Paper presented in Panel S25 'Scientific Research and the strengthening of traditional medicine and intercultural health: evaluating impacts and potentials in Latin America' XIII Congress of the International Society of Ethnobiology, Montpellier, France, 22 May 2012.

Dynamic Conservation of Traditional Midwifery: Paths of research and practice

Françoise Barbira Freedman
Department of Archaeology and Anthropology
University of Cambridge
fb205@cam.ac.uk

As a female medical anthropologist who experienced two pregnancies in Peruvian Amazonia while doing field research, I have become progressively aware not just of the extensive ecological knowledge associated with pregnancy and the birth and care of babies, but also of the value of this endangered knowledge in the dynamics of interculturality. While conservation efforts have been mostly concerned with medicinal plants related to priorities identified in international health agendas, few researchers have been specifically concerned with plants used by Amazonian women in midwifery. The work of Elaine Elizabetsky stands out in this regard (1997)

As well as documenting midwifery plant knowledge that is part of the materia medica of the Keshwa Lamas indigenous people in the Peruvian Upper Amazon, my aim is to highlight and address the urgent need for a broader conservation programme that would include not only concrete knowledge (use of local plants, techniques for easing the delivery of babies and promoting postnatal care) but also the modes of transmission of this knowledge across generations of women and sometimes of men too.

Marilyn Strathern (2004:4-5) identified '…the complex interfacing when social science gets linked up with natural science, both as an outcome of its own theory driven questions and as an outcome of its largely responsive mode'…

Firs of all, social science and more particularly anthropology needs to address the urgency of finding new pathways for the improvement of maternity care worldwide, as the WHO Millenium Goals are pushed back in time and maternal and infant mortality figures have either remained stationary or worsened in the last decade. The Safe Motherhood Initiative, that raised hope in the last decades of the twentieth century with the promise of a greater integration of local practices in maternity services, did not yield significant results. In spite of some original research on the training of local midwives (Jordan 1989) the programme

as a whole stumbled on the issues raised by the 'interfacing' of different modes of knowledge and practice.

The Cambridge VIMA project

Rather than attempting to contribute to a more functional integration of health services in contexts of medical pluralism, from a perspective of applied medical anthropology, my project consists in creating a dynamic grassroots conservation initiative involving local midwives directly as agents. The VIMA (Virtual Indigenous Midwifery Archive) was conceived in the context of the Cambridge University EthnoBio Net, a research network linking university researchers working on/with local knowledge across disciplinary boundaries. Both Darrell Posey and Marilyn Strathern were influential instigators of this network that has transformed over two decades. WOLP (World Oral Literature Project), also rooted in the Anthropology Department at Cambridge University, provides a strong connection and logistic support for the development of VIMA not just as a state of the art virtual archive but also as a vibrant interactive network. Clips and short documentaries can now overcome the obstacles set by illiteracy, that barred the best indigenous midwives from access to the Safe Motherhood trainings. At the same time, the visual materials can elicit dialogue and further research in the development and application of models that can promote better maternal health and birth outcomes at the grassroots level.

In the conception of VIMA, all the terms used raise significant issues that continue to be related to Darrell Posey's thinking about ethnobiology. The virtual aspect of the archive is the least problematic, as there are already incipient networks linking midwives working among indigenous minorities, whether they are indigenous or not.

Originally labelled WIMA, World Indigenous Midwifery Archive, the project was re-labelled VIMA, Virtual Indigenous Midwifery Archive, in order to reduce the formal slant on a global approach and emphasise the openness of the virtual platform to individuals and groups in various areas of the world.

The inclusion of non-indigenous midwives (and perhaps of some obstetricians who support midwifery) seems desirable yet immediately raises the issue of ethnic boundaries and collaboration across them. In the Amazon region of Peru, Ecuador, Bolivia, Colombia, Brazil and Venezuela, maternity care is intricately bound with the history of colonialism and the influence of Christian missions, whether Catholic or Protestant. There are historical layers of disempowerment of local midwives as outsiders stepped in to introduce successive forms of modernity even before the creation of health posts and hospitals. As the practice of midwifery outside the parameters of health services became illegal in the 1990s throughout Latin America, women living in rainforest communities, like

other indigenous women in other parts of the world, faced the hazards of transfer to urban hospitals. Some of these women are members of indigenous groups that have recently re-claimed their group identity –such as the Keshwa Lamas- while others are either women of mixed blood or women who do not ascribe to an indigenous identity although their ascent and culture are clearly indigenous. The label of Indigenous Midwifery should therefore be understood as a generic one, encompassing the terms 'traditional' and 'local' that plague all distinctions between cosmopolitan Western and 'other' cultures.

'Midwifery' in VIMA also needs to be understood in the context of the interface between social science and medicine. Beyond a narrow framework of maternity care, local perceptions of gender, of relations between humans and non humans in the cosmos and also fundamental attitudes to risk and to reproduction in a broad sense need to be taken into account. While these aspects are often glossed over in brief descriptions of 'culture' in maternal health initiatives and reports, they deserve full respect and consideration in the context of the VIMA archive. The few projects that have been focussed on the improvement of communication and cultural understanding betweeen doctors, local nurses/trained midwives and local women/untrained midwives have yielded positive outcomes in contrast with dramatic case-studies of mis-communication (Kaufert and Lock 1998). The main assumption underlying the VIMA project is the requirement to relate maternity care to local cosmologies and ontologies with the aim to avoid the cultural dichotomy between beliefs and practices that are outlawed, yet continue to be held, and the discourse of health care.

At the Fourth World Conference on Women in Beijing in 1995, indigenous women utilized the vast forum of nongovernmental and international organizations present to demand that the world pay attention to their particular realities as it embarked upon the International Decade of Indigenous Peoples. In Ecuador, state conceptions of the 'indigenous' body circulate alongside Andeans' and Amazonians' notions of themselves and with international conceptions: the national indigenous rights movement parallels an international reproductive rights movement. Overwhelmingly, international NGOs and multilateral organizations—such as the International Planned Parenthood Federation (IPPF) have supported both forms of activism in Ecuador. WRA (White Ribbon Alliance for Safe Motherhood) has explicitly aimed to create common platforms of action at community, district and national levels in over 100 countries and its 'respectful maternity' agenda includes a special recognition of indigenous midwives and birthing women. VIMA has been developed in relation to the 2011 WMBI 10 steps policy (World Mother Baby Childbirth Initiative, a human rights approach to optimal maternity care). www.imbci.org within the global midwifery movement.

VIMA is conceived as an integral aspect of the broad current reclaiming the value of indigenous/local kowledge, without excluding the need to evaluate this knowledge in the light of scientific research. In the Amazon region, because knowledge associated to midwifery is part of an animistic understanding of the world and linked to shamanism, it has been particularly hidden and suppressed, derided as superstition yet called upon in situations protected from the prying eyes of controlling outsiders. The relation between explicit and implicit aspects of this knowledge may be more easily accessed in visual documents than in analytic papers and reports. The very documentation of aspects of midwifery that presently are not valued or even considered to be part of indigenous culture can also contribute to a greater awareness that these aspects, as much or perhaps even more than the plants used to help women in childbirth, need to be included in the remit of dynamic conservation.

The term 'archive' in VIMA may be the most controversial in the eyes of indigenous actors, with its implications of an object frozen in time and localised in the Cambridge University Museum of Archaeology and Anthropology. Some effort is required to relate the VIMA project to current museum initiatives in other parts of the world (most particularly Canada and Australia) that truly include the active participation of indigenous actors: artists and craftsmen/women, educationalists. To my knowledge VIMA is the first project of this kind related to midwifery but a lot can be learned from colleagues who are not only practising but also theorising dynamic conservation linking museums and local living contexts. Creating a platform in which fruitful dialogues can develop between anthropologists, local midwives and other interested parties can also contribute to broaden understandings about what constitutes 'traditional knowledge' as assemblages of practices that have evolved in space and time and to greater self-determination about the modalities of integration of maternity care that are most beneficial in specific local settings, whether urban or rural.

Research questions underlying VIMA

VIMA as a project needs to engage with four research areas ridden with conflicting issues related to debates about rationality, objectivity and medical pluralism in the history of anthropology

- Research on ritual and healing efficacy
- The ambiguity of 'ethno-sciences'?
- Gender relations
- Who controls the value of health related traditional knowledge?

Rituals of pregnancy and birth

There is a vast pool of empirical knowledge associated with birth rituals, owned by both women and men, with levels of special expertise. In the Amazonian 'couvade' rituals, still practised in most areas, parents together make the body and soul of their child through diet and behaviour rules inscribed in an animistic ontology. Sickness affecting pregnant women, new mothers and their babies is explained in terms of the relations between humans and non-humans (animals, spirits) in a cosmology that broadly spans the whole of the Amazon basin and is endorsed by all Forest People, whether indigenous or not. The widespread resort to shamanic treatment of these afflictions needs to be brought out not as pseudo folklore or rituals that have fallen into disuse but as a live tradition that impacts on the wellbeing of new families irrespective of their religious beliefs or use of modern care services. Rather than dismissing shamanic rituals and explanations, and besides presenting them in academic anthropology, a gradual engagement with their surreptitious hidden practice may generate new debates. Midwifery is not an aspect of shamanism that permeates recent developments in neo-shamanism worldwide but VIMA may contribute to raise the awareness of connections that have not been perceived so far by either local actors or analysts.

The ambiguity of ethno-sciences

The ethno-botany of plants used by wo in Amazonia has privileged the search for fertility drugs and contraceptives (Maxwell, 1990). There have been few applications of pharmacological research on Amazonian plants to needs in maternity care such as wound healing and post-traumatic states of women after medical interventions in hospitals, although these applications could be straightforward.

Ethno-botanical accounts include interviews with female market vendors in Amazonian towns who have collected and appropriated indigenous knowledge and mixed it with other knowledge and practices that are part of Latin American folk medicine. The combination of these different streams of knowledge and practice, including the use of over-the-counter drugs such as oxytocin injectable doses and a number of analgesic pharmaceuticals needs to be accepted in VIMA as part of the emerging discussions of best practice among local midwives.
by women of mixed descent in towns.

While VIMA includes and invites new explorations and scientific evaluations of plant-based medicines that are used by local practitioners, it may be necessary to take a clear political stance about the priority given to make beneficial local products accessible to local populations rather than engage in drug-discovery processes that can only bring benefit in the long term and at high cost. This

stance needs to be reflected in clear guidelines about the protection of data that may result in intellectual property. It is an area of VIMA that is not yet finalised and that requires careful consideration and consultation with expert lawyers linked with the International Society of Ethnobiology.

Gender relations

Men's shamanic training encompasses midwifery knowledge in some parts of Amazonia. While WHO Safe Motherhood initiatives have included female midwives only, any discussion of traditional knowledge related to midwifery implies investigating gender relations and working both with male and female shamans/birth attendants.

It is not possible to differentiate obstetric practices from symbolic knowledge in what Schultes called 'the healing forest'. Moreover, gender relations have evolved in a historical context of ethnic resistance and resilience that also needs to be better understood.

Keshwa Lamas midwives transmit their plant knowledge through generations in their gardens: this is possible due to the maintenance of a hunting/horticulture traditional life-style besides the cultivation of cash crops such as coffee but the availability of forest plants is becoming increasingly precarious. Male shamans know plants valuable in midwifery in the wider context of their initiatic plant knowledge, relying more on the use of barks and other tree parts than on the dominant female use of herbals that are devoid of spirit power.

Midwives, shamans and health posts: who controls the value of health-related traditional knowledge?

Participatory approaches and models of cooperation with maternity units have not proved possible yet in Peruvian Amazonia: male shamans and Mestizo midwives make uncertain alliances around health posts but indigenous midwives are illegal and invisible. Yet participant fieldwork revealed that without exception all pregnancies and births involved shamanic rituals and that pediatric care combined the use of health post resources and shamanic treatments, often with damaging consequences for the babies.

In parallel with the search for new models of care that may work better for indigenous people, traditional knowledge is also a source of inspiration for maternity care in affluent countries.

VIMA acknowledges the possible local conflicts of interests involved in the 'reclaiming value': some of the Maya midwives who tour the world teaching cosmopolitan midwives their 'traditional' practices using the 'rebozo' cloth may not be endorsed in their local communities. They may clash with local health authorities or on the contrary work in association with them. Conversely cultural integration of indigenous practices in hospital maternity care, such as

the 'Parto Vertical' (birth in alternative positions to the lithotomy supine position) initiative in a few Ecuadorian local maternity units, may or may not be well received by local women.

The documentation of indigenous midwifery practices, even those that are currently illegal, may contribute a valuable resource for the conservation of midwifery care worldwide. Local practices for addressing breech deliveries, the birth of twins, shoulder dystocia, retained placenta and even maternal hemorrhage, all of which are potential causes for maternal deaths, may provide safe alternatives in situations where transfer to hospital is not possible.
The design of VIMA includes the creation of local interactive nodes within global maternity networks involving WHO and UNICEF advisers, towards the discussion of what constitutes 'best practice' from the perspective of indigenous mothers.

Other possible derived outcomes from VIMA

Story telling
Portraits and stories by local midwives themselves in an interactive virtual platform confer voice and agency to women in their own traditional ways of talking to one another. In many parts of the world, men make decisions related to the use of health care services and mediate between women and researchers. VIMA aims to use the social power of narratives to encourage women to express their points of view, while accepting that this may take unexpected forms.

Creation of dynamic conservation gardens
In areas where practical knowledge relies on the availability of natural resources on site, it may be desirable to encourage the creation of gardens or reserved natural areas. Conservation of traditional habitats and their resources has already permeated the development of indigenous identities to such an extent that the link between 'midwives' gardens' and VIMA may develop spontaneously rather than being a top-down concept. Conservation gardens, which may develop in similar ways to 'shamans' gardens in Amazonia in the last two decades, provide a basis for 'dynamic conservation in situ', with simultaneous transmission of plants and knowledge

Laboratory research verifying the scientific validity of midwifery knowledge as traditional knowledge (TK)

TK gains respect through confirmation of bio activity but experimental research and trials related to pregnancy and birth have high ethical barriers
All TK issues (indigenous/traditional, IP of knowledge and rights, apply to midwifery knowledge which is also contested from inside
New research methods need to be designed to establish some of the maternal practices of indigenous women as 'knowledge' in the first place: certain ways of pacifying babies have recently been validated by the neurophysiology of early musicality (Malloch and Trevarthen 2009)

Why is VIMA something worth doing?

- Midwifery TK is embedded in communities, it is key to social reproduction and its loss is analogous to language loss
- There is a desperate need to create local models of maternity care that work and to 'decolonise maternity'.
- VIMA has the potential to facilitate cross-gender dialogue around knowledge owned by men and women in harmony in the current process of re-invention of cultural identities

The dilemma of being either dispassionate or passionate anthropologists, scientists or activists, is no longer applicable. Darrell Posey's plea that ethnoscientists have a moral obligation to support the communities where they work in preserving free access to natural resources and also to the cultural values associated with biodiversity needs to be implemented with the use of innovative research methods that engage actors directly from the grassroots.

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