions and hospitals, gain increasing control over childbirth, women and midwives.

There is, however, a growing counter-current in that under the conditions of globalisation with its increased communication networking, midwives, or at least those who are able to access the global networks, are communicating directly with each other — by-passing official institutions and developing a knowledge-base that is not necessarily sanctioned or authoritative. Nonetheless, the mere act of writing down and sharing information about practice with other midwives and women around the world is, perhaps, beginning to formulate a legitimate body of knowledge that challenges the dominant medical model. Certainly, questions and challenges to the medical establishment are being put forward both by women and midwives, one only has to look at the midwifery web pages to appreciate the extent of this activity. In consequence, what we are beginning to see is a global hidden curriculum developing that is beyond the control of socialising agents, but generally, those midwives and women who wish to practice alternative approaches to childbirth in America and England, still have to do so outside the mainstream organisations. But this might be not be possible or indeed, might be inappropriate in the context of the developing world.
As the midwife becomes increasingly removed from the community context of childbirth she loses the integrated knowledge of the unity of mind and body. She gains more technical knowledge but loses social knowledge. The result is a closing of the mind – if it is not directly relevant to the physical work of childbirth then it is irrelevant.
Making Midwives: TBA Training

Governments and development institutions view the training of "TBAs" as an aspect of health service delivery. Accordingly, they define birth assistance as "medical", whether or not the people involved define the practices associated with birth in terms of health and sickness. In Ghana, Malawi and Malaysia women who perform a ritual service become defined, for the purposes of training, as midwives who perform medical services act (see appendix 5 for objectives of TBA training in Ghana for example). A spectrum of birth-related concerns, spanning issues of ritual pollution, the vulnerability of pregnant women and infants to witchcraft, to issues of modesty and embarrassment are reorganised in the framework for training TBAs. Within local understanding, for instance, the main role of the woman who cuts the birth cord may be to carry away the ritual pollution associated with birth. For many Ghanaians and Malaysians ideas about witchcraft and pollution are as real as a placenta.

In effect, training programmes redefine the practices of the trainees. Birth is easier to speak about and speak to than African and Malaysian notions about spirits that cause illnesses, for instance. Everyone can agree, for example, whether or not the placenta has been delivered, while no such agreement is possible for the chasing away of ghosts. There is predictability to the known events of pregnancy and childbirth and concreteness to many of the techniques for dealing with it. Because birth assistance involves many actions externally manipulating parts of the body, it is easier to collect statements from women about "what we do." TBA and midwifery training programmes
work with a presumed common and obvious concern with the management of pregnancy, labour, and birth.

The development perspective, consequently, regards the traditional midwife’s role only as a potentially medical one, whose main purpose is to safeguard the health of mother and child. In general, all practices are treated as if they fit a common idealised role of "midwife," even though it is well known in international policy circles that not all "birth attendants" fit the image of the midwife who cares for a woman throughout the pregnancy, birth, and postpartum period. Training programmes are nevertheless structured so as to re-create systematically the trainees in the image of the traditional midwife. Trained TBAs and midwives are fashioned as technicians and the varying social, emotional, protective, or polluting roles the trainees might actually be playing are subsumed under the role of managing birth itself.

The "obviousness" of this common reality is deceptive. Different cultures understand, organise and manage birth in their own way (see Jordan 1993). Anthropologists insist that the social aspect of birth can never be separated from its physiological aspect, for the physical events of childbirth always take place within a shared understanding of "the best way, the right way, indeed the only way to bring a child into the world" (Jordan, 1993:4).

TBA training, however, is based on the notion that the "cultural" dimension of childbirth can be separated from the "physiological" dimension. While careful not to interfere with beliefs and customs if they are deemed "harmless," they introduce a
biomedical understanding of birth through the back door by focusing on a physiological
realm separated from social considerations. Training programmes for midwives as a
whole convey a biomedical ideology not simply through the theory of physiology and
disease causation they teach but also through the insistence in the format of training
themselves that the physiological be clearly separated from social, moral, and religious
concerns. These are the very people who take responsibility for training TBAs. The
medicalization of birth attendants, tacitly enacted through training, requires trainees
themselves to fragment their practices, to distinguish between the "medical" and the
"social" aspects of what they do.

There are aspects of Ghanaian, Malawian and Malaysian women's practices that are left
out or marginalised in training programmes, precisely because of the importance placed
on techniques and physiology. Nowhere is there a space created for the emotional and
social significance of birth. This accounts, I think, for some of the astonishing
omissions in discussions of "local ideas and practices." The many ways Ghanaians, for
example, give special care to pregnant women, new mothers, and babies vanish in
development accounts. How they show care can only be grasped within the framework
through which they themselves perceive dangers and problems. An example from
fieldwork is captured in the following description of a birth I attended in Ghana.

_Crouched in the corner of the dark hut, the TBA sat and waited quietly. I sat in the
opposite corner and watched, silently. The woman lay on her side, labouring
without a sound. Outside we could hear the singsong voices of the women as they
stirred the pot of porridge they had prepared for the labouring woman to keep her_
strength up. They were waiting for the birth and from time to time one or other of them would come into the hut to quietly give support. Through the touch of a hand, a stroke of her brow, giving a sip of water or porridge, they expressed their caring, their concern and their connectedness to the event. This sisterhood was an important part of the ritual of birth. It seemed to be significant in relaxing the women and perhaps even reducing her pain. The men were not present – this was women's work. The TBA did not examine the woman or take measurements of her pulse or blood pressure every fifteen minutes, there was no external monitor beeping away in the background. The scene was startling in its quiet peacefulness—its lack of intrusion. (Dora's birth experience- Ghana, 1991)

Cross-cultural research on childbirth has shown just how historically specific the notion of medically managed childbirth is (see Jordan, 1993). A medicalized construction of pregnancy and childbirth dictates that these states must be managed and monitored by specialists. In North America and the United Kingdom, in fact, women who give birth without professional management are regarded as negligent (Tsing 1990). Furthermore, obstetricians tend to treat women in labour as unruly 'workers' who must be monitored in case they damage "the product" (Martin 1987). Emily Martin has shown that the time-management and efficiency approach that breaks the process of childbirth down into stages facilitates the comparison, evaluation, and control of women in labour. Tacitly, childbirth that is not supervised by a trained expert is considered suspect, both in the United Kingdom and the United States.
These deeply ingrained cultural assumptions are being transferred to developing countries in notions about how birth is best managed. The fact of expert management itself may be as important to this moralistic sense of what is "best" as the actual techniques that might have positive effects on maternal and infant mortality. TBAs are looked to as the experts who can adopt the role of manager. Public health nurses on behalf of development institutions can supervise their practice, in turn.

Finally, the structure of training programmes itself communicates certain messages to the trainees. For Ghanaian, Malawian and Malaysian women, training programmes are features of a wider world of "development" and "modernity." They are but one aspect of a larger process in Ghana, Malawi and Malaysia by which being "modern" becomes associated with a higher social status (see Pigg 1992, 1993). When women attend training programmes they learn what "modern" people are supposed to do and say. This knowledge is authoritative for these women not simply because the trainers present it as such but because training comes out of institutions that are creating an authority for "developed" ideas overall. What is learned in training has more relevance in the context of status negotiation, where it matters socially that one appear "developed," than it does in the contexts in which births actually take place. Training programmes thus likely widen women's sense of the disparity between "modern" practices and their (now devalued) local realities.

In considering how authoritative knowledge is displayed in interactions, we need to look beyond the rooms where birth takes place to the other sites where authority is produced and reproduced. Training is one such site, to which I turn next.
Knowledge Production in Development Ideology

The irony here is that in the attempt to create programmes tailored to local conditions, a great deal of what local people think, believe, and do is filtered out through the circulation of information about the "local" in the apparatuses of development knowledge. The authoritative knowledge about childbirth communicated in training is linked to the production of authoritative knowledge about "local ideas and practices." It is therefore important to understand the process that produces the knowledge of "traditional beliefs and practices" on which "culturally appropriate" health development is based. The discursive regulation of what can be said in development begins in the regulation of what can be known.

The research techniques used to gather baseline information and evaluate programme effectiveness already screen what is considered relevant and irrelevant information. Questionnaires, surveys, and focus groups are designed with certain ideas about "traditions" already in mind. In this process, a mobile, dislocated concept of tradition comes to be filled with the facts from Ghana, Malawi and Malaysia.

The authoritative knowledge about local practices that is presented in reports fundamentally alters these practices by inventing new terms in which they can make sense. Facts are selected and rearranged in a way that produces an image of "local tradition" for development observers that not only distorts local practices out of recognition but also virtually ensures that local ideas are silenced and shut out of
development. In the process of collecting, summarising, and analyzing data some aspects of local reality pass easily from one stage of reformulation to another, attaining the status of information about local ideas and practices, while other aspects remain silent and invisible. One thing that occurs to me is how or whether the discourse of anthropology has informed ideas about traditional birth practices. Western anthropological models tend to focus on concerns such as prohibitions and rituals, that is the classic subject matter of anthropology, and not on other issues. Could it be that anthropology has influenced what is looked for in terms of local practices, for example, because Evans-Pritchard (1972) talked about Azande witchcraft, everybody else looks for witchcraft, even if it is 'not there' or could more sensibly be described in another way.

The first question most development observers ask about a custom or a practice is "Does this do harm?" This is of course an important question to ask. But being too quick to seize on "harmful customs" blinds us to the wider context in which these practices occur. These are then readily translated into training programmes.

There is more than insensitivity or misuses of words at stake here. Translations circulate endlessly through what teachers ask students and what teachers hear students say. Training occurs, moreover, in contexts in which public health trainers, whose native language is not English, are taught using English terms specific to development jargon (for example, TBA), oral re-hydration therapy (ORT)). These workers then use this terminology with villagers who consult them, turning abbreviations such as TBA and ORT into words. Even when specific indigenous words are retained, their meaning...
inevitably changes when interspersed in the English utterances of a foreign official, or institutionalized in the development office jargon of Ghanaian, Malawian and Malaysian staff.

The issue is not one of correctness or authenticity in language use but of social relations, institutional procedures, and power. Discourse has concrete consequences. Villagers find themselves having to interact with development institutions that have structured their programmes around static and distorted representations of "tradition." To obtain desired resources they have to construct themselves in the way development has 'imagined' traditional people to be. Development persuades local realities to conform to development categories, and only those aspects of local reality that can be successfully disguised in these categories can be incorporated in programmes and planning.

Paradoxically, development practices of knowledge production help to perpetuate the "gap" between planning and local realities that so concerns development planners. This gap is the product of systematic techniques for framing and understanding "local ideas and practices." The language used in development work becomes entangled with actual institutional practices, and together they reiterate what Wood (1985) called the "delinking" of people from their social context. This "delinking" has an effect on several levels according to Pigg (1995). Noticeably, it facilitates bureaucratic administration by narrowing the vision of complex realities. Yet, at the same time, the resultant simplification that facilitates administrative plans generates problems of programme implementation in the field. When development programmes based on decontextualised, distorted notions of "traditional ideas and practices" are set in motion in actual villages
they face numerous practical problems. Important messages fail to be communicated effectively. Even programmes explicitly planned with "traditional ideas and practices and "the local level" in mind fall far short of "bridging the gap" in the way intended. The decontextualization resulting from the practices of translation detailed above detracts from the programme effectiveness even as it serves bureaucratic purposes. It is difficult for development institutions to really resolve these contradictions, for "delinking" also serves a greater ideological purpose by positioning development itself as transcendent and authoritative.

This heightened focus on TBAs is a function of the distinction made in development discourse between its own role as a catalytic force coming from "outside" and the inner world of closed traditional societies (Pigg, 1995). The picture of global social differences created by implication a role for mediators and cultural brokers. TBAs were imagined to fit perfectly in this interstitial space. They had similar concerns and interests, allegedly, as fellow health promoters, but were dissimilar to educated professional practitioners in that they were characterised as trusted cultural insiders who were able to carry development messages into the unseen heart of traditional societies. The shift toward treating traditional practitioners as a resource, was part of the cycle in development through which past mistakes became lessons that continually provided new and improved solutions. It therefore increased the appearance of progressive advancement on which development rests. Regardless of where people are located in the world, their experiences tend now to reflect the culmination of a shift in their consciousness and who almost all now view themselves in direct relation to an explicit image of modern life.
Under the collective rationality of the development model both policy and implementation, subsume "local tradition". Training programmes, while aiming to enhance the expertise of local practitioners, require that participants understand that whole areas of their experience and knowledge are irrelevant to the development context. Local practitioners are both portrayed as, and made into, people whose knowledge has a limited, local importance.

Development programmes seldom work as imagined. The usual response to the disjuncture between the assumptions behind development programmes and the realities of local life has been to instigate more and better research about local ideas and practices. Even when such information is provided, however, it is rarely used effectively, as Justice's work (1984, 1986, 1987) on development bureaucracies has shown. The persistent assumption is that adjustments made to the development model would resolve its inherent problems.

Pigg (1995) suggested that the development paradigm, with its prescribed formulae for cultural beliefs and practices, should be abandoned. Instead, other vocabularies for framing concerns about health and culture should be developed. In rushing to provide better "sociocultural information," researchers and planners fail to question how the very definition of "sociocultural" is constrained by development interests. The language used by development agencies is produced by and reproduces a power asymmetry that becomes more entrenched every time development visions turn into policies and policies turn into actual programmes. It is past time to consider that development
discourse also produces distinctive problems, and in fact these problems are necessary
to development power and must be perpetually re-created to sustain it.

Development mediates the circulation of differing medical modes, ensuring that those
deemed traditional remain local, limited, and context-specific while modern medicine
acquires a global and universal role. This is how cosmopolitan obstetrics becomes, in
Jordan's (1993:199-214) words, a cosmopolitical obstetrics whose authority rests on a
certain distribution of power. At present in mainstream international health development
other modes of knowledge are recognized as "different" and granted a limited sphere of
authority within the bounds of "tradition," but development nevertheless subsumes these
other modes of knowledge under the authority development claims for itself. This
authority comes not, as development rhetoric implies, from the presumably self-evident
superiority of the medical solutions it advocates. Rather, development has authority to
the extent that it is able to make its solutions -- whatever they might be -- appear self-
evident. The language practices of development systematically dismantle a socially
animated local reality, rendering its pattern as a whole inexpressible within development
terms. Development appears as a naturally transcendent, necessarily global institution
juxtaposed against limited, fragmented, decontextualised "local traditions." It is from
this constructed position of transcendence that development claims the authority and the
obligation to provide solutions for certain societies.

Development discourse presents a certain vision of the way social difference is arranged
in the world. In emphasising the difference between "traditional" and "modern," it
removes differences within and between the societies labelled traditional. On this basis
development powerfully channels the circulation of information. It is through development's mediation that the "lessons" from a programme in one country are transported and applied in another. When this happens, it is not a pure "Western" framework that is being imposed on a given locale in Asia, Africa, or Latin America. Rather, what is transported and put in place, as observed by members of the focus groups and supported by follow-up discussions with, is a model created out of the relationship between the "modern" and the "traditional". (Focus Groups - Ghana 1991; Malawi 1991; Malaysian Focus Group, 1994; Priya, 1997 (telephone interview); Ghanaian, Malawian and Malaysian midwives in Oslo, 1996; and Manila, 1999).

For the particular answers development offers to be inevitably the right ones, all local problems must be understood as variations of the same problem. The notion of "the traditional" is therefore essential to development discourse, as the common denominator of disparate situations that development can bring under control. Development institutions (and by implication, the interests served through their power) establish their right of entry into local worlds by creating a burgeoning model of modernity.

The authority development (and its experts) has to describe societies, name problems, and propose solutions comes from the aura of truth that development agencies create (Escobar 1988). So, for example, the term "TBA" appears not only to be efficient but also quite innocent. It is a term that allows varieties of the same kind of practitioner to be conveniently grouped together in development rhetoric. Planners argue that it is necessary to translate from local terms such as those for the many Ghanaian, Malawian and Malaysian forms of "birth assistance" into more general terms; otherwise, it is said,
information about local conditions would be impossible to organise and manage. This in fact is exactly my point: without such translations local reality would literally be closed to the power arrangements of development management.

Midwifery knowledge, like other forms of knowledge, is socially constructed to perpetuate power positions and elite groups. This standpoint advances the belief that there are many ‘truths’ and that each has equal value to what has been traditionally offered in midwifery education as ‘truth’. Disciplines by their very nature profess to represent objective and universal truth and their claim to universalism is only evident because the dominant cultures are, in effect, exporting knowledge-as-truth packaged as a commodity since they have the technical resources to do so. The notion of universalism in this context is not based on shared and agreed perspectives but on an assumption that different groups will either be assimilated into the dominant model or use it as an ideal model for practice. Even if the general aims of the curriculum in economically deprived countries are determined locally, precise curriculum objectives and, moreover, the materials to be used, are on the whole, imported along with specialist consultants to assist in curriculum design and delivery.

The disciplinary context for knowledge production is not ‘innocent’, objective or value-free. Globally, the disciplines form a power complex mandating particular canonical texts, ways of knowing, and institutional settings as the prime condition for knowledge production. The power of advanced societies such as America and those in Europe over developing worlds has become one based on knowledge production and dissemination.
Increasingly midwifery education is moving into higher education institutions and separating itself from the somewhat pejorative image of hospital-based training schools. In all the case study countries midwifery programmes were linked to or embedded in higher education institutions. These programmes are in alignment with the values, beliefs, and status consciousness of mainstream society. They are culturally thought of as the entry criteria for the profession. As a socially valued educational pathway, state and professionally approved programmes carry concomitant benefits, including social recognition and prestige. State sanctioned midwifery qualifications and awards are the gateway to advanced degrees, which bring prestige, possibly greater remuneration and empower their beneficiaries to practice midwifery, teach new recruits, to effect changes in practice, influence legislation, and to carry out research. In general, it appears that the higher the level of university training of a group of professionals, the higher the social prestige of the entire profession. Being present on a university campus enables students to learn about and participate in a wide variety of learning experiences and gives them access to excellent libraries and other resources.

While didactic learning is usually primary in universities, midwifery training, like training in other health care professions, always includes some form of preceptorship, in which students are exposed to one-on-one experiential learning with more than one preceptor. Because the clinical parts of university-based midwifery training are mostly
carried out in hospitals, students become exposed to and develop expertise in dealing with individuals of diverse sociocultural and economic backgrounds, a wide range of birth complications and unusual health conditions, along with the latest medical technologies. Educators generally work with students to help them develop a critical sense of which technologies have efficacy, under which circumstances, and which ones do not.

A criticism often levelled at university training is that its standardization stifles individual creativity (Bloom, 1987; Kliwer, 1999). Davis-Floyd (1998) did not find this criticism to apply to the nurse-midwifery students she interviewed in America. In her conversations with them, it was clear that they were accustomed to thinking "out of the box." They reported that this kind of unbounded thinking is strongly encouraged by most of their teachers. Nevertheless, a very real problem to university-based nurse-midwifery education in that training offered in large cultural institutions such as universities will inevitably reflect hegemonic philosophies and practices. In the cultural realm of birth, the patriarchal medical model is hegemonic; midwifery training carried out in such institutions will inevitably incorporate many elements of a highly medicalized, patriarchal, and technocratic approach to birth. Thus, midwives will often be required to intervene in birth in ways contrary to the midwifery model in order to successfully graduate and practice.

According to Spring and Stern (1998) horizontal violence and abuse is rampant within the nursing profession and I would argue that it is highly likely to be the same in midwifery. It is too often unidentified, and tolerated. This issue transcends the personal
and has become widespread and institutionalized in some venues.

For Spring and Stern (1998), the semantic difference between violence and abuse is an important one. Generally speaking, the word violence conjures up a clear image of the behaviour and the effects. It is easily recognisable and definable. It connotes a physical injury or hurt inflicted by another. Often, not always, there are visible indicators. Horizontal abuse occurs concomitantly with horizontal violence and although abuse can and does also refer to physical maltreatment, it more strongly speaks to the intuitive arena. It can occur without the component of violence. Its target is the place where individuals emotionally exist and attacks the true essence of our humanness. It is much harder to 'see' the wounds, measure the injuries, and statistically chart them. It is behaviour that is designed to humiliate, degrade and injure the dignity and worth of the individual.

In short, horizontal midwifery violence is an inter-group manifestation of conflict that results from oppression. Every colonized group\textsuperscript{12}, in other words, every group in whose soul an inferiority complex has been created by the death and burial of its local originality, finds itself face to face with the language of the 'civilising' nation or group; that is the culture of the 'mother' country. The colonized person is elevated above her jungle status in proportion to her adoption of the mother country's cultural standards (see Fanon, 1967).

\textsuperscript{12} Midwifery, in this context, is seen as being colonized by science and medicine.
The behaviour of the oppressed that is often directed towards other individuals in the group that would be totally inappropriate if that same behaviour, action, word, tone, attitude, judgement, was directed towards a woman in childbirth.

The politics of oppression, according to Leap (1997:689) include recognition that oppressed groups appear where there is inequalities, where hierarchy assure divisions among the oppressed, and "where certain members of the oppressed group can be enticed or intimidated by fear of losing or sharing perceived power, into serving as the tokens on behalf of the interests of the oppressor".

**Why does horizontal violence exist?**

1. From the point of entry into Midwifery Education the focus is on the woman and her needs. Midwifery is chiefly concerned in how women's needs are met. The humanity of the midwife, with his/her own potentially conflicting needs is seldom, if at all, attended to. The questions about the midwife are not formulated and the issue is rarely raised. The midwife learns through his/her socialisation not to have any needs of his/her own. If by chance, he or she does, the need or want comes second. Therefore, midwives are socialised from the onset to be other-directed (specifically woman-oriented). Midwives often come from families of origin that have trained/educated them well. A high percentage of midwives have come from situations in which they learned to be "caregivers" to survive during childhood. Midwifery provides them with an opportunity to do this professionally. The more
outer-focused a midwife is, the increased rewards he/she receives within the profession.

2. Many midwives experience injustices daily. Generally being outer-focused they seldom stop to evaluate the impact upon their emotional well-being of the behaviour to which they have been exposed. Many have become desensitised to the effects upon themselves.

3. Midwifery remains a predominantly female profession. As such, it trails far behind the progress women have made in society as a whole. The profession remains oppressed (Freire, 1997). Midwives, at the time of this thesis, continue to fight to establish their identity, value and worth. Midwives continue to struggle to find their voice. Too often, they feel helpless and powerless to affect change. The result of this is to turn their own negative feelings of anger, frustration, and self-criticism on colleagues in a displaced effort to gain some power. It is an adaptive behavioural response.

4. Hastie argued that "midwives eat their young" (1995). This has been passed down from one generation of midwives to another. As such, each of us was socialised into a culture in which this behaviour has a long tradition. Midwives themselves, however, seldom recognize horizontal violence and abuse among their group (Leap, 1997). If it is recognised, they often do not object to it. Midwifery professionals who do recognize and object are all too often responded to with comment such as: "You're too sensitive!" "Can't you take a joke?" "He/she didn't mean anything by it" "Don't take it so seriously." These responses in themselves are examples of
horizontal midwifery abuse. They are in the form of words. There are many other shapes and forms - among them are actions, looks, gestures, and judgements.

On occasion others may use midwifery horizontal violence to maintain and foster their own agenda. Horizontal abuse and violence, however, is so familiar to the vast majority of midwifery professionals that it is taken for granted as normal behaviour. Thus midwives use denial, minimisation and rationalization to maintain the status quo and ignore both the victims and the effects.

The mistreatment of midwives by other midwives has been institutionalised to the extent that it’s destructive effects and long term consequences for the profession are no longer recognised. It robs midwives time, emotional energy, motivation and creativity that could be devoted to enhancing and recreating themselves and the profession. These are the very practitioners who influence the context and outcome of childbirth in all the countries within this study. Moreover, they are in a prime position to transmit their understandings and practices globally. It is naïve to think, as Leap (1997:689) points out, that a feminist analysis of horizontal violence in midwifery is sufficient to change the context in which we work. Leap considers that the key to moving beyond a midwifery culture where horizontal violence persists can be found in developing models of midwifery care that offer autonomy and positive interprofessional collaboration. She considers that such a model would engender increased self-esteem for midwives and break down the hierarchies that keep us trapped. Brodie (1996 quoted in Leap, 1997) found that where midwives work in models of care that allows a closer relationship with
women, much as they do among the Amish or traditional midwives in Africa, the needs of the women are seen as paramount and there is a shift of allegiance away from the institution or professional group.

Concluding Discussion: In place of development - dialogue not training

I do not believe that it is a mistake to try to work with women and midwives in other countries. My research has led me to some ideas about what working with midwives could be like. Most importantly, I am convinced that paying lip service to cultural appropriateness is insufficient. I agree with anthropologists that attention needs to be paid to "local culture," but we need to think carefully about how we pay attention and how we translate between cultural understandings of birth. It is important not to generalise about "tradition" but to talk instead about particular values, situations, and practices as they appear in specific contexts. This does require much more work and knowledge on the part of anyone who would attempt to be a professional expert on midwives and childbirth in many countries. It also requires a different, more holistic kind of research on childbirth.

Generic plans are of limited use, and they can never be a substitute for place and context-specific birth activism. What would a "training" organised around the understandings of birth in a Ghanaian, Malawian or Malaysian, community look like? Moreover, and perhaps more importantly, in multi-ethnic communities what would childbirth look like in perhaps a Native American Indian, Afro-American, Asian, Afro-Caribbean, and so on, community? It would have to be a dialogue, a discussion rather
than "training." It would not begin with a biomedical model of managed obstetrical care that is then adapted to certain local idiosyncrasies. It would have to begin with the knowledge, values, and concerns of the women involved instead of with the assumptions that their understandings are inadequate and deficient. It would have to take into account the politics of gender and generation in families and the politics of class, caste, and ethnic relations in specific communities. It would not necessarily begin by targeting birth attendants in developing countries, but educationalists, academics, researchers and midwives in more advanced societies that peddle their wares abroad.

Biomedicine may have some answers that are good for everyone in the world, but it does not have all the answers. We have to be more humble about biomedical certainties, just as we have to avoid romanticising "indigenous knowledge" as unequivocally good. Biomedical standards change but the recognition that they do change is often missing when health development efforts take on an evangelical certainty vis-à-vis the practices in non-western societies. How certain are we about what is "best"? If developing countries were in a position to rectify North American or European childbirth practices, which of our customs would they most want to alter? The one-way flow of information in development may be harmful to us all. Which leaves us with the question:

Some universities are globalising and offering standardized curricula by a number of modes including distance and electronic vehicles. But is it just another form of cultural, economic and in the context of childbirth, medical imperialism?
Chapter 12

The Midwifery Curriculum

A Selection from Culture? (Lawton, 1973)

In the previous chapter, we considered the cultural implications for midwifery education and practice, which highlighted some of the emerging curriculum issues against the backdrop of a new world order that proclaimed a determination to work for, among other things, common interests, interdependence, and cooperation between nations to eliminate gaps between 'developed and developing' countries. The United Nations (1974) worked to ensure accelerated economic and social development, to correct inequalities and redress existing injustices to ensure peace and justice for present and future generations. These far reaching objectives set in train a development agenda which, for example, saw the rise of education consultants working with different developing countries to create 'modern' curricula to meet the targets established by the various donor agencies, such as the United Nations, World Health Organisation (see for example, WHO, 1975, 1978, 1986) and the World Bank.

In this chapter I build on the themes raised in the previous chapter and begin to examine the nature of the curriculum as seen in the different countries explored. Threaded through the chapter are the continuing theme of cultural types which has been developed further to consider education and curriculum planning from the perspective of hierarchists, entrepreneurs, isolationists and egalitarians.
Curriculum as a selection from culture: From a content and hierarchist perspective

When asking the question to what extent is midwifery knowledge universal, one has to identify what is common to childbirth in all cultures. In my own illustrations from Africa, Malaysia, America and England, I would argue that not even the birth processes themselves are common and that birth is ultimately a culturally defined activity dependent on the socio-economic and political environment in which birth takes place.

Kelly argued that a difficulty arises for those who wish to base decisions about content of the curriculum on considerations of the culture of the society when we attempt to state specifically what that culture is (Kelly, 1989:36). In modern advanced industrial countries no one pattern of life could be identified as being the culture of that society. Most modern societies are pluralist in nature since it is possible to discern in them a number of different and sometimes conflicting cultures or subcultures. Moreover, it is important to recognise that quite apart form subcultures being different to each other, most individual members of society will participate in more than one of these subcultures at different times or in different aspects of their lives. Thus not only do most modern societies contain different ethnic groups, each with their own traditions, beliefs, customs and so on, but they also contain different religious and social groups, and groups that come together for many different purposes with shared or professional interests which will have their own norms and own culture.
Increasingly, in developing countries such as Ghana and Malawi, urban centres are becoming increasingly pluralistic. So there is not only the situation in Ghana, for example, where there are more than ninety different tribal groups, all with their own cultural norms, customs and language, settlers from other countries have moved into the cities to work bringing their own cultures. So we see Asians, Europeans, South Africans, Americans and so on, creating a cultural chop suey. What is of concern is the implication that even if it is believed that the content of the curriculum should be based on culture, it will be impossible to assert with any real expectation of acceptance what that culture is and therefore what the content should be. All that this line of argument achieves is to demonstrate that the curriculum is a battleground of competing ideologies.

The problem is exacerbated by the fact that societies are far from static and this implies that culture is forever in a state of flux. Furthermore, western cultures are characterised not only by rapid change but also by deliberate change (Taba, 1962:54). A number of different implications for the development of a midwifery curriculum arise from this. The first emphasises the impossibility of the task of deciding into which aspects of culture the midwives should be initiated.

The second concerns the question about what should be the relationship of the university, and specifically, the midwifery curriculum, to the greater society. Is it the university’s role to transmit culture or to transform it? Third, it raises questions about what universities should be attempting to do for their students in a society that is subject to rapid change. Should the university be engaged in skills training or education
for lifelong learning? Clearly, in the current phase of rapidly changing social and professional contexts, practitioners need to be equipped to cope with it and even exercise some degree of control. This would suggest that universities should go beyond the notion of initiation of midwives into the culture of the community. To go beyond socialisation and acculturation, to the idea of preparing practitioners for the fact of social change itself, to adapt to and initiate changes in the norms and values of the community. This requires that practitioners be offered much more than a selection from the culture, even if this could be identified and sufficiently well defined for adequate educational practice. It also suggests that instead of endeavouring to promote in the midwives a body of knowledge, we should be concerned to plan the curriculum to address the capacities we are seeking to develop in them.

If this is the only viable role universities can take in a rapidly changing universe, if we can equip midwives to take their place in society and their chosen profession only by developing in them the ability to think for themselves and make their own decisions, then the question whether the university is there to transmit to or to transform the culture of society has been answered in part. The adoption of such an approach takes the university well beyond the mere transmission of information – a role in a rapidly changing society that would seem untenable. If the university is not itself to transform the culture, it is certainly there to produce people who can and will transform it.

There is another problem that arises if we attempt to establish as the content of the midwifery curriculum those things that are regarded as being essential valuable elements of the culture. That is that this can lead to alienation of some of the students.
whose experience outside the university may be very different. Resulting in a rejection of the education they are offered. This is probably a root cause of the problems of retention in university courses.

This point highlights the weakness on this line of argument since it will be apparent that even if we see it as the task of educators to initiate midwifery students into the culture of society, it would not be possible to offer them the whole of the culture, however defined. A selection would have to be made and, as this is so, any notion of the culture of the society, no matter how acceptable in definition or content, will in itself not provide appropriate criteria for selection. Justification for selection would need to be sought elsewhere. This brings us to the realisation that attempts to base decisions about the content of the curriculum on a consideration of the nature of society are essentially utilitarian arguments that seek a social or sociological justification for curriculum content. This charge can only be avoided if there is an argument put forward that what is valuable in the culture is of universal value, because it has some intrinsic merit that justifies not only its place in the curriculum but also in society itself. Some would argue that there are values that are timeless and transcendental. It is on these grounds that educators argue for inclusion of art, music, literature, values and ideas in the midwifery curriculum. These form a cultural heritage, a human heritage that is universal rather than from any particular nation.

To take this view is; of course, as Kelly (1989:40) stated to propound a very different argument from that which seeks justification in the culture itself. It brings us back to the wider question about the nature of knowledge and whether any body of knowledge has
or can have intrinsic, objective, absolute value or status. The focus of curriculum content then, continues to be the nature of knowledge and any curriculum that seeks justification for content in terms that are not of utilitarian or instrumental must commence with an examination of the nature of knowledge, which is not unproblematic.

The issues are, therefore, if the curriculum is a selection from culture, then who has the power to make such a selection and from whose culture? As discussed in the previous chapter, in Africa and Malaysia, donor agencies such as the World Health Organisation and the World Bank, in giving financial support to developing countries can and do influence internal social, political and health policies. Like ripples on a pond, the western ideals are impacting on the ways of doing birth in different countries by creating imperatives for measurement, by imposing modern ideas of time and place of birth. By training practitioners in the mode of western birth practices, local cultures are conducting birth as perceived to be ‘right’ way of birth in the western world.

For a considerable period of time the dominant culture of modernity has been destroying other cultures. In late modernity, however, we are beginning to question some of the values of the earlier era where universalism almost pre-supposed that we could write a curriculum selected from culture because culture was seen as static and science was viewed as ‘truth’. But in late modernity, culture is highly diverse and changing – becoming increasingly ‘creole’ on the one hand and fundamentalist on the other – with science operating without conclusive ‘truth’. What we are seeing is many different cultures operating in different contexts and none can claim to be the conclusive ‘reality’. Thus any curriculum based on a selection from culture is one that is based on
an idealised version of culture. In curricula concerned with childbirth and midwifery, once we have moved beyond physiology, and that can be disputed as being from a single medico-scientific perspective, arguably little else is universal. We may be able to perhaps distil out a core curriculum but all else is cultural and relating to the ideologies, policies, and discourses of the society.

Have we taken seriously enough those cultures? Let us reflect back to the glimpses of childbirth and midwifery in the country studies. In Africa, Mama Yawa’s story (page 132-133) and the spirit mediums in Aowin society (page 136) illustrated the commitment to community, the long standing relationships with women in the village and the resultant conflict experienced by traditional midwives as they struggled to come to terms with the changing nature of their practice. Flora (page 142) showed how midwifery practice is moving from a community-based activity governed by age-old rituals to modern midwifery practised governed by new rituals. The gown and gloves worn in Flora’s story symbolises society’s view of childbirth as being dangerous and polluting, as before, but now this was to be contained within sanitised surroundings of a hospital where women were separated from their communities, family and attendants.

In this individualised birth context, the midwife is not only isolated from the woman socially, but also emotionally and physically as midwives increasingly take on roles of control and surveillance, become increasingly specialised in their tasks and align themselves to a production, industrialised model of childbirth. The curriculum is then one that meets the purpose of the role rather than one that needs the needs of the women. It is perhaps no longer a selection from culture but a selection from policies.
established by medical-social and political agendas, influenced by both internal and external forces. In developing countries, those forces may well be represented by agencies such as the World Bank and World Health Organisation.

Of course, for more traditional cultures, creating a curriculum based on a selection from culture may be much easier. The only problem is that the notion of construction of a curriculum is a very western 'scientific' concept. That is not to say that in traditional cultures, learning is not planned, for in discussion with traditional midwives in Africa, it was clear that they had time-honoured patterns of learning about childbirth. One traditional midwife interviewed had been training her niece for more than seven years and she did not consider that she had, as yet, learned enough. The apprenticeship was seamless with working and learning about women, their bodies and how the world around them operated so that birth could happen safely. Moreover, the traditional midwife would only reveal her secrets as and when they were needed, so if the occasion did not demand sharing of information, then it was not shared until the time was right. Thus the initiate learned what was relevant to the moment rather than packing a suitcase at the beginning and then being launched off into the world of work on her own.

In this model, which I call the isolationist model of curriculum (figure 12.2), the neophyte midwife and the traditional midwife work together as a team, experiencing, sharing and learning as they work with women. For some lay midwives in America this was also the case, particularly among the Amish in Pennsylvania and among the midwives working on the Farm in Tennessee where the experience of childbirth is centred in the community and is viewed as a natural part of everyday life, as illustrated
by Rachel’s story (page 209). These communities are separate from mainstream society and thus can develop their knowledge base away from the dominant societal regimes. They work and live as part of the community, and midwifery practice becomes a part of everyday life ungoverned by notions of productivity, and demarcation between ‘work time’ and ‘home time’.

The glimpse of Malaysian childbirth and midwifery practice shows the impact of the rapidly increasing urbanisation with a concomitant drive for middle-class status in a country where religion continues to dominate cultural forms. Noor Bee’s story (page 155-157) highlighted the move from collective ownership of birth at village level to societal ownership of birth at state level. It was the national policies, guided by global imperatives, that were in conflict with the village belief systems that created the problems for Azizah. Malaysia is a country that is striving to be modern and moreover, technologically advanced. A high mortality rate would arguably detract from that image. Consequently, health policies are mainly concerned with reducing mortality and Malaysia has looked to the western world to provide a model that would assist in this endeavour. The curriculum for midwives is focused on the demarcation between traditional beliefs and modern practices, a move away from birth at home, and away from what might be seen as ‘natural’ birth to modern birth, hence the comment that ‘only peasants squat’ (page 143 and 388).

The model of curriculum adopted (see appendix 6) clearly lies in the hierarchist arena. The hierarchical model of curriculum (figure 12.1), leading to state licensing, tends to
be dominant in Africa, Malaysia, America and England. In most curricula models the

**Figure 12.1 Determining forces for curricula design**

![Diagram showing hierarchical objectives]

...legitimacy of knowledge and practice and the curriculum content, determined by the

dominant cultural ideals and policies were enshrined in hierarchical objectives. The

features most commonly seen in state approved midwifery curricula in the case study countries were:

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• State regulated curricula were either seen as products and education was instrumental in achieving the required outcome – license to practice (especially in America), or the curriculum was seen as content and education as the vehicle for the transmission of that content.

• The education and training programmes were time bounded with an emphasis on quantifiable measurement of achievement of academic and practice outcomes.

• Socialisation into the dominant culture was a prime concern (usually hospital culture with the medical team at the apex of the hierarchy) In Ghana and Malawi, for example, students midwives were required to live in hospital accommodation away from families and friends thus underlining the liminality of training. They were also expected to wear their white uniforms in the classroom, again emphasising the change in status and separation from their previous lives.

• Emphasis on safety and hospital birth under the control of medical practitioners and an instrumental approach to childbirth were significant features found in all curricula.

The observed outcomes of these common features were:

• A distancing of midwives from women
• Narrowing of women’s vision and knowledge about their bodies
• Closing of midwifery mind and narrowing of vision to see only what is legitimised knowledge and practice
• Focus on status creation – fostering opportunities for horizontal violence
• Generation of fear and anxiety among midwives and women
• Change in language (as seen in Africa and Malaysia) which ultimately feeds back into indigenous culture and changes the view of women and their bodies, birth and their children.
In considering the four cultural types, as depicted in figure 12.2, a clear exemplar of the hierarchist approach to curriculum design can be seen in the curriculum as product — education as instrumental model. This is the model most commonly found in America and England and being transmitted to Ghana, Malawi and Malaysia. On investigation in the case study countries, I found that such curricula were generally devised within educational establishment away from the context in which practitioners are required to perform.

A concern with curriculum objectives and more latterly learning outcomes, has been a striking feature of curriculum planning for many years now. The impetus for this came initially from those who were impressed by the progress of science and technology and believed that the same kind of progress could be made in the field of education if a similar properly scientific approach were to be adopted. As is so often the case, the origins of this movement came from the United States of America. In the United Kingdom and elsewhere, the ‘objectives approach’ has subsequently been incorporated into midwifery education.

One of the earliest proponents of the objectives movement expressed concern about the rather vague, imprecise nature of the purposes of education and instead claimed that the age of science demanded exactness and certitude (Bobbitt, 1918, ch.6; Davies, 1976:47). Bobbitt suggested that teachers should be required to write out their objectives in clear, non-technical language so that students could understand. He also distinguished between what he called ‘ultimate’ objectives, those for the curriculum as
Cultural Types and the Curriculum

Hierarchist

- Risk averse
- Characterised by hierarchical order
- Subject-Discipline-Content Driven
- Formal, organised, officially sanctioned - controlled by policies, rules
- Scientific, Unchallengeable
- Characterised by examinations, etc.
- Knowledge comes from close working women over years - development of personal theory
- Unstructured apprenticeship model - e.g. Amish midwife tradition
- Characterised by separatism
- Guided by tradition

Entrepreneur

- Risk taker-Radical
- Characterised by innovation and cutting edge methods
- Exciting
- Takes best from all experiences - combines structured and unstructured - freedom to learn
- Engages students in discourse, dialogue, challenge
- Characterised by personal development, student centred approach
- Structure based on needs of students - negotiated
- Equality between teacher and student
- Integrated approach to curriculum content
- Assessment continuous

Isolationist

- Egalitarian
a whole, and 'progress' objectives, those for each class, or in our terms courses, modules, or units, and in addition, for each stage of progress. The cry was taken up by others and in 1924; Charters attempted a 'job analysis' of teaching and offered a method of course construction based on this approach. His suggestion is highly relevant today in that the 'ideals' of education are first identified, then the activities that these involve and finally analyse both of these to the level of 'working units of the size of human ability' (Charters, 1924 cited in Kelly, 1989:51; Davies, 1976:50). In Charters' view, these small steps need to be mastered one by one and in this way the whole curriculum could be reduced to a series of units and the composite structure could be set out in a chart or graph. This is the model for curriculum modularity today.

This development was accompanied by an interest in testing as a major feature of educational development in the 1930s, and laid the foundations for linking the pre-specifications of objectives and testing of performance. Thus was introduced into educational practice the kind of precise, scientific methods that had begun to yield such dividends in other spheres of human endeavour and especially in industry – so we can see the industrialisation of education, which reflects the current industrialisation of childbirth.

The main characteristic of the 'objectives' approach to curriculum planning was linear and hierarchical sequencing. A classic example of this can be seen in Bloom's taxonomy where the hierarchical nature of the interrelationship of these objectives is
fundamental. This is apparent from the graduation of objectives in the cognitive domain from the acquisition of knowledge of specifics, through such higher-level cognitive abilities as classification, comprehension, application, analysis, and synthesis, finally acquiring the ability to make evaluative judgements. This is exemplified in the Malaysian curriculum (appendix 6) which demonstrates the division of educational objectives into three domains – the cognitive, the affective and the psychomotor. In the United Kingdom a recent review of the nursing and midwifery curriculum has re-emphasised this approach (United Kingdom Central Council, 2000).

Bloom (1956) in devising his taxonomy also offered another distinction in his division between the head, the heart and the hand – cognitive, affective and psychomotor. I believe that this the division between the three domains of knowledge acquisition is perhaps the single causative factor in the so-called theory practice gap in nursing and midwifery education and practice. The separation of mind from physical activity in the practice of learning, especially in midwifery, has, I believe, lead educators to create separate units of learning – either theory or practice, separate criteria for assessment of theory and practice, separate evaluative tools and even demarcation in who assesses what – practice is assessed by practitioners and theory by academics.

More latterly the affective domain in Bloom’s taxonomy has generally been ignored since it was and is assumed to be much too difficult to assess. Yet, for midwives, this is a highly significant area for consideration, since childbirth, and consequently an important aspect of the practice of midwifery, is ultimately expressive and concerned with feelings, attitudes, and values which science cannot easily have power over. As a
result of this dilemma, education and practice have become increasingly instrumental in approach and outcome.

A major contributor to this instrumentation is that the pre-specified objectives are unequivocally behavioural (Kelly, 1989:57) in nature. Tyler, informed us that

‘the most useful form for stating objectives is to express them in terms which identify both the kind of behaviour to be developed in the student and the context or area of life in which this behaviour is to operate’ (1949:46-7).

For Mager (1962:13) the objectives specify what the learner must be able to do or perform when he or she is demonstrating mastery of the objective. Consequently, the focus of this model of educational planning is on the modification of student behaviour – essentially a reductive process. Success is seen in terms of students being able to demonstrate such modification through assessment of the units of learning. Great store is placed in modular curricula on students demonstrating achievement of the learning outcomes above all else. This has the effect of rendering anything else the student might have learned of lesser importance. There has been increasing evidence in my own experience of the increasingly instrumental view of education in which students will only partake of learning experiences if it leads to a reward for achievement, in modular curricula this relates to the accumulation and transferability of academic credits.
Another feature of the behavioural approach to curriculum design that must be noted here is that, like all scientific approaches to the study and planning of human activity, it endeavours to be value-free. This thesis demonstrates that childbirth and consequently midwifery practice is steeped in values.

We must consider briefly the main reasons why some people have been and are still concerned to promote this approach. I would concur with Kelly (1989:60) that there appears to be four reasons for this, which he called the logical, the scientific, the politico-economic and the educational arguments for the use of objectives.

The logical argument claims that part of what it means for an activity to be rational is that it should be directed toward some clear goal or purpose. If education is to be regarded as a rational activity it must state its goals or purposes. The logic of this argument is difficult to deny although it does not necessarily lead to the adoption of a strictly behavioural objectives approach. For to state that the curriculum must have purposes is not to say that those must be broken down into linear hierarchy of behavioural objectives that seems to be essential to this model.

The second main contention that has been offered in support of this model is the scientific argument. This represents an attempt to bring about in education a precision, accuracy and technological efficiency that is admired as the key to advances elsewhere in modern industrialised countries, and thus to render education more respectable in that context. This was clearly the motivation of early exponents of this approach prompted by the application of scientific method to the study of human performance.
and achievement in industry by men such as Frederick Taylor (Davies, 1976). Promoted by the predominance of behavioural psychology in educational theory in the early years of the twentieth century, this argument increasingly gained force whose main thrust was to reduce human behaviour to scientific analysis of an essentially means-end ethos and to advocate this methodology to educational planning.

The politico-economic argument is made on a more mundane level but it is one that has become increasingly important through such developments as the national vocational qualification - competency-based education movement in the UK, so that both its existence and its effects must be clearly recognised. This has extended to higher education with the argument that most educational provision is made at the taxpayers or employers expense and they are entitled to a clear statement of what their money is being spent on and thus of what the intended achievements and outcomes are. More importantly and significantly educational institutions are being called to public and political account for student outcomes in all fields from primary school to higher education.

Finally, some reasons that might be described as educational have been advanced in support of the pre-specification of curriculum objectives. Taba (1962) argued that pre-specified objectives was crucial for evaluation, and that evaluation was in turn crucial for effective teaching. She stated (op cit: 199) 'that those things that are most clearly evaluated are most effectively taught........it is difficult to defend the 'frills' from current attacks because attainments other than those 'essentials' are not readily
demonstrable'. This is a powerful argument if one is prepared to accept the underlying assumptions.

The most fundamental criticism of the objectives approach to curriculum planning is that its attempt to reduce education to a scientific activity, analogous to the processes of industry, commits it to a view of human beings and of human nature that many find unacceptable. For to adopt this kind of industrial model for education, as for childbirth, is to assume that it is legitimate to mould human beings, to modify their behaviour, according to certain clear-cut intentions without making any allowance for their own individual wishes, desires or interests.

This view also assumes that human behaviour can be explored, analysed and explained in the same way as the behaviour of inanimate objects. Furthermore, it assumes that people can be studied scientifically by methods similar to those used by physical scientists or biologists and that their behaviour can be explained in terms of causes rather than purposes, by reference to external forces acting on the individual (i.e. teaching) rather than internal drives and choices of a personal kind.

This passive model of humans is rife in the theory and is not acceptable to those who take the view that people should be regarded as free and active agents in the learning process, responsible for their own destiny and who, as a direct consequence of this, believe it to be morally wrong to deny learners that responsibility and freedom to learn. To approach education in a manner that regards it as an instrumental activity is to lose one essential ingredient that makes education what it is, namely a process whose
justification must lie within itself (Kelly, 1989:83). A curriculum-as-product model of education renders it instrumental and, as a corollary of so doing, often adopts a passive model of human beings. This practice that leads teaching that is more aptly described as instruction or training or even indoctrination, than education that ultimately places constraints on both learner and educator that inhibit the freedom of interaction some have claimed to be central to the educative process.

The concern here has not been to argue against the use of an objectives model but to point out its limitations and the implications of its use in an attempt to ensure that those who do adopt this model are fully aware of what that means. For an important implication is that an instrumental approach to education must lead to the emergence of a society, or more specifically a midwifery culture, which does not learn, except perhaps by accident, to value things for their own sake. Such a society would be one in which utility is the sole concern, a culture in which all are absorbed only by the means of existence and never by a consideration of its ends. This approach to educational planning has wide-sweeping implications for not only education itself, but also for the nature and indeed the future of society, perhaps even global society if such a thing exists, and for the attitudes to human life and existence (MacIntyre, 1964).

Having discussed the purposes of the curriculum we now turn to an exploration of the content of the curriculum and attempt to define from where it should be selected.
The Hierarchist Model of Education: Curriculum as Content- Education as Transmission

Many people, from a variety of standpoints, continue to see curriculum merely as content and the process of education as no more than the transmission of knowledge-content assuming that no more is required of the curriculum planner than a list of subjects and a timetable for delivery. This was found to be true in Africa, America, and many institutions in the UK as well as Malaysia (see appendix 6 for an example of a midwifery curriculum from Malaysia). It is an approach that is simple and clear to policy makers, employers and students alike. Even educators, that one would presume would know better, are increasingly providing a shopping list of ‘goods’ for consumers of education and training. I would argue that those adhering to this approach would issue from the hierarchist platform (see figure 12.1 and 12.2).

The major weakness in this approach is that at no stage does one find any justification, for either the subjects or their content, except in vague and unanalysed phrases such as ‘which they need to learn’, ‘relevant to today’s market’, or in overtly utilitarian considerations such as ‘practical applications’ and ‘the challenge of employment in tomorrow’s world. We hear of ‘bench-marking’, of competency targets, graduate outcomes and ‘standards’, all defined in terms of subject-content and offered as though they are non-problematic. We gain the impression that attempts are being made to ‘cash-in’ on the some kind of philosophical argument about lifelong learning, fitness
for purpose, fitness for practice and fitness for academic award and yet these arguments are nowhere adduced nor are the utilitarian arguments made explicit. So that to all appearances these definitions are ‘plucked from the air’ by managers and are complied with by educators.

Justification is needed for any curriculum plan and unless that justification is to be offered only in utilitarian terms some kind of education justification must be provided or at least sought. The lack of justification is the major weakness of the content-transmission model of education. There is little in the model itself that demands of educators a justification for their curricular prescriptions, so that it becomes all too easy to let tradition dictate the curricula for them consequently instrumentalism has its own way as the curriculum drifts from one delivery to the next. That is a major problem as I see it with a modular curriculum that is fundamentally subject oriented.

The concept of education as transmission or curriculum as content is simplistic and unsophisticated because it leaves out the major dimensions of the curriculum debate and discourages the critical stance that enables the transcendence of the narrower, more specialist perspectives of contributory disciplines. The curriculum should to seek to reconcile theory and practice; to look at the actualities of midwifery education from inside, to aspire to praxis so that an attempt can be made to generate a body of theory that has direct relevance for midwifery education and practice. Finally, but most importantly the curriculum must endeavour to seek conceptual coherence and raise questions about the ultimate point and purposes of midwifery practice and not merely those concerning the mechanics of implementation.
Curriculum as content and education as transmission does not raise and cannot raise questions about the purposes of education, unless it sees these merely in utilitarian terms. And this does not encourage midwifery educators to take into account the midwives who are recipients of this content and that process. Their task is to learn what is offered to them as effectively as they can, in the time frame designated. If the effect of the process on them is of any significance this model does not offer any means of evaluating the possible effects beyond assessing the extent of their assimilation of the content. Any other consequences of such learning are beyond the scope of, and relevance to, the model.

Yet it could be argued that it is precisely that effect or these consequences that are at the heart of what might be meant by the term ‘education’, unless it is to be synonymous with instruction or training. The Malaysian and African curricula make no attempt to disguise their curricula as education since they tend to entitle the course midwifery training. The curricula in both Africa and Malaysia were, at the time of fieldwork, modelled on British curricula of twenty years ago when I entered into midwifery in England.

*Virtual Learning: Cultural Imperialism*

It could be argued that virtual learning springs from the model of curriculum that is mainly concerned with transmission of content. In regard to the question how can midwifery education be designed in the west and transmitted over the global network or
in educational programmes delivered in the rest of the world meet the diverse needs of
different countries and localities, I believe the answer lies in the developmental
approach to curricula design. In releasing the educational experience from the bonds of
a discipline based orientation, except where it is relevant to the situation under study; in
releasing the content of a curriculum from being a selection from the dominant culture
and in placing the emphasis on community and individual development, engendering
collaboration rather than competition in learning; in being open about the purposes and
principles upon which the curriculum is built, I believe that a curriculum designed
anywhere in the world such as this could be transportable. The problem with curricula
currently designed in the west is the assumption that that is the only way of seeing the
world.

Most distance learning materials are designed along the same lines as a traditional
curriculum using objectives and standardised content for transmission. As already
argued, these approaches fail to address what is important in midwifery education and
furthermore may lead to cultural imperialism if transmitted overseas. If a midwifery
curriculum is to be transmitted over the Internet, then curriculum planners need to
engage in a careful balancing act to avoid overtly or covertly transmitting ideologies
whilst being open and sharing information and experiences. The nature of student
interaction with the virtual programme is crucial in determining the level of sharing
those ideals and care must be taken to ensure that the sharing is not in one direction only
– that the ‘exotic’ is not romanticised unduly nor the scientific valorised.
From personal experience of delivering such programmes over the network, it is clear that the skill of the teacher is as necessary to students at a distance for the purpose of avoiding imperialism as they are in face to face situations in the classroom. The teacher must be able to hold multiple ‘truths’ to be able to be responsive and challenging to students at a distance. I believe if we are to avoid cultural imperialism, then the teacher cannot be absent whether in the classroom or over the Internet, but it does beg a question about the teacher’s own motives, and values in the educational process and the cultural type to which she aligns herself.

National policies, influenced by external agencies, are, by and large, determining curriculum content, what is left out, whose knowledge is legitimate and valid and what outcomes should be expected from the midwifery course (as can be seen in the Malaysian government midwifery curriculum in appendix 6). The result, however, appears not to address issues of equality, as one of the ideals of sharing knowledge among the people’s of the world to reduce the gap between developing and developed countries. There seems to be a widening gap between rich and poor, traditional and urban in each country as Noor Bee’s (page 155-157) and Angelee’s (page 169) stories highlight. The case for broadening the curriculum needs to be made, starting perhaps with an exploration of indigenous knowledge.

The Case for Indigenous Knowledge

A case for situated knowledge that focuses upon the key concerns of women at a local level can be found among the literature concerning indigenous knowledge. It could be
argued that the vision of a truly global knowledge partnership might be realised only when the people of the developing countries participate as both contributors and users of knowledge. There is, therefore, a need not only to help bring global knowledge to the developing countries, but also to learn about indigenous knowledge from these countries, paying particular attention to the knowledge base of the rural and impoverished communities. The literature on indigenous knowledge does not provide a single definition of the concept. Nevertheless, several traits distinguish indigenous knowledge broadly from other knowledge (see figure 12.3).

Indigenous knowledge is unique to a particular culture and society. It is the basis for local decision-making in agriculture, health, natural resource management and other activities. Indigenous knowledge is embedded in community practices, institutions, relationships and rituals. It is essentially tacit knowledge (Polanyi, 1967), that is not easily codifiable but provides the basis for problem-solving strategies for local communities, especially the poor.

Indigenous knowledge perhaps represents an important component of global knowledge on development issues but is so far an under-utilised resource in the development process. Learning from indigenous knowledge, by investigating first what local communities know and have, can improve understanding of local conditions and provide a productive context for activities designed to help the communities. Understanding indigenous knowledge may increase responsiveness to clients enabling adaptation of international policies and practices to the local setting that may help
Indigenous Knowledge (IK)

Indigenous Knowledge is local knowledge

IK is unique to every culture or society.

IK is the basis for local-level decision making in:
- agriculture, - health care, - food preparation, - education, - natural-resource management,

IK provides problem-solving strategies for communities

IK is commonly held by communities rather than individuals

IK is tacit knowledge and therefore difficult to codify, it is embedded in community practices, institutions, relationships and rituals.

Why is Indigenous Knowledge Important?

IK provides problem-solving strategies for local communities, especially for the poor

IK represents an important contribution to global development knowledge

IK systems are at risk of becoming extinct

IK is relevant for the development process

IK is an under-utilised resource in the development process


improve the impact and sustainability of development assistance. Sharing indigenous knowledge within and across communities may help enhance cross-cultural understanding and promote the cultural dimension of development. Most importantly, investing in the exchange of indigenous knowledge and its integration into the assistance programmes of the World Bank and its development partners may help to reduce poverty.
The integration of indigenous knowledge into the development process, and subsequently the curriculum, is essentially a process of exchange of information from one community to another. Exchange of indigenous knowledge is held as the ideal outcome of a successful transfer and dissemination (World Bank, 1997). This may be seen as essentially a learning process whereby the community where an indigenous knowledge practice originates, the agent who transmits the practice, and the community that adopts and adapts the practice may all learn during the process. It could be argued that indigenous knowledge should play a greater role in the development activities of the World Bank and its development partners. It may, however, lead to the destruction of the very nature of indigenous knowledge itself once it is recorded and catalogued in the way of the western world.

In order to facilitate, at an international level, access to information about Best Practices and to establish contact between the actors participating in them, the MOST (Management of Social Transformations) Programme, a branch of the United Nations Education and Social Organization (UNESCO), created the Best Practices Database. On the basis of the four criteria for Best Practices, MOST is collecting information from all parts of the world about a variety of projects, policies and strategies related to the eradication of poverty and the reduction of social exclusion.

The idea of a Best Practices Database\(^\text{13}\) is based on the observation that carefully documented case histories can provide excellent guidelines for policy making and

\(^{13}\) Currently, the MOST Database provides examples of Best Practices for policies and projects in Poverty Eradication, Social Exclusion/Integration, Women and Gender Equality, Homelessness and Housing, Economic Development, Community Participation and Urban Governance, and Crime Prevention.
planning of new projects. The goal of a database on Best Practices is to present and promote creative, successful and sustainable solutions to social problems arising from poverty and social exclusion in order to build a bridge between empirical solutions, research and policy. The model projects or policies are aimed at improving the quality of life of individuals or groups suffering from poverty or social exclusion. They are typically based on the cooperation between national or local authorities, non-governmental organizations (NGOs) and local communities, the private sector, and academic communities. They include a variety of activities in all parts of the world. For example, in England homeless people sell 'The Bid Issue' magazine so they can earn a living and re-integrate into society. This has grown from a monthly to a weekly publication with a circulation of 350,000 copies and has paved the way for street papers in thirteen European countries, South Africa and Australia.

For UNESCO/MOST (2000), calling these activities "Best Practices" suggests that they can and should be replicated, that ideas can and should be generated from them, and that they can and should contribute to policy development. The following four characteristics are common to all Best Practices related to poverty and social exclusion:

1. **Best Practices are innovative.** A Best Practice has developed new and creative solutions to common problems of poverty and social exclusion.

2. **Best Practices make a difference.** A Best Practice demonstrates a positive and tangible impact on the living conditions, quality of life or environment of the individuals, groups or communities concerned.
3. **Best Practices have a sustainable effect.** A Best Practice contributes to sustained eradication of poverty or social exclusion, especially by the involvement of participants.

4. **Best Practices have the potential for replication.** A Best Practice serves as a model for generating policies and initiatives elsewhere once evaluated.

These ‘best practice’ characteristics, in clearly matching the ideals espoused in the United Nations Resolution (1974) that proclaimed a determination to work for, among other things, common interests, interdependence, and cooperation between nations to eliminate gaps between ‘developed and developing’ countries; to ensure accelerated economic and social development; to correct inequalities and redress existing injustices to ensure peace and justice for present and future generations, drive the policy agenda for curriculum development and learning.

*Curriculum as Process and Education as Development: Education as Social Action*

The development of team midwifery in the United Kingdom has sparked innovative approaches to curriculum design that facilitative of promoting self-empowerment of midwives, personal efficacy and fosters development of midwives as agents of sustained and effective change. This model would be classified as an egalitarian model of curriculum (figure 12.2). The curriculum in this context aims to be dynamic and interactive drawing on participants’ personal theories and experiences in the field, sharing them with their peer group, fostering an appreciation that all practitioners are expert systems. The academic and practitioners are viewed as equal partners in the
venture but recognising that the lecturer has a particular role in spurring them to inquire further, deeper and wider into their knowledge base and experiences. The curriculum follows a philosophically defined structure agreed in partnership with students and other stakeholders.

For Lave and Wenger (1991) participatory education was a way of learning that enabled practitioners to engage in absorbing and being absorbed in the 'culture of practice'. For them being absorbed in the culture of practice both learning and socialisation are part of the process of developing competence in the chosen field of study. As in the examples from both TBAs and the Amish midwives, there is little observable teaching but there is significant learning taking place. For Lave and Wenger, then, a learning curriculum is essentially situated in the context of practice.

Initiate midwives bring with them their own life stories that add to the sum of the practice experience and becomes a part of the process of situated learning, creating an interaction between the midwife and the social environment of practice. As Kirkham stated,

There is a real sense in which situated knowledge is more complex and more relevant to the care of individuals than conceptual teaching (1997:191).

For as Nelson and Wright, (1995) pointed out, women have multiple dimensions of difference. Figure 12.4 highlights the complex nature of childbirth ecology in which women and midwives have to negotiate a way through in order to achieve successful
and satisfying birth. The flow chart points out the interactions between social, emotional, gendered experiences of the life course, the impact of political, economic, and legal imperatives quite apart from the power relations in medically oriented childbirth systems. Furthermore, recognition is given to the *inter* and *intra*-body relationship between the woman and her unborn child. All of this creates a rich and diverse environment for learning, not only by the initiates but also the women themselves.

One of the main criticisms for the objectives model of curriculum planning was that is assumed a passive model of the individual and considered it appropriate to regard education as concerned to mould human behaviour according to certain pre-determined goals and blueprints. This must be the case with any curriculum whose prime concern is with extrinsic goals, unless, as Kelly (1989:93) stated, the person being educated sets those goals.

The starting point in a developmental model of education takes the opposite view of human nature and human potential. It sees the midwife as an active being, who is entitled to control over her or his learning and practice, and consequently sees education as a process by which the degree of such control available to each practitioner can be maximised. All the fundamental underlying principles of the curriculum flow from this standpoint, which is offered not as a scientifically demonstrable theory rather as the value position that its advocates adopt and which they recognise as the right of others to reject.
In the following section a recently validated midwifery curriculum acts as an exemplar for the curriculum as process and education as development model (see appendix 7 for further details). The programme attempts to address the developmental needs of midwives whilst bridging the divide between a focus on behavioural objectives based learning outcomes methodology (derived from the positivist doctrine of technical rationality, Schon, 1988) with a more humanistic approach to education. It aims to promote excellence in midwifery practice, based upon the analysis of practice knowledge and skills undertaken in the field with experienced and articulate midwives.

The new curriculum was based on a work-based modular programme developed and validated during 1993 for practising midwives designed to empower them through their engagement in human inquiry within the practice arena. The programme required that the midwives entered into an interactive process with the researched, e.g. other midwives and women in childbirth, thus becoming both co-researcher and co-subject in meaning seeking dialogue (Reason and Rowan, 1991).

The curriculum emerged as a result of action research designed to elicit the essential midwifery knowledge and practice skills within the context in which they were practising. In this way continuous evaluation and revision took place (Sisto, and Hilliger, 1996).
During focus group discussion with midwives undertaking and having completed the programme, they identified that as they began to delve deeper into practice and engage in learning conversations with their peers and women in childbirth, they became aware of the need for in-depth understanding of their own and other’s worlds. They came to recognise the changing nature of practice and appreciated the implications of the compression of time and space that results in the obsolescence of knowledge, leading them to understand the need for continuing learning. They valued the opportunities for developing contextually derived meaning in and from practice.

The role of the midwifery lecturer was crucial in the stimulation of critical thought, therefore, it was essential that they became actively involved in the exploration of practice and participated in the research process, becoming both co-research and co-subject. The purpose of this approach was to avoid the danger of adopting methods disguised as facilitation and experiential learning that may disguise instrumentalism with a ‘human face’. The emphasis on methods and techniques reinforces the notion of theoretical supremacy because of the de-contextualised nature of such approaches. Usher (1992:12) maintains that we need a critical scepticism and a suitable degree of uncertainty whilst paying attention to the need for a careful deconstruction of theory that arises through practice; theory that arises about practice and the discourses that surround practice, recognising that nothing should be taken for granted.

Jarvis (1992:246) points out that practitioners as learners may encounter a disabling dissonance on return to a structured practice environment governed by the dominant hierarchist culture in which inertia reigns supreme and practitioners and managers may
engage in horizontal violence to maintain the status quo (Leap, 1997:689; Clements, 1997:9-14). (see also pages 315-335 of this thesis for discussion on horizontal violence). In these situations the learning and teaching transaction may produce little change as learners are often rewarded for ritualistic and repetitive behaviour whilst experimentation and creativity may be actively discouraged.

*It is really difficult returning to the workplace after attending a course. You get all fired up, find it really stimulating and you go back saying you are going to do something – then nothing happens. Colleagues are not interested in what you have learned – they dismiss your ideas and eventually you give up. There is not a culture of supporting midwives returning from courses – I wonder why we bother sometimes since all most people are interested in is getting through the day. (Jackie, 1998)*

The development of excellence involves a need for generating new cognitive approaches, which will help to effect a perspective transformation (paradigm shift in the context of this curriculum), by encouraging the exploration of individual values, beliefs and philosophies. Central to the programme philosophy is acknowledgement that midwives bring their own personal experiences to the learning experience. It is recognised that acceptance of diametrically opposed values of personal versus professional often leads to dissonance within the practitioner. However, as identified by Mezirow (1990) dissonance may pre-empt a change in thinking (perspective transformation), which will ultimately enable the student to ‘travel with a different view’ (Bass, et al 1999).
The curriculum framework enables experienced practitioners to develop both professionally and personally, facilitating the recognition of strengths and weaknesses through a process of reflexivity, whilst providing flexible learning opportunities that enable achievement of excellence in practice. For Bass et al (1999), the notion of excellence implies the holistic understanding of a subject and relates to outstanding practice. Excellence in practice is considered by the team to be important for professional and personal autonomy and accountability. For them, by developing the art of midwifery and furthering knowledge concerning the related sciences, excellence in practice becomes achievable.

Learning on this programme is interactive; between the client, practitioner, practice facilitators, managers and midwifery tutors. Learning is seen as dynamic process, which fosters self-awareness and the acquisition of knowledge and skills to improve both the quality of service to women, their babies and families, and the development of midwifery. In the rapidly changing scenario of childbirth and midwifery practice, Bass et al consider that it is crucial that midwives are able to provide a service which reflects the political, professional and organisational skills established within government policy and strategic documents.

The notion of the learning organisation is important here, and particularly so in the context of this curriculum innovation. Crucial to change in practice is the necessity for support for individual practitioners while they come to terms with the changes they are personally going through. Both managers and lecturers have a role to play
in this, but for real change to take place, it is necessary to achieve a critical mass of people to carry changes through and to avoid potentially damaging situations for both practitioners and women in childbirth.

If practice is to fundamentally, and not cosmetically, change, then the organisation will need to adopt a learning and experimental ethos with members acting as learning agents for responding to changes to the internal and external environment resulting in a process of continuing transformation (Pedler, et al, 1991). These transformations can only come about if the symbols that represent childbirth change.

*Midwife Stories as Vehicles for Symbolic Exchange: Learning from Situated knowledge*

A major feature of this curriculum is the use of storytelling as a means of generating symbolic exchanges between midwives both within the UK and overseas. A recent trip to the Farm in Tennessee facilitated just this type of exchange between the Farm midwives, women and the British midwives. One respondent informed me that what was clearly evident was the seamlessness of the women and midwives. She reported that during times of story telling, and sharing information about birth, she could not tell who were the midwives and who were the mothers. Moreover it did not seem to matter. This brings us back to the four cultural types since this model would fit more closely to an egalitarian cultural type and yet it survives because the women and midwives operate outside the dominant medical and social construct of childbirth and midwifery education (figure 12.2).
Perhaps in order to engage in this form of education for childbirth and midwifery practice a sanctuary of normal birth has to be created – isolated from the rest, an area where women and midwives can work and learn together. In this model there is no separation between educators and practitioners, they are one and the same. Neither is there a separation between practitioner-teachers and researchers since all three roles are combined in a context of continuous inquiry. The creation of a sanctuary is perhaps to create a liminal space to allow the transition between one form and the next. But unlike liminality as described by Turner (1969) this model represents a transition from one stage of development, like the caterpillar into the next – the butterfly. During this period of change – the liminal phase, there is a need for isolation and distancing from the world.

For real change to occur in childbirth and, as a consequence, midwifery education and practice, there may well be a need to remove midwives and women from the dominant model and the institutions that perpetuate them. There is a need to develop a social model of curriculum that is inclusive rather than exclusive. That addresses the complexity of women’s lives within the context of their environment and fosters dialogue and interaction between women, midwives and the various players in the social world.
Summary and Conclusion

In this chapter I have attempted to address the questions:

- Some universities are globalising and offering standardized curricula by distance and electronic means. But is it just another form of cultural imperialism?
- What is the nature of the curriculum and how should it be designed for the future?
- How can midwifery education designed in the west and transmitted over the global network or in educational programmes delivered in the rest of the world meet the diverse needs of different countries and localities?

To answer the question I have explored the differing models of curriculum planning and in so doing have attempted to show the inadequacies identified in the approaches most commonly in use. Criticism of curriculum design from the perspective of its content, and the approach through the pre-specification of objectives have led to the emergence of a third curriculum model that requires that we start with an analysis of processes and a statement about procedural principles that are to inform educational practice. This approach, like all other, is not value-neutral but reveals a positive ideological stance and offers a clear basis from which subsequent procedural principles are derived. Of course, the normative and value-laden characteristic of the developmental approach to curriculum design is much criticised but advocates claim these as major strengths, and that in essence all education planning by definition is value-laden and normative and that it is ideological. That being so, the only satisfactory starting point for such planning is in a clear and honest statement about norms, the values, the ideology from which it is being taken. For as Kelly stated:
Education itself is not a value-neutral process, so that curriculum models based on the idea that is it, or can be, as well as those based on some spurious notion of the objectivity of educational values are at best unsatisfactory because they do not grasp the ideological nettle, or at worst dishonest because they pretend it is not there to be grasped. (Kelly, 1989:113).

The egalitarian model reflects more appropriately the role of the teacher in relation to the education of midwives for it fosters an interactive relationship between women, midwives and teachers not least by providing the teacher and student with principles upon which to base professional judgements rather than offering rigid hierarchical frameworks.

This is the point, which takes us naturally to a conclusion of the study and has put me in a position to make some recommendations, which is the subject of the final chapter.
Chapter 13

Conclusion and Recommendations

I have tried to illustrate and develop my argument through examples from different times and places. From the start I attempted to capture the reader's imagination by using the metaphor of 'pebble in a pond' to represent globalisation. I threw a pebble in the pond and reflected on globalisation and wondered where the ripples would take us. Globalisation, like the ripples on a pond, would naturally have differential effects as it traverses the different parts of the world but what did globalisation mean to the lives of women in childbirth and the midwives who attend them? I tried to capture and hold the meaning of globalisation, but I found it to be an elusive concept which I likened to 'holding a moonbeam in your hand. I finally alighted upon a definition of globalisation as the symbolic exchanges that occurs as a result of contemporary engagement with other people in the world through a variety of means that result in exchanges of ideas, beliefs and practices. This led me into an exploration of one of the key ideological exchanges – modernity. Because what I believe to be happening is the globalisation of modernity – the spread of the ideology as well as the practices of industrialisation, consumerism, developing markets, technology that has the effect of re-colonising the developing world. I then turned to my case studies to track the symbolic exchanges experienced by women and midwives.
I started with Africa, which, in my view, is the outermost ring of the ripple. Whatever pebble the first world drops in the pond, it always ripples outwards and has an effect, even if it is only a counter ripple in response. In this chapter I explored with women and midwives how globalisation, modernisation, and development strategies was changing their daily lives. What I was seeing was not only the physical movement of people toward urban centres but also a movement in thinking and practices among those people who still reside in villages even in the remotest areas of Ghana and Malawi. There appears to be a shift from a traditional, community oriented world-view to a modern world-view. This appears to be a more profound shift for those people living in urban centres with easy access to, or can be easily accessed by, the modern world. So what does that mean for the experience of childbirth? Evidence flowed from women and midwives about how the changes were impacting on the them, as I journeyed around Ghana and Malawi gathering stories. I was told about the lives and experiences of traditional midwives, whose stories revealed the increasing symbolic exchange of western medical ideology that began to overlay and be assimilated into traditional concepts. Traditional midwives were being trained to observe western rites of sterility that they found impossible to carry out in their own contexts, for example.

Another story from Africa illustrated the juxtaposition between the herbalist and spirit mediums in one township in Ghana. Here the symbolic movement from a community orientation in which the spirit mediums have responsibility within the village to ensure that the whole community is kept healthy, under the guidance of the paramount chief. This means that the mediums, who also act as traditional midwives, not only deal with physical concerns and physical boundaries but also with the spiritual boundaries as well.
For spirit mediums, the community is a living organism that is made of up parts, but like a conductor of an orchestra; her concerns are with the total ‘symphony’ not individual instruments. Herbalists, on the other hand, only deal with individuals and do not concern themselves with the community as a whole. Their only concern is looking at the body and the metaphor they used was ‘body-as-car’ – cars have an engine and if it goes wrong, then the mechanic – the herbalist (or doctor in western societies) will fix it. The body-as-machine metaphor has reached the very heart of communities in Africa proclaiming the extent of the symbolic exchanges on that continent. There is in addition a gender issue here since spirit mediums are now mostly women who moved into those positions vacated by the men as they became more exposed to western ideals through educational opportunities, denied to the women, and engaged in increased travel and exchange with other herbalists around the country.

I next looked at areas of midwifery practice in hospitals and found the sediments of modern obstetric rituals in practice during childbirth. The story is about a midwife who is delivering the woman in an open ward and it is like Piccadilly Circus with people walking backwards and forward. There is no notion of privacy, that is a luxury they cannot afford. Once again, they have taken the concepts of sterility and attempted to apply it in situations that immediately defies their attempts at control. The midwife wears sterile gloves, she is masked and wearing a green gown and boots but everyone else is walking about without any of those things. Moreover, the midwife goes from one woman to the next without changing her ‘sterile’ garb so one must question whom it is there to protect. The imperative to practise as in western hospitals is strong and yet all the African practitioners have are the dregs of the scientific ideal, the realisation of
what may be required, and that is questionable even within advanced, wealthy societies, cannot match the reality of the situation. Consequently, pollution rituals that are being transported are seriously problematic because they define action.

Leaving Africa behind, I then journeyed to a country further in on the ripple. Malaysia has experienced a greater degree of the impact of modernisation and indeed, is rapidly modernising and urbanising. Malaysians aspire to achieve the same level of technological revolution as seen in other Far Eastern countries. Once again I saw the similar symbolic exchanges amongst the women and midwives as I saw in Africa. The Malaysian’s however, claimed to have achieved more than ninety percent of births conducted mainly by physicians in hospitals unlike childbirth in Africa where the majority of births occur in rural villages with traditional midwives. The experience of poor women in Malaysia was less than satisfactory in their view but they found ways to compensate by engaging a traditional midwife to conduct the various rituals the women still consider important, thus, once again, overlaying the traditional with the modern and vice versa.
Consequences of the global pebbles on the global pond

The consequences of globalisation for women in childbirth and the preparation of midwives cannot be looked at from the perspective of a single discipline. Globalisation itself results from a confluence of a number of interactive processes, (figure 13.1), which can and should be considered from variety of disciplines. These define the everyday experience of life for individuals and groups throughout the world at different levels of intensity depending upon place (that is location, rural or urban) exposure to transnational ideologies (media, communication, educational forms) and wealth.

Figure 13.1: Consequences of Globalisation
Escalating global inequalities mean that only a shrinking minority of humanity can actually consume. But the “culture-ideology of consumerism”, disseminated through omnipresent symbols and images made possible by advanced communications technologies, is a powerful message that imbues mass consciousness at the global level. See figure 13.2 for examples of symbolic exchanges where there are trends and counter-trends – like the ripple son a pond, emerging from dominant cultures with influences in popular culture emerging from the south and east of the world.

Having explored the outer most ripples, I thought I should look at the centre where most of the pebbles are dropped, so I went to America and looked at what is happening there for the majority of women and found, as expected, highly technical childbirth in hospital. I had anticipated that but what was surprising was that the attempts to humanise birth were such a thin veneer. To gain a different perspective I spent some time with an Amish midwife who provided a completely diametrically opposite view to the one I had gained among the nurse-midwives. The nurse-midwife interviewed were very committed to normal birth but their definition of what was normal was very different to that seen elsewhere in that they considered electronic monitoring, intravenous infusion, amniotomy and episiotomy to be normal. The four nurse-midwives in group practice within a small, very wealthy private hospital had been given sanction to deliver women, but realised that they were there on sufferance and so could
not 'rock the boat' too much and felt they had to adhere to hospital protocols that included electronic fetal heart monitoring and so on. In order to make sense of their practice they were forced to redefine what they did as normal, separating normal from natural birth, which they did not support ideologically. For them, women and childbirth need structure and control. This led me to think about the models that midwives use when working with women in childbirth and I began to start putting women and midwives into groupings that matched Mary Douglas' cultural types built upon myths of childbirth. At this point I began to reflect back on the cultural types that African and Malaysian women and midwives would fit into and wondered if cultural types only related to women in modern societies who had consumer choice.

Finally I looked at my own country, Britain and what has happened here. On the ripple scale, I believe the United Kingdom to be placed in the centre as an advanced society, but it is an interesting centre for midwives and women have more choice and we are in a state of transition, perhaps much more so than America. Britain, in my view, comes under pressure from American ideology just as other countries and because we are sufficiently wealthy we are well placed to adopt that ideology perhaps more so than other countries because we are so wedded to the risk ideology. The emphasis of risk is all encompassing among obstetricians who perhaps are more vulnerable to medical ideology as a result of their training than midwives who either fail to read the research or have been taught to read research with a critical eye. Nevertheless, the concept of childbirth risk is dominant and powerful and has determined institutional protocols, and the practice and education of both obstetricians and midwives.
What do the stories tell us?

The narratives informed us about the decline of community and the secularisation and institutionalisation of childbirth ritual that is increasingly bound up with technologicalisation and medicalisation. The evidence from the narratives, interviews, observations and content analysis of documentation and curricula reveal the symbolic exchanges of western approaches to childbirth among women, medical practitioners, health organisations and midwives. This has resulted from a number of key factors that appeared to be influential in these exchanges. These included:

1. **Time compression**: The globalisation of modernity is causing a rupture between internal and external time with external time being compressed and moving further away from internal physiological time frames. The consequence of this is that external time frames are imposed and so induction and acceleration of labour, the ending of a pregnancy that is deemed to have lasted too long and the speeding up of labour to fit some notion of how long labour should last is endemic. Standardisation of labour is now global. The measurement of labour
by assessing the dilatation of the cervix and the imposition of the stages of labour to which the woman's body must conform is now almost universal. There is the conviction the cervix only dilates progressively consequently, there is no recognition that perhaps other factors may impinge and cause a retraction of the cervix. The separation of body, mind and spirit creates disjuncture for women and dislocates them from their body's processes and allows others to dictate what happens in their own bodies. Thus disempowering them and creating a loss of control with the consequences of stress, loss of identity and isolation from community and their traditions.

2. Individualism: moving away from notion of communal health and increasing individuation.

3. High Status – (that is, being heard, achieving recognition as a significant part of society, ability to exercise some degree of authority and power over their own, and perhaps others, lives) becomes the goal of urban people - reflected in birthing practices (e.g. will not squat in labour because that is what the peasants do); breastfeeding practices - bottles are considered more sophisticated and allows more freedom for the woman.

4. Loss of respect for rural people – Rural people, according to one respondent, are considered stupid because they do not have the education of urbanites. Moreover, the urban mind is considered to be harder and less tolerant tending to ridicule traditions, which is all part of the process of breaking down the fabric of the old world. Rhetoric of government who are wanting to maintain traditional culture and values and yet introduce factors such as finance that increase urbanisation;
5. *Language* - changes in language from situated to professional fosters distancing from past.

6. The *inevitability of modernity* - creeps in regardless of attempts to keep it out. Society is not changed solely by mass media, as is believed in Malaysia, for example, but by the influx of people from other cultures for whom various changes have to be made - hotels, shops and their goods, and so on. Local people are required to provide the expected consumer goods and services required. Moreover, researchers, teachers and their ideas, books, journals and other literature, create ripples in the pond also. As people travel to other countries, for example, students undertaking education in America or England, are not only changed in themselves, they then carry back ideas and begin to influence changes, however subtly, in their own communities. Even urbanites going into rural areas cause a ripple effect that brings about change. Gareth Morgan (1997) states that it is the small somewhat inconsequential changes that individuals might bring about can ultimately result in major change overall (80/20 rule). There is now a critical mass of people who have been exposed to modernity and so it is 'past the point of no return'.

7. *Ritualisation of modern technical processes* - antenatal examination; antenatal screening; measurements in labour; etc. If these are done, the baby will be all right. So training in Malawi, Malaysia and Ghana - results in the replacement of old rituals for new (New lamps for old - but they are still lamps). Therefore training inappropriate and dangerous because it gives a false sense of security and a waste of huge sums of money and time. Also with the drive for measurement _i.e._ research - they are measuring what is measurable not what is important.
8. *Disorientating dilemmas for TBAs* - de-skilling them as they are exposed to Western methods and practices - they will not then be able to pass on traditional knowledge and skills to their apprentices thereby eliminating a whole knowledge base again - distancing women from their history - inevitability of change

9. *Forceful dictates from West* - i.e. women should only give their babies breast milk - forces women all over the world to end up bottle feeding - the majority of women would traditionally give their babies other fluids as well as breast milk - some cultures believe breast milk is too much for their babies at first and so would probably not breast feed at all.

10. *Technologicalisation* becomes an important tool in the process of star-making - adds to the drama of the situation - adds to the complexity ratio - midwives chase this dream too - the more complex - the better and more proficient they seem - the bigger they are stars

11. *Medicalization & medical oppression:* The medicalization of childbirth

12. *Doctor as culture hero*

If doctors see themselves as the star and that status and power reinforces their sense of self, personal identity and value and midwives see themselves as the star for the same reason, how do the women see themselves? It depends on to whom they relate their story - to have a baby in hospital with all the high tech equipment and doctors dancing attendance on one - sounds like stardom in the village - but privately, she may well feel like an appendage - if she is noticed at all and may well see the doctor as the star. There must be a difference in urban and rural areas and this must also depend on their cultural type also. The consumption of stardom. (Karrie, 1997)
Figure 13.2 Symbolic Exchanges: Trends and Counter-trends

**Dominant Trends from Advanced Technological Societies**
- Technological scientific medicine
- 'death-as-enemy' metaphor is used to drive increased surveillance
- Stethoscopes and white lab coats - masks, theatre garb as symbols of authority and power
- Language exclusive; research and measurement as dominant ideologies - mainly conducted by advanced societies
- Emphasis on time and control through monitoring and measurement
- Individualistic; blame rests on individual
- Isolated from community - emphasis on birth in hospital
- State takes control away from family through legislation
- Diagnosis rests with doctor
- Systems of experts and specialists
- Doctor as culture hero
- Midwives as earth mothers?

**Counter Trends from Advanced Technological Societies**
- Partnership between women and midwives as symbol of shared power
- Language inclusive; emphasis on communication and shared language; research considers what is important not just what is measurable
- Emphasis on physiology
- Community and family oriented; shared decision-making
- Women take control of childbirth experience
- Women become expert systems in their own childbirth
- Midwives as earth mothers?

**Influences from East and South**
- Traditional medicines - indigenous knowledge
- Community oriented - holistic but also individual - blame for individual ills rest with cosmos
- Community implicated as well as individual in ill health
Concerning Cultural Types and Myths of Nature

I explored the concept of medically defined obstetric risk that generates fear in people for many different reasons and when I returned to look at my cultural types model, I saw that the midwives and women I had engaged with fell into all four, or perhaps five cultural types.

As discussed earlier, there are the hierarchists who believe in structure and organisation, the egalitarians, who subscribe to partnership and I call the checo-warriors (childbirth eco-warriors) who will campaign for better childbirth for women, the isolationists who separate themselves from the dominant organisational culture and its protocols, the entrepreneurs, who are creative risk takers, working mostly on their own, who try innovative schemes to bring about change and another that I defined as ritualists. These people may be found both among traditional midwives in rural areas of developing countries and conventional midwives in the most advanced societies – the metaphor that best describes them perhaps is ‘just in case’. Perhaps what determines ritualist actions is fear and that fear emerges from a feeling that regardless of whatever information one might have that is contrary to your deep seated anxieties, you have to engage in the ritual just in case it all goes wrong. In this way it is almost like a belief in God or some mysterious force that will punish you if you fail to pay the correct tribute. These feelings were exhibited among midwives in every country and among medical practitioners and women also. When asked why particular practices were still conducted despite evidence refuting their validity, the reply was often well yes I know
all that but I still do it just in case' this was the answer given by a traditional midwife regarding putting cow dung on the baby's cord. Many would explain that as just ignorance, but when questioning midwives in a group who were undertaking an advanced degree the response was the same only in a different context with a different set of practices that had likewise been discredited. Perhaps these rituals work to anchor them to their firm belief systems and to a sense of stability and continuity and this works for both beneficial and detrimental rituals.

The clinging to some rituals may also be part of some notion of expertise, whether it is professional or non professional, expertness comes from what you know and how you practise that and perhaps it is a concern about relinquishing that. The rituals, whether conducted by the traditional midwife in the village or the professional nurse-midwife in the hospital are perhaps maintained to reinforce power positions. Rituals serve to define the span of control, only the practitioner has the authority and power to conduct the ritual, as in the example from Malaysia, where the TBA is the only person who can conduct all fourteen rituals surrounding childbirth whereas the professionally trained midwife can only conduct four of them. The powerful position is difficult to relinquish since as soon as they are challenged to give up rituals, in effect they are being forced to de-professionalise on one level.

*In terms of childbirth this may not be a bad thing because women should be with women on an egalitarian level. We have been questioning ourselves about whether we have the notions of professional right anyway and even with midwife teachers and students, it is not an equal partnership and should we be*
reinforcing what is professional behaviour rather than talking about what it should be to be a woman with a woman in this time of ecstasy. Those rituals are also bound up with what it is to be professional and power and control. But some rituals are also good rituals. You tend to think of ritualistic behaviour as being people who don’t question what they are doing but we also see good rituals where people come in from a perspective which we saw in Tennessee which was a ritual of non-interference, completely standing back, the birth area is sacred – that was a ritual. They went for a real dance making this place sacred – that was a good ritual, so it works on both levels. (An interview with Janice, 2000)

Together the case study chapters provided a platform from which to explore the social and cultural implications for the education of midwives and further developing the myths of childbirth model in the context of education. The myths of childbirth are concerned with our concepts of where we place the nature of women’s bodies in relation to childbirth, on the continuum of being robust to being completely fragile. Such placing determines the way we approach practice, the way we approach education and the way we approach childbirth itself as women. Therefore if a person comes from a hierarchist perspective she believes that birth needs to be structured. It needs to be conducted in a hierarchical power structure with people at the bottom ‘doing as they are told’. This is the same in education, where there are exams, tests and assessment and there is a body of knowledge that the teacher transmits to students who are passive. Whereas if a person comes from an egalitarian point of view, the structure is negotiated
and shared, knowledge comes from a variety of different sources, it is all examined for its merits, some are rejected and others are accepted. Therefore the myths of childbirth are quite important in terms of where people choose to place themselves in the system.

In America there are different models of learning ranging from apprenticeships, that adhere to a model of learning rather than a model of education and formal curricula that prepare midwives to masters' degree level. The latter tend to undertake their preparation in a hierarchist institution that conforms to a model of education, which is defined, structured, tested and validated in universities. So where we place ourselves in terms of learning midwifery is interesting. In Britain, of course, there is no choice; the profession of midwifery has placed itself in the hierarchist model. Alternative models of education and curriculum are strongly discouraged, and practice is tightly controlled by institutions. This is ultimately leading to a closing of the mind, a narrowing of the experience.

You also get a closing of the minds because in the end it becomes so scientific and when you are trying to match the scientific body of evidence with something as natural as childbirth you realise they don't match.............. you actually start to think that you are the one who hasn't got the answers and you try to compete with a scientific body of knowledge but you can't trust your intuition, you can't trust watching, observing, touching – you can't trust those ways of knowing so you start to identify more with the scientific body of knowledge which becomes even bigger and better and more advanced than you could possibly be. The average person couldn't keep up with it so in effect you start to close your mind because you realise it doesn't
even make sense any more because you try to match the two and they don't match. You try to keep up with science and that is where the closing of the mind comes because you actually start to (not deliberately) to identify with what the scientific paradigm.............. are persuaded that this is the right way and that what you see, feel and hear from women is the wrong way and you actually then block yourself off to all the other ways of knowing which make sense to you – you know they do. I think it is about that as well – you find that it is incredibly ......difficult..... to ...maintain your good........ intentions to listen to women but you have to identify with one and because we work in a culture where the emphasis is on scientific.... then the technical, rational way of knowing is what is held up as the right way. We work in a culture where the profession and society sets great store by that and our knowledge becomes secondary. This causes real tension because I believe that most midwives in their heart are finding it difficult to marry the two together which is why they are having to reject one or the other and what they reject, unfortunately, is their intuition and women's wisdom. (Janice, 2000)

This way of thinking and practising and educating is spreading across the world and is beginning to dominate all the way going back down the ripples to the smallest communities under the conditions of globalisation. But the interesting thing that is happening under those same conditions is that we now have a spin-off from the fact that women and midwives are now using the World Wide Web and Internet to communicate with each other in a way that was denied to them before. The route for accessing authoritative and legitimised knowledge was through hierarchical institutions of education and service. Practitioner and women had to go through that process of
education to access information about childbirth generally and the only other information was that of pseudo-scientific, folklore science mediated by the popular press that would fashion the information according to their social and political stance. Nowadays with the Internet women, midwives, lay midwives, and anybody with an interest who has access to the technology, which is increasingly becoming available to all classes, can share information, rally support explore other ways of birth from different cultures. I would argue that through the use of the Internet a community of women and midwives is developing that is a global in scale and exists in real time. This community of midwives and a global community of women have and can share knowledge and wisdom that is different to the dominant medical paradigm.

The impact of the global network works in two key ways that is generating global data on midwifery knowledge as midwives and women increasingly share personal theories they had not written about or were not legitimised through publication. These practitioners and women are finding a way of subverting the dominant elite who control the professional publications, who only accepts articles that are within the dominant mode. As midwives and women write their stories and share their experiences, there is an emerging form of alternative legitimation. Previously midwives’ knowledge was secretly shared in the coffee room over cups of tea or in the corridors. It was rarely wider than that, so there appears to be a significant level of symbolic exchange occurring. Exploring the Internet revealed more than fifty different web pages concerned with childbirth and midwifery that can be accessed by anyone with an interest, which may ultimately bring about a major shift in the ways women and midwives think about childbirth. Women are going to be as informed, if not more so,
than the midwives and obstetricians who are supposed to be the 'expert systems'. Women will become their own expert systems to a certain extent and will be well placed to challenge the dominant medical view. Ultimately, the body of knowledge would then become shared and perhaps a common language would be developed.

Despite this potential shift in access to knowledge, the possible contribution to knowledge, women's knowledge and experience may remain trapped among their group, not considered authoritative or legitimate by the medical fraternity. Western allopathic medicine, according to Comaroff (1982:54), like all forms of healing, expresses a particular social and cultural realisation of existential universals. As a domain within a more inclusive system, moreover, it exists amidst a range of alternative therapeutic forms, whose ideology and practice comprise a series of rather different resolutions of the paradoxes of personhood, well-being and illness generated within the wider society. But the dominance of bio-medicine as the orthodox system of healing is legitimised both by formal mechanisms of control, and by the tacit hegemony of the conception of knowledge, which it shares with the mainstream culture. Bio-medicine is interposed between formal science - the special source of 'truth' about natural processes - and the everyday experience of such processes. In its management of the dislocations entailed in illness and suffering, it projects a forceful image of selfhood and reality.

The curative process mobilises potent symbolic capital. Western doctors as well as traditional healers globally manipulate symbolic media that connects the physical with the social order (Comaroff, 1982:52). In the face of the fear and anxiety that often
accompanies infirmity, curative processes powerfully reinforce the logic of inherent meanings and implicit images of self and its context drawn from the wider cultural system. Medicine reaches down to the very heart of the deep-seated paradoxes of the human condition which childbirth lays bare, harnessing the physical symbols through which these are expressed with values reflecting specific concerns. Returning the woman to ‘normal’ thus reaffirms the integrity of an implicit construction of reality and its enveloping symbolic order. Tangible medical knowledge provides the explicit rationale for this process, presenting as ‘natural’ what is actually a culturally constituted and socially motivated image of childbirth (after Figlio, 1976:17-35). Childbirth cuts across everyday accommodations and the reflex patterns of action which seem to reinforce them. It often heightens awareness of more fundamental dilemmas not adequately addressed in particular healing processes, but fundamental to the social orders they represent. Affliction may thus lead to more comprehensive ‘dis-ease’ within the social system itself. This is just as it is seen by the Aowin spirit mediums in Ghana who view dis-ease as much an affliction of the community as the individual.

As a discrete body of knowledge and technique, medicine has become progressively disengaged from the language of cosmology and morality, from a system of knowledge addressing the relationship of between human beings, and from nature and spirit. In the dialectical process of modern history, the fragmentation and the progressive disengagement of spirit and matter have reinforced and been reinforced by the rise of empiricism and industrial technology and is spread symbolically through the processes of globalisation. Consequently we have seen a shift from traditional ideas about childbirth to modern beliefs, ideologies and values represented in my model be a shift in
allegiances towards hierarchical values and practices among midwives, and women (see figure 13.3). For the language of childbirth globally has become part of the circumscribed discourse of science, designed to exclude from its frame of reference all unspecific references, and closing off areas of women’s lives irrelevant to its particular concerns.

Empirically derived facts about the nature of the biological organism challenged social and moral philosophy as the key to the mysteries of human life. The seemingly elusive entities of mind, value and collective consciousness became more and more difficult to reconcile with the rational-empiricist theory of knowledge. Explanatory theories that locate women as physical beings in a framework of social and moral relations (i.e. formal religions and social philosophies) have become increasingly implausible, for their basic symbolic categories are severed by the contrasting logic of the dominant production modes and the dichotomised ‘natural’ and ‘social’ sciences. Women in modernised societies, at least in America and England and increasingly in cities in Ghana, Malawi and Malaysia, experience themselves less and less in terms of symbols and collective action which integrate the physical, social and moral dimensions of being, and more in terms of categories which radically dichotomise self and other, and introduce the set of related symbolic oppositions alluded to above. Reconciliation of these distinct domains becomes increasingly problematic, for social and moral relations become eclipsed, and their role is replaced by the impersonal ‘natural’ or ‘rational’ principles of formal knowledge.
Cultural Types and the Childbirth Choices: Shifting Allegiances
A Response to Globalisation-Localisation

Hierarchist

- Large numbers of midwife practitioners, educators and women are moving into this arena under the forces of globalization - from all other cultural types.

Entrepreneur

Hierarchist

Isolationist

- A small number of women in America and UK are aligning themselves with isolationists from the other cultural groups.

Egalitarian

- Social capital being created and re-created by players.

Entrepreneur

Hierarchist

Egalitarian

- Increasing numbers of midwife practitioners, educators and women are growing dissatisfied with hierarchist modes of operation and are moving into this arena under the forces of globalization.

Movement out of cultural alignment - size denotes level of migration in response to the forces forming social capital
Yet through personal experience, especially in childbirth, women disconcertingly challenge the adequacy of tacitly assumed material individualism and some are shifting allegiances toward more egalitarian modes of operation or indeed, are isolating themselves to achieve their personal goals (see figure 13.3). At such times they come face to face with universal conundrums of human existence as they are refracted through the lens of their socio-cultural system, and projected in such contexts as that of childbirth practice (after Comaroff, 1982: 58). For childbirth stresses the ambiguities of physical and social being, and of life and death as urgently as for any other human population, and they more often than not look for the resolution of dilemmas in medical processes. Americans, in particular, however, are caught within the contradictions of their own socio-cultural order, for the ideology of modern Western capitalism, that of rational individualism, rests upon the reinforcement of the very symbolic oppositions which, in the context of childbirth, they sense and try to transcend. Thus, with an alienated image of self, caught in the opposition of mind and body, and cut adrift from the wider social and moral context, they attempt to impose 'meaning' upon an estranged world.

There is evidence to suggest that the dependence of the sick upon others - with or without special skill - engenders ambivalence in most cultures (Illich, 1976). But the extreme dependence upon specialist knowledge and professional intervention which has developed in modern Western societies has led to considerable popular dis-ease - although, it has not really led to such consciousness as would make it possible to confront the contradictions upon which the dissonance is based. Indeed, the conditions
for the development of such consciousness within the logic of scientific-technological culture was the subject of considerable debate among students of ideology (see Marcuse, 1972: 138; Habermas, 1971:111; Mandell, 1980:501). Moreover, what is deemed scientific by the public and policy makers in government is often folklore science, pseudo-science that has been translated by the popular press for public consumption. In this way the true details of the scientific results are distorted and disseminated to a larger audience who have little or no access to the full research papers. Furthermore, it seems that as each scientific theory is abandoned for the next by scientists, this is not the case with either the popular press of policy makers who cling to old studies while adding new data thus creating a miss-match of information that is often inappropriate upon which to base decisions about health care, lifestyles or childbirth practice.

It is these confused data that are being distributed globally through media networks and the world wide web and play an active role in promoting American foreign policy (see appendix 8).

*The unpenetrating mind*

The consequence of this, I would argue, is a ‘closing of the mind’ for many midwives, which ultimately results in a reduction in their knowledge about the ways in which the women’s bodies work in childbirth. The reliance on technical measurement means that midwives may no longer acquire the skills to listen and learn from situated knowledge.
The behaviour I witnessed during interactions with women in childbirth and the subsequent telling of the story, was an indication of how subtly and indirectly midwives communicate with one another. It also demonstrated that their language was composed of significant nonverbal elements. As well as noting what midwives said to each other, I paid a great deal of attention to the forms of behaviour around me. As a result I am convinced that I have discovered more than I would have otherwise. Probably my most useful means of obtaining insights into the way midwives conceive their social and professional world involved the informal meeting place where midwives gathered, the coffee bars, and restaurants during conferences or over the Internet. In many ways, these midwives were able to take a step back from their day to day working lives, escape for a few hours from the oppression they experience, to free their thoughts and explore ideas with other midwives. For many, the feeling of anonymity released their thoughts and freed them to exchange information, share stories and ‘gossip’ about the behaviour of others. One of my strategies was to begin a conversation with midwives and others would join in to elaborate on what was being said or to disagree with it. One evening, in the company of six midwives, I began an open discussion about what symbols represented midwifery values as reflected in the following field note excerpt.

According to the focus group midwives, it recently emerged that a number of midwives were undertaking a course to learn how to use the Penard stethoscope, traditionally a midwife’s main tool for listening to the fetal heart. The fetal stethoscope remains symbolic of normal labour.
and carries the expertise and hegemony of the midwife. Sue reminded the group that fetal stethoscopes were given away at the 1996 triennial congress of the International Confederation of Midwives in Oslo. This was to emphasise the role of the midwife as a practitioner of the normal. Three thousand midwives from all over the world attended that conference and received a Penard stethoscope. Midwives from developed countries were asked to donate their Penards to midwives in developing countries at the end of the conference as a practical resource for those midwives without technical resource. For Sue, this symbolised the handing on of the badge of the midwife. For others, who had not been present and caught up in the atmosphere of the conference, it was symbolic of the passing down of obsolete tools to a more primitive culture. The inference being that midwives in modern societies had no practical use for the Penard stethoscope.

Three years later, some midwives were participating in an activity to symbolically reclaim their idealised role. The reason given for the course was that midwives, because of the extensive use of modern technology in the form of electronic fetal monitoring machines, had lost the skill to hear and recognise subtle changes in the fetal heart. They were unable to give what they described as 'normal' midwifery care. For many midwives, therefore, the machine had been appropriated into concepts of 'normal' midwifery practice.

Helen argued that midwives are merely replacing low level of technology with a more sophisticated version. Kay believed that the skills required however are different. The fetal stethoscope requires skills of careful and intuitive listening so that the midwife can
detect fetal heart rhythms and differentiate the fetal heart from the placenta or cord pulsations. The electronic version requires skills in applying the machine correctly to the woman’s abdomen and reading the resultant fetal heart trace. Midwives needed special training to read the results of the trace.

Andy argued that using the fetal stethoscope requires intimate contact with the woman whilst using the machine distances the midwife from the woman. After first applying the machine, there may be no further physical contact with the woman, except to undertake internal examinations or deliver the baby. The most significant difference, however, Sharon suggested, was that listening to the fetal heart through a Penard stethoscope remained in the midwife’s control. Only she can hear the fetal heart, only she can interpret and record her findings. It was an act that required knowledge, skills and confidence in her ability and a great deal of trust on the part of the woman in childbirth and the midwife’s colleagues.

For Allie that was the crux of the matter. There was an increased level of risk perceived by those who did not control this activity. The fetal monitor, on the other hand, provided information that was accessible by everyone. Interpretations could be publicly agreed. Once the data entered the permanent record and it would become an historical text. The power, in this situation, lies not with the midwife but within a hierarc. usually headed by a doctor.

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

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

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

According to Fairclough (1985) and Wodak (1995) critical discourse analysis attempts to explore 'hidden' relationships between a piece of discourse and wider social and cultural formations to show how the discourse is shaped by relations of power and struggles over power to reveal links between discourse, ideology and power. For Corson (2000) a critical discourse analysis usually involves much of the following:

- An interest in uncovering inequality, power relationships, injustices, discrimination, bias and so on;
- An investigation of language behaviour in natural language situations of social and cultural relevance – public institutions, media, political discourse, and so on;
- Interdisciplinary research addressing subjects too complex to deal with inside a single field of study;
- Inclusion of an historical perspective on the research study;
- Researchers who 'take sides' in order to improve the lives of people in some way;
- Research that changes social practices and emancipates people.

The intricate link between discourse and power is central to all of this because any exercise of power by human beings is affected by the discursive nature of power itself. As Foucault (1972, 1977b, 1980) observed, history instantly teaches us 'that discourse is not simply that which translates struggles or systems of domination, but is the thing
for which and by which there is struggle; discourse is the power which is to be seized' 
Foucault, 1984:110). Rather than a privilege that an individual possesses power is a 
network of relations constantly in tension and ever-present in discourse activity. It is 
exercised through the production, accumulation and functioning of various discourses. 
Discourse here is the fickle, uncontrollable 'object' of human conflict, although no-one 
is outside it completely or sufficiently independent of discourse to manage them 
effectively. Corson (2000) argued that this conflict that takes place over and around 
discourse can be one-sided if the balance of power consistently favours some group 
over others. This can be clearly seen in the obstetric versus midwifery discourse 
exhibited in the decisions and regulations that are among its constitutive elements, its 
means of functioning along with its strategies, its covert discourses and ruses that are 
not ultimately played by any particular person, but which are nonetheless lived by the 
group (see hierarchical cultural type, page 33). These ensure the permanence and 
functioning of the institution and the violence serves to silence midwives voices 
(Parker, 1992; Skillings, 1992; McCall, 1996; Farrell, 1997; (Leap, 1997:689; 

So to the question of the validity of my research. As I reflect on my experience of 
research I have reaffirmed that the childbirth is a highly complex amalgam of 
interlocking processes set within a context of a increasingly complex universe. As space 
and time compress, childbirth becomes ever more standardised and routinised and yet 
the very nature of globalisation offers opportunities for change and diversity. Ultimately 
what I was attempting to do was to make sense of my own experiences of being an
educator and practitioner-researcher engaged in interpreting and re-interpreting the women’s experiences of the world, and childbirth from different perspectives.

What I learned was that my experiences and that of others do not fit comfortably into suitably defined and labelled boxes marked medicine, body, mind, economics, environment, social, cultural, science, magic and so on. Women and their experiences of childbirth continually evade the boundaries that have been demarcated by obstetricians, policy makers, insurance agencies and midwives who fall into a hierarchist mode.

The broader framework of contextual issues surrounding the multi-dimensional study directed me to an extensive examination of the literature regarding modernisation, globalisation, economic and structural reform, sustainable development, environmental issues, socio-cultural factors, economic imperatives and the role of global corporations in determining the lives of women in childbirth. The study has enabled me to look at the impact of symbolic exchanges on women and midwives and challenged me to consider Safe Motherhood and midwifery education and practice in this context.

The Limitations and Strengths of the Research

I consider that the greatest strength of this study was not only its breadth and depth, but also that it was undertaken in the cultural context. I was privileged to work with women and midwives at every level of those societies under study – from government to village levels.
It is acknowledged that this is a highly complex and ambitious research project. To address issues of childbirth in one country would have been deemed courageous but to consider childbirth in five countries on four continents was perhaps, on reflection, foolhardy. The sheer quantity of data alone was daunting and proved difficult to control at times but the validity of the research, I would argue, did not come from the volume, but from the multi-perspective and multi-dimensional approach adopted in engaging with women, midwives and birth attendants in five countries. Consequently, the validity comes from veracity rather than numerical calculations.

What could have been perceived as a weakness of the study, that my primary purpose for being in Malaysia and America was to enact another role, became, in the end, a strength. Despite finding myself constrained to specific areas of those countries rather than having the freedom to travel more widely to collect data, my role as an educator teaching research, developing curricula and meeting students and staff also had the effect of opening avenues for study, access to materials and participants that might have otherwise been denied me. For example, it would not have been a simple matter for me to access the Amish community without the assistance of the nurse-midwives in Pennsylvania.

Another fundamental weakness of the research was my own lack of local languages. I had to rely on translators in Africa and Malaysia that brought with it inherent challenges and difficulties. It was not always possible to check out my interpretations with the women involved at the time or in some cases later since many of the interpretations came later once I had left the country. Moreover, lacking sufficient insight into local
customs meant that I had to rely heavily upon local midwives for guidance. This was both a weakness and strength since the approach taken by the local midwives was one of enfolding me into the community. I was ‘adopted’ in Africa as one of their own – lost to the New World – (since I am West Indian) and they considered that I had to be re-integrated into their community. Consequently I learned a great deal more, perhaps, than I would have otherwise and gained access to ceremonies and birth that an outsider would have had to spend much longer with the various groups to achieve. This, in the long run, allowed me to gather ethnographic data in a much shorter time frame than is usual. It is clear, however, that much longer periods of time need to be spent with selected groups of women and midwives in different countries to truly delve deeper beneath the surface of what could be, in effect, only superficial changes. One possible research question would be to what extent does resistance to western ideology exist and how is this manifested globally. I would be interested, for example, to what extent does resistance in developing countries, if it exists, mirrors resistance in western countries.

Concerning the research methods and tools used at this juncture, is appropriate. Because I was engaged primarily in the education of midwives before the methodological establishment of this study, the research methods evolved out of my practice as a practitioner-researcher. The highly complex nature of women in childbirth required a complex and integrative approach. In order to arrive at an understanding of the determinants of women’s lives and their births, I needed to study the world in which women lived. I needed to explore the environment, the social-cultural complexities of their lives, and the economic, technological, medical, political forces behind and inherent to globalisation to arrive at an integrated picture. That is not to say that I did
not face difficulties. Each country presented different challenges. In Africa I soon
discovered that using use tape recorders generated more interest in the technology than
in answering my questions. The children soon stole the machine for their own use.
Besides which, my lack of language ability meant that any recording would need to be
translated and therefore would defeat the object of the exercise. Instead I learned very
quickly, as the Africans do; to mime and recite the story back to them until the women
were satisfied that I had understood their meaning. I later made field notes to capture
the essence of the story, which I clarified with my escort the following day.

I began by saying that this thesis was my story and in recording the data and writing the
thesis itself meant that I had to engage in a selection from field notes for analytical
purposes and then a further selection to provide illustrative material to illuminate the
thesis. Any research of this complexity will entail a double selection process from data,
even if it is not acknowledged, and may in itself present an aspect of subjectivity in the
writing.

I found the storytelling approach to be unequivocally valuable. It allowed me to access
areas of women's lives as well as my own life, to make sense of the experience.
Maintaining a daily diary permitted me to take a heuristic approach to the study since
this became for me a personal, as well as a professional journey. Personal bias, of
course, played a significant part of the research, yet, in recognising this, the breadth of
the study and depth of the experience, I believe, compensated for any indulgences that I
might have engaged in. The danger was one of not seeing the obvious, both on the part
of the participants and the researcher. It would have been all too easy to see the poverty
in Africa and Malaysia and been swept away with the deficiencies in childbirth systems and yet maintain a balanced view of the people and their struggles. The Africans I met struggled – but mainly overcame difficulties with ingenious inventions. The American Nurse-Midwives faced their own challenges and had novel solutions. In attempting to maintain honesty in the research I used a technique of interplay of stories – juxtaposing one set of issues against another to ‘see’ from different perspectives to avoid falling into the trap of exoticism.

Participants’ responses, some may argue, could well have been only that which they thought I wanted to hear. This was especially a concern in Malaysia where it is considered impolite to disagree with a ‘guest’ or teacher, or with someone they considered further up the hierarchical ladder. I found that the telling of stories helped considerably with this aspect. I was not asking direct questions to which respondents were required to ‘tell the truth’; I was inquiring about their lives as they told them through stories. Many of these stories were written in English by some of the women and midwives I encountered for my benefit and they were very eager to transmit their ideas and beliefs.

This thesis gives some indication of the tremendous variations of childbirth and the midwifery curriculum worldwide. In each culture all participants normally share a feeling of appropriateness - the woman giving birth, her family, and her professional or lay attendants. It is difficult, therefore, to separate, within any given cultural setting, what is physiologically necessity and what is social production. It may not be as simple as that. Culture is itself multidimensional and not merely a product of the geographical
location. For many women and midwives, there is a growing tendency to choose, sometimes aggressively, a cultural stance that may well vary from the cultural position of people within their locality.

Applying cultural theory (Schwartz & Thompson, 1990; Thompson, 1988; Thompson et al, 1986) to the confused and stormy debates on childbirth policy, I have listened attentively to debates about childbirth and have attempted to extract the basic assumptions from the varying arguments. Ultimately we arrive at a point of infinite regress where no conclusion is made and eventually explanations end with the different strands in the childbirth debate making appeals to the way that pregnant women are. Following Thompson et al (1990), I attempted to track down four distinctive myths of nature as these apply to pregnant women. Each is the account of the world that will justify the way of life to which the individual is committed. The commitment is not a private intention. It is part of the culture with which the speaker has chosen to be aligned.

All midwives have to balance contradictions inherent in their social and working lives as well as contradictions between their traditional values and the modern ones that they either have imposed upon them or invoke. In Malaysia, for example, with their three major ethnic groups and three different value systems, the Indian women are expected to abide by the traditional values of Indian society, thus for the village Indian woman who works in the employment market, she not only violates traditional Indian values prescribing women's economic dependence, but also modern market values that praise men, but not women, for pursuing employment success. These women facing,
negotiating and balancing multiple value contradictions reveal the contradictory implications of modernity values that are being globalized.

Moreover, the gathering momentum of obstetric control over childbirth presents women and midwives with further value conflicts. According to DeVries (1992), the way an occupation gains power, or acceptance, in Western societies, is to emphasise the risk involved in life events: the greater this risk and uncertainty, the more value and power the profession has. This concept is increasingly being globalized. DeVries believes that midwives have less of a chance of acquiring a respected place within modern medical systems because of their emphasis on being the experts in the normal and the low risk. Midwives try to reduce the emphasis on risk and fear in birth and instead value the inherent normalcy of birth and the power of the birthing woman.

Whatever the ultimate outcome might be - greater homogeneity or heterogeneity of culture - and this is hotly disputed, the contemporary phase of globalization has thus resulted in more people than ever before becoming involved with more than one culture (Featherstone 1990:8). Consequently, the midwifery curriculum has to have elements that reflect both global and local cultural concerns that enable students of midwifery to become and remain open to differing perceptions.

**In Conclusion**

This thesis has addressed the following questions:

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

Given Lawton's (1974) definition of a curriculum being a selection from culture, further question, therefore, must be:

Can there ever be a universal midwifery curriculum that is constructed from something other than a policy driven selection from culture or move beyond hierarchical objectives model of curriculum or one that is based on medical ideology concerning content orientated to address childbirth dilemmas, or is the ripple effect going to continue to generate different curricula?

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

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

   • What are the defining characteristics of globalisation, modernization and development?
   • Does globalisation inevitably mean modernization?
   • Does globalisation inevitably lead to Westernization or Americanization?
• Does globalisation only progress in one direction – centre to periphery – fast to slow world?

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

• How do women construct their lives in a rapidly changing social and cultural context?

• How do the changes impact on childbirth practices?

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

• What is the value of science in childbirth?

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

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

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

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

The starting point for this study was the evidence that the midwifery curriculum is intimately linked to and concern the lives and experience of women in childbirth. The
curriculum cannot be based on an abstract set of ideas but must, in my view, be connected with the women whose lives we as midwives come into contact with. In opening the door to glimpse some of their experiences, I now begin to see the limitations of curricula based solely on either a content and transmission model, or hierarchical objectives with the curriculum as product and education as instrumental model which are the most commonly adopted models globally. Both models will tend to keep midwifery trapped in the hierarchist arena with the resultant narrowing and closing of the midwifery mind. Some curricula are emerging that challenge the hierarchist platform and may engender more than cosmetic change sin the future if midwives are enabled to participate in organisations that recognise the value of the midwifery model.

Those who bear the brunt of the system’s dysfunctions, that is midwives and women in childbirth, have been stripped of decision-making power and are held in a state of confusion regarding the cause of their distress by corporate-dominated media that continually bombard them with interpretations of the dangers of childbirth based on the perceptions of the power holders. An active propaganda machinery controlled by the world’s largest organisations including the WHO, World Bank, and other non-Governmental organisations, constantly propagate myths and rituals to justify the spread of the dominant western medical ideology and mask the extent to which the global transformation of human institutions is a consequence of the sophisticated, well-funded, and international interventions of a small elite whose money enables them to live in a world of illusion apart from the rest of humanity.
As midwifery educators become increasingly global in their reach, we must now begin to appreciate the issues surrounding the globalisation of modernity, which has taken human beings in one direction, trading synthesis for analysis, sacrificing community for the individual, creating a blame culture born of the tyranny of risk, and losing focus on the real issues concerning childbirth in the process (Maclean, 1999).

It is within our means, however, to reclaim the power that we have yielded to the dominant institutions and re-create communities that nurture cultural and biological diversity, thus opening vast new opportunities for social, intellectual, and spiritual advancement beyond our present imaginings.

*Recommendations: The Future of Midwifery Education and Practice in the Context of Globalisation and for Further Research*

The symbolic exchanges impinging on women's lives and midwives' practices as a result of globalisation revealed in their narratives of childbirth point to a lost world where some of the pre-modern practices may be more valuable than current ones and perhaps late modernity is allowing us to more clearly identify them.

The curriculum for midwives should enable them to see the wholeness of childbirth, which might include practice experience in other countries so that they might understand the different ways of birth and set the reality of practice in the context of their own practices.
What emerges from the stories and the issues raised by globalisation's 'ripples on the pond' is perhaps the need for more research into women's satisfaction with childbirth globally.

In opening the door of globalisation and localisation I now realise that we do not have enough knowledge and experience of the different cultural types of birth and more research needs to be undertaken in order to answer the questions I started with more fully.

1. **Understand Global Processes**: Midwives should recognise the processes of globalisation and localisation and appreciate the impact of modernisation, and development upon women in childbirth during their preparation programmes so that they can be better placed to make judgements about the types of practices they transmit and the potentially oppressive tendencies of the dominant cultures.

2. **Examine Health Care Systems**: Every health care system should examine its procedures and protocols to tease out the negative effects of unjustified medical ideology, but moreover, organisations need to examine their procedures and practices that may foster and perpetuate horizontal violence.

3. **Re-Define Midwife**: Recognise the differential nature of the practice of midwifery around the world and avoid reducing the art and science of midwifery to a single closed and scientifically biased definition. Reducing midwifery practice to solely the participation in antenatal, labour and birth renders it ineffectual since women's health begins before birth and is continues throughout the lifespan. Being 'with
woman’ does not mean being ‘with woman during pregnancy and birth’ which is recognised in many traditional cultures that provide continuity throughout a woman’s lifetime. Our definition of a midwife must include the traditional midwives who are so insensitively and derogatorily called TBAs.

4. **Develop a genuine midwifery model:** That a true midwifery model is developed that is based upon living and learning from women. I am unconvinced that a midwifery model that is based on contemporary practice in hospitals, using technological basis can ever truly explore what it means to be pregnant and give birth or to be a mother. That requires looking, listening, watching, hearing and spending a significant amount of time with women. This time is not available in hospital settings with time being the determining factor of care and where midwives have set duty spans that do not coincide with women’s labours and births. The empirical midwife movement in the United States according to Tritten,

    ...is one of those few islands where technology, money and brainwashing haven't taken over common sense, evidence, and woman centeredness. The brainwashing process has never gained a foothold because the lay midwife's training is not within the medical model. This re-creation of "authentic midwifery," a term coined by Dr John Stevenson of Australia, is a unique contribution of these lay American midwives.... (Tritten, 1999:1)

5. **Expose the moral imperatives in the profession:** The midwifery profession should examine its underpinning values and beliefs – does the profession only exist to protect and serve itself or is it really there to serve women?
6. **Conduct and value as credible midwifery research** that is based on collaborative inquiry with women and for women. A spirit of inquiry among women and midwives working and learning together may answer many of the unknown questions about childbirth, such as physiology of cervical retraction.

7. **Change Education Programmes and Research their effectiveness in achieving the desired goals and purposes.**

Education programmes should examine the basis upon which they are developed and begin to move from a hierarchist model to one that is more egalitarian, recognising that this may be a long and difficult process but must be achieved if childbirth is to change beyond cosmetic refinements. Programmes should begin to recognise the potential of midwives to engage in social action and social change, that midwifery is more than just transmitting anatomy and physiology or ‘doing the mechanisms of birth’. Such a model of learning would necessarily be collaborative and interactive within and between groups of people. Figure 13.4 shows a model of interactive collaboration between diverse but inter-dependent inquiring groups of people. In this model, women, initiates and midwives work collaboratively to achieve desired outcomes of the childbirth process. Midwives can and do make a significant impact on the way society is and can make changes to the benefit of women in childbirth.

7.1. **Social Action and Social Change:** Empowerment should be based upon people identifying and analyzing their own issues, developing theories or perspectives...
to enhance their understanding of the roots of their issues, and determining the course of action most appropriate for their situation. Cultural synthesis is an important issue here for it does not mean that objectives of 'revolutionary' action should be limited by the aspirations expressed in the world-view of women and midwives. If this were to happen (in the guise of respect for that view), the revolutionary leaders would be passively bound to that vision. As Freire (1972:149) stated,

'Neither invasion by the leaders of the people's world-view nor mere adaptation by the leaders to the (often naïve) aspirations of the people is acceptable.'
Figure 13.4

A Collaborative Social Action Curriculum Model

Creating social values:
Developing new thinking and practice
Moving from rhetoric to reality of childbirth

Public/Voluntary Sector Organisations

Extended Collaborative Community

Core Collaborative Inquiry Group

Inquiry Support Group
Women, Students

Inquiry Support Group
Women, Students

The answer lies in synthesis that requires leaders on the one hand to identify with women's and midwives' demands for the humanisation of childbirth services, while on the other hand they must set the meaning of that very demand as a problem. By doing this, the leaders pose as a problem a real, concrete, historical situation of which the demands for the humanisation of childbirth is only one part of the problem and satisfying that demand alone cannot comprise a definitive solution. Another part of the problem is the demands for better working conditions for midwives, free from horizontal violence (Leap, 1997). Salary demands alone cannot comprise a definitive solution for the essence of this solution can only be found if midwives can become the owners of their own labour since any purchase or sale of labour is a type of slavery (see Freire, 1972:150).

7.2. **Perspectives on Women:** Whether in the village in Africa or the urban centres of northern England, people's experiences and backgrounds will influence how they view women and social action. To understand someone's perspective on women and social action, we need to understand their background and experience.

7.3. **Leadership and Social Action:** In an empowerment model for social action and social change, leadership is group-centred; leadership is rooted in the needs,
perspective, and direction of the group directly affected by a situation. Important leadership skills in an empowerment model include: interpersonal communication skills; ability to encourage others to distinguish personal troubles and social issues; respect for the ability of others to identify, explain, and solve their own problems; and accountability to the group.

7.4. Commonalities and Differences: In an empowerment model of social action and social change, groups work toward a common purpose while also recognising diversity within the group. Recognising diversity means a group works to understand the ways that differences in power and culture among people affect their experience of a situation and the implications of these differences for theory and action.

7.5. Gender Socialisation: Gender socialisation is a multi-dimensional, socially constructed process, which can affect the ways women, and men participate in social action and which can be altered by social action. Suppression of the woman's voice and denial of her experience also affects the richness of the midwife's knowledge and understanding. Obstetrical practice has worked over the years to silence women's stories.

7.6. Transforming Knowledge: People learn about gender, race, and class through social institutions, such as the media, hospitals and schools, not only through the content presented, but also through the format of presentation. To transform knowledge about gender, race, and class requires altering both content and
method but moreover, altering the way in which education is conducted. Learners should be enabled to inquire and work collaboratively with others, should be able to search out their own meaning and work closely with women to develop their tacit knowledge and personal theories.

8. **Re-examine and challenge medical education and practice**: That educators, policy makers and other stakeholders examine the nature of medical education and the effect of the 'scientific' paradigm on women in childbirth so as to address the criticism of the past three decades. Little has changed since the attacks on the medical profession by Foucault, Illich, Goffman and others. With the increasing availability of information across the world wide web and women being able to access not only what their doctor tells them, but also alternatives opinions held by equally credible scientists and medical personnel, the challenge will become greater and far from using technology to protect themselves, as seems to be the case for its unjustified use, the evidence from the technology will be increasingly turned against practitioners. What we are beginning to see in the United States as well as in the United Kingdom, is a diminishing desire of doctors to enter obstetrics because of the fear of litigation. This in the end may have both beneficial and deleterious effects in the long term.

What I would wish to recommend, ultimately, is global societal change. That seems to be the precise requirement to ameliorate the deleterious effects of centuries of scientific determinism and instrumentalism. That is not to say that science is bad and that we have not gained considerably from science, rather, it is to argue that a balance needs to be
achieved if science and medicine are to avoid iatrogenic consequences. There is no going back to the past, neither would I want to. I have no wish to return to the kind of life I sampled with Ama in her village in Ghana, rising at four in the morning, walking miles on rough dry ground to gather water and wood, pounding ‘fufu’ to feed the family. I live a different kind of life, as do most women in modernised and urbanised societies. No, I am not calling for regression but progression to a place where life can re-capture the essence of community and maintain the benefits from the advances of justified science and technological development. I would wish to progress to a point where midwives and women, comforted by the presence of science, can spend time together, learning about the true nature of birth within the context of birth, not in a laboratory or classroom studying decontextualised, abstract theories of women in childbirth.
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Appendix 1

The Research

Part I: Rationale and Processes

Significant and rapid changes have occurred across the broad range of research disciplines. New insights, methods, and paradigms have emerged, sometimes bringing with them controversy, uncertainty, and challenges to predominant perspectives. More than ever, research is affected by many internal and external forces including the development of new research tools, a changing work environment, and economic pressures.

New research tools carry with them their own imperatives. These new tools create an impetus towards greater specialization as well as a contrary thrust towards a more integrated understanding of the connections among diverse domains of knowledge. In many areas, research has shifted from individuals working alone in libraries or laboratories to multidisciplinary team endeavours, often with members of the team located in multiple centres across the country or around the world. Research, as a direct consequence of the reflexive society, has also shifted away from seats of higher learning to the practitioner undertaking research within his or her own workplace or area of practice. For as Jarvis (1999:xii) points out, with society becoming increasingly reflexive as a social consequence of modernity, practitioners have as an inevitable outcome, to become reflective. Reflective practice and learning creates practitioner-researchers.
Under the conditions of globalization and increased mobility of practitioner-researcher, cross-cultural investigation becomes of increasing interest and value. Cross-cultural investigation of changing childbirth practices is of interest because given that childbirth is a universal event, it is important to arrive at an understanding of the effects of global structural reformation upon childbirth. Since it is difficult to perceive the changes from within one's own system, it is therefore necessary to look outside the system to determine what changes are taking place and the implications of those changes.

In addition, since giving birth in most societies is women's business, a study of the ways in which birthing is managed from a global perspective in different cultures cannot but improve and broaden our appreciation of the organisation of female networks, interests, and strategies. It is only in the last twenty-five years that anthropology has come to recognise that our views of social organisation consistently ignored the many and varied places of women in society, resulting in distorted and impoverished ethnography (Rosaldo and Lamphere 1974). An investigation of an event in which women figure essentially and centrally provides some access to women's ways of organising and accomplishing childbirth.

It is for this reason that cross-cultural perspectives can be expected to provide information for a better understanding of childbirth, an understanding that is not available from the internal viewpoint of any particular system. Because comparisons are being made within a socio-representational framework, the results should tell us about the ways in which childbirth is socially organised and culturally produced and should
provide strategic guidance for the changes that are unavoidable in the daily activity of contemporary birth.

**Challenges to Cross-cultural Studies**

Cross-cultural studies in many respects present both general and specific difficulties. I had to face the challenge of being unable to speak the languages in Africa and Malaysia, and of trying to understand the meaning behind the language used in America, Africa and Malaysia where English was spoken. Challenges were also be found in three other levels, namely:

- Insufficient documented data: general paucity of information on childbirth and midwifery education and practice in Africa and Malaysia
- Narrow documented data: particular bias of data available, particularly in regards to non-medical approaches to childbirth and references to the wider global dimensions – economic, political, technological, media, and social changes as they impact on women in childbirth.

**Insufficient data**

Given that the study was concerned with an event that is common, physically and socially clearly marked, and significantly implicated in the social life of any group, it was surprising that information on childbirth practices and, as a corollary, midwifery
education, was sparse. Indeed, data useful to holistic conception of childbirth were primarily notable for their absence. There was practically no good, direct, personal observations of childbirth among villagers by competent observers in Africa and Malaysia at the time of my study and little documented data about birth in hospitals other than statistics gathered that emphasised death rates. The experience of childbirth and its meaning for and impact on women, and the ritual hospital practices undertaken were all neglected.

When Jordan’s book was first published in 1978, she claimed that there was not a single ethnographic film on nonmedical birth in a non-western society. Medical reports were often handicapped by obstetrician’s orientation to pathology and by the fact that doctors working in Africa, and the United Kingdom tended only to see the cases of abnormal childbirth. Physicians in America and Malaysia may conduct ‘normal’ births but often these births are accompanied by technological interventions such as intravenous infusions, internal and external fetal monitoring devises and so on. The opportunity to ‘see’ childbirth as perhaps a TBA or midwife working in the community in England is often not available to them.

My own extensive literature search for material on birth in different cultures revealed that more than two thirds contained little or no description of normal birth within professional publications. This lack of data is significant given that the birth of a new member into a social group not only is important for the perpetuation of that group, but also transforms the status of women, the father, and the family. The status of the birth attendant also changes as adds this experience to her ever growing store from which to
draw upon in future births. Childbirth not only has cultural and interpersonal significance, but also religious, political, and economic implications.

This lack in producing descriptions of indigenous births can partly be explained by the fact that, although birth is commonplace compared to the events anthropologists normally investigate, it is also exceedingly difficult for male anthropologists to gain access to - and most anthropologists, until fairly recently, have been male, Caucasian and middle class. This is not to say that in principal male anthropologists cannot study birth. The fact is, they have not done so. Part of the reason for this is that male anthropologists themselves have attached less importance to the activity of childbirth, which was often conducted in the private sphere, away from the public eye whereas puberty rites, warfare, kinship organisation, economics, and the like were conducted as public spectacles. Moreover, their lack of attention to birth in the past may well have reflected the status of women in the early development of the social sciences (Rosaldo and Lamphere 1974). On the other hand, it must be recognised that access to the birth event is quite generally difficult for outsiders to attain.

Narrow Data

In addition to the paucity of documentary data, a second obstacle to cross-cultural investigation was to be found in the nature of the information that was available. It fell into two categories: one is medically orientated, the other is narrowly anthropological. Medical personnel have from time to time given accounts of birth in other cultures, but these reports tend to focus on the physiological (and often abnormal) features of
pregnancy and childbirth and usually left out what is of interest here - namely, the impact of changing society on women in childbirth. Somehow this gets left out of theoretical works on birth. Moreover, anthropologists tend to focus on the woman, while doctors tend to focus on the fetus as a separate entity. This is fundamental in the thinking of amongst the various cultural types and leads to different approaches to childbirth. It affects women’s thinking too, particularly in relation to the dominant ideology of the culture in which they live.

The statistical compilations of the World Health Organisation and other demographic surveys contain extensive multinational data on such variables as infant and maternal mortality and morbidity, the availability of medical personnel and facilities, the nutritional and epidemiological status of the population, and so on. These data are useful for positioning obstetric care within a country’s health care system and, when level of development is held constant, provides some idea about medical “success” of a country’s childbirth practices. They tell us little, however, about the changing nature of socio-interactional aspects of childbirth under the conditions of modernization or globalization.

The second category of cross-cultural investigations of childbirth, anthropological studies, defines its areas of investigation narrowly. Anthropologists traditionally have been occupied with such topics as kinship, ritual, conflict, belief systems, and the like, and the information available on non-western societies reflects this emphasis. Thus we have fairly detailed information on ritual ways of disposing of the placenta or the umbilical cord, but we know little about the nature of the decision-making process (or
the knowledge which informs that) during childbirth or the influence of the conditions under which birth takes place.

**Ethnographical approach**

As the process of giving birth is characterised by a high degree of non-public intimacy, as it has to do with bodily functions and bodily displays, collecting data by asking questions proves unsatisfactory in fundamental ways. Quite apart from taboo topics and culturally conditioned inhibitions, childbirth is an event of great interactional complexity, where people know how to do it, without necessarily being able to talk about the details of what they do. The insider view is particularly relevant to an assessment of justificational procedures and they add some interesting and important perspectives to the study, however, insider views are insufficient for an adequate understanding of how the total system works. As a midwife myself, I was already well versed in the knowing the ‘how of birth’, that is to say, I am knowledgeable about the behaviours in which birth participants engage as competent performers in the UK. I was concerned, however, to gain detailed insight into other forms of system-specific ways of ‘doing’ birth, therefore, participation in and observation of the process was necessary.

The second problem that must be avoided in investigations of this nature, is the gratuitous imposition of own-society categories (and in this case, particularly medical categories) for the collection of data about childbirth. For example, one independent midwife in the UK (private communication, 1999) was attempting to re-discover and develop a clear midwifery discourse that was distinctly different from a biomedical
focus of birth now so ubiquitous in maternity and women’s health care she found in the
England, and I found in all five case study countries. She was focusing on defining a
midwifery diagnosis of the onset of labour in an attempt to escape medical definitions of
labour. But the very use of the term diagnosis placed her study firmly within the
medical discourse just as the notion of an onset of labour did. For some midwives,
labour is merely a continuum of the contraction of the uterus throughout pregnancy,
gaining in strength until the birth is achieved. The notion of putting discrete boundaries
around specific phases of pregnancy and labour comes out of the western tradition and
modernity where life is segmented and separated. Again, this is not to say that medical
categories are irrelevant, but merely that immersion in the phenomenon, participation in
the birth event, must suggest the relevant features for description and analysis. For this
reason, anthropological participation as the fundamental methodology that, in
combination with other methods, promises to provide the foundations for a holistic
conceptualisation of the meaning of the event, its associated contextual determinants,
and its relevance to cross-system issues regarding the conduct of childbirth and the
education of midwives.

My particular notion of anthropological participation, as described by Jordan (1993:11),
incorporates more than my physical presence or joining in the activities of the “natives”.
First, my interest lies not in childbirth as a product, an object with specifiable
characteristics, but as social production. That is to say, my concern is with the actors
involved in childbirth, with the production of what actors talk about as the ‘way of
birth’ and what directs and underpins decisions made about childbirth. From this
interest springs a consistent orientation to, and taking note of, the recurrent features of
childbirth in particular settings, the observable and reportable verbal, nonverbal and symbolic activities that are undertaken in accomplishing, for example, an African or Amish birth. An integral part of my participation was the noting, the asking of questions about, the comparing of what I came to see as features of particular birth settings.

Secondly, my orientation was to the performing of birth by women and others, including all persons (professionals and non-professionals, including myself) who were engaged in the common task of creating an event and making it visible as the activity at hand. In the particular birth events on which this investigation was based, participants sometimes came from different cultural backgrounds or spoke different native languages. Some of them had never attended a birth before, and others had themselves borne children or witnessed births in various kinds of settings or had managed births as professional specialists. Each person’s participation was seen as providing resources for constructing the birth as a locally rational event.

Such things as instructions for what to do next, demonstrations of correct procedures, questions about how it’s done elsewhere, discussions of the relative benefit of this way versus that way, citations of authorities and textbooks, stories of how it is done in a particular case, and so on, constitute some of the methods participants used in the course of conducting a birth. Impairment of an event’s proper course in participants’ eyes (i.e. “problems”) provided an occasion for players’ collaborative restoration work, that is to say the re-establishment of a normative order. Restoration work, which may often be symbolic, as well as physical, verbal and non-verbal, thus, provides access to what is seen as locally normal.
Research Design

Ghana

This qualitative research study was conducted among a population of Ghanaian women living in nine out of the ten regions in Ghana:

The women interviewed were from a number of the main ethnic groups. The Akan people occupy practically the whole of Ghana south and west of the Black Volta. The coastal Akan (Fante) were the first to have relationships with Europeans and absorbed aspects of British culture and language; for example, it became customary among the Fante to accept British names as family names. The Ewe occupy southeastern Ghana and the southern parts of neighbouring Togo and Benin. On the west, the Volta separates the Ewe from the Ga-Adangbe, Ga, and Akan.

Some of the interviews were conducted in Chichewa, translated into English. However, in a few cases, particularly for those with a higher level of education, the interview was conducted in English.

The interviewees were purposively selected so as to acquire a relatively accurate representation in terms of the culture of childbirth for women. The ethnic groups selected represent the regions of the country. This sample included women originating from villages and urban centres of the country enriched the data, as the details given by
the women, although similar in many instances, were also quite diverse. Consequently, this approach enabled me to compare and contrast the experiences of women in childbirth.

Between October and November 1991:

48 people were interviewed during fieldwork in Ghana, including:

- Senior officers in the Ministry of Health, (Medical Director of Health, Chief Nurse)
- Director, Department of Education and Manpower Planning
- Staff within the Department of Maternal and Child Health; HIV/AIDS Directorate; Regional Nurses
- Senior members of the Catholic Church
- Nurse & Midwives Council
- Doctors
- Ghana Midwives Association
- Nurse and midwife educators at the University of Ghana in Accra; plus teachers and students from the 10 Schools of Nursing (one in each district in Ghana)
- Nurse-midwives in Korle Bu Teaching Hospital, Komfo Anochi Teaching Hospital, Kumasi.
- Health Centres
- Traditional Birth Attendants in villages
- Women: during pregnancy, childbirth and the postnatal period.
Observations

- 9 hospital births were observed in different hospitals
- 2 births were observed in Private Maternity Homes
- 3 births were observed conducted by TBAs
- 1 birth – personal participation in one village

Malawi

This qualitative research study was conducted among a population of Malawian women living in the suburban areas of the cities of Lilongwe and Blantyre and in the surrounding districts. The informants were selected from these areas because the areas were easily accessible and convenient in terms of transportation.

The women interviewed in Blantyre were from the ethnic group of the Yaos, those interviewed in Lilongwe were mainly Chewa although three of the women were from the Ngonde tribe who were originally from villages in the northern region. The Chewa predominate around Lake Malawi and are the country’s largest single ethnic group speaking Chichewa, the national language. The Yao predominate in the south, speaking Chiyao. They are also found in Salima, Dedza and Nkhtakota in the central region of Malawi. This group is mostly Muslim. Some of the interviews were conducted in Chichewa, translated into English. However, in a few cases, particularly for those with a higher level of education, the interview was conducted in English.
The interviewees were purposively selected from three ethnic groups, namely, Yao, Ngonde and Chewa, so as to acquire a relatively accurate representation in terms of the culture of childbirth for women. The three ethnic groups selected represent the Central and Southern regions of the country. This sample that encompassed women originating from villages and the more densely populated regions of the country provided a rich source of data.

Between November and December 1991, 35 people were interviewed during fieldwork in Malawi, including:

- Senior officers in the Ministry of Health, (Medical Director of Health, Chief Nurse)
- Staff within the Department of Maternal and Child Health
- Doctors
- Nurse and midwife educators at the University of Malawi
- Nurse-midwives in Kamuzu Central Hospital, Old Wing, affectionately known as Bottom Hospital, Lilongwe; Queen Elizabeth II Central Hospital in Blantyre, Thyolo District Hospital, serving a large tea plantation in southern Malawi;
- Health Centres including a Health Centre in a Refugee camp
- An America nurse-midwife running Project Hope in Thyolo[^14]
- TBAs in villages and those participating in a TBA Refresher course

[^14]: In southern Malawi, high up in the hills amongst the tea plantations an American nurse-midwife was running a Safe Motherhood and Child Survival programme funded by Project Hope. Project Hope is a non-profit making health organisation established in 1958 to bring improved medical care to developing countries. HOPE stands for Health Opportunities for People Everywhere, the philosophy under which HOPE was founded, and under which it operates today. Through HOPE, health personnel in developing countries learn modern medicine, surgical, dental, nursing and administrative techniques, which they then can teach to others in their field. Eventually HOPE trained personnel take complete responsibility for health improvement programmes, which have become
Women: during pregnancy, childbirth and the postnatal period.

Family men

Observations

- 5 hospital births were observed in different hospitals
- 4 births were observed conducted by TBAs
- 1 birth – personal participation in one village

Most women in the villages interviewed for this study sought the services of TBAs during labour and delivery as opposed to formally trained midwives in the hospitals because of lack of transportation to the hospitals and fear of the midwives who were often regarded as impatient and unsympathetic. Nevertheless, the women did appreciate the significance of hospital deliveries.

Malaysia

This qualitative research study was conducted among a population of Malaysian women living in the suburban areas of the Kuala Lumpur and in the surrounding district. The informants were selected from these areas because the areas were easily accessible and convenient in terms of transportation.
The women interviewed in Kuala Lumpur were from the ethnic groups of the Malay, Indian and Chinese. The Malay group was mostly Muslim, the Indian group were either Christian or Hindu, and the Chinese group were mainly. All of the interviews were conducted into English.

The interviewees were purposively selected from three ethnic groups so as to acquire a relatively accurate representation in terms of the culture of childbirth for women. This sample that encompassed women originating from villages and the more densely populated regions of the country provided a rich source of data.

Between November and December 1993, 25 people were interviewed during fieldwork in Malaysia, including:

- Senior officer in the Ministry of Health, (Chief Nurse)
- Obstetrician
- Staff within the Department of Maternal and Child Health
- Nurse and midwife educators
- Nurse-midwives in State and private Hospitals
- TBAs in villages
- Women: during pregnancy, childbirth and the postnatal period.

Observations

- 8 hospital births were observed in 2 different hospitals (1 private and 1 State)
• 2 births were observed conducted by TBAs

Pennsylvania, USA

This qualitative research study was conducted among a population of Williamsport, Pennsylvania, USA. The women lived in the suburban areas and in the surrounding districts. The informants were selected from these areas because the areas were easily accessible and convenient in terms of transportation.

The women interviewed in Williamsport were mainly descended from the Germanic ethnic group and were not representative of the ethnic cultures across America. To establish a cultural contrast, a number of interviews, observations and discussion occurred among the Amish. The interviews were conducted in English.

Between October and November 1995:

18 people were interviewed during fieldwork in Williamsport, including:

• Staff within the Local Department of Maternal and Child Health
• Nurse and midwife educators
• Nurse-midwives
• Health Centres personnel
• Amish midwives
• Women: during pregnancy, childbirth and the postnatal period.
Observations

- 7 hospital births were observed in different hospitals
- 1 birth – personal participation in hospital
- 1 Amish birth

England

This qualitative research study was conducted among a population of southeastern England. The women lived mainly in the suburban areas and in the surrounding districts. The women interviewed were from a number of ethnic groups: black Afro-Caribbean, Africa, Malaysian, Chinese, and Caucasian. All the interviews were conducted in English.

The interviewees were purposively selected so as to acquire a relatively accurate representation in terms of the culture of childbirth for women.

Between January 1994 and December 1997, 35 people were interviewed during fieldwork in England, including:

- Senior midwives from the Professional Body
- Midwife educators
- Midwifery Managers
- Midwifery students (post-qualifying)
- Midwives
• Women: during pregnancy, childbirth and the postnatal period who volunteered to share their stories.

Observations

• 7 hospital births were observed in 3 different hospitals
• 7 birth – personal participation in community (3) and hospital (4)

The Challenges of being a Practitioner-Researcher

The primary goal of practitioner research is to improve practice through better understanding. This type of research is best conducted where the action happens. There is a clear distinction between practitioner-researcher where the goal is to analyse what is happening and action research (Titchen, 1993; Winter, 1989; Stringer, 1996) where the primary purpose is to implement changes. Practitioner-researchers begin with what is already familiar, for midwife teachers these are the students and the women in childbirth with whom they are involved in practice settings. As a result, it is difficult to gain distance and perspective, but by doing so, they may accomplish something even more difficult: they may begin to examine themselves as part of the context. This examination of themselves as significant factors appears to be a fundamental characteristic of practitioner-researchers. Practitioner-researchers observe from an involved distance and in some instances they participate whilst observing. To the extent that this doing of observations becomes a habit and its own reward, practitioners may see and think differently about themselves in their professional roles. (Mohr and MacLean, 1987, p. 62)
Practitioner-research is valid because it is grounded in real life situations. This type of research uses lavishly detailed descriptions — of women, practice, activities, conversations, students, etc.—because the researcher knows the significance of the context. A practitioner-researcher is sensitive to the context-dependent nature of her study, and she documents this context as thoroughly as possible.

The researcher is not concerned with replicability. Her primary goal is to become a more skilful practitioner. As practitioner research becomes more prevalent, researchers will be able to compare their findings with those of other practitioners and some trends may be found across programs.

In a true learning community, inquiry becomes everybody's work. Teaching, learning, community involvement, leadership, organizational management and change, and professional growth all take place in a continual dynamic of asking good questions and finding evidence that can guide our practice (Mary, Lecturer, UK, 1992).

In health care generally, practitioner inquiry has emerged as a powerful approach toward improving practice. A variety of activities occurs under the umbrella of practitioner inquiry, all of which are grounded in the knowledge and questions held by practitioners (Fingeret and Cockley, 1992). Its characteristics intersect with those of other concepts such as self-directed learning, reflective practice, woman-centredness, learner-centredness, and action research. Lytle, Belzer, and Reumann (1992, p.16)
define inquiry as a "social and collaborative process" through which practitioners actually contribute new knowledge development.

Proponents of practitioner inquiry in all fields of would possibly support the following views:

- The knowledge transmission model of midwifery education is insufficient. Although contemporary educational curricula and teaching methods expose participants to new ideas and may renew enthusiasm for midwifery practice, "there is little evidence that this approach works well and more reason to believe that it seldom leads to noticeable improvement or change in professional practice" (Osterman & Kottkamp, 1993, p. 33).

- Midwifery education and practice should be consistent with what we know from cognitive science (Fingeret & Cockley, 1992); "Knowledge is useful only in so far as it enables persons to make sense of experience. It is gained from the inside" (Berlak & Berlak, 1981, cited in Osterman & Kottkamp, 1993, p.37).

- The voices of women and midwifery practitioners are uniquely positioned to provide an inside view of childbirth practice (after Lytle, Belzer, & Reumann, 1993).
The Process of Inquiry

The participants in an inquiry project engage in the following activities:

1. **Reflecting on practice and identifying a problem, issue, question, or concern**
2. **Gathering information through observation; focus groups; interviews; study of records, including student work; assessments; lesson plans; case studies; professional reading; workshops and conferences**
3. **Sharing what has been learned through informal sessions with colleagues, facilitating workshops, or writing and publishing**
4. **Monitoring and evaluating the changes that occur and judging the quality of the changes**
5. **Implementing the action plan**
6. **Studying the information gathered; analyzing, interpreting or critiquing the information**
7. **Planning some action to be taken such as a new approach, strategy, or other intervention**

The process described here is primarily action-oriented; that is, it is expected that some changes will be implemented as a result of the reflection and investigation. Inquiry can
and does occur, however, without initiating specific changes; rather, it might involve exploring present circumstances, examining ideas, or developing one's own theory. Lytle, Belzer, and Reumann (1993) assert that practitioner inquiry is not field-testing the ideas of others, nor is it simply implementing a new strategy that one is already convinced will work. Instead it is a process of generating ideas through reflection and examination of practice, and exploring the implications of those ideas within the practitioner's setting.

Challenges to Inquiry

Practitioners implementing inquiry-based approaches in all case study five countries (Individual and focus group interviews in Ghana, October 1991; Malawi, November, Malaysia, 1993; America, 1995 and UK, 1997, 1998) cited a number of practical concerns. These include:

- Insufficient time – It was accepted that practitioner inquiry is an activity embedded in, rather than added on to, practice, nonetheless, they concluded that time needs to be built into practitioners' work schedules if they are to engage in reflection, meet with colleagues, study the literature, collect and analyse data, and document activity.

- Trust -- Historically, midwifery practice and education has been conducted largely in private. If practitioners are to be expected to make public the problematic aspects of their work lives, the culture of the practice and education institutions must change to invite greater levels of trust among midwifery practitioners, educators and
managers.

- Support -- If inquiry is to inspire innovation, support for the process and its outcomes must be clearly articulated and sustained by institutional managers. Support includes not only exhibiting genuine interest and providing ongoing encouragement, but also being willing to adopt new ideas.

- Expectations -- Some practitioners enter into the inquiry process with great expectations for bringing about significant, often long-awaited changes only to find that policies in the larger system constrain particular innovations. If practitioner inquiry does not provide an impetus for policy-level changes, it may serve to further discourage some already disenfranchised practitioners.

In a sense the research undertaken was serendipitous because I was working as an educator in the different settings with another agenda but at the same time I was investigating and searching out the answers to my questions. The duality of the role sometimes created problems insofar as my inability to separate the roles of researcher and practitioner, particularly in the British context, since I was officially performing as a midwife in familiar surroundings and with familiar procedures. It became quite challenging at times to step outside myself to question the underpinnings of my own actions as part of the research. The practice of midwifery is so familiar and almost automatic in some instances that one drops into old patterns of behaviour very readily and uses language that is the norm. To guard against this I had to constantly create disjunctures in my taken-for-granted knowledge and the reality of the situation I found
myself in. I found I had to engage in a process of strange-making, that is trying to look
at the situation from an entirely different perspective and to use different language in
my routine, everyday experience of working with a birthing woman. This task was
much more easily achieved in Africa, Malaysia and America where the contexts and
language were very different.

One of the major challenges was trying to overcome what might appear to be
inconsistency in my research approach. From a quantitative viewpoint, one could argue
that the number of interviews, the category of people interviewed and the number of
observations were different in each country. I am sure such an apparent ad hoc approach
to the study would generate questions about validity of the research. But one of the most
significant features of childbirth around the world and who is allowed to assist in the
process of childbirth differs from one country to the next. It is by its very nature
inconsistent. In any case, a drive for consistency is in itself a feature of modernity. I was
engaged with women and midwives presented themselves in real life I was dealing with
the ‘swampy lowlands’ – the complexity of practice and everyday life that does not
easily adhere to scientific paradigms. That is not to say the research was not rigorous.
Each situation was interrogated from a number of different perspectives as described in
the conceptual framework (chapter 2) and enacted within an ethical framework as
described below.

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Research within an Ethical Framework

In the context of this research that involved humans, the ethical principle of respect for persons had a very important implication, namely, those research participants were regarded as partners in research. Informed choice was central in this ethical code. Prospective research participants or their representatives (authorised third parties) had to have the information they needed to make an informed choice. They also had to be in a situation in which their choices were voluntary and not affected by threat, coercion, manipulation, or undue inducement. The term informed choice has been used, in most instances rather than that of informed consent to signal those prospective participants had a choice as to whether or not to participate. Thus, consent on the part of the prospective participant was an acceptable choice, but so equally was refusal. Only on the basis of an informed choice to participate could the research proceed. Even then I had to make an independent judgement of the harms, benefits, and general appropriateness of the criteria for participation.

Since some research participants were vulnerable, especially in terms of the inability to make informed or voluntary choices, it was important to reflect upon the relationships I had with participants. Thus, when individuals from traditional communities, who were non-English speaking or had not encountered foreign researchers, were research participants, I had to appreciate that I had a relationship with the individual that was based on trust and integrity. I had a responsibility to make an independent assessment of the appropriateness of research participation for prospective participants who were
perhaps not competent or who were unable to act voluntarily. Researchers involved in a
care relationship with participants must be careful to live up to the explicit or implicit
commitments made to them as patients, clients, students, and the like.

**Four Basic Principles**

The approach taken in this ethical framework was to guide and evoke thoughtful actions
based on principles. A principle is a consideration that should be taken into account
when making a decision but may itself not be decisive in the circumstances. More than
one principle may apply to a specific case, and principles may point towards opposite
actions; for example, the principle of beneficence may conflict with the principle of
non-maleficence. In their best uses, principles serve as shorthand reminders to
researchers of more complex and context-specific moral knowledge.

The four principles within this framework are based on the Belmont Report (1979) and
Beauchamp and Childress' Principles of Biomedical Ethics (1994). They are cited here
because they have been widely adopted in many research communities. However, it can
be argued that principles can be used in formulaic ways as a mantra, which discourage
rather than encourage thoughtful reflection and action. Accordingly, a number of
alternative approaches to ethics were also considered.

1. The first basic principle is **respect for persons**. This has two fundamental aspects:
   first, there must be respect for the **autonomy** of those individuals or groups who are
capable of making informed choices and for their capacity for self-determination;
   second, there must be protection of persons with impaired or diminished autonomy,
that is, those who are incompetent or whose ability to volunteer is seriously compromised. Those who are dependent or vulnerable must be protected against abuse.

2. The second basic principle is non-maleficence, or do no harm to others. Here, harm is understood in terms of wrongfully injuring, whether deliberately or negligently. Sometimes this principle is best understood as an absolute prohibition of certain types of inhumane treatment. For example, the notion of non-maleficence is expressed in various human rights provisions, such as those forbidding torture, genocide, and the exploitation of vulnerable groups in research (e.g., prisoners, children or the incompetent). As well, certain types of research (e.g., genetic alteration) may be prohibited provisionally because they currently lack in sufficient information to adequately assess future consequences. Usually, however, the principle of non-maleficence is interpreted in light of the principle of autonomy and in terms of the threshold for normally acceptable risk. Autonomous individuals or groups are able to waive their rights not to be harmed, usually to increase the probability of benefits for themselves or for others. However, there is generally thought to be significant ethical limits as to how much harm individuals may freely assume. In some circumstances, not harming can be extended to an obligation to prevent, and even remove, harms caused by others. Still, this principle has a negative or prohibitive moral flavour, which is directed against actions that harm or injure people, or violate fundamental rights.
3. The third basic principle is **beneficence**, or doing good to others, which, in contrast to non-maleficence, moves into the positive category of providing benefits to others. This concept has particular relevance for researchers in service professions such as social work, education, health care, and clinical psychology. Three types of benefits can be advanced as legitimating goals of research involving humans: benefits for participants themselves, benefits for society, and the advancement of knowledge. In most research, the primary benefits produced are for society and for the advancement of knowledge rather than for the participants themselves.

4. The fourth basic principle is **justice**, one criterion of which is fairness in the distribution of benefits and burdens. This concept should alert researchers to questions of distributive justice and has particular relevance in cases where groups of individuals (in particular, women and minority group members) have been excluded from research studies, much to their detriment. Justice also is particularly relevant for dealing with individuals or groups that are vulnerable and are unable to sufficiently protect their own interests and, as a result, are open to exploitation or neglect.

It is important to understand that these ethical principles do not exist in isolation from each other. Furthermore, good judgement and sensitivity are required to decide the extent, degree, and context for the application of potentially conflicting principles. An awareness of such potential conflicts can lead to the development of useful strategies to minimise them.
Other Approaches

Besides the four basic principles discussed, there are other ways of approaching the ethics of research involving people. In common, each requires respect for persons, regardless of their social or economic status, physical or mental condition, ethnicity, race or culture, or even their individual moral merits.

One alternative ethical approach adopted was through thoughtful reflection on the moral virtues that a good researcher would possess and exhibit, for example, an ethic of care which involved an empathetic understanding of the hopes and fears of research participants. Other virtues included candour, compassion, prudence, fairness, and courage. Ethical action required balance and judiciousness. Candour could have degenerated into insensitivity, compassion into unfairness, courage into folly, and so on, but a keen understanding of the context of my actions were indispensable in exercising moral virtues or using ethical principles to guide choices.

Another helpful approach was in terms of reflecting on relationships of power and socially structured allocations of privilege and status. Feminist researchers and ethicists have been concerned with such relationships and the ways in which they perpetuate disadvantage and inequality. This type of approach to ethics was extremely illuminating in examining the diverse research agendas of various parties and in dealing with prospective participants who had been systematically disadvantaged. Alternatively, a communitarian approach to ethics enables an examination how individuals participate in and identify with their communities and groups. This approach emphasized qualities
implicit in social roles and relationships including, for example, the role of the researcher in relation to research participants.

Summary

Researchers have a responsibility to research participants, their institutions, and sponsors to ensure the integrity of their research. This refers not only to scholarly integrity but also to the integrity or, literally, the wholeness of the research itself. In presenting oneself as a researcher who seeks the involvement or participation of prospective participants to carry the research to a successful conclusion, one has made an implicit promise regarding the quality of the research and its general benefits. Researchers must endeavour to live up to this promise.
There are two major questions that are addressed in this study. The first question - what are the consequences of globalization for women in childbirth captures a group of questions concerning to what extent do the balances of power between competing discourses construct, negotiate and control, and in some instances impose, what is accepted as the cultural commonsense of birthing practice in specific environments. The second key question arises out of the first and asks from what culture should a midwifery curriculum be selected from or can a curriculum be written and what are the implications of these upon the education and practice of midwives.

The study is ethnographically based with the emphasis upon the elucidation of specific case studies that take note of the more general and comparative materials available. In ethnography, the analysis of the data is not a distinct stage of the research process. The analysis started in the pre-fieldwork phase, in the formulation and clarification of the research problems over time and continues into the process of writing up. Looking back, my formal analysis started to take shape in my analytic notes, concept maps, diagrams, stories, reflective writing and memoranda; informally, it is embodied in my ideas, hunches, and emergent concepts. In this way, as Hammersley and Atkinson (1983:174) suggest, the analysis of the data feeds into the process of research design with the collection of data guided strategically by the developing theory. Thus theory building and data collection are dialectically linked. I would not claim a strategic purpose, since
much of the research was almost tacitly developed over time. The interesting aspect of this was that I have used the same approach throughout, based on my deep fundamental humanistic philosophy, which is a way of life rather than a tool for the purposes of performing an act.

The case studies consist primarily of descriptive data, mainly as a result of observation, participation, dialogue about individual and group experiences which is an attempt to avoid the criticism that much ethnographic research suffers from a lack of reflexivity in the relationship between analysis, data collection and research design. I have attempted to provide data to enable particular interpretations to be checked against experience in the field.

The case studies do not in themselves hold sustained theoretical discussions, and since I am concerned to draw out the wider implications of what in themselves are very specific, particular and focused case studies of women's experience of birth and maternity services in Ghana, Malawi, Pennsylvania, USA, Malaysia and the UK, I have supplemented these with comments and data from other sources.

I am well aware that the material lends itself to other perspectives and interpretations and that the ethnography is partial in both senses of that word. Nevertheless, the sheer discrepancy between the intended work and the actual thesis is, I believe, largely a result of the constraints imposed by the actual observations made, as against my expectations. In this I have tried to avoid the pitfall of the influence of naturalism with
its inherent emphasis on 'capturing' the social world in description with the result of leaving little time for theoretical reflection.

In methodological terms I regard myself as a 'everything but the kitchen-sink' ethnographer, happy to incorporate any information that comes my way. Most of the evidence has emerged from multiple case studies looking at midwifery, traditional birth practices, government policies, educational curricula, storytelling by midwives and others, media (both television and newspapers), observations of local customs and rituals, commerce and consumption practices. I found consumption practices a useful source of information about everyday social life, so I visited markets and shops in all countries studied; I reviewed the newspapers daily, cutting out articles from African, American, English and Malaysian newspapers and magazines; listened to the radio and television programmes wherever available (which was problematic in some of the areas visited especially in the rural areas of Ghana and Malawi); I also examined advertisements. I searched for attitudes to childbirth consumption practices from institutions such as the Church (very important in Africa, Malaysia and America), government bodies and educational authorities. Following the same logic I often found it useful to talk to doctors, nurses, teachers and other professionals as well as people working in shops markets, behind bars or in domestic service.

The fieldwork was carried out in five countries, on four continents. The African countries were selected deliberately to provide a north-west - central-east comparison for the study of safe motherhood. Thereafter, the selection of Malaysia and Pennsylvania, USA was not intended to be representative. Rather they were chosen as a
result of serendipity since my job took me to those countries to teach, develop curricula, promote research, and in the case of Malaysia, help the nurses and midwives of the country develop in line with national economic and health goals. The value of the research areas was that they did give me an opportunity to explore both the 'modern' and 'developing' world situations and helped significantly in achieving a wide geographical dispersal from which to draw conclusions. Since the study commenced, my span of experience has widened further to include Russia, Norway, Finland, Holland, the Philippines and Cyprus, however, these have been excluded from the present study.

I made use of direct recording of conversation, the results of which may be found in the direct quotations that appear in the text. By the very nature of the topic area - childbirth and midwifery practices - for it was women who were likely to be the most important informants, and my fieldwork was considerably enhanced by the fact that I was working as a midwife, and in Africa, I believe my Afro-Caribbean ethnicity opened areas of discussion that might otherwise be deemed irrelevant (or unimportant to me as the researcher) by my informants. My willingness to dress in the local costumes also, I believed helped. I had dresses made in Ghana, Malawi and Malaysia, so that I could mingle with the people (especially the women who seemed to take great delight in examining my clothes and suggesting colours, ways of wearing the dress and cloth, make-up and hairstyles. I was treated very much as a young woman to be initiated into the culture and ways of doing things in Ghana and Malaysia. The gifts of beads and gold and naming me Adjuwa (Monday born) in Akan and Mamma Yaa (Thursday born) as I was made a Queen Mother in one village in central Ghana, exemplified my acceptance into the community whilst recognising my difference and status.
In Malawi, my guide was a senior civil servant working in the family unit of the Ministry of Health. He displayed a much more detached approach and I found that I gained much less insight into the cultural practices of Malawi than I did in Ghana and Malaysia where my connections were through the female networks. In Malawi I did gain a sense of the male orientation though. I did meet with midwives and women, TBAs etc., but it was always in the presence of men who tended to answer questions and direct the conversation. The political regime in Malawi at the time also inhibited discussion since there was an underlying fear of reprisal. Interestingly, the Ministry gave me access to all written materials in their library - reports and government publications, research undertaken by outside agencies.

I observed and interviewed licensed and traditional midwives in Africa, Malaysia and America and midwives in England. In Ghana, I was privileged to participate in birth rituals and the delivery of two women in two different villages. I interviewed government ministers, educationalists, civil servants, teachers, and had informal discussions with members of the general public.

I wanted to include some diversity of income, accessibility to services (water, roads, transport, housing, sanitation, schools, health care, etc.), educational level, employment, religion, ethnicity but without any formal sampling criteria. I also obtained information through forming friendships and through the networks of people I was directly involved with (driver, guides, interpreters, students, teachers, clerical staff, librarians). I also had connections with the British Council staff in Ghana, Malawi and Malaysia.
A guide and interpreters assisted me in Ghana and Malawi. In Malaysia, the midwives I worked with and who showed me around the hospital and villages all spoke Malay English.

The fact that I had three sons was held to be very special especially in Africa, Malaysia and among the Amish community in Pennsylvania, USA, where motherhood (and the birth of sons) is highly regarded. This gave me access to various celebrations and major lifecycle events - such as wedding and funerals, particularly in Ghana and Malaysia.

Data collection processes to formulate the case studies:

The Narrative Method, Oral History and Storytelling

This thesis borrows from two time-honoured traditions. The first is storytelling, in the form of oral history or narrative biography; the second is that of social activism and critique. Storytelling and biography are research-oriented activities whose purpose is discovery and analysis, which may or may not be put to the service of social activism (LeCompte, 1993:9). Social activism is intended to ameliorate oppressive conditions under which groups of people function. In this thesis, I have worked from the stance that women in childbirth and midwives lives have been silenced since much of the knowledge, experience and history of ‘ordinary’ midwives has escaped recording (Hunter, 1999). This is a great loss to midwifery knowledge and practice since the
experience of both past and present midwives may have potential and actual relevance to midwives and the women they serve, today.

Many women in childbirth around the world, including those in Africa, Malaysia, England and America have been deprived of voice without their consent and may be considered victims of oppression. The fact that these silenced lives must be named implies, as LeCompte points out, that those who live silenced lives may be unaware of their own oppression, or, if they were once conscious of oppression, that they may have suppressed that knowledge.

I sought out the silenced because their perspectives were often counter-hegemonic and their voices served to critique the existing global and local social structures. In a sense, research on the silenced is part of the postmodern tradition and yet in another sense, research on the silenced and the unheard becomes problematic with the very act of sampling and defining the population to be studied. Researchers, according to LeCompte,

"define them as silenced to and by those in power. While the subjects of such research may, in fact, come to share the researcher's definition, being selected for participation in such research may creates a new set of frames through which and by which participants are defined, frames created by the researcher and not by the informants themselves". (1993:10)
The initial mission of the researcher or participant observer/narrator is to define the powerlessness (within a specific context) of a group of individuals, and then to define the members of that group whose story ‘must be told’. The researcher then elicits their story and interprets it for those who have not heard it.

‘In this way the researcher becomes a hermeneut – an interpreter – whose task is to render the voices of the unheard in a language accessible both to them and to a wider and presumably more powerful audience.’ (LeCompte, 1993:10-11)

I found that narrative, oral history and storytelling forms of research, as discussed in chapter 2 (43-46), tended to be much more comfortable and revealing in countries that have an oral tradition than in many "Westernised" cultures. So for people in Malaysia, Eastern Europe, Africa, Cyprus, research, using storytelling is a valuable medium. Midwives, generally tended to use storytelling as a means of sharing experience, for as Leap and Hunter (1993) pointed out, get a group of midwives together over a cup of tea and the most amazing stories emerge.

Narrative storytelling is a reaction to the strictures of positivism. Critical, feminist and post-structural researchers such as Harding (1987) and Harraway (1991) among others have suggested that positivistic science imposes a false distance between researcher and the researched by mandating that the researcher maintain an artificially impersonal stance toward people studies. As a consequence, research informants are treated as objects of investigation, which ultimately results in partial, and therefore false and elitist reality. The narrative approach is a relevant and enriching technique for uncovering,
describing and interpreting the meaning of experience. The resulting stories are presented almost as raw data allowing informants to 'speak for themselves'. It must be acknowledged, however, that the discourse is still one selected by the ethnographer and while it may seem powerful and authentic, it remains only partial since it presents whatever perspective that emerges from those parts of the story the ethnographer includes in the text. This often leaves the researcher as an 'absent presence', therefore, even critical ethnographic discourse remains embedded in historical context and social conventions (McLaren, 1992:80). Such research cannot be presented without considering the power relations inherent research context, since, as Foucault (1980) reminds us, each of them define truth in its own terms.

A further problem with narrative research is that retrospective interpretations of subsequent experience can play the trick of laying new meanings in old events. In part this is because the need to make a coherent, seemingly planned story of one's life constantly overwhelms the more honest ambition of describing it as it was. As it was is usually a series of false starts and premature stops, a mix of ill-sorted and conflicting ideas, and of feelings and intellectual insights all jumbled up together in a melting pot. Memory is unfortunately opaque, leading us to dissemble instead of revealing. Even if accurate descriptive records are kept of the experience at the time, later interpretations and analysis would necessarily be different to those formed at the time since the experience has already changed us - moved us on from that experience and given us new insights as we look back upon it.

*Focus Groups*
"In contrast to deconstruction, which views language and texts as nothing but the free play of signifiers, Bakhtin believes that all individual expression is ultimately the product of various voices that are linked to one another through the socially constituted fabric of language. We learn our language by assimilating the voices of others, and we speak back to our community of peers through re-externalized modes of discourse. This philosophy [is] known as dialogics..." (Honeycutt, 1994)

There are many definitions of a focus group in the literature, but features like organised discussion (Kitzinger 1994), collective activity (Powell et al 1996), social events (Goss & Leinbach 1996) and interaction (Kitzinger 1995) identify the contribution that focus groups make to social research. Powell et al define a focus group as

a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research. (1996: 499)

According to Gibbs (1997) focus groups are under-used in social research, although they have a long history in market research (Morgan 1988), and more recently in medical research (Powell & Single 1996).

Gibbs, while describing focus groups as a form of group interviewing she swiftly reminds us that it is important to distinguish between the two. Group interviewing involves interviewing a number of people at the same time, the emphasis being on
questions and responses between the researcher and participants. Focus groups, however, hinge on interaction within the group focused on topics that are determined by the researcher (Morgan 1997: 12). Kitzinger (1994, 1995) argued that interaction is the crucial feature of focus groups because the interaction between participants highlights their view of the world, the language they use about an issue and their values and beliefs about a situation. Interaction also enables participants to ask questions of each other, as well as to re-evaluate and reconsider their own understandings of their specific experiences.

Focus groups elicit information in a way that allows researchers to find out why an issue is salient, as well as what is salient about it (Morgan 1988). As a result, the gap between what people say and what they do can be better understood (Lankshear 1993). If participants reveal multiple understandings and meanings, multiple explanations of their behaviour and attitudes will be more readily articulated.

There are, moreover, benefits to participants of focus group research that should not be underestimated. The opportunity to be involved in decision making processes (Race et al 1994), to be valued as experts, and to be given the chance to work collaboratively with researchers (Goss & Leinbach 1996) can be empowering for many participants. If a group works well, trust develops and the group may explore solutions to a particular problem as a unit (Kitzinger 1995), rather than as individuals. Focus groups, however, can be intimidation consequently not everyone may experience these benefits and other methods, such as individual interviews, storytelling and so on, may offer those most affected alternative means of participation. The skill of the moderator becomes crucial
in this context. One approach I used in focus groups where one or more participants were less vocal than their peers, was to ask them to tell a story of their experience. This worked quite well in that the individual could talk freely about something familiar to them, a subject upon which they were comfortable and enabled them to gain a measure of confidence in the group.

A further advantage of focus groups to clients, users, participants or consumers is that they can become a forum for change (Race et al 1994), both during the focus group meeting itself and afterwards.

Focus groups can be used at the preliminary or exploratory stages of a study (Kreuger 1988); during a study, perhaps to evaluate or develop a particular programme of activities (Race et al 1994); or after a programme has been completed, to assess its impact or to generate further avenues of research. They can be used either as a method in their own right or as a complement to other methods, especially for triangulation (Morgan 1988) and validity checking.

The main purpose of using focus groups in this research is to draw upon participants' attitudes, feelings, beliefs, experiences and reactions in a way which would not be feasible using other methods, for example observation, one-to-one interviewing, or questionnaire surveys. These attitudes, feelings and beliefs may be partially independent of a group or its social setting, but are more likely to be revealed via the social gathering and the interaction which being in a focus group entails. Compared to individual
interviews, which aim to obtain individual attitudes, beliefs and feelings, focus groups elicit a multiplicity of views and emotional processes within a group context.

It is arguable that the individual interview is easier for the researcher to control than a focus group in which participants may take the initiative. Compared to observation, a focus group enables the researcher to gain a larger amount of information in a shorter period of time. Observational methods tend to depend on waiting for things to happen, whereas the researcher follows an interview guide in a focus group. In this sense focus groups are not natural but organised events. Focus groups are particularly useful when there are power differences between the participants and decision-makers or professionals, when the everyday use of language and culture of particular groups is of interest, and when one wants to explore the degree of consensus on a given topic (Morgan & Kreuger 1993).

**Potential limitations**

Despite the many advantages of focus group research, as with all research methods there are limitations. Careful planning and moderating can overcome some, but others are unavoidable and peculiar to this approach as follows:

- The researcher, or moderator, for example, has less control over the data produced (Morgan 1988) than in either quantitative studies or one-to-one interviewing. The moderator has to allow participants to talk to each other, ask questions and express doubts and opinions, while having very little control over the interaction other than
generally keeping participants focused on the topic. By its nature focus group research is open-ended and cannot be entirely predetermined.

- It should not be assumed that the individuals in a focus group are expressing their own definitive individual view. They are speaking in a specific context, within a specific culture, and so sometimes it may be difficult for the researcher to clearly identify an individual message. This too is a potential limitation of focus groups.

- On a practical note, focus groups can be difficult to assemble. It may not be easy to get a representative sample and focus groups may discourage certain people from participating, for example those who are not very articulate or confident, and those who have communication problems or special needs. The method of focus group discussion may also discourage some people from trusting others with sensitive or personal information. In such cases personal interviews or the use of workbooks alongside focus groups may be a more suitable approach. Finally, focus groups are not fully confidential or anonymous, because the material is shared with the others in the group.

Focus groups were convened among all female senior nurses-midwives in Ghana, Malawi, America, Malaysia and the UK. They provided opportunities for brainstorming ideas around the changing nature of midwifery education and practice as a result of major structural changes. Focus groups are basically group interviews, although not in the sense of an alternation between the researcher's questions and the participant's responses. Instead, the reliance is on the interaction within the group, based on topics
that are supplied by the researcher, who typically takes the role of a mediator. The fundamental data that focus groups produce are transcripts of the group discussions. I used this approach as part of all the case studies to gain different perspectives on the phenomena under study. Participants within the groups offered individual insights whilst reflecting on, and reacting to, the opinion of other people, with which they may disagree or of which they were unaware. Apart from the range of opinions that was obtained, underlying conflicts were revealed that would have otherwise remained unknown. Even where no conflicts arose, the sharing of experience provided valuable insights into the phenomena. The greater depth of data collected had the overall advantage of the interview or questionnaires. Its proclivity to subjectivity and interviewer bias, often identified as disadvantages, were in fact an important factor when considering interpretations of personal experience in the real world.

Generally, then, focus group research share the following characteristics:

- Involves organised discussion with a selected group of individuals to gain information about their views and experiences of a subject matter.
- It is particularly appropriate for obtaining several perspectives about the same topic during an interview session.
- The benefits include gaining insights into people's shared understandings of everyday life and the ways in which others influence individuals in a group situation.
- Problems arise, however, when attempting to identify an individual view from the group view, as well as in the practical arrangements for conducting focus groups.
The role of the moderator is very significant. High-quality group leadership and interpersonal skill are required to moderate a group successfully.

Document content analysis

A review of literature and official documents relevant to the study can provide a secondary source of data to:

- identify previous research in the area
- discover where there are gaps in the subject area
- delineate important variables for the study
- suggest relationships among variables
- see if emergent theory has some relationship to theories already recognised

According to Cohen and Manion (1989), research reports are capable of transmitting first-hand accounts of events and therefore could be accepted as primary data, however, we are warned by Cassell and Symon (1994) that these could be subjective and inauthentic records of actual events and process. Denzin and Lincoln (1994) do assure us, though, that document validity or reliability is secondary to considerations of the relationships between the social construction of the text and its 'evidence-derived' meaning. A radical re-definition of documents by which they become ‘products’, like speech, of a system within which they were defined and made meaningful' through conversion to text, can be a useful means of gaining useful data.
Triangulation

The concept of triangulation originates from the world of navigation and military strategy. Its purpose is to establish one’s location utilising geometry by taking multiple reference points to locate an unknown position accurately (Mitchell, 1986). In research, triangulation may be defined as combining methods in a study, which considers an unknown (or known phenomenon to gain a different perspective). This may involve simple or complex processes dependent upon the level of triangulation the research design demands.

Triangulation as a research strategy has received much attention particularly in nursing research in particular. Mitchell (1986) and Denzin (1989) describe a triangulated study as a combination of different theoretical perspectives, different data sources, different investigators (Banik, 1993; Duffy, 1987), or different methods within a single study (Jick, 1993). Measurement from several vantage points supports comparison, allowing the phenomenon to be revealed and identified. The purpose of this is to promote credibility of the study in terms of increasing reliability and validity, thus overcoming the deficiencies and biases that stem from any single research method. The aim of triangulation is to achieve results from which the information obtained reflects the phenomenon being studied rather than the method used to measure the phenomenon (Mitchell, 1986).

Triangulation has been seen as an attempt to compensate for the deficiencies and enhance the merits of both quantitative and qualitative research methods (Denzin, 1989) and yet
triangulation, often advanced as a means of securing the validity of data, often makes unwarranted assumptions concerning the status of the criteria of one method in relation to others. Sim & Sharp (1998) argue that to the extent that triangulation does secure validity, this is likely to be in terms of scope of the findings rather than accuracy of the findings. Some authors recommend the use of multiple methods and the mixing of quantitative and qualitative data (Mitchell, 1986, Duffy, 1987; Denzin, 1989, Jick, 1993) because, the integration and mixing of methods and theoretical perspectives counterbalance the weaknesses of one method with the strengths of other(s) used and deepens the understanding of the phenomenon under study. Other authors (Nolan & Behi, 1995, Sim & Sharp, 1998), however, consider the bringing together of qualitative and quantitative methods in triangulation tends to ignore fundamental questions concerning the meaningfulness of data generated from methods that emerge from divergent epistemological frameworks.

Sim and Sharp (1998:23) argue that despite its popularity, triangulation raises a number of problematic methodological and philosophical concerns, namely that triangulation is not always a necessary ingredient of a research project (Bryman, 1992), as some questions may be adequate answered by a single method and the use of different theoretical frameworks, in theory triangulation, mistakes the true nature of a theory and overlooks the distinctiveness and incommensurability of different theoretical perspectives.

A form of triangulation was used in this study, not to confirm the validity of any particular data, but instead to penetrate to the heart of the culture. I wanted to see from
different perspectives how far symbolic exchanges had penetrated to the heart of institutions and individual and community lives; to see how these exchanged manifested themselves in local social, cultural, medical and midwifery policies and how these impacted upon the midwifery curriculum in each country under study. Care was taken, however, to ensure that the methods used were consistent with the interpretive epistemological framework.
Research Issues

Language and the researcher

Because of the nature of this investigation, I was faced with issues and problems of language from a number of different perspectives. The most significant was, of course, my ability to communicate directly with a number of the women and midwives I engaged in conversation with. In Ghana, particularly in the rural settings, the villagers spoke very little English and I needed the skills of an interpreter to ask my questions and to translate the answers given. I had to rely upon the abilities of a number of interpreters since Ghana has more than ninety-two languages and countless numbers of dialects. In travelling across the whole of the country and entering into all ten regions, I came across many of these languages and despite English being the official language of the country; it was clearly Ghanaian English which has a quality unlike English spoken in the United Kingdom. The use of certain words, although the same, had different interpretations and meanings in the context of Ghanaian society. Thus I had double jeopardy - I had to interpret the interpretation of the stories told to me by the women.

What was valuable was that I was enabled to learn some phrases and gather insights into the ways of expression that allowed a degree of understanding of the meaning behind the words used purely from living, eating, and participating in the daily lives of the people I encountered. I became immersed, as far, as was possible in the short time I spent in Ghana, in the culture and participated in their important ceremonies. I had a
clear advantage since the Ghanaians adopted me as their own, I looked like them and I dressed like them. I was made a Queen Mother in one village which gave me access to a number of rituals and I personally had to undergo a ritual of incorporation myself to validate this acceptance.

It was interesting to note the format of my initiation into the culture for the Ghanaians treated me much as a child, and therefore ‘taught’ me the proper ways of living and being in society, whilst at the same time, treating me as a ‘wise’ elder who would provide them with careful guidance and support. In both scenarios, I was allowed to penetrate into the culture in ways that may not have been possible under other circumstances.

It was a somewhat different story in Malawi. The language problems existed as in other countries. In similar ways I had interpreters to translate for me but because of the status of women in Malawi, my access to women and midwives was curtailed by the presence of my male guide. Women do not speak in the presence of a man who is not their husband. His presence during the storytelling inhibited the women and I had to find other ways of communicating and uncovering their lived experiences through unofficial means. This was provided through my Malawian friends many of whom had studied and achieved their degrees in the United Kingdom and so were able to assist in translation and interpretation of meaning of the stories imparted.

In Malaysia I has the services of a number of my students who were studying for a nursing and midwifery degree. They were able to provide access to stories from women
and from their own lived experiences as midwives, which were rich and extensive. I was able to gain access to childbearing women through these connections and discovered a wealth of information much as I had achieved in Ghana because my companions were women perhaps.

**Mental Images and the researcher**

I had not anticipated a language issue in the United States of America but I did find difficulty with how words were used and the concepts that lay behind the words that were in some cases very different to those used in the UK in relation to childbirth. The ideologies underpinning childbirth and the images those conjured up were in diametrical opposition to the ideologies I encounter among groups of midwives in England. I found, however, when I had a conversation with the Amish and lay midwives, that the ideologies and mental images that shape the birth experiences of women were almost identical. Interestingly, on interviewing some midwives in the UK, I found an increasing correlation between the constructs of birth in high technology situations. The mental images or metaphors for childbirth used by women and midwives in this study became an important issues for the research.

**Research participants and the researcher**

The research participants were serendipitously chosen as I travelled around the globe. I had a clear criteria of whom should be included in the study, namely, women who were pregnant, or had given birth and their birth attendants (please refer to the charts overleaf
showing the different levels of inquiry and the research participants encountered in each country). An important part of the study was the births I observed and participated in by invitation. Through this experience I achieved a greater understanding of the context and the rituals surrounding childbirth in each of the case study countries. Clearly, these births could not be taken as representative of the experience of all women in those countries but they did provide an in-depth insight to add to my years of midwifery experience. In a sense, I had a much greater advantage than perhaps other researchers who may not have had the background in this particular area of research, which allowed access and opportunities to participate. This became highly relevant in Ghana when I was allowed to touch a pregnant woman in the market. It is taboo in Akan culture for a pregnant woman to allow herself to be touched by a stranger because the baby may die. However, because I was a midwife, I was permitted to examine the woman, at her invitation.

*Traditional societies and the researcher*

In translating information about "local ideas and practices" into development discourse, "traditions" are systematically rendered as isolated "beliefs" and "customs" with little social basis aside from the fact that they are features of a traditional society. The decontextualization of "tradition" is accomplished through certain habitual procedures embedded in research.

*Emphasising the exotic.* A preconceived notion of what "tradition" looks like guides how data are sorted. Explicit references to rituals, supernatural beings, and pollution
beliefs get recorded; the more obviously different from an unmarked "Western norm" the more likely it is to be noticed. This makes local traditions seem exotic, odd, and arbitrary.

- *Privileging rules over practice.* The more precise and explicit an informant's statement, the more likely it is to be written down and repeated. Researchers inquire about "rules" and prohibitions (e.g., asking about postpartum taboos on sexual intercourse in a direct way, assuming people can and will articulate "custom"). When explicit rules cannot readily be found, this is often taken as evidence that no concern or concept exists. For example, if there are no rules about what one "must" feed pregnant women, this is frequently taken as evidence that there isn't concern with the diet of pregnant women. As Pigg (1995) informs us, in reports written in English, almost all Nepalese words that appear in reports are nouns which, she suggests, is an indication of the emphasis on things over actions. The stress placed on structure and rules reinforces a notion of "tradition" as stagnant, rigid, and passive.

- *Reifying cultural identity.* Implicitly, "tradition" is understood to be a place or a social identity. For example, if a survey is conducted in a Ghanaian village populated by people known as Ashanti, then respondents' answers are taken to represent what "Ashanti culture" leads people to do and think. Much that is not necessarily tied to ethnic identity is extrapolated to other people labelled "Ashanti." Ethnic identity is taken to override all other social factors that might structure opinion, ideologies, and action.
In general, the danger is that the information gathered may be inadequate to account for the connections between the practices reported and the social circumstances that animate these behaviours. It was crucial to avoid compiling information that dutifully alluded to local ideas and practices without actually taking them into account for if explanatory anchors, in the form of women's narratives perhaps, are lacking, decontextualized references to non-western practices rhetorically reinforce an impression that "traditional" beliefs are disjointed assertions easily dismantled and replaced with reason.
Appendix 2: Globalization: Some Key Ideas

<table>
<thead>
<tr>
<th>Author</th>
<th>Date</th>
<th>Key Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cockerham</td>
<td>1995: 60</td>
<td>Claims that modernization in turn has stimulated globalization. He considers that the advantage that western culture possesses in acting, as the major global culture is its intimate association with modernization and globalization.</td>
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<tr>
<td>Robertson</td>
<td>1992: 8</td>
<td>Would not see globalization equated with or seen as a direct consequence of an amorphously conceived modernity, he considers that the spread of technology is related to the spread of Western capitalism as the pre-eminent mode of conducting business in the contemporary world.</td>
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<tr>
<td>Giddens</td>
<td>1989</td>
<td>Globalization is the development of social and economic relationships that stretch worldwide. Increasingly, countries are becoming part of a world-system. However, localities are not necessarily rendered homogeneous. Local transformation and the engendering of ‘local nationalisms’ are, as he says, as much part of the processes of globalization as are the lateral extensions of social connections across time and space (Giddens, 1990:64).</td>
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<tr>
<td>Aharoni</td>
<td>1993</td>
<td>Modern technology has enabled global networks of finance, communications, trade, professional business services, e.g. research &amp; development, accounting, auditing, insurance, transportation, legal services, advertising and after sales service and education to connect people, corporations, and governments together in a systematic fashion. However, globalization does not mean that all societies are becoming the same or that nations are uniting; rather, it means that the nations of the world are becoming more interdependent.</td>
</tr>
<tr>
<td>Wallerstein</td>
<td>1989</td>
<td>Increasingly, countries are becoming part of a world-system. Decisions, ideas, and innovations, as well as social, economic, and political relationships cross national boundaries and link people more now than ever before in history. Inevitably, therefore, if one wanted to be ‘modern’ one had in some way to be ‘Western’ culturally. Whilst Western religions and language may be rejected, the ‘modern’ person, at the very least, must accept Western technology. However, the implications of accepting the technology is such that other more insidious processes of transmitting Western ideologies and cultural forms take place. The importance of individual and collective activity to change environments and life-worlds of indigenous populations, which lie outside of the politic-economic aspects of globalization, is reflected in the arguments surrounding the place of culture in Wallerstein’s World-Systems Theory.</td>
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<tr>
<td>Worsley</td>
<td>1990:93</td>
<td>The relative impotence of the majority of the world’s population to control its own life-fate is symbolised in the limits upon the effectiveness of the Non-Aligned Movement, for all its power to win votes at the UN in Manhattan. The self-consciousness and self-activity of the peoples of the Third World are not confined to the activities of elites at international meetings. All across the globe, non-governmental popular organizations such as the Consumers’ Association of Penang, or the Kerala Popular Science Movement (KSSP), or SEWA, the organization set up by illiterate Outcast women workers in Ahmedabad, denied membership of male-dominated trade unions, who went on to establish their own bank, are constantly, day in and day out, fighting to change the world, and to improve their life-circumstances. Like their contemporaries in Eastern Europe, too, they have been far more concerned with the struggle to establish democracy: with the right to self-expression and self-determination: than with differences of economic system.” Moreover, the deliberately balkanised microstates such as those of Africa and the Caribbean, especially, were quite unable to exert any influence over a world market controlled by the developed industrial countries. Increasingly, the power exerted over them was being exercised not by the states which had formally been their colonialist oppressors (from whose control they thought they had escaped), but by</td>
</tr>
</tbody>
</table>
a new kind of non-governmental agency, the multinational corporation. One of the unintended outcomes of well-intentioned Western charitable organisations, claims has been that stirring Western consciences with images of starving children has resulted in the formation of a stereotype of the Third World which omits the vast transformations of the newly-industrialising countries and of the shift from a world dominated by reliance on agriculture to a world in which the majority of people live in cities. It also omits the self-activity of people themselves, who are not waiting for Western Technology, or Western know-how, and are using both the indigenous experiences of millennia as well as modern technology.

Questions Wallerstein’s notion of the ‘three worlds’ in his central concepts of core and periphery. For Worsley, Wallerstein’s (1979) model is another variant of political economy, which fails to sufficiently take culture into account. Without a cultural dimension, Worsley argues, “it is impossible to make sense of a modern world in which nationalism, religion and inter-ethnic hostility has been far more important than internationalism and secularism” (p92)

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Featherstone</td>
<td>1990</td>
<td>The most prevalent global culture, defined as cultural processes which transcend national boundaries and sustain the exchange and flow of goods, people, information, and knowledge is that of Western European-North American capitalism. Western-style capitalism dominates the world economy and has produced an approach to conducting trade that is centred on a particular language (English) and norms regarding such matters as dress (Western business suits); financing; procedures for record keeping; use of contracts; methods of manufacture, shipment, and sales; means of communication (telephones, fax machines, and now digital video connections through the computer) - which shape cultural relationships and understandings between people and companies in different countries.</td>
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<tr>
<td>Hanmerz</td>
<td>1990</td>
<td></td>
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<tr>
<td>King</td>
<td>1990</td>
<td></td>
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<tr>
<td>Dezalay, Gessner &amp; Schade,</td>
<td>1990</td>
<td>Aspects of this have become integrated into international law. These methods of conducting business, involving systems of communication and behaviour, extend beyond the world of trade and commerce and into global forms of research, higher education, travel, leisure, lifestyle, and health care, particularly as it relates to the domination of Western medicine ideologies that has at its centre the concept of risk and the fear of death. The media, particularly television plays a significant role in spreading Western ideology and practices, which is why in some parts of the Far East for example; television programmes are severely censored. However, this is, in itself, under threat because of the emerging availability of cable television.</td>
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<tr>
<td>George Orwell</td>
<td></td>
<td>Once suggested that changes in the national diet are probably more important events in a country’s history than changes in dynasty and religion. Orwell might have regarded, as particularly significant, a change in diet which also represents a deep-rooted shift in social mores - the substitution in infant feeding of the bottle for the breast. Moreover, the manipulation of individual’s values by mass media techniques of multinational corporations would have incurred his enmity. Threatened by the decline in birth rates in the developed world, businessmen looked to the creation of infant formula markets in the developing countries to sustain long-term corporate profitability.</td>
</tr>
<tr>
<td>Bader</td>
<td>1979:235</td>
<td>Claims that literally millions of infants in developing countries are the unwitting victims of this myopic mentality, what paediatric nutritionists Derrick B. Jelliffe calls &quot;commerciogenic malnutrition&quot;. This raises issues of morality and trust.</td>
</tr>
<tr>
<td>Boyne</td>
<td>1990</td>
<td>Argues that Wallerstein still employs a view of culture as merely derivative and reactive to the &quot;brute and disinterested objectivism of world-systems theory&quot;, which Wallerstein forcefully contests.</td>
</tr>
</tbody>
</table>
Abbercrombie 1980/90

Argues that global processes are dominant but in a different sense from that understood in much of the dominant ideology debate (Abbercrombie et al 1980, 1990; Thompson 1990). Contemporary developments do not produce a straightforward dominant ideology, that is, sets of ideas which in some way involve legitimation, dissimulation, unification, fragmentation and reification (see Thompson 1990:60). Ideologies are characteristic of modernity and there can be a partly rational discourse about those ideas and about their supposedly ideological character (Lash 1990a). And it may be that such ideas are indeed operated to produce coherence amongst the dominant ideological class rather than amongst the whole society, as Abbercrombie et al (1980) argue.

Appadurai 1990

Appadurai (1990) who attempts to detail five different dimensions of such global cultural flows, dimensions which move in non-isomorphic paths and which challenge simple notions of a cultural centre and a subordinate periphery. These dimensions constitute building blocks for what Appadurai terms 'imaginary worlds', the multiple worlds constituted by the historically situated imaginations of persons and groups spread across the globe. Such worlds are fluid and irregularly shaped.

The five dimensions of such global cultural flows are ethnoscapes - the moving landscape of tourists, immigrants, refugees, exiles, guestworkers and so on; technoscapes - the movements of technologies, high and low, mechanical and informational, across all kinds of boundaries; finescapes - via currency markets, national stock exchanges and commodity speculations, there is the movement of vast sums of monies through national turnstiles at bewildering speed; mediascapes -the distribution of electronic capabilities to produce and disseminate images and the proliferation of images thereby generated; and ideoscapes - concentrations of images often in part linked to the ideologies of states or of movements of opposition, ideas derived in part from the Enlightenment (Appadurai 1990:296-300).
Appendix 3: The Amish Community

The Amish according to Erikson et al, (1979) have many strict beliefs and practices placing much emphasis on distinct behaviours. The major beliefs and teachings that set the Amish apart correspond with the following ideas.

- They emphasise a need for an "inner baptism" with the Holy Spirit. Baptism as an infant is not spiritual enough. A sinner needs to heartily repent and turn away from all sin in order to surrender to Christ.
- They believe each man and woman must become a Disciple of Christ. Each individual must open up to Christ at any cost to reach full maturity and spirituality. This task can not be completed without strict Church discipline.
- They stress the idea of a brotherhood church. They omit all titles and refer to each other as brother or sister. They do not allow wealth, education, or ordination to separate one member from another.
- They regard each member as a nonresistant follower. The Amish renounce any rage or violence in human relationships believing it is better to suffer than to inflict suffering on another.
- They rely on direct interpretation of the Bible. They believe the Scriptures were written to be obeyed. They take the words of the Holy Texts very literally. For example, it is because of John 13 that they find it necessary to humble themselves to
their neighbour and wash his feet. To the Amish this is a lowly service that they must submit to in order to be bound to Christ. It is also due to their strict interpretation that the Amish believe they must endure suffering (bear their cross) in order to reach salvation.

The idea of Meiduiing is a very important belief of the Amish. Any person who leaves the Amish church, marries an outsider, or breaks any moral law must be excommunicated. An excommunicated person becomes an outsider and is shunned by everyone in the community including family and friends.

The Amish have a strict teaching of moderation. It is because of their direct reading of the Bible that the Amish require each member to abide by strict rules concerning the world around them. First, the Amish must only make a living through a rural or semirural occupation. Secondly, the Amish accept minor technologies but shun most new age inventions. They allow only items that are necessary for survival, for example, while the Amish have no phones in their homes, because of the worldly intrusion they would bring, they do have "community phones" for outgoing calls in case of emergencies, making medical appointments, or conducting business. The Amish, however, find automobiles and electricity sinful.

**Role of Women in Amish Society**

The role of Amish women was described by Mary as a very special one. First, there is a distinct, strict order of those served. God is always first and foremost, and is served by
the women before everyone else. Secondly, the husband is the woman's second priority. Her family, namely the children, are served third. Then she tends to the home, and lastly, her garden. The women work in the fields alongside their husbands. They are expected to make all meals from scratch, and the dish must be healthy and wholesome. Also, the house must be kept clean by the woman, or she is seen an unfit wife and mother.

_Innovation and Change in Amish Society_

The Amish society, however, has not escaped the influences of the dominant culture. A rapid increase in the Amish population was the one factor that led to gradual change and innovation in Amish society. Population pressures increased the price of land and led to shortages of available farmland in some settlements. The Amish responded to this pressure by adopting farm management strategies of the larger society such as reducing the farm size and field crop production, placing more emphasis on the production of milk by increasing the size of a dairy herd, or specialising in the production of hogs for market.

Another response to demographic and economic pressure was to migrate to a new area of the country. In one decade (1974-84) the Amish established 71 new settlements. However, not all attempts to establish a new settlement were successful. In the same decade 11 settlements ceased to exist, including two experimental settlements in Honduras and Paraguay.
An alternative to migration for many young Amish people was to seek employment outside agriculture. By 1990, fewer than half of the heads of households in the three largest settlements were farmers. Many Amish worked in small businesses which specialise in the construction of horse-drawn farming implements, buggies, blacksmithing, construction work, cabinetry, and so on. Others sought employment in industry. In the large settlements certain industries, particularly recreational vehicle and mobile home industries, consciously decided to seek Amish employees who were reliable workers and refused to join labour unions. While Amish factory workers did not typically live in towns, they tended to live on smaller plots of land, have more leisure time and more cash available than their agricultural counterparts.

In many areas changes in Amish life occurred as a result of government intervention. When local governments decided to consolidate public schools, many Amish chose to develop their own private schools.
Appendix 4

**Increase in Internationally Co-authored Scientific and Technical Articles**

<table>
<thead>
<tr>
<th>Country of Author</th>
<th>All articles with Authors from this Country</th>
<th>Internationally Co-authored (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>132,278</td>
<td>142,792</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>30,794</td>
<td>32,980</td>
</tr>
<tr>
<td>Former USSR</td>
<td>29,610</td>
<td>21,749</td>
</tr>
<tr>
<td>Germany</td>
<td>26,637</td>
<td>30,634</td>
</tr>
<tr>
<td>Japan</td>
<td>25,088</td>
<td>39,498</td>
</tr>
<tr>
<td>France</td>
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<td>India</td>
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<td>Sweden</td>
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<td>Switzerland</td>
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<td>Israel</td>
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<td>4,322</td>
</tr>
<tr>
<td>China</td>
<td>1,100</td>
<td>6,200</td>
</tr>
</tbody>
</table>

Sources: Institute for Scientific Information, Scientific Citation Index, CHI Research Inc.; Science Indicators Database; National Science Foundation. Frosch, 1999
Appendix 5

Goals and Objectives of TBA Training

Goals
The goal of TBA training is first to reduce maternal deaths and illness and secondly to reduce infant deaths and illness. These goals can be broken down more specifically in several objectives.

Objectives
1. To reduce maternal deaths (or illness) from the three major causes during pregnancy:
   A. haemorrhage (including ruptured uterus from obstructed labour)
   B. infection (including both puerperal fever and septic abortion)
   C. Toxaemia
2. To reduce the risk of death by encouraging adequate maternal nutrition enabling the stronger, better nourished women to withstand both the expected and unexpected difficulties of repeated pregnancies
3. To reduce long-term maternal disability from urinary or rectal fistulas resulting from perineal or vaginal tears during delivery.
4. To reduce the risk of death by reducing the number of pregnancies to which a woman is exposed (encourage the use of modern family planning methods and prolonged breast feeding)
5. To reduce infant mortality and morbidity due to neonatal tetanus, asphyxia, infection, diarrhoea and malnutrition.


Although TBAs need to be identified, trained and supervised, it is important to avoid disrupting longstanding relationships between villagers and TBAs, or creating demands and dependence on the health service that cannot be met. Programme planners should establish only those organisational procedures, which are necessary to achieve the objectives of the training programme (Gordon, 1990).

I would question how such a programme could fail to be anything other than disruptive? The TBAs would require a high level of medical knowledge and skills to ensure the goals and objectives are reached.
Appendix 6 Malaysian Midwifery Curriculum

Ministry of Health – Malaysia Midwifery Course – One Year

Course Objective

On completion of the one year Midwifery Division 1 Course, the nurse student midwives will be able to function competently as members of the health team in the hospital and community.

Specific Objectives

1. At the end of the course she will have acquired knowledge, skills and attitudes to care for a woman during pregnancy, labour and puerperium in the hospital and the community.
1.1 Mastery in the conduct of normal delivery
1.2 Skills in carrying out and co-ordinating nursing care, as a member of a health care team
1.3 Shows caring attitudes towards mothers during pregnancy, labour and puerperium
1.4 Ability to apply communication and interpersonal skills to meet the needs of mother and her family.
1.5 Ability to promote health education to individuals in the hospital and to family groups in the community

Course Organisation and Structure

Length of course – 1 year (12 months)

<table>
<thead>
<tr>
<th>Theory Blocks</th>
<th>Practicum</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Block I</td>
<td>1st 5 weeks of training</td>
<td>Antenatal ward – normal and abnormal</td>
</tr>
<tr>
<td>Block II</td>
<td>16th–20th week of training</td>
<td>Postnatal ward – normal and abnormal</td>
</tr>
<tr>
<td>Study day</td>
<td>32nd to 35th week (1 day per week)</td>
<td>General nursery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Special care nursery</td>
</tr>
<tr>
<td>Revision block</td>
<td>50th week of training</td>
<td>Labour wards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinics – antenatal &amp; postnatal</td>
</tr>
</tbody>
</table>
**Course Content**

<table>
<thead>
<tr>
<th>Unit</th>
<th>Topic</th>
<th>Theory Hours</th>
<th>Demonstration &amp; Practicum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit I</td>
<td>Introduction</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Unit II</td>
<td>Anatomy and Physiology</td>
<td>42</td>
<td>-</td>
</tr>
<tr>
<td>Unit III</td>
<td>Normal and Abnormal Pregnancy</td>
<td>40</td>
<td>23</td>
</tr>
<tr>
<td>Unit IV</td>
<td>Medical conditions in pregnancy</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>Unit V</td>
<td>Perinatal and Neonatal Paediatrics</td>
<td>35</td>
<td>17</td>
</tr>
<tr>
<td>Unit VI</td>
<td>Normal and Abnormal Labour</td>
<td>50</td>
<td>28</td>
</tr>
<tr>
<td>Unit VII</td>
<td>Puerperium</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Unit VIII</td>
<td>Family Health</td>
<td>72</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>265</strong></td>
<td><strong>98 = 363 hours</strong></td>
</tr>
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</table>

**Summary**

<table>
<thead>
<tr>
<th>Component</th>
<th>Weeks</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Theory</td>
<td>11</td>
<td>22.4%</td>
</tr>
<tr>
<td>Practicum &amp; Field Practice</td>
<td>38</td>
<td>77.6%</td>
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<tr>
<td>Course leave</td>
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<td></td>
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<tr>
<td>Exam</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td></td>
</tr>
</tbody>
</table>
Student Assessment

1 Student evaluation shall consist of
1.1 Theoretical assessment
1.2 Clinical assessment

2 Examinations (Theoretical)
2.1 At the 20th week of training (cumulative assessment)
2.2 At the 40th week of training
2.3 Final examination at the end of training

3 Examination (Practical)
3.1 Clinical skills – ongoing assessment
3.2 Final examination – at the end of training

Methods of Assessment

1 Theory
1.1 Essay type of questions
1.2 Multiple choice questions for anatomy
1.3 Multiple exam questions

2 On-going assessment of clinical skills
2.1 Checklist on eight stipulated procedures as in Lampiran 1

3 Final practical examination shall consist of viva and practical
3.1 Practical:
3.1.1 History taking
3.1.2 Examination of pregnant woman
3.1.3 Instruments
3.1.4 Drugs

Examiners: There should be 2 examiners comprising one obstetrician and one midwifery tutor.

Summary

1 Theory examination = 100%
1.1 Cumulative assessment = 40%
1.2 Final examination = 60%

2 Practice examination = 100%
2.1 Clinical skills assessment = 40%
2.2 Final examination = 60%

3 Pass
To pass the examination, the candidate must pass in both the written paper and practical examination. The pass mark shall be 50% in each.

4 Distinction
To be awarded a distinction the candidate must achieve 80% and above in both the written and the practical examination.

5 Failure
If a candidate fails in the written examination only or practical examination only or both, she shall resit the whole examination.

6 Re-examination
Candidate is allowed to sit for the examination three (3) times only.
Clinical Experience required for sitting for final examination

<table>
<thead>
<tr>
<th>The student must have obtained the following experience:</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 History taking (Booking)</td>
<td>30</td>
</tr>
<tr>
<td>2 Examination of pregnant woman</td>
<td>30</td>
</tr>
<tr>
<td>3 Perform vaginal examination</td>
<td>10</td>
</tr>
<tr>
<td>4 Conduct delivery</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>30</td>
</tr>
<tr>
<td>Home (not less than)</td>
<td>1</td>
</tr>
<tr>
<td>5 Perform and repair episiotomy</td>
<td>5</td>
</tr>
<tr>
<td>6 Assist in resuscitation of newborn</td>
<td>1</td>
</tr>
<tr>
<td>7 Perform postnatal examination</td>
<td>10</td>
</tr>
<tr>
<td>8 Child appraisal</td>
<td>8</td>
</tr>
<tr>
<td>9 Family Planning</td>
<td></td>
</tr>
<tr>
<td>9.1 Motivation</td>
<td>10</td>
</tr>
<tr>
<td>9.2 Management</td>
<td>10</td>
</tr>
<tr>
<td>9.3 Pap smear</td>
<td>3</td>
</tr>
<tr>
<td>10 Witness abnormal delivery</td>
<td></td>
</tr>
<tr>
<td>10.1 Caesarean section</td>
<td>5</td>
</tr>
<tr>
<td>10.2 Forceps/vacuum extraction</td>
<td>1</td>
</tr>
<tr>
<td>10.3 Breech</td>
<td>1</td>
</tr>
<tr>
<td>10.4 Multiple</td>
<td>1</td>
</tr>
<tr>
<td>10.5 Manual removal of placenta</td>
<td>1</td>
</tr>
</tbody>
</table>

Clinical Skills Assessment (on going)  
Lampiran 1

1. Management of 2nd stage of labour  
2. Management of 3rd stage of labour  
3. Examination of placenta  
4. Vaginal examination  
5. Performing and repairing episiotomy  
6. Health education  
7. Home visiting
Block 1

1. Unit I  Introduction
2. Unit II  Anatomy and physiology
3. Unit III  Normal Pregnancy
4. Unit V  Normal Neonate
5. Unit VI  Normal Labour
6. Unit VII  Normal Puerperium
7. Unit VIII  Family Health
   - health education
   - nutrition for mothers
   - planned parenthood (concepts and policies)

Block II

1. Unit III  Abnormal pregnancy
2. Unit IV  Medical conditions in pregnancy
3. Unit V  Complications in neonates
4. Unit VI  Abnormal labour
5. Unit VII  Complications in puerperium
6. Unit VIII  Family Health

Study Day

1. Group discussion
2. Clinical presentation of cases
3. Case conference
4. Research

Revision

Revision in preparation for final examination
Revision of whole syllabus in the form of:
- discussion
- written quiz
- quiz

Objectives of clinical postings

1. Antenatal Ward
   For the student to gain experience in:
   - the care of antenatal mothers
   - the management of complications of pregnancy

2. Labour Ward
   For the student to gain experience in:
   - the management of mother in normal labour
   - the management of the newly born infant
   - the management of mother with abnormal labour and operative deliveries

3. Postnatal Ward
   For the student to gain experience in:
   - the management of mother and baby following normal labour
   - the management of mother following operative and instrumental deliveries
   - the management of mother with puerperal complications

4. Special Care Nursery
   For the student to gain experience in:
   - management of low birth weight babies
   - management of neonates with complications

5. Family Planning Clinic
   For the student to gain experience in:
   - management of family planning clinics

6. Domiciliary Training Centre
   For the student to gain experience in:
   - management of home confinement
   - provision of maternal and child health services
Appendix 7

The Enhanced Midwifery Programme (ENB A31 - United Kingdom)

Philosophy

The programme aims to promote excellence in professional practice, which is based upon the analysis of practice knowledge and skills. This involves a need for generating new cognitive approaches, which will help to effect a paradigm shift, by encouraging the exploration of individual values, beliefs and philosophies. Central to the programme philosophy is acknowledgement that midwives bring their own personal experiences to the learning experience. The acceptance of the diametrically opposed values of personal versus professional may prove to create dissonance. However, as identified by Mezirow (1987) dissonance may pre-empt a change in thinking which will ultimately enable the student to travel with a different view. The curriculum framework will enable the experienced practitioner to develop both professionally and personally, facilitating the recognition of strengths and weaknesses through a process of reflexivity, whilst providing flexible learning opportunities which will enable achievement of excellence in practice. The notion of excellence implies the holistic understanding of a subject and relates to outstanding practice. Excellence in practice is important for professional and personal autonomy and accountability. By developing the art of midwifery and furthering knowledge concerning the related sciences, excellence in practice will become achievable.

Learning on the programme is interactive; between the client, practitioner, practice facilitators, line manager and tutors. Learning is seen as dynamic process, which fosters self-awareness and the acquisition of knowledge and skills to improve both the quality of service to mothers, their babies and families, and the development of midwifery.

In the rapidly changing scenario of midwifery practice it is crucial that midwives are able to provide a service which reflects the political, professional and organisational skills established within government policy and strategic documents.
Guiding Principles of Curriculum design

The curriculum design will encourage the development of both professional and personal growth, as an active process of refining and changing preconceived theories, notions and ideas which permeate the culture of midwifery challenging and influencing the provision of maternity services for women. This will be achieved by utilising the same underlying principles as follows:

The Art & Science of Midwifery

The functional and conceptual analysis served to identify a prevailing concern that there was a heavy emphasis on the 'medical model' in the care of childbearing women. This recognition suggested a need to identify and focus on the 'midwifery model', which emphasises the normality and physiology of the birth process. Therefore, it was felt that core elements of the award would have a major focus on the art of midwifery, as well as the more scientific elements of the midwives' role thus restoring a degree of equilibrium.

The Continuum of Childbirth and Holistic Practice

The continuum of childbirth is a further principle, as is the need for holism in practice. Ultimately, we are aiming to facilitate practitioners who are able to offer holistic care to women which is responsive to their needs and base don a model of childbirth and midwifery as part of the life cycle. The concept of a practitioner who is a catalyst for sustained change is another key theme, which emerges from the philosophy and also reflects the recommendations of the ENB (1998) in their revised framework for continuing professional education.
Philosophy of Care

There is a need to increase awareness of the philosophical significance of supporting the existing ideology relating to care in pregnancy, childbirth and the postnatal period. Any new curriculum must focus on the establishment of new perspectives to take motherhood and midwifery forward within a framework of mutuality of care; embracing attributes of caring which will enhance the experience for the mother and her family, and that of the role of the midwife. This is achieved through the emphasis upon unity of care, which reflects the partnership between the woman, and the midwife based on empathy, companionship and mutuality. The framework will promote unconditional positive regard based upon the core condition of respect. This shifts the emphasis from the societal or professional mandate to that of the individual. In essence, the relationship is more 'collaborative, that of companionship' (Davies & Neal, 1996:261) on the woman's journey, enabling the midwife to also travel with a different view.

Inquiry Based Learning

A key educational principle, which reflects the design of the programme, is the engagement of the learner in the process of participative and experiential learning. Inquiry based learning is an attempt to integrate disciplines into real professional situations. Subjects are not taught as separate entities, which reflects the complexity of the relationship that exists between midwives and mothers, or midwives and other disciplines/agencies. The role of the teacher becomes that of facilitator.

Inquiry based learning may help to break down the barriers between theory and practice by integrating these areas and by preparing the students to develop professional decision-making skills based on an exploration of all available evidence and grounded in a practices-based scenario. The bridging of the theory-practice divide should lead to a greater acceptance of evidence-based practice. The philosophy of theory 'being grounded in practice should also serve to encourage students to recognise that evidence is not simply research findings but may be practice or client based. This feeds into the need for midwifery to explore and define its own epistemology.
Post-structuralism

The final theme, which underpins this philosophy, draws upon post-structuralist theories. As noted by Cameron et al (1995), a conceptual model, which is, based on post-structuralism presents an approach to addressing the barriers, which may be encountered within professional education. The approach shifts the focus from meta-theoretical concepts to one of examining discourse, subject positions and local action in order to facilitate the exploration of development of opportunities and possibilities for change.

The guiding principles, which underpin the philosophy, were utilised within the curriculum model to inform three major themes within the curriculum model; those of paradigm shift, locus of control and profession in transition.

Curriculum Model

An eclectic approach drew upon a number of theoretical models, which were seen to have relevance to the philosophy of the curriculum. Fraser's (1998) braided curriculum model was adopted to accommodate the three key curriculum themes identified by the Development Team:

a) Paradigm shift
b) Locus of control
c) Profession in transition

The development team also recognised the relevance of four other educational theories upon which the curriculum model was further developed:

- App's (1988) Emancipatory learning process model is a dynamic process in which phases may take place simultaneously. It has as its purpose the freeing of people from the personal, institutional or environmental forces which may prevent them from seeing new perspectives for their lives, from attaining broader and deeper
goals in their lives, from gaining control in their lives, their communities and beyond. This particular approach emphasises self-empowerment and will facilitate the sustained change in practice fundamental to the achievement of the award outcomes.

- Beattie's (1987) Four fold curriculum model, which is represented by the need for a map of key subjects, a schedule of basic skills, a portfolio of meaningful experiences and an agenda of important cultural issues. The model has specific relevance to the paradigm shift, which is necessary to promote a midwifery model of care. Midwives need to develop a deeper and broader understanding of the environment of care including the professional culture of midwifery in addition to the culture of motherhood and childbirth in the context of women's lives.

- Skilbeck's (1984) situational analysis of Midwifery in the 1990's and towards the next millennium, incorporating a process model approach to curriculum development. This approach informed the functional analysis undertaken by the Development Team.

- Roger's (1983) Humanistic curriculum model, where the emphasis is based on relevance, participation, absence of threat, facilitation, self-awareness, acceptance and trust, all of which are vitally important when studying within the sensitive area of midwifery.
AMALGAM OF CONCEPTS

1. PHILOSOPHY
   - Poststructuralist
   - Humanistic
   - Inquiry Based Learning
2. EDUCATIONAL THEORY
   - Situational Analysis (Skillbeck)
   - Functional Analysis (Beattie)
   - Emancipatory Process (Apps)
   - Clinical Wisdom (Benner)

Adapted From: Fraser D (1997)
               Hammet (1998)
**Curriculum Themes**

In light of the above analysis 3 key themes emerged which guided the framework design including paradigm shift, locus of control and profession in transition:

**Paradigm Shift**

There is an overwhelming need both within and without the midwifery profession to reconsider the current models upon which midwifery care is based. Evidence suggests that a midwifery model should replace the obstetric and nursing models, which have dominated childbirth for several decades. This then implies that change agency is an important aspect of any midwifery curriculum, although Hillier and Sisto (1996) further showed that there was a need to produce practitioners who acted as catalysts for sustained change. The concept of transformational management then becomes a vital component in this curriculum.

The curriculum is firmly based within the concept of mutuality of care, where the culture of partnership is seen as being of paramount importance. This dovetails with the notion of continuum of care in midwifery practice and is also evident in current political debate, where the issues of personal rights and responsibilities are both immediate and vital to the concept of partnership. The benefits resulting from such a symbiotic relationship could have major significance in terms of personal efficacy for both woman and midwife, which may lead to a change in perspective at a professional, and even a societal level.

**Locus of Control**

The main emphasis here is on the provision of holistic, woman-centred care. The concept of 'care' has been analysed elsewhere by members of the team to ensure that the focus of this remains on the woman rather than the caregiver. This implies that a holistic approach to care is required, and that the autonomy of the woman is promoted and retained. The locus of power and control must rest with the woman immediately shifting
the balance of the relationship between the woman and her midwife to that of empowerment and partnership equally. The concept of autonomy is also of paramount importance in the role of the midwife, not least in terms of promoting models of practice, which support this and offer increased job satisfaction and ownership of professional integrity. The mechanisms, which exist to protect the woman during childbirth, may act against the exercise of autonomy by midwives. It is essential that midwives explore the extent to which the supportive mechanisms including supervision, management and self-regulation empower midwives.

**Profession in Transition**

Informed choice has become one of the major issues underpinning the practice of midwifery in recent years, and the promotion and protection of this concept is an important issue for consideration within this model. This also links with the issue of health improvement, where the focus is as much on prevention and intercession as interventive treatment which often carries risk when used on a regular or routine basis.

This also implies a need to enable practitioners to challenge and change practice, which does not appear to be evidence based.

A series of recent professional and political documents have highlighted the issues which midwives and other health care professionals face in the current climate, Warner et al (1998, p 18), in a document commissioned by the UKCC, suggest a need for "reassessment and re-evaluation of professional roles and core values":

The general concept of choice as fundamental tenet of political ideology is well established in the UK and is unlikely to be reversed. In relation to health services, the right of the individual to make informed choices about their treatment and care is axiomatic, although the reality of the service at present is more often one of 'provide-capture' - health care is dominated by the staff who provide the service with a corresponding lack of regard for the user voice. (Warner et al 1998, p 18.)
The curriculum aims to address this anomaly in order to equip midwives with the skills needed to ensure that informed choice is a reality for all women within a variety of community and other settings. Issues, which underpin this theme, include exploration of the midwife as the lead professional in care, professional accountability, interdisciplinary working and innovative models of midwifery practice.

**Aims of the Programme**

The programme aims to reflect an amalgam of aims drawn from

- BSc (Hons) Professional Midwifery Practice ENB A31 Guidelines
- APU Graduate Aims/Outcomes

**Functional Analysis of Role of Midwife**

The programme aims to:

- Build upon the midwife’s existing knowledge and skills moving towards excellence in midwifery
- Influence practice through development of knowledge, ideas, values, attitudes and philosophy, and in so doing define and develop an epistemology for midwifery,
- To facilitate development of practitioners who are skilled agents of change, able to promote development and change in practice through diverse means, including reflection and by role modelling.
- To prepare practitioners who are able to explore their own knowledge base, set goals and targets for personal and professional change and enable midwives to delve deeper into practice and demonstrate progress towards achievement of excellence in practice
Learning Outcomes

Upon completion of the programme the midwife will be able to: -

- Demonstrate in-depth knowledge and understanding of midwifery theory and practice which indicates progress towards achievement of excellence in practice.
- Demonstrate reflective, evidence-based critical thinking skills which are utilised to inform and influence evolving attitudes towards birth
- Initiate and implement practice developments for long term and sustained change in midwifery practice
- Demonstrate the ability to practice as an assured, skilled and proficient midwife within a variety of contexts.

Programme Content

The modules have been designed to reflect the three major curriculum themes, which underpin the curriculum philosophy – locus of control, paradigm shift and professional transition.

These themes are interwoven with the specific theoretical content of each module, thus allowing for the inclusion and integration of theory, philosophy and practice. Such an approach should result in a programme, which encourages the development of a more holistic practitioner who is able to marry the theory and delivery of care in a flexible and responsive way. Therefore, the so-called ‘divide’ between theory and practice becomes irresolute, and a seamless theory-practice continuum will replace the existing ‘ideological hurdles between theory and practice. This will serve to foster the development of practitioners who are ‘change agents’ able to provide the full spectrum of woman centred, midwife led care.

The use of inquiry based learning and teaching methodology will facilitate ‘braiding’ of the themes, and the underlying philosophy by presenting lateral, real life, and practice based perspectives.
Work Based Learning

Much of the learning required on the programme will be undertaken within the workplace. The taught element is provided to support learning within the clinical environment. The practice hours are a fundamental component of the total programme hours and include time for reflective practice, dissemination of information, portfolio development, private study and comparative placements (overseas as appropriate).

Learning and Teaching Strategies

The learning and teaching strategies utilised within the programme are fundamental to the curriculum philosophy and the design and delivery of the modules. They are indivisible from the learning outcomes and assessment strategy in that an interdependent relationship exists. The whole learning process is supported and facilitated by the learning and teaching strategies utilised. The framework is based upon the concept of inquiry-based learning (IBL) utilising participative and experiential techniques. It is important to provide students with the opportunity to engage in activities that encourage self-awareness and promote acceptance of individual values, beliefs and attitudes. This will be achieved through the following strategies.

Assessment Strategy

Student progression and achievement of the learning outcomes is both formatively and summatively assessed throughout the programme in partnership with the student practice supervisors and programme/module leader.

The assessment strategy for the ENB A31 programme has been designed to assess theory and practice in an integrative and equitable manner. The strategies to be used were developed in parallel with the modular outcomes of teaching/learning strategies. In this way assessment is an integral aspect of the learning process and does not represent
unnecessary hurdles for students. Successful completion does lead to a professional award, which is based upon evidence of proficiency within professional practice. The programme has incorporated assessment strategies, which are based upon the realities of professional practice when working with women and the women's experience of maternity and women's services. Such an approach is essential if the potential of students is to be fully realised. A diverse and creative range of approaches are embraced enabling students to fully explore women's health and make realistic and achievable recommendations for improving women's services.

**Guiding Principles of Assessment**

- Assessment decisions and criteria on which they are made must be explicit and open to scrutiny
- Assessment of theory and practice is seen as an integral whole. Formative and Summative assessment are therefore inclusive,
- Discussion between assessor and student about theoretical issues which arise from practice is most likely to occur where these issues can be documented reflexively,
- The completed portfolio of learning should provide a record of experience gained, thus evidencing learning that has taken place,
- Competence needs to be expressed and linked with the notion of continual professional development.

**Formative Assessment Process**

The formative process enables student development throughout programme. The strategies employed will enable learners, lecturers and assessors, to identify individual strengths and weaknesses and provide on-going feedback to inform the development of future learning needs. A student file will be maintained, which will serve to record and monitor the learner's progress.

Students registered on the pathway will be required to compile a portfolio of learning. The portfolio represents a record of individual learning and also provides a continuous source of evidence upon which to assess the achievement of the programme's learning outcomes.
It was felt strongly that there should be an emphasis upon participative interactive assessment where competence in skills such as those utilised in communication, team building, problem solving, and negotiation should be adopted. Self and peer assessment was additionally considered. It was considered that the proposed curriculum style would encourage the development of greater peer and individual involvement for assessment purposes.

**Student Experience**

**Academic Support**

The establishment of appropriate support systems, which reflect the academic, personal and professional needs of students undertaking the programme was crucial. To facilitate the student's needs, the following systems will be implemented and reflect current field standards:

Prior to commencing the programme, students who need additional study skills will be advised to undertake appropriate modules or study packages provided by the University.

During individual modules, students will be offered a minimum of one hour's academic tutorial time with the module leader. This recognises the University's position that academic staff should not be proof reading student's draft assessment, but to give guidance and support on plans for assessment, further literature sources, and advice on writing to Level H and ensures equity in student support. This time has been built into the resource analysis and reflected in lecturers' workload.
All students accessing the programme will have a personal tutor who will act as an academic and professional guide. The personal tutor will provide a minimum of one hour's support per semester to each student.

_Work Based Learning_

**Practice Facilitator Support**

Each midwife on the programme has an identified Practice Facilitator who is appropriately prepared/qualified to fulfil the role.

The facilitator is expected to meet with the Programme Leader during the course of the programme to discuss the learning need of the midwife and to develop strategies to enable the student to achieve them. They will also be invited to attend update sessions with other practice facilitators and programme leader.
Transmitting American Ideology Globally: American Foreign Policy

Whereas America previously intervened to support authoritarian regimes in the interests of creating a stable environment for American capitalism, often under the cloak of anti-communism, in the 1980s and 1990s, a more subtle policy for promoting the interests of US and transnationalised capital emerged under the rubric of “promoting democracy”. This policy shift has been accomplished by an impressive array of new methods for sustaining the hegemony of the dominant fraction of transnationalised capital, spearheaded by, but not necessarily synonymous with the US, along consensual lines within the penetrated states. In fostering a new “transnationalised” elite in strategically important developing states, America placed less reliance on military intervention and on covert CIA operation which were ever less “plausibly deniable” in the wake of the Intra-Contra affair, and more on “political operations”. These operations include propaganda, and overt assistance to various political groups and movements such as trade unions, youth and women's groups.

Even if the methods of US foreign policy became more subtle and flexible, Robinson (1996) argued that the essential objective - maintaining the social stability conducive to the penetration of “targeted” states by international capital - remained broadly unchanged. For Robinson, what America promoted was in effect democracy almost by name alone, hence America’s overarching concern with instituting its outward procedures, in such a way that “free and fair elections” became virtually a byword for democracy.

Thus Robinson preferred the term ‘polyarchy’, or ‘low intensity democracy’, revealing the oxymoronic quality of what America promoted. “Low intensity democracy”, like alcohol free lager, gave the appearance of the real thing but without the damaging side effects: after all, from the perspective of the transnationalised elite, “there are potentially desirable limits to the indefinite extension of political democracy”, as Robinson (1996: 68) quotes Samuel Huntingdon (1989:115).
In short, for Robinson, the US as a means of harnessing and co-opting popular anti-autocratic and grassroots movements promoted polyarchy. By providing the institutional semblance of democracy, while leaving economic inequalities unchallenged, polyarchy served to suppress popular and mass aspirations for comprehensive democratisation of social life. Paradoxically, concluded Robinson, in the very denial of these popular aspirations for political participation and a more just socioeconomic order, "polyarchy" appears unlikely to produce the long-term stability it seeks.