The act of giving birth has long been recognized in nearly every society as far more than a physiological event. Jordan’s consideration of birth as a biosocial phenomenon that blends human biology with the cultural-specific social matrix in which it is embedded (Jordan and Davis-Floyd 1993) drew from anthropological recognition of the role of childbirth in cultural reproduction—and the (re)production of metaphysical beliefs and experiences (Van Gennep 2013 [1908]). In the decades since, anthropologists have extended this recognition to demonstrate that birth, in addition to being a rite of passage that transforms participants’ identities and roles (Raphael 1975; Yearley 1997; Davis-Floyd 2004; McCallum and Reis 2005), is also a political event (Ginsburg and Rapp 1991), one that has been of intense interest to colonial powers as a part of the projects of race, class, and nation making (Stoler 1989; Boddy 1998, 2007; Guha 2018; Theobald 2019).

Wherever European powers colonized, they had to account for local religious infrastructures and spiritual practices. Moreover, spreading Christianity, envisioned as the true religion and apogee of civilization, was a salient pretext and justification for overseas conquest. In nineteenth-century Africa, European exploration, commerce, and Christianity went hand in hand, but not always in the same way. In southern Africa, Protestant clerics arrived well before administrative cadres and served as ‘shock troops,’ setting in motion transformations of mundane habits of body and mind meant to reshape local subjectivities (Comaroff and Comaroff 1991). By contrast, in Muslim areas of early twentieth-century Sudan, British military personnel preceded Christian missionaries whom they prohibited from overt proselytizing lest it fan the flames of Islamic fervour they had so recently struggled to quell (Daly 1986; Boddy 2007). However, a handful of Church Missionary Society (Anglican) missionaries in the larger towns were permitted to open nursing stations, and later hospitals and elementary schools for girls. Through these endeavours they sought to exercise a subtle Christian influence by shaping the minds and bodily habits of existing and future mothers, thereby making the local household into a site of colonial reform (Boddy 2007; cf. Mitchell 1991). Elsewhere, too, the female
body drew ‘the attention of imperial officials,’ demonstrating ‘how crucial its management was believed to be for social order and political stability’ (Ballantyne and Burton 2005: 5).

In the sixteenth-century Spanish colonization of Mexico, missionization and the conversion of Indigenous peoples to Catholicism were immediate priorities. In the Yucatán peninsula, Catholic authorities were able to use existing infrastructures of Maya state religion to promulgate Catholicism by retraining young Maya nobles, many already scribes and priests of Maya religion, as Catholic scribes and clerics to support the work of Franciscan monks (Hanks 2013). Hanks notes that integral to this process was the notion of ‘building new men’ out of the Maya through the careful re-ordering of bodily practices and comportment, hastened by the establishment of missionary schools (2013: 392). The first generations educated in these schools were children of Maya nobles, who served dual roles as priests of the Maya religion alongside their mandated positions as Catholic priests and monks. Maya priests were also expected to serve as healers and keepers of traditional medical knowledge; their education into a Catholic habitus altered, over generations, the way Mayas viewed the body. Thus, pregnancy and birth eventually came to be understood largely through a Catholic lens, associated more with the Virgin Mother than with the goddess Chak Chel.

Anthropological studies of birth and religion have asserted that birth’s transformative power as a rite of passage lies in birth’s duality, its proximity to death, that lends the event its metaphysical and spiritual importance and necessitates rituals and practices to ensure good outcomes (Klassen 2001; Güemez-Pineda 2002). In the purportedly non-religious setting of Western biomedicine, Davis-Floyd (2004) argues that the liminality of birth likewise activates biomedical rituals, rooted deeply in the biomedical imperative to resist death. In all contexts, even those claiming that childbirth has no metaphysical significance, the event is nonetheless entangled in metaphysical conceptualizations of personhood, life and death, and what it means to bring life into the world.

In this chapter, we provide a collaborative, comparative example of the ways that religion, birth, and colonization intersect in midwifery practice in two apparently different settings—British Sudan and the Yucatán, in Mexico. Despite their markedly different histories and temporal collisions with colonialism, and the divergent ways that religion becomes or remains involved with birth, midwifery in British Sudan and midwifery in Yucatán are both marked by the deployment of colonial power in attempts to control women’s bodies and delimit the cultural and religious (re)production of the birth event.

**Midwifery in Sudan**

Among Arabic speaking peoples along the Nile in the northeast African country of Sudan, Islam informs all aspects of life, even for those who are not observant Muslims. Popular Islam is the matrix in which both daily routines and significant life transitions are enmeshed. From waking, to eating, to greeting others, all acts are sanctified by the invocation b’ism Allah, ‘in the name of God.’ Changes to one’s social and physical status occasioned by circumcision (khitan, also tahur, purification), marriage (‘iris), and childbirth (wilada) are marked by a set of structurally similar rites that draw from a pool of cultural symbols linking human and agricultural fertility, the bounty that Allah provides (Boddy 1982, 1989). Such rites refer to one undergoing transition as a bride (‘arus) or groom (‘arís), signifying the potential for fruitfulness being enacted or enhanced. Girls at the time of circumcision, brides, and newly delivered mothers are fed special foods (see also Kenyon 2004), among these a concoction of milk, sorghum flour and fenugreek (hilba) intended to ‘bring blood’ (byjib dam), as blood is deemed the source of their fertility and health. Wedding symbolism suffuses both male and
female circumcision rites, as well as those surrounding birth; following each delivery, the mother is re-presented to her husband and kin as a bride. A man’s offspring are referred to as his ‘crop,’ his seed having grown by Allah’s grace in the field of a woman’s womb, nourished by the ample blood therein. Traditional birth attendants, and increasingly physicians and medically trained midwives, assist women and girls by preparing their bodies to properly receive and deliver Allah’s gifts.

Until biomedical birthing techniques were introduced by the British in 1921, deliveries in Sudan were performed by traditional midwives known as dayat-al-habl, midwives of the rope, a birthing method in which the parturient woman grasped a sturdy cord suspended from the main beam of a house and delivered in upright posture, knees bent, with the midwife positioned on a mat below to open her circumcision scar and ‘catch’ the babe as it emerged. British colonial officers considered rope birth to be dirty and barbaric; medical personnel sought to replace it with the passive recumbent position for delivery, and to teach hygienic procedures to the Sudanese. The British were especially horrified by the widespread and particularly severe practice of preadolescent female genital cutting that traditional midwives were tasked to perform, and set about to modify if not eradicate the custom. Arguments for colonial intervention into both birth practices and female circumcision cited compassion and humanitarian advance; they were, however, supported by a frank concern that women’s customs were impeding fertility, hence population growth, and thereby restricting the local supply of ‘free’ labour available for post-World War I colonial development projects (Boddy 2007).

In what follows I describe the introduction of obstetric midwifery to Sudan under British auspices, how it merged with traditional practices and blended with the meanings of reproduction in vernacular Islam. The work of biomedically trained local midwives obliquely provided the colonial state with access to Sudanese domestic space, a largely feminine space otherwise resistant to colonial intrusion given local modesty protocols and the relative separation of Muslim men’s and women’s worlds. As such, it provided an opportunity to instigate reform, indeed, to colonize bodies and minds (Boddy 2007).

The impetus for a biomedical midwifery school in Sudan came in large part from Molly [Grace] Crowfoot, who in 1916 accompanied her husband to Khartoum where he served as Director of Education. As a young woman, Molly had become interested in Christian Socialism and women’s rights. She trained as a professional midwife at Clapham Maternity Hospital in London (Textile Research Centre n.d.) established by one of the earliest female doctors in England, Dr. Annie McCall. McCall’s maternity hospital opened in 1889 and was the first in England to be staffed entirely by women doctors; they exclusively trained female students, some of whom were preparing for service in the empire abroad (Vauxhall History Online Archive 2012; The Victorianist 2011). The model of all-female health workers for women was in keeping with Victorian modesty protocols and had profound implications for midwifery education in Sudan.

Both Crowfoots were intensely interested in anthropology and archaeology, plus keen observers of Sudanese customs and rites. Molly’s willingness to participate in all aspects of Arab Sudanese life, assist local weavers at their tasks, learn craft production techniques, and document local ceremonies, ornaments, and imagery, allowed her access to local women hitherto difficult for a foreigner to achieve. Upon attending a traditional birth in the native town of Omdurman she was shocked to witness the effects of the practice of ‘al tahur’ (literally, the purification, female genital cutting), which at the time involved removing a child’s exposed clitoris, labia minora, and edges of her labia majora, then stitching the remaining flesh together so that the sides adhered. When healed, this formed a
scar that all but concealed the girl’s vaginal opening. Their childhood genital reconfiguration posed inevitable difficulties for women giving birth. Crowfoot’s troubling experience led her to beg the Director of the Sudan Medical Service to open a midwifery training school in Sudan. In 1920, when the Great War had ended and development projects put on hold for its duration were resumed, he acquiesced. Here is Molly writing about the venture to Dr. McCall in 1923:

I would so like you to know what the missionary impulse of your Clapham training has achieved out here.

The Maternity Training School in Omdurman has now been working for three years—the town ‘dayas’ old and young have now received training from Miss Wolff and are under her inspection, & now women from the provinces are beginning to come in too.

You may remember that I came to Clapham once in a state of agitation—I came to try & regain a little bit of Clapham hopefulness & determination. When I first came out here in [1916] I had meant to do something to help native women here & my training helped me to find out (what may go in and out of the country without learning) the misery one of their customs (the tahur el farohen [lit. ‘pharaonic purification’]—a very severe form of female circumcision) causes them in girlhood & in marriage & in childbearing. At last I got a chance, the late Director of the Medical Dept., Dr. Crispin planned a maternity Training Scheme on the lines of the Egyptian schools, & asked me to report on their work & keep a look out for a Nurse who might be sufficiently adventurous to start up here. I recommended Miss Wolff, whose work in the Fayoum [Egypt] I admired & who I found (I believe because of Clapham) to have something of the missionary spirit.³

‘Miss Wolff’ refers to Mabel E. Wolff, a nursing sister and trained midwife who spoke Arabic, having been born in Egypt where she was practising when Crowfoot met her. Wolff was recruited to open the Midwifery Training School in January 1921 in the native town of Omdurman, across the Nile confluence from Khartoum. She was joined by her sister Gertrude in late 1929, four years after Gertrude had, in turn, come to Sudan to train female nurses at the Omdurman Government Hospital.⁴ Together the sisters were a formidable pair whom British officials dubbed ‘The Wolves.’ They were Christian women who understood that religion—whatever its form—was as immanent in their charges’ lives as it was in their own. In her first lecture to midwives Mabel cautioned, ‘You must remember that in midwifery there are two or more lives dependant on your skill and care, each baby you help from darkness to the light of Day, is a gift from God and you should be at all times worthy to receive it.’⁵

It is impossible to disentangle medical midwifery training in colonial Sudan from British desires to stop or at least moderate pharaonic genital cutting and mitigate its harms. Owing to the practice, a local woman could not give birth on her own; traditional midwives were thus crucial to reproduction and welcomed into women’s homes. As Wolff wrote,

No child can be born without the assistance of a midwife or some other person, as to allow the passage of the child, there has to be an incision of the infibulated vulva at each delivery. Should the unfortunate woman be alone at the time, she is liable, infact [sic] almost sure to get a complete and serious perineal rupture.⁶
The Wolffs believed the practice to have roots in Old Testament times and explained its origins thus:

It dates from a little before Moses was born—Pharao had a dream in which he dreamt a male child would be born who would when grown to manhood kill him—so to prevent such a thing happening he ordered circumcision with infibulation for all females, thinking thereby he would prevent conception but when he found this method wasn’t the success he had anticipated he next ordered the death of all children or newly born babes.7

Since both Christianity and Islam are Abrahamic faiths, the Wolffs saw themselves as sharing history with Muslim Sudanese, however untutored and oblivious to biblical teachings the latter might be. Where others saw barbarity, the Wolffs saw opportunity and hope. Though reviled by colonial officials for being dirty and for performing both female genital cutting and the inevitable remedial stitching after every birth, traditional midwives enjoyed favourable status in Sudan and were respected by the people for their expertise. Midwifery was a profession available to mature ever-married women, especially those who were widowed or divorced and had borne children themselves. Having been married, their morals and honour in entering others’ homes were not impugned. Moreover, their situation meant they were not at a husband’s beck and call, affording the mobility their practice required. While Mabel would have preferred to train younger women, she understood the need to compromise. ‘Single unmarried girls never practice midwifery,’ she wrote, ‘and unfortunately educated women, old enough to train, do not at present exist, so candidates were selected from amongst the old untrained midwives who had a considerable influence over the people.’8 In the first year of the school’s operation, she was able to recruit four nonliterate practising dayas, two of them quite elderly, to a brief training course. She described her experiences in her first annual report of 1921:

Most of the Diayas were unwilling to live in the school and suspicious of what the training would mean to their work and very doubtful as to my capability or knowledge of Sudany deliveries. The patients likewise shared their view, dreading any interference with their customs, one being that the Diaya must deliver under cover of a ‘tobe’ [length of cloth], by the sense of feeling only; the first case we attended, at the most critical moment, some one enveloped both the Diaya and my head in a tobe & for a few moments we were quite helpless, or at least I was, being unused to such an ordeal; another trial of the work is the extreme ignorance of labour pains and the many useless calls before actual labour begins, due mostly to the fear of having no Diaya present for the release of the baby at delivery.9

By the end of 1921 Wolff reported a modicum of success:

the results have been most promising and encouraging; the knowledge & cleaner methods employed by the school trained dayas [are] greatly appreciated particularly by the high class natives who were at first suspicious & chary of changes & interference with their customs.

An increasing number of patients are abandoning their old untrained family daya in favour of the school dayas, & I find having free access to their houses, & my
knowledge of the language has been a means of gaining the peoples confidence & enables me to teach & influence them against the harmful ‘customs’ without in any-
way hurting their susceptibilities [sic] or interfering with their religion.10

Midwifery, however, was not particularly lucrative, as it was entailed in religion:

Midwifery work in this country is, with the exemption of a few of the larger & more
civilized places a very unremunerative profession, as most of the people look upon
it as a charitable work and that the midwife by her kindly and necessary help gains
thereby sufficient ‘Heavenly blessings’ to amply compensate for her trouble; it is
stated by holy men that if a midwife delivers 99 Primiparas on her death she is enti-
tled to enter Heaven, though it gives her no material benefits in this world.11

Families who could afford to, paid the midwife a nominal fee following a successful birth (but
nothing for other results); it was also customary to gift her a cake of soap and cone of sugar,
some perfume, grain, dates, rendered fat, and part of the animal sacrificed to celebrate the
birth.12

Traditional dayas not only attended births and circumcised girls.13 They also tattooed wom-
en’s lower lips before marriage and scored children’s faces with vertical and horizontal tribal
marks (shillukh).14 Wolff lobbied tirelessly to have all practising midwives licensed regardless
of their skill, so as to better follow them, know what services they offered, encourage them to
register births, and influence their daughters and sororal nieces—who would normally appren-
tice with female kin—to come to her school and train. ‘I feel strongly,’ she wrote in 1921, ‘that
until only recognized licensed midwives are allowed to perform circumcision operations and
facial scar marking, our influence over the midwives, as well as amongst the majority of the
people, will always remain unsatisfactory.’15

She also pressed the government to pay trained dayas a salary; not only might this induce
women to enrol, but the threat of its withdrawal would act as a disciplinary tool to ensure train-
ees’ cleanliness, the propriety of their procedures, and the suitable care of their equipment.16

Ultimately, the government agreed to pay them small ‘subsidies’ or stipends, rather than sala-
ries subject to periodic increase.17 As their meagre grants were barely sufficient to maintain
their equipment and supplies, let alone support themselves and their children, they continued
to perform tasks for which they could claim compensation in cash and kind.

Circumcising and tribal marking formed the more profitable parts of a traditional mid-
wife’s practice and were always in demand. Instead of proscribing these, Wolff used them
as entry points for medically trained dayas, thereby enabling Western science to infiltrate a
range of intimate domestic routines, including those surrounding post-natal care for mother
and child. This did not mean she condoned local practices: ‘Since my advent in the Sudan
I have never ceased to preach and teach against the Pharaonic circumcision, to my midwives,
my patients, their relations, to women generally as well as to the menfolk. And in this Cru-
sade I am ably seconded by my sister and our staff midwives.’18 However, she recognized
that, as the practice was so utterly commonsensical to their clients, it would not be abandoned
overnight. Instead, she and her sister taught trainees to perform a less damaging operation
with all care for hygiene, an operation which nonetheless modified female genitals so the
vulva appeared ‘covered’ or ‘veiled,’ as was culturally apt. In this way, the Wolffs ensured
that biomedically trained midwives had access to intimate family space and could build con-
fidence in scientific medicine among local Sudanese. The school’s revised form of female
genital cutting came to be known as tahur al-wasit, intermediate circumcision, or, just as
often, *tahur al-hakuma*, government circumcision, an unfortunate association for which the sisters eventually paid.¹⁹

Before considering why, let me first suggest how the Wolffs’ pedagogy contributed to their predicament (Boddy 1995, 2007). The Wolffs’ lesson book shows that they taught by using similes from vernacular Arabic, images that women could readily understand. As the majority of those who trained at the Omdurman school were nonliterate, they learned by viewing drawings, memorizing, and practising on a paper maché torso and Caucasian baby dolls. Local similes helped anchor the sisters’ teachings in students’ minds. Take, for instance, their agricultural description of conception: ‘When an Ovum ripens, it drops down through one of the tubes into the Uterus and if by chance it meets a male seed, it will germinate and like a tiny seedling it will take root and grow in the Uterus into a baby.’²⁰

The Wolffs taught that:

> Pharaonic Circumcision . . . is very dangerous to the health of the woman and especially to the child at birth, there is fear that the woman may become infected with Puerperal fever by the entrance of microbes through the unavoidable ‘birth’ wound.²¹

They went on to explain:

> Most illnesses are caused by the entrance into the body by way of the mouth, the eyes, through the skin or a wound (or ulcer) of minute living things which cannot be seen except with a microscope.

> Just as there are a great variety of insects and seeds, so there are microbes, each disease being caused by its own particular microbe. Microbes exist almost everywhere in the world, they are found in water, in the air and mostly they live in dirty and airless places and houses, especially on our hands and beneath our nails, for our hands are always exposed and touching everything.

> There are microbes that will turn milk sour and meat putrid and food poisonous, but if food is sterilized and kept in sealed tins, the microbes cannot penetrate and the contents such as tomato sauce, milk, sardines and numerous other foodstuffs, will keep good for long periods but as soon as the tin is opened microbes get on the food and it will soon be poisoned and unfit to eat.

> If our bodies are healthy and strong like the sealed tins, the microbes cannot harm us, but if microbes get a hold of us, they may give us some illness according to the microbe that has infected us.²²

Such teachings implicitly confirmed local meanings of pharaonic circumcision: the values of bodily closure and containment, of maintaining the womb as a clean, moist, nurturing space within an uncontaminated container. Together with the intermediate form of circumcision that, while less damaging than the traditional form nonetheless produced a smooth partially covered genital area that was both modest and aesthetically desired, they helped hybridize scientific medicine and vernacular tradition. It was perhaps inevitable that the Wolffs’ methods would lead to clashes with superiors, particularly after public inquiries from the League of Nations and a Parliamentary committee in the 1930s revealed British complicity in perpetuating ‘barbaric customs’ (Boddy 2007). In 1937, the sisters retired under a cloud of suspicion despite their achievements. ‘When we left . . . there were definite signs in Omdurman that the majority were performing a modified type of Pharaonic circumcision and there was certainly a great improvement and less suffering
due to better care and hygienic methods. Regardless, their successor immediately banned trained midwives from performing any form of female genital cutting (save necessary episiotomies), whereupon a rush of untrained practitioners stepped into the breach. Eventually, a law was passed in 1946 banning the pharaonic form and its variants, yet condoning the so-called Sunnah circumcision in which the clitoris and labia minora are cut, on the understanding that this was religiously acceptable and did not have the same ill effect on reproductive health (Boddy 2007). The law had little effect; when I worked with village midwives between the mid-1970s and 1990s, they performed the modified pharaonic type. However, rope birth was no longer practised, having been replaced by the biomedical recumbent position; dayas sterilized their implements and used local anaesthetics before episiotomy or circumcision, disinfectant on the wound, and surgical suture to re-stitch the mother after birth.

Conjunctions and distinctions

One might think that there is little in this story to link contemporary midwifery and birthing practices in Maya regions of Quintana Roo with those in colonial and post-colonial Muslim Sudan. Historically, however, traditional medical practices in both areas draw on images of the human body as being integrally part of its environment, not naturally bounded and individuated (see also Mkhwanazi, this volume). Both were influenced by the ancient Hippocratic humoral theory of medicine that circulated through the Roman and Byzantine empires, was codified by the Greek physician Galen in the second century CE and added to by Muslim and Jewish physicians under various Islamic empires, including that of Muslim Spain. Humourism was the dominant theory of anatomy and medical practice throughout the Middle East, North Africa and Europe in the fifteenth and sixteenth centuries and was carried to Mexico with the conquest where it was selectively absorbed into local ideas. It stipulates that health requires a proper balance of significant fluids in the body, as determined by the types of foods one eats, their relative properties of heat and cold, the exposure of the body to cooling and heating influences including incense and smoke. In Sudan, an incense brazier burns beneath the bed of a woman in labour and after giving birth. Forty days after delivering, she takes a smoke bath (dukhan), sitting naked under a blanket for several hours over a pit in the kitchen floor filled with smouldering fragrant woods. The personalized sauna is intended to reclose her body and make her enticing to her husband once more.

In the Yucatán, The Ritual of the Bacabs, a compilation of rituals, chants, spells, and medical practices written in the late eighteenth century but containing pre-colonial healing and religious lore, has recently been reinterpreted as describing the rites and practices of pregnancy and childbirth (Knowlton and Dzidz Yam 2019). Though likely influenced by the Galenic and humoural paradigms that had been introduced to the Yucatán peninsula by the Spanish, this compilation nonetheless presents one of the very few windows into pre-colonial midwifery rituals and practices of the lowland Maya. The sacred chants and rituals it recounts contain instructions for midwives that include feeding labouring women humourally ‘hot’ foods, positioning her next to the household three-stoned hearth for warmth, and using a temazcal or sauna before and after parturition to ritually purify new mothers (Knowlton and Dzidz Yam 2019). The similarities to Sudanese birthing rites and practices are clear, but The Ritual of the Bacabs is so infused with references to pre-colonial Maya religion that its translation and interpretation has been a profoundly difficult undertaking for contemporary scholars. It is impossible to understand the chants, rituals, and instructions without a deep familiarity with pre-colonial Maya gods, goddesses, and religious lore, and for this reason Knowlton and Dzidz Yam’s 2019 translation, made possible in part through ethnographic research with
contemporary Maya curanderos, is the first to correctly recognize these chants as related to midwifery practice.

Scholars of gender in colonial Mexico note a dearth of historical data and archival material related to women (Jaffary 2016; Vail 2019; Knowlton and Dzidz Yam 2019), citing a general lack of interest in women and women’s lives on the part of chroniclers of the era, and a reluctance to delve into what was considered to be the private, somewhat taboo domain of femininity. In Yucatán, this hesitancy applied also to the documentation of Indigenous Maya culture and practices, and, in marked contrast to Guatemala and central Mexico, there is almost no trace of reproductive practices or women’s lives in the colonial record. When such references do emerge, they may, as in the case of The Ritual of the Bacabs, be interpreted solely as religious texts without recognition of the blending of religious theory with mundane, earthly instructions for midwives.

Despite the inextricability of lowland Maya religion from midwifery practice in pre-colonial Yucatán, midwifery practice in the current day, and perhaps for centuries, retains few vestiges of pre-Christian, pre-colonial ritual and thought. As Knowlton and Dzidz Yam (2019) note,—though ethnographic work with contemporary Maya midwives and j-meen, or curanderos, helped to fill in lacunas about the medical nature of the practices described in the compilation—the practitioners they spoke with were unaware of the pre-Christian religious significance and symbolism embedded within the practices. This has generally been observed by medical anthropologists working with lowland Maya midwives in the contemporary era—in the rare instances in which there is overt recognition of the sacred during birth, the referent is to Catholicism or, increasingly, evangelical Christianity (Jordan and Davis-Floyd 1993).

A tamed cavern

In pre-colonial lowland Maya religion, geologic formations structure humans’ relationship not only to life and land but also to the afterlife and other worlds. The hundreds of thousands of caverns that punctuate the rocky limestone shelf of the Yucatán peninsula are the only source of fresh water, of life, in a land absent of rivers, and they are the route to the underworld, a pathway cluttered with ghosts, monsters, gods, and human and non-human spirits. Religious practices of purifying, ‘taming,’ and feeding caves have survived to the present day, as have rituals related to the appeasement of the monsters that can lie within. However, similar traditions, and their associated meanings, have been stripped away from the practices that guide human souls from the underworld to the middle world, the planet’s surface, through birth.

The following vignette is based on Sarah A. Williams’ ethnographic fieldwork with midwives, families, and Maya communities in the Mexican states of Quintana Roo and Yucatán during 2016 and 2017, and is a part of a broader project examining midwifery birth practices, the effects of racialization and racism on Indigenous maternal health, and Indigenous midwives’ efforts to protect midwifery practice.

José pauses his praying in Yucatec Mayan and dips a dried gourd into the bucket of hot water and steeped herbs before shaking its contents over the (imported) glowing volcanic rocks in the centre of the temazcal. He resumes chanting, his voice cutting through the hissing steam to carry a prayer-song that I recognize as a Mayan translation of a Nahuatl temazcal prayer. The gods he calls are Nahuatl-Toltec, rather than Maya, and other than the translation of the prayers, this ceremony is nearly identical to the temazcales that I have attended that were guided by Nahuatl-speaking shamans from central Mexico. José and his older brother, Juan, have invited me and two white midwives into the Quintana Roo countryside to camp on their grandfather’s land and spend time together. On our second day, we help José and Juan
build a large bonfire around a pile of volcanic rocks. While the rocks heat to glowing in the mosquito-filled dusk, we construct a temporary temazcal out of woven branches covered with blankets.

Once inside, sitting cross-legged around the radiating abuelitas, or ‘little grandmothers,’ José sets an intention in Mayan that the temazcal will purify our bodies and strengthen our hearts, so that the midwives, sacred guardians of new lives, will emerge from the sweat bath with renewed energy for their work. His prayers during the two hours we remain inside emphasize the power of midwives and their work. After he closes the temazcal, he leads us to a path through the forest lined with candles, leading to a dark fissure in a rocky outcrop. The candles continue inside the narrow, downward-sloping tunnel, leading to a cave cenote, where the freshwater that lies underneath the limestone Yucatán peninsula has bubbled up to meet the air. We strip off our sweat-laden dresses and slip quietly into the water, listening as José describes how his grandfather was the first j-meen to wrestle with the cave, returning over and over to pacify it so it would be safe to enter, drink from, and use for rites. ‘He tamed it, and I continue his work,’ José says. He sees these rituals as a reclamation of ancient family and cultural traditions that nearly died with his grandfather.

Because he did not take an interest in ‘the old ways’ until he was a young man and his parents viewed them as a violation of their Catholic faith, José has had to learn much of what he knows about temazcales from curanderos in other traditions (see also Hendrickson, this volume). While temazcales were both a sacred and quotidian practice for the ancient Maya, they are not considered to have been actively practised in an unbroken line since colonization (Vail 2019), and are quite rare today outside of tourist attractions. While José has integrated core aspects of what Yucatec Maya scholars call the ‘Maya cosmovision’ into his practices, what has been lost due to colonization, Christianization, and attrition is filled in with similar rituals and oral material from other Indigenous Mexican cultures.

Despite these broader incorporations, the respect and sacredness accorded to midwifery in the ceremony draws on a firm foundation in pre-Conquest Maya religion, which directly connects midwives to the patron goddess of childbirth, Ix Chel, or her iteration as the crone goddess of midwives, Chak Chel. So strong was the pre-colonial connection between midwives and the goddesses of Maya religion that Bishop Diego de Landa referred to them as ‘sorceresses’ and noted that they directly and symbolically called upon Ix Chel and Chak Chel to assist during births ([ca. 1566] 1978: 56). Landa, Bishop of the Archdiocese of Yucatán from 1573–1579, is most famous for his careful records of Maya language, culture, and religion, and his subsequent purge of the same through the persecution of Maya priests and nobles, the torture and murder of Mayas suspected of practising their religion, and the destruction of Maya codices and thousands of religious artefacts. The Church had drawn heavily from Maya noble and priestly classes to populate the Yucatecan priesthood, and many early Mayas in the Church maintained their sacred roles in both religions. However, nominal conversion to Roman Catholicism was unacceptable to Bishop Landa, who was determined to eradicate all manifestations of pre-colonial Maya culture. Midwives, identified as heretic practitioners of the dark arts by colonial authorities, would likely have been particularly at risk and thus under pressure to obscure the non-Catholic religious meaning of their work. This decoupling of Maya religion from midwifery practice was exacerbated during the nineteenth century, when midwifery in Mexico was identified by the emerging profession of obstetrics as both a professional threat and unwelcome reminder of Indigenous cultures, and urban midwives medicalized their practices to maintain respectability (Jaffary 2016). Today, midwives generally tie techniques that can be traced to pre-colonial medico-religious practices to Christian explanations or communicate them through biomedical terms; other Maya religious practitioners
such as j-meen remember the holiness of midwives, but midwives themselves, often elderly, socially conservative, firmly Roman Catholic Maya women, do not claim an ancient lineage that leads back to a goddess. In the wider culture in Yucatán and Quintana Roo, midwives are often treated disrespectful and with suspicion, and racialized in ways that fix them as backwards, uneducated, and un-modern. In some rural villages, midwives are often called kaakpaach (prostitute or whore, in reference to their need to be out of the home at all hours of the night) instead of xkampaal (woman who catches babies).

In Yucatán, formal government intervention in Indigenous midwifery practices outside of colonial-era persecution did not really begin until the 1960s, when government interest in developing the coast for tourism led to increased investment in infrastructure and social services, and the WHO and UNICEF began to prioritize rural and Indigenous health. As Jordan and Davis-Floyd (1993) reported, these early interventions often took the form of training courses, where midwives were taught basic hygiene, identification of obstetric complications, and medical definitions. The midwives’ understanding of these concepts was often uneven, as was their application, but Jordan notes that even by 1979, many midwives had incorporated practices and tools that they found useful (1993). By the early 1970s, Indigenous women in the region were blending traditional midwifery care with biomedical reproductive care and contraception, and anthropologists indicated that reproduction was moving fairly easily into the biomedical sphere (Elmendorf 1979). By 2019, many older Maya midwives in the states of Yucatán and Quintana Roo had been attending Ministry of Health-run training courses for decades, and had integrated a biomedicalized framework into their practice.

In the Yucatán peninsula, the personal trajectories of traditional midwives often turn out to be diverse and multi-nodal, going long periods without attending births as their own lives change. However, most currently practising traditional midwives began learning midwifery not in a school or formal institutional setting, but as an assistant to a grandmother, mother, aunt, or neighbour. Many midwives cite the don or God-given gift for calling them to receive babies and serve women. Sometimes the don becomes clear when a midwife is very young, still a child or teenager, and other times it only emerges when a woman has had children of her own and is recognized by her community as someone with a gift for birth. Though apprenticeship to an older midwife is the normative route to traditional midwifery, some midwives also learn on their own, absent formal instruction by a more experienced birth worker, through experiences with community members who come to them based on the recognized strength of their don, or, occasionally, because there is no one else available to attend them.

Many traditional midwives in the Yucatán reference such non-institutional, experiential forms of education as the foundation of their knowledge. For some, as they became more serious about midwifery as a personal commitment or calling, and as the state Ministry of Health began expanding their capacity-building programs for midwives, participating in biomedically-based trainings and certification programs served as an important step in growing their skills while simultaneously building their reputations and social capital. As access to biomedical healthcare improved in the Yucatán throughout the late 1990s and early 2000s, many midwives found that the don was no longer sufficient for demonstrating competency, and official certificates of completion for maternal health training programs became an important way to set oneself apart and inspire clients’ trust.

Though midwives’ explanations of the biological systems and theory supporting practices could be variable and their ability to recount the ‘why’ of techniques depended on the extent of their own schooling levels, many traditional Maya midwives have incorporated biomedical principles into their practice. My life history interviews with Maya midwives showed that regardless of how their work was framed by others, most—no matter how elderly, rural, or
traditional they appeared to be—had collaborated with, learned from, taught, and assisted doctors and obstetricians. As Carmela, a midwife in her late sixties, explained, ‘We were taking courses from the doctors. . . . Doctor Juan taught us many things there. Because he’s good people [sic], he taught us lots of things.’ Another Maya midwife in her early sixties, Cecilia, emphasized: ‘and in addition to that [apprenticeship with grandmother], I also learned many things with doctors. . . . I already knew this work. . . . But, those other things—I learned to place an IV [from the doctor].’

As these histories suggest, traditional Maya midwifery has not for decades, possibly centuries, been a purely traditional Indigenous practice. Rather, its roots and techniques are pluralistic and ever-shifting depending on the resources of the midwife, her access to and relations with biomedical practitioners and state services, and clients’ preferences. Client preference, in particular, adds an interesting complexity to the question of medical pluralism, which often presumes discrete categories of medical/healing practice, which are blended by clients, rather than practitioners. However, as these examples show, a hallmark of traditional midwifery is that midwives practised medical pluralism as they select from and blend a multiplicity of medical traditions.

**Discussion and conclusions**

In post-colonial countries, we can trace how biomedicine and birthing practices became an extension of the colonial imperative to control nature and the as yet uncolonized wilds of women’s bodies. How women experience birth and who is permitted to guide them became the grounds for an ideological conflict surrounding truth and who could own it—the same conflict that played out in nearly every other area of specialized knowledge. Different colonial and religious contexts open up spaces for co-optation and selective integration of technologies and forms of knowledge promoted by the state. Rather than a complete adoption of biomedical norms, midwives more often adapt and apply what is useful to them and the women they serve and leave the rest aside. We can consider this a practitioner’s version of what Klassen (2001) has termed ‘technopragmatism’ in midwifery clients—a careful evaluation of birthing techniques and the application only of those deemed appropriate and necessary.

In comparing these two examples—midwifery practice in colonial Sudan and that in the Yucatán—it becomes clear that colonial authorities seek to change, incorporate, and mobilize midwifery with the intention of initiating broader societal shifts in religion and beliefs about the social and physical body. In the colonial through to the contemporary era, the investment of governing authorities in midwifery practice and women’s health implicitly acknowledges the interconnected nature of birthing practices, religious beliefs, and ideologies of gender and race. Changing religious beliefs can have a profound effect on birthing practices. Likewise, colonial authorities recognized that birth—as a rite of passage, form of social reproduction, or sacred event in and of itself—was an important medium through which to access and alter the religious beliefs of candidates for conversion.

While midwifery may not be an obvious tool of ‘civilization’ in Sudan or the Yucatán today, it remains a key conduit for Christian modes of thinking about the body and personhood as individuated, to the extent that these are inexorably embedded in Western biomedicine. As Mexico and Sudan transform in the neoliberal era, self-consciously oriented towards modernization and nationalism, midwives and their practices continue to be drawn into serving state projects, surveilling women’s bodies, and the processes of reproduction on which those projects depend.
Midwifery and traditional birth attendants

Notes

1 The British conquered Sudan in 1898 together with Ottoman Egypt and ruled the region as a condominium until 1956; British held all senior posts and Egyptian officials subordinate roles.
2 Much NGO literature refers to this as female genital mutilation (FGM). Activists may use local terms such as *khitan al-banat*, girls’ circumcision, while others prefer the more neutral acronym FGC, female genital cutting. The WHO uses a blend: FGM/C.
3 Draft letter, M. Crowfoot to Dr McCall, undated, Molly Crowfoot papers courtesy of the Crowfoot family.
4 Draft, M. Wolff to British Social Hygiene Council, February 1933, Sudan Archive Durham University (hereafter SAD) 582/10/4.
5 Sudan Arabic Text Book for Midwives of the Sudan, SAD 581/5/7.
8 M. Wolff, Report to The British Hygiene Council, February 1933. SAD 582/10/5.
11 M. Wolff to Atkey, Director SMS 17 January 1929 SAD 581/1/1.
12 M. Wolff to Atkey, Director SMS 17 January 1929 SAD 581/1/11.
13 Boys were circumcised by male sanitary barbers.
14 Both customs died out in the colonial period, but not pharaonic circumcision.
15 M. Wolff to Atkey, SAD 582/2/51.
16 M. Wolff to Atkey, 17 January 1929. SAD 581/1/12.
17 Atkey to M. Wolff, 3 March 1929. SAD 582/1/58.
18 Wolff to Director, SMS, Omdurman, 1 February 1931. SAD 582/8/10.
19 See also Bell (1998).
20 ‘Elementary Practical Lessons’ for Midwives of the Sudan. SAD 581/5/12.
22 ‘Elementary Practical Lessons’ for Midwives of the Sudan. SAD 581/5/16.
23 M. Wolff to Lady Huddleston, 14 October 1946. SAD 582/8/35.
24 A Mesoamerican form of sweat lodge.

Bibliography


