On the global scale, the ramifications of the distinction between midwives who meet the international definition and those who do not have been profound. Those who do are incorporated into the health care system. Those who do not remain outside of it, and suffer multiple forms of discrimination as a result.

(Davis-Floyd 2008: 168)

Traditional birth attendant, midwife, partera, dai, sage-femme … Across the globe, there are many names for those (in their great majority, women) who care for other women—and often provide care for infants and children, too. The word “midwife” and its translations cover a wide variety of situations. From Malawi to Mexico, the stereotypical figure of the traditional midwife is that of an older woman who has not received formal schooling and relies on her empirical knowledge to help women from her community deliver their children at home. These women often became midwives through apprentice-style learning, either by attending their own births, those of other women, and/or learning through an older midwife, usually a relative. Most of them do not possess formal, institutional training in midwifery, but have acquired a strong knowledge through spiritual and/or empirical training, and are recognized in their community. At times, they are considered health workers and integrated into the health system alongside nurses and obstetricians; at others, they are pushed at the margins of the healthcare system without any recognition.

Since the 1980s, anthropologists have documented the various forms of training of midwives both in the Global North and the Global South (Jordan 1993). By taking a close look at midwives’ practices—which include not only care for women during pregnancy, birth, and postpartum, but also a full spectrum of reproductive care—medical and cultural anthropologists have highlighted the power relations at play in the field of birth between the different actors involved: Mothers and parents, homebirth midwives, nurse-midwives, obstetricians, other medical personnel, and government workers among them (Davis-Floyd and Johnson 2006). Anthropological contributions to the study of midwifery include the theorizing of the midwifery model of care, in comparison with the biomedical model of care dominant in hospitals worldwide (Davis-Floyd 1993; Rothman 1979); the analysis of “authoritative knowledge” (Jordan 1997) at play in doctor-patients interactions; and the documenting of the diversity of midwifery practices across the globe and the current challenges midwives face.
Starting in the 1990s, the push towards the “professionalization” of midwifery in the Global South has brought center stage a new generation of younger women pursuing midwifery as a career path. These professional midwives are formally trained in midwifery schools and actively organize to seek recognition within the state system (Dixon 2020). Some of them also integrate a spiritual and cultural component to their practice, leading anthropologist Robbie Davis-Floyd to call them “postmodern midwives” (2008). In the Global South, professional midwives represent a little over a third of all midwives and the great majority of births are still attended by traditional midwives (UNFPA 2014). These midwives are at the center of international, national, and local policies aiming at curbing their practices under the premise that these are unsafe (El Kotni 2019). Yet these arguments about safety are derived from maternal mortality rates, which are due to a variety of factors including poverty and isolation, but not necessarily unsafe midwifery care.

As women who care for other women across their reproductive cycles, midwives are key figures in the anthropological study of reproduction. An anthropological approach to midwifery highlights the social crossroads at which these women practice, with careful attention to gender and power dynamics inside and outside of hospitals. The increased medicalization of pregnancy and childbirth draws new lines of power between patients and medical professionals and among these professionals as well. Drawing on the work of anthropologists in different countries, this chapter presents the diversity of midwives’ practices across continents, but also within countries. Starting with a brief historical overview, I highlight how the medicalization and the masculinization of birth went hand in hand. I then discuss two key concepts in the anthropology of midwifery, authoritative knowledge and the biomedical and midwifery models of care, before detailing the contemporary fight for legitimacy of midwives in the Global North and South. I illustrate how this fight is intimately tied to policies aiming at controlling traditional midwives’ practices through my own work in Mexico. I conclude by discussing birth models from which all could benefit.

**Midwifery: A brief historical overview**

The World Health Organization defines midwifery as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life” (International Confederation of Midwives, World Health Organization, and White Ribbon Alliance 2016: 1). Globally, midwives have the capacity to deliver up to 87% of reproductive care (UNFPA 2014). However, despite research in Canada showing that planned home birth with a registered midwife is associated with “very low and comparable rates of perinatal death and reduced rates of obstetric interventions and adverse maternal outcomes compared with planned hospital birth attended by a midwife or physician” (Janssen et al. 2009), the idea persists in many high-income countries that the hospital is the safest place to give birth. For example, in the US, 99% of babies are born in hospitals. Among these, 91.5% are delivered by obstetricians and 7.9% are caught by midwives (Galvez 2011: 87). Numbers are similar in other countries of the Global North: In Israel and Japan respectively, 99.4% and 99.8% of babies are born in hospitals (Ivry 2009: 20).

Even in contexts where the quasi-totality of women give birth in hospital settings, it is important to keep in mind that the medicalization of birth happened over a brief and recent period of time and has gendered roots and consequences. In fact, the history of contemporary midwifery is one of the displacement of women’s empirical knowledge about women’s health by a masculine, biomedical model. In *Witches, Midwives and Nurses*, Barbara Ehrenreich and Deirdre English (2010 [1973]) analyze how the witch-hunts of the sixteenth, seventeenth, and
part of the eighteenth centuries in Europe and North America mostly targeted women who possessed some form of medical knowledge, often related to medicinal plants; these healers were also often midwives. The decimation of women healers continued across centuries and contributed to the establishment of Western medicine by effectively eliminating all competition. The witch-hunt period also coincides with the colonization of the Americas, which resulted in the destruction of traditional medical practices, the control of women’s reproduction, and the genocide of Native people across the continent (Smith 2015).

In Europe and the US, the shift from home to the hospital as the best place to give birth mirrors the displacement of women/midwives as key protagonists of childbirth by men/doctors. In France and many other European countries, until the seventeenth century, women gave birth at home surrounded by female relatives and with the help of a traditional midwife (*matrone*) (Morel 2018). The development of obstetrical instruments, such as the forceps in England, led to the incorporation of male surgeons, who were called to intervene during difficult births in an attempt to prevent maternal deaths. However, because he was only called for emergencies, this male doctor had little chance to improve his skills or develop social knowledge around the physiological process of birth (Odent 2013). Relying on their mastering of tools, and despite their low success rates in preventing maternal deaths, these male specialists were called upon more and more frequently by the parturient’s family and managed to replace traditional midwives in some contexts.

While traditional midwives were pushed aside, a new category of midwives emerged in the eighteenth and nineteenth centuries: Educated professional midwives. In France, schools opened all over the country and tens of thousands of young women are trained (Sage Pranchère 2017). Backed by the state, these young women collaborated in vaccination campaigns and reached out to women in rural areas, further contributing to replacing older, rural midwives as agents of reproductive care. In the meantime, maternal mortality in public maternity wards, which was at times over 30 times higher than at home (Morel 2018), only started to diminish in the 1890s following new sanitary protocols regarding asepsis and hygiene. Both in France and in the US, the routinization of hospital birth took place in the 1920s and was backed by government policies. In the US, physicians started gradually displacing midwives starting in the mid-eighteenth century through similar mechanisms: By portraying birth as a pathology and not a physiological event, which thus required the intervention of a specialist. Physician-attended births became the norm for White women in the twentieth century while in Black and immigrant communities, traditional midwives still attended births (Kline and Hayes-Klein 2020). Public health personnel and government campaigns actively targeted African-American midwives, excluding them from reproductive healthcare (Fraser 1998). In the state of New York, a 1907 regulation arguing for better hygiene to fight against maternal mortality led to the replacement of traditional midwives by trained nurse-midwives (May and Davis-Floyd 2006). The eradication of traditional midwifery has had long-standing impacts on low-income communities and women of color. In 2019, African-American, Native American, and Alaska Native women were three times more likely to die from complications related to pregnancy than White women (Rabin 2019).

In France in the 1930s, nativist policies encouraged women to give birth in the hospital by paying for hospitalization expenses and offering 12 weeks of half-paid maternity leave. In moving from home to the hospital, women’s birth experience shifted from a family event to a solitary experience. Midwives no longer practiced independently, but became part of the medical personnel, inserting themselves into bureaucratic and power hierarchies.

The institutionalization of childbirth and of midwifery that occurred in Europe also impacted other regions of the world through the process of colonization. The surveillance of women’s reproduction was key in the assertion of colonial authority (Jaffary 2016; Van Hollen 2003). As
described by anthropologist Sarah Pinto, in India, the “‘training’ of ‘traditional’ figures [became] part of colonial medicine and the basis of many rural women’s relationship with the state” (2008: 214). The control of midwives was key in reaching rural women. Under British colonization in Malaysia, the training of midwives was used as a strategy to reduce infant mortality and as a way to obtain compliance to Western medicine from the local population; “midwives were regarded as gatekeepers, whose support or resistance to Western health services would determine community acceptance and compliance” (Manderson 1998: 37). These training practices map gendered and ethnic power differences not only between (female, Indigenous) midwives and (male) European doctors, but also between midwives and European female doctors who could not compete with their male counterparts in their home country and were offered positions in the colonies (Van Hollen 2003). In *Maternities and Modernities*, Ram and Jolly (1998) provide an overview of the medicalization of childbirth in Asia and the Pacific. They describe how the perils of maternal mortality have been used to intervene in the cultural practices of birthing. With the goal of “modernizing” colonized countries—shaping societies to mirror European practices—settlers built medical facilities and discouraged women from seeking care with traditional midwives. Fluency in biomedicine became associated with values of progress and modernity, whereas traditional care was synonymous with backwardness and risk—an opposition still at play in a postcolonial world (Jordan 1993; R. Davis-Floyd and Cheyney 2019).

**Authoritative knowledge**

In her pioneering work, *Birth in Four Cultures*, Jordan describes how certain types of knowledge “[carry] more weight than others, either because they explain the state of the world better for the purposes at hand (‘efficacy’) or because they are associated with a stronger power base (‘structural superiority’), and usually both” (1993: 152). What she coins as “authoritative knowledge” (Jordan 1997), then, is not a matter of correctly or incorrectly assessing a situation, but the legitimacy of one way of knowing over another. In the case of pregnancy and birth, biomedical authoritative knowledge is the authority of physicians’ diagnostics over women and midwives’ bodily knowledge and experiences. Medical workers’ authoritative knowledge relies on technology while extending beyond it: “Authoritative knowledge isn’t produced simply by access to technology, or an abstract will to hierarchy. It is a way of organizing power relations in a room that makes them seem literally unthinkable in any other way” (Rapp 1997: xii).

Because they provided alternatives to biomedical authoritative knowledge, some governments pushed for midwives’ integration into the medical system as a means to supervise their practices. For example, anthropologist Sheila Cosminsky shows the impact of biomedicalization of reproductive knowledge on traditional midwives in Guatemala. In the face of medicalization, midwives lose their authoritative knowledge

[ due to] the application of the biomedical model of obstetrics, which views pregnancy and birth as disease or abnormal states, thus to be treated by the official medical system. The process of medicalization involves the contestation of midwives’ authoritative knowledge by biomedicine, which becomes accepted as the authoritative one.

*(Cosminsky 2001: 179)*

**Different models of care**

The historical differences in the emergence of biomedicine and midwifery are reflected in contemporary approaches to reproductive health, even if caregiving practices are more of a
spectrum with overlapping practices than a binary opposition. To map the differences in the way these professionals provide care, in the late 1970s, sociologist Barbara K. Rothman (1979) theorized two models of reproductive care, which she coined the midwifery model and the biomedical model. The midwifery model is a model of care that is built on the long trusting relationship between the pregnant woman and her midwife and encourages shared decisions between them. It also minimizes technological interventions. On the other end of the spectrum of care, the biomedical model—which is the dominant model today—relies heavily on the use of technology. In this paradigm, women’s knowledge does not matter for the medical personnel, who tell them how to behave during labor and delivery, and are considered the sole custodians of knowledge relevant to the birth outcome.

A couple of decades later, these two models of care were expanded by Davis-Floyd, who described what she calls the technocratic, humanistic, and holistic models of care (Davis-Floyd 1992, 2001). In the technocratic model, the body is perceived as a machine that can be fixed through technology. In a world that values technological innovation, the reliance on technology during birth is associated with scientific progress and modernity. The technocratic model relies on the belief that more interventions and more technology lead to better birth outcomes—even if in practice it is not always the case (Janssen et al. 2009). In contrast, the humanistic model of care emphasizes the fact that the body is an organism, in connection with the mind, while the holistic model of care places the mind–body dyad in interaction with its environment. In the last two models, women’s bodies do not need to be fixed, but are believed to be fully active in their birth, able to make decisions based on their intuition, their embodied knowledge (Ivry 2009), and the information that the medical staff shares with them.

Midwives working outside of the hospital setting (in freestanding birth centers or at home) usually provide care within the humanistic or holistic model. Many midwives working in hospitals also try to provide patient-centered care, but are often caught in bureaucratic and biomedical hierarchies of power.

**Midwives’ fight for legitimacy and authority**

Since the 1970s, international policies aiming at improving mother and child health have focused on the training of traditional birth attendants (TBAs) to improve both the general and reproductive health of their communities (Kruske and Barclay 2004). As older, often Indigenous, women with little formal education, traditional midwives care for women with whom they share many socioeconomic characteristics; in rural areas, midwives and their patients are often part of the same extended family networks. While traditional midwives hold socially valued positions in many contexts—as elder women, as healers, etc.—it is important to note that this is not always the case. For example, in India even before the professionalization of obstetrics, traditional midwives (dai) were women from lower castes and did not hold power or authority (Van Hollen 2003). Birth work is stigmatized because of its contact with bodily fluids, and often the dai is called after births that are attended by family members (Pinto 2008).

In contrast to TBAs, skilled birth attendants (SBAs), which include professional midwives, have been pushed forward by international organizations to improve sexual and reproductive health (UNFPA 2014; UNFPA, PAHO and Comité Promotor por una Maternidad Segura en México 2014). TBAs moved from being perceived as allies in diminishing international maternal mortality rates in the 1970s and 1980s to portrayed as a barrier to adequate maternal care in the 1990s after the rates did not decrease (Berry 2010; Pigg 1997). While during the first period TBAs were at the center of international and national attention and were
Midwifery in cross-cultural perspectives

provided with biomedical material and training to attend births, during the 1990s the focus shifted to encouraging a more formalized professional education of SBAs (Berry 2010; Kruske and Barclay 2004). Still today, international maternal health policies support professionalized midwifery programs that integrate formally educated midwives into the healthcare system (UNFPA 2014; Walker et al. 2013), while traditional midwives often lack supplies and support for their practice.

Anthropologists have questioned the TBA category and the shift in the World Health Organization’s (WHO) policies regarding traditional midwives. In her work with traditional midwives (parteñas) in Guatemala, Cosminsky points out that the term TBA is both ethnocentric and “medicocentric” (2012: 187), implying the only recognized form of learning is the biomedical one and dismissing all other forms of training that these midwives go through, including self-attending their births, apprenticeship with an older partena, and/or attending births of family and community members. The opposition between traditional and skilled birth attendants is infused with a technoscientific bias (Gálvez 2011) which associates skills with the use of technology. The categories of TBA and SBA reflect global power inequalities: Institutions from the Global North (UN, WHO) dictate which midwives are allowed to practice and under which conditions. For these institutions, TBAs are, at best, considered partners which can help improve the UN Maternal and Child Health (MCH) goals of the millennium. At worst, they need to “phase out of tradition” in order for MCH goals to be attained (Pinto 2008: 225). Not only are TBAs and their knowledge devalued, but these women are also portrayed as incompatible with the experience of a safe birth. Yet, despite an intense and sustained crackdown on their practices, they still provide the majority of maternal care in developing countries (UNFPA 2014).

Using examples from anthropological research in different parts of the world, I share a brief overview of the contemporary tensions between midwives and national governments, and the difficulties of gaining legitimacy for both traditional and professional midwives. The first tension arises when states try to implement professional midwifery programs at the expense of traditional midwives. Such was the case in Peru (Quiroz-Pérez 2012) and Mexico (Carrillo 1999; also see case study later in the chapter), where the implementation of obstetrics and gynecology as a discipline displaced other forms of birthing. The institutionalization of midwifery started in the nineteenth century in Peru, when a new generation of educated midwives who were White or mestiza were trained to staff the newly founded maternity services. At the same time, traditional Indigenous midwives faced restrictions in their practice. The impact of this racialized approach to childbirth remains today. Despite embracing “intercultural birthing” policies, a profound disconnection remains between rural Indigenous women’s desires for birth and the options offered for them in medicalized settings (Guerra-Reyes 2019).

The differential treatment for professional and traditional midwives is also apparent in Indonesia, where professional midwives (bidan) embody the state’s modernization project while traditional midwives (dukun bayi) practices are strictly monitored (Hildebrand 2012; Paramita Rebuelta Cho 2020). Like in Mexico (see case study), the latter are seen as needing official training and have to attend various workshops organized by local clinics and public health officials in order to continue practicing. In some of these meetings, traditional midwives are expected to share some of their knowledge with the medical staff. However, recent research has documented that this “exchange of knowledge” actually disguises the colonization of traditional midwives’ knowledge: “When they asked us, we told them everything we knew and now they don’t want to call us anymore” (Paramita Rebuelta Cho 2020: 248). Traditional midwives feel they are on the losing end of the “exchange,” with increasing restrictions placed on their scope of practice.

At times, the restrictions placed on traditional midwives’ practices push women to seek care exclusively, like in Tanzania where the strong bond between a woman and her traditional mid-
wife has been replaced by distancing with the biomedical midwives. Women now express a preference to deliver in health facilities (Strong 2020). However, in my own research, I have shown that the opposition between professional and traditional midwives is not clear-cut; these women often live and work in the same communities and share patients who often seek care from both. In practice, there is not a strict division between traditional and professional midwives, but rather a wide spectrum of individual practices (El Kotni 2019; El Kotni and Faya Robles 2018). Biomedical practitioners and government employees often perceive traditional midwives as an obstacle to quality healthcare even though they fill the care gap when those are not available. When traditional knowledge is devalued, midwives can seize medical tools as a symbolic way of reaffirming their authoritative knowledge. In India (and as I have observed, in Mexico), the tension between traditional midwives and biomedical workers is illustrated over the use of Pitocin (synthetic oxytocin) in medical settings to stimulate uterine contractions. Even though shots are available in pharmacies in India and Mexico, biomedical professionals in both countries prohibit traditional midwives from using them. Beyond arguments around the proper use of Pitocin, when traditional birth attendants provide shots, they also cross a symbolic power line. In India, they are accused of “profaning medical technology” (Pinto 2008: 129) while in Mexico, of inappropriately using it. In Indonesia, the same battle over legitimate knowledge is illustrated through the dispute around the use of umbilical cord scissors, a tool used to cut the umbilical cord after delivery (Hildebrand 2012). Traditional Indonesian midwives feel legitimate to use the tools and demand the official right to do so, while clinical staff—be it professional midwives, nurses, or doctors—claim that such tools pertain to their practice.

In the Global North, the battle around the legitimacy of midwifery is less articulated around the use of tools than the place of birth (home, birth center, or hospital). For example, in the US, two types of midwives coexist: Certified Nurse Midwives (CNM), who form the vast majority of midwives, and Certified Professional Midwives (CPM), also called Direct-Entry Midwives (DEM). The first ones have a nursing degree and operate in their great majority in hospitals, while the majority of DEMs’ practice is focused on homebirth. DEMs do not necessarily go through nurse certification, and many undertake an apprenticeship-style practice, learning alongside an experienced midwife for years. Both practitioners provide attentive care to women in the different settings in which they operate. Many midwives experience a tension between their spiritual calling and the bureaucratic regulations of their profession. As Robbie Davis-Floyd and Christina Johnson point out in their edited volume, Mainstreaming Midwives, “to professionalize is to accept a level of regulation and bureaucratic conformity that can compromise independence of practice” (Davis-Floyd and Johnson 2006: 7). Indeed, while CNMs receive a salary, DEM make a living by billing their clients. For parents, the ability to “choose” a homebirth with a DEM then is very often divided across race and wealth lines (Craven 2010). The race division is also reflected in midwifery itself, and organizations such as the National Black Midwives Alliance support Black midwives and Black communities’ access to midwifery care. The social and racial diversity of midwives is an important topic of debate for US midwives today and has yet to be resolved.

Canadian midwives have also had to face the dilemma between regulation and autonomy. Through her research, anthropologist Margaret MacDonald has interrogated the shifts that occurred with the Midwifery Act in Ontario in 1994. She documents how it has resulted in some midwife–doctor collaborations and the acceptance of midwives and their model of care in some hospital settings (MacDonald 2008). A strong disparity in midwifery care access still exists, however, especially due to the “birth travel” policy. This policy is directed toward women living in remote rural/reserve areas, but predominantly affects Indigenous women, who are evacuated from their community to give birth in hospitals in the south of the country, sometimes weeks
before their due date. This forced mobility has cultural and health consequences for First Nation women (Cidro et al. 2020). Birth workers, organizations, and families are resisting this policy. They organize to provide cultural safety, regain sovereignty over birth, recreate the transmission of knowledge within communities, and support women to give birth in their home communities (Wagner et al. 2007).

**Case study: The training of traditional midwives and their displacement to the margins of care in Mexico and Guatemala**

I have been conducting research with traditional midwives in Mexico since 2013 (see Figure 28.1). These women often live in rural areas and have learned to be midwives through empirical training (by birthing alone and/or attending births alongside other midwives). Most of them are also knowledgeable in medicinal plants (see Figure 28.2) and some of them also act as traditional healers in their communities. Across the country, these midwives often represent the closest and most affordable health care option for women, in a context where access to medical facilities is unequally distributed and a strong division between rural and urban areas remains. While nationally 96% of births are attended by medical practitioners (UNFPA et al. 2017), in rural areas traditional midwives attend up to three-quarters of births (Sesia 2015).

The relationship between the Mexican state and traditional midwives is a complicated one, and each state—sometimes each district—has different policies regarding the conditions under which midwives can practice (Dixon et al. 2019). State attempts at controlling the practice of traditional midwives trace to the colonial period (Carrillo 1999; Jaffary 2016). Like in other contexts, the development of the new discipline of obstetrics strongly relied on midwives’ empirical knowledge. Doctors practiced alongside traditional midwives, slowly replacing them as the new authority figure in childbirth in medical institutions. Yet rural women continued to seek the care of midwives, women who were culturally and geographically closer to them (Sesia 1997). The trust between women and their midwives has persisted throughout the centuries and still represents one of the main reasons why rural and Indigenous women prefer the care of traditional midwives (Sesia 1997; Vega 2017).

![Figure 28.1 Wrapping the baby to protect the umbilical cord. Source: Courtesy of Doris Braune.](image-url)
In the mid-twentieth century, consistent with international guidelines and funding pushing for the training of traditional midwives as a means to diminish maternal mortality rates, the Mexican Ministry of Health developed training courses in its local clinics. In her ethnography of childbirth in the state of Yucatan in the 1970s, Brigitte Jordan documented how training sessions were focused on asepsis and hygiene while midwives were not always provided with the proper material to practice safely. Often, the organizers distributed briefcases for official pictures and took them back afterward (Jordan 1989, 1993). In the following decades, the training sessions persisted with a shifting focus at times (family planning, maternal mortality), but were still centered around the idea that midwives and their practices needed to be controlled (Argüello-Avendaño and Mateo-González 2014). Internationally, midwives’ training courses were considered only an interim measure until all women could be attended exclusively by biomedically skilled personnel (Kruske and Barclay 2004).

In Mexico, midwives were (and are) also seen as key agents in reaching the women they care for, who are often out of reach of the biomedical health system. This explains why, despite a shift in international policies which now focus on training professional midwives to improve maternal health, the training of traditional midwives persisted in Mexico, though at varying levels in each of the states (Dixon et al. 2019; El Kotni 2019). The workshops are not designed to create collaboration between midwives and biomedical personnel; the main message of the training continues to encourage traditional midwives to refer their patients to public clinics at the onset of labor. For traditional midwives and families, referral to hospitals can be interpreted as a failure of their system of care. Some midwives feel that this control over their practices is infantilizing and develop individual and collective strategies of resistance. In my work, I have documented the fight of one organization of Indigenous midwives in the face of the biomedicalization of birth in the state of Chiapas (El Kotni 2016).

In Mexico, the articulation between different models of care is not coordinated at the national level. In my research, I have examined the relationship between traditional midwives and public health workers. I have documented the bureaucratic control over midwives’ practices (El Kotni and Ramírez Pérez 2017) and how training that aims to diminish maternal
mortality rates contributes to curbing these older, Indigenous women’s practices, subordinating them to biomedical authoritative knowledge (El Kotni 2019). Across the country, midwives from all backgrounds are pushing for recognition of their practices (Dixon et al. 2019; Dixon 2020). The diversity of midwives’ profiles sometimes leads to divergent interests. Young women trained in unofficial midwifery schools often seek to establish their practices, attending home birth or working in private birth centers. They see midwifery as a profession. For rural and/or Indigenous midwives, midwifery is a calling to which they respond in addition to their other activities (Vega 2017). In Indigenous communities, these women still play an important social, medical, and religious role. Some of them are registered with their local health clinic and seek to become integrated into the healthcare system while others organize among themselves to autonomously safeguard their practice. The Organization of Indigenous Doctors of Chiapas (OMIECH) has organized workshops to strengthen midwifery knowledge in Chiapas since 1985. In recent years, the organization has published several statements on the disappearance of traditional medical knowledge and opposing a bioprospecting project aimed at patenting medicinal plants used by healers and midwives (Alarcón Lavín 2011) as well as government training programs curbing Indigenous midwives’ practices. In 2017, a new network of midwives called Nich Ixim (corn flower) was launched in Chiapas. Members of the network, both professional and traditional midwives, have also made public statements demanding formal recognition of their work by the government.

The themes that I have documented in the training of traditional midwives in Mexico are echoed in the neighboring country of Guatemala, where the repeated emphasis on referral is incompatible with the hospitals’ material capacities, which cannot handle all the births considered risky (Cosminsky 2012). These themes recur in observations in other countries where hospitals are understaffed and underequipped, and where traditional midwives still “fill the gap” between institutional promises and everyday realities (Hildebrand 2012; Strong 2020).

Despite their important role in maternal and infant health, the knowledge of traditional midwives is not recognized as valuable as biomedical knowledge. These women face discrimination from medical institutions and are often blamed for bad birth outcomes and maternal mortality (Cosminsky 2012; El Kotni 2019; Paramita Rebuelta Cho 2020). In Mexico, Indigenous midwives are among the poorest fringe of the population. These aging women often have difficulties finding apprentices and are not only worried about the loss of their knowledge and the future of women’s health, but also about the loss of cultural and spiritual traditions.

**Conclusion: Toward birth models that work?**

Historically, the development of obstetrics has pushed aside the role of midwives in favor of a biomedical, masculine model of birth. Today, midwifery still exists in its diversity and the different types of midwives are all dedicated to providing reproductive care. The World Health Organization has named 2020 the year of the midwife and calls for more midwives to improve women’s health globally. But traditional midwives are often on the losing end of such policies, as their knowledge is not valued in the curricula for standards of care. In some contexts, the institutionalization of midwifery—a process fraught with tensions—has provided recognition for midwives. In others, it has been used as a tool of control over the type of care these women provide.

The anthropology of midwifery highlights global similarities in the power dynamics at play between traditional midwives, professional midwives, medical personnel, and state regulations. It provides us with tools to think about the everyday consequences of shifting policies. In Mexico, midwives who have been provided with tools to practice for decades are suddenly left out of...
the modernization project. While “natural” births in private clinics can cost tens of thousands of dollars, most Indigenous midwives still live in poverty, at the margins of this new market of birth (Dixon et al. 2019; Vega 2017).

Anthropological research on midwifery also asks what type of knowledge is valued and questions the opposition between tradition and modernity. In Birth Models that Work (Davis-Floyd et al. 2009), anthropologists, midwives, and medical practitioners explore alternatives to the biomedical model of care and share examples of successful collaborations between health workers and women who give birth. Recommendations include collaborative training where doctors can learn from midwives and the centrality of women’s choice in the care they receive, for example, regarding the place of birth or the ability to move between positions during labor. One of the examples cited in Birth Models that Work is the CASA (Centro para los Adolescentes de San Miguel de Allende) midwifery school in Guanajuato, Mexico. The first professional midwifery school in the country blends peer-to-peer empirical training while also preparing students to be able to work in a biomedical environment (Dixon 2020). Such collaborations result in better health outcomes for mothers and babies, as these midwives are more prone to rely on evidence-based medicine than doctors (Walker et al. 2013). This new generation of midwives seeks to provide more humanized care to women, and has been praised as acting as a bridge between tradition and modernity. They embody what Robbie Davis-Floyd (2005) has called the “postmodern midwife,” who carries on traditional knowledge while being scientifically informed, technology savvy, and politically engaged. However, on a structural level, these midwives also contribute to the displacement of traditional midwives towards the margin of care. Globally, traditional midwives continue to provide continuity of care to women in rural areas. They fight for the implementation of new models of care, where those giving birth are at the center. The impact of international, national, and local politics on traditional midwives’ practice and the stratification some policies create between schooled midwives and empirical midwives constitute areas of ongoing and future research.

Notes
1 Most people who go through pregnancy and childbirth identify as women, but not all. People all over the gender spectrum give birth.
2 Mestiza/o refers to people of mixed ancestry (Indigenous or African and European).
3 Published on Facebook on September 26, 2019: https://www.facebook.com/areademujeresomiech/posts/2168698976592324

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Mounia El Kotni


Comité Promotor por una Maternidad sin Riesgos en México; Observatorio de Mortalidad Materna en México; CIESAS.


