

## INTRODUCTION

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This book brings together and explores writings on the theme of time in relation to childbirth. The contributors include anthropologists, and midwives who have found anthropological approaches useful in their work. We aim to present a comparative approach, in order to gain wider insights from analysis of different cultural and organizational settings. Much of the work included in the book has taken place in so-called Western<sup>1</sup> or biomedical<sup>2</sup> settings, but nonetheless involves a comparative element by including a variety of cases and attempting to learn from the differences and similarities between them. As well as cross-cultural comparison, we look at differences in concepts, experiences and approaches within Western settings, and particularly the recent development of 'alternatives' to biomedicine which have developed in response to many concerns about the medicalization of childbirth, including the ways in which time is managed.

In this book we also aim to show, through case studies, how anthropological methodology and theories have been used by maternity researchers, including practitioner researchers, to help them take a different look at the familiar world of practice and to 'make it strange', to enable a fresher or more open and critical focus to emerge. The different studies show how biomedical practices are not always evidence based, for example, but deeply rooted in established hierarchies of thinking and practice. They also illuminate the ways in which beliefs about time, and the way it is managed, are integral to biomedical practice, and found in biomedical settings such as obstetric hospitals, as much as they are in settings which are commonly thought of as 'traditional' or 'cultural'. They highlight how authoritative knowledge and practices maintain their power, as anthropologists Jordan (1993) and David-Floyd (1994) have argued, through coming to be seen as right and natural, as well as by association with professional power.

Time is a fundamental theme in considering childbirth. It is concerned with social and cultural as well as physical reproduction, and with the continuities and ruptures between generations. Childbirth forms a kind of historical moment and point of transition. Childbirth is central

to all cultures, and the ways in which birth is managed are profoundly culturally shaped, so much so that it can never be described as a purely physiological or even psychological event. It is an event where different cultural assumptions, expectations, ways of doing, are 'impressed' upon the participants through the established ways of managing birth. Women and their attendants in birth are not simply passive vehicles of cultural assumptions and practices, however, but actively use and negotiate established norms (Lock and Kaufert 1998; Unnithan-Kumar 2004). The studies in this book illustrate this well, and show how women, midwives and other birth attendants are affected by issues of power and control, but also actively attempt to change established forms of thinking and practice.

The theme of time has been central in anthropological literature and theory. A number of anthropological studies have focused on time as a means of exploring and analysing the role of culture in cognition and debates about the relativism or universalism of concepts of time have formed an important thread in anthropological theory. Birth (as opposed to say death) has not been such a common theme, even though birth and death both form fundamental points of rupture or transition culturally. Nonetheless, much of the general anthropological work relating to time can be usefully applied to matters of childbirth, and Chapter 2 in this volume focuses on anthropological theory and writing both in relation to time and the increasing number of publications which look at issues of birth as well as death.

In the U.K., the twentieth century saw massive changes in the way childbirth was managed, and time, as well as place, was central to this. There has been much discussion of the shift of birth from home to hospital, and from a domestic to a public arena, but less so of the implications of the changes involved for the ways in which time is managed around childbirth. It is also an area where enormous changes in practice that took place in the 'West' were also being spread to 'non-Western' countries as authoritative knowledge and practice (Jordan 1993). The forms of measuring, marking, accounting for and managing time have played a major, but relatively unremarked, role in this. In postcolonial situations, authoritative knowledge was supported by notions of status and power associated with 'Western' medicine, and this has been particularly evident in the arena of women's health and reproduction (Unnithan Kumar 2004; Van Hollen 2003). In Chapters 2 and 7, for example, contributors discuss studies that have looked at how the development of biomedical practices was aligned with status and power in non-Western settings, so that women and practitioners found it difficult to question or challenge new birth practices or accepted them as signs of development, even when there is little evidence to support such claims. Even in wealthy and technologically developed countries such as Japan, discussed in Chapter 11, radical changes in the management of childbirth were introduced as part of rapid social changes under the influence of the U.S.-led postwar administration. As a result, biomedicine has influenced childbirth policies

and practices globally, although for many women – especially poor, rural women who lack access to health care facilities – other ways of managing childbirth continue, and resistance to aspects of biomedical hegemony is also growing in a range of countries. This book explores cases in which such power and resistance may be played out through the ways in which time is conceptualized and managed.

## **Anthropology of Health and Healthcare: Theory and Method**

Much of the research that has taken place on health and healthcare internationally has taken place within the contexts of other disciplines besides medicine itself. These include psychology and social sciences, management studies and economics. Nonetheless, research within medicine has tended to confine itself to clinically focused research on diagnosis, aetiology and treatment of disease (Good 1994; Martin 1989).<sup>3</sup> Recent exceptions to this have been the interest in illness narratives, which has grown from collaboration between anthropologists and medicine (Kleinman 1988; Good 1994) and interest in complexity theory as a means of understanding the complexity of health care practice as well as disease and illness (Downe and McCourt 2008).<sup>4</sup> Biomedicine has tended to view its status as universal, lying outside the domain of cultural systems, so the role of social sciences has been mainly in areas such as the understanding of patients' beliefs, practices and experiences, or perhaps of practitioners' experiences and perspectives. However, sociologists and anthropologists have also conducted research on how healthcare is organized and delivered, and this research is more likely to treat biomedicine, even in its universalized forms, as socially and culturally situated.

Much of the early sociological work on health and healthcare did not start from the standpoint of viewing biomedicine itself as a cultural system. Instead, the beliefs and practices of other cultures, or 'folk' systems, were viewed in this way – as 'other' and therefore the proper objects of anthropological or sociological attention (Helman 1984).<sup>5</sup> Similarly, health sociologists were often employed to bring an understanding of the patients' perspective, or to analyse organizational and policy issues, with the aim of making the delivery of medicine more effective or efficient (Singer 1989; Young 1982). Where there was a focus on health belief systems or behaviours, this was primarily concerned with explaining why patients often do not comply with medical advice. The concern to identify health belief systems in order to improve compliance with treatment, and improve health education or prevention initiatives has also been a motivation for employing anthropologists to work on health related research, often expecting them to focus on the different beliefs and practices of minorities regarding health. One more recent example is the employment of anthropologists in public health oriented studies of HIV/AIDS, where they have been able to make significant and positive contributions (see, for example, Poehlman 2008), but we need

to be mindful of working with assumptions that public health problems are primarily rooted in minorities' cultural beliefs and practices, rather than in structural inequalities. In the case of organizational studies, the emphasis might be more on efficiency – for example, analysing how professionals respond to protocols – and helping ensure the smooth running of healthcare systems. Singer (1989) has discussed how the type of employment of anthropologists – whether in independent academic posts or as contract researchers within multidisciplinary research teams, for example – may affect their capacity to stand outside the system and view it through a different lens. This is similarly a major challenge for researchers attempting to critically analyse their own discipline and sphere of practice, but the chapters in this book provide examples of how anthropological methods and theory can help practitioner-researchers do so.

As the anthropology of health and medicine has established a niche within the discipline (as with sociology) a more critical medical anthropology (Frankenberg 1980) has developed in which anthropological research is able to contribute to interdisciplinary work to improve health and healthcare while taking a different, theoretically informed and questioning view (Lambert and McKeivitt 2002). The goal of critically engaged theory should be to understand the way in which medical science and medical practice take shape. It should look at forms of knowledge and practices and should aim to describe the ways that possibilities for change and improvement are limited and circumscribed (Singer 1989); in other words, to analyse medicine as a cultural system, that operates within a social, political and economic context, linking power and knowledge, rather than a value-free system that simply applies scientific knowledge, which in itself is treated as value free.

Critical medical anthropology has employed the Marxist concepts of persuasive power or hegemony (a dominant ideology or form of knowledge) to analyse the operation of authoritative knowledge that is important to areas such as medicine. Hegemony may be maintained by both structural power and the internalization of authoritative knowledge. It comes to be seen as part of the natural or cosmological order, and is maintained by all, not just the dominant group, so that it is less likely to be questioned except in situations of crisis or disruptive change or, even if questioned, remains difficult to challenge. In maternity this would apply to the roles of midwives in continuing the use of technologies that have come to be seen as part of 'the way things are done', even if not scientifically evaluated.

Midwives tend to view themselves as guardians of 'normal' or 'natural' childbirth. A midwifery philosophy of birth is one that sees birth as part of life, rather than as primarily a medical event. The orientation is not primarily one of risk, although midwives are trained in monitoring pregnancy and labour so that they can refer to an obstetrician if medical complications develop and intervention may be needed. The philosophy could be described as one of 'watchful waiting' (see Chapter 4, this volume) and has also been described by van Teijlingen (2005) as a social

model of birth. In contrast, obstetric training is highly oriented towards management of childbirth as a risky medical event. The application of the medical model in hospitals in countries as varied as the U.K. and Brazil heralded routine uses of technological interventions originally designed to assist with complications in childbirth. Many midwives contested such routine practices, and took a questioning approach, campaigning and designing clinical studies to evaluate their effects (Tew 1995). However, many midwives have continued to use practices such as recumbent (lying flat) birth positions and electronic foetal monitoring, despite the lack of evidence to support their routine use, rather than the more traditional or low-tech approaches which are less intrusive to women's labours. Direct coercive force doesn't need to be applied in such a situation by individual obstetricians for the dominant ideas of what is right and proper to operate. In such a situation, although individuals and groups sometimes do challenge dominant knowledge and practices (Martin 1989), a number of practitioners and patients may also come to accept its norms (Davis-Floyd 1994). They may lack alternative sources of knowledge, or the self-confidence with which to question or challenge it. Additionally, although direct coercive force is not used, sanctions – such as professional exclusion or bullying when dominant knowledge and practices are questioned too openly (Hunter 2004) – pressure to conform to hospital protocols for risk management purposes, or fear of disciplinary action may severely constrain the choices of both women and professionals. Writers using an anthropological perspective – such as Kirkham (1989, 1996), in an ethnographic study of relations and behaviour on the labour ward – have observed how midwives, despite their concerns about dominance of obstetric theories, play a considerable role in maintaining this dominance. Such issues of knowledge, power and control form an important context to the practices around time discussed in this book, and will be returned to in different chapters. Theories of power and control in childbirth have also been developed in depth in the work of Martin (1989), Jordan (1993), and Davis-Floyd (1994, 2001), among others, on birth in the U.S.A., and such work is discussed further in Chapter 2 and subsequent chapters of this volume.

Although the anthropology of health has only recently been recognized as a distinct area within anthropology, a focus on health has always been at the core of anthropological studies, since it is so central to the life of communities. Traditionally, there has been much focus in anthropology on teleology – attempts to understand and explain the ultimate causes of things – including different cultures' attempts to explain the nature of suffering. In much of the early ethnographic work there was an explicit focus on ways of dealing with illness and death, perhaps because of their visibility and because of the importance of life transitions, which are treated ritually, in some way, in all human cultures. In contrast, childbirth was less visible in ethnographic texts. This might perhaps have reflected a male-gendered bias within anthropology, a tendency to pick up on those aspects of a culture which are seen as important or interesting, such as

public and political rituals. However, childbirth has been traditionally treated as part of the domestic arena, rather than the public one, and one to which males often had no access. It was, quite literally, less visible. With a more reflexive and critical approach to ethnography in recent decades (Clifford and Marcus 1986), a greater focus on gender, and revived interest in areas such as kinship as a result of the response to the development of new reproductive technologies, that situation has changed. This work is discussed further in Chapter 2 of this volume.

Childbirth is, of course, quite different from illness, but the potential for health problems to develop in pregnancy and labour, and the reality of maternal and infant deaths, which remain high in many countries,<sup>6</sup> have placed the ways of managing childbirth firmly in the healthcare arena. In Western and non-Western countries alike, pregnancy and birth are subjects of medicine. Much of the history of childbirth, especially in the modern era in Europe, has been one of medicalization, an issue which will be explored further in Chapter 1. In other cultural contexts, where biomedicine forms part of a more plural system of healthcare, childbirth still touches on medical care, with traditional midwives, such as the *dais* of South Asia, often having status as healers or working alongside and acting with traditional and spiritual healers (Unnithan-Kumar 2004; Van Hollen 2003). Midwives are often seen as mediators between health and illness as well as between the material and spiritual world, and between life stages.

However, childbirth is also part of the wider subject of how women's health and reproduction are managed and socially situated. Anthropological work has been particularly valuable in highlighting how far women's reproduction is treated as a matter of concern to community and state and even to the postcolonial world order of relations between states. That is not a focus of this book, and has been well covered elsewhere (see, for example, Ginsburg and Rapp 1995; Unnithan-Kumar 2004), but it does occasionally show as a thread in the weave. In Chapter 7, for example, Becker discusses how the childbirth experiences of Canadian aboriginal women, and their forced removal from their own land and traditions, has to be understood within that wider context of attempted state management of social and biological reproduction. Even in the U.K. settings of other chapters, the lack of choices faced even by more privileged women is revealing of the complex relations between the micro- and macro-social levels of social interests at play.

In recent work a number of anthropologists working from a feminist perspective, or focusing on healthcare systems, have focused on the degree to which women's bodies are treated as metaphors or representations of wider issues (Ginsberg and Rapp 1995; Lock and Kaufert 1998; Martin 1989; Scheper-Hughes and Lock 1987; Van Hollen 2003). This is particularly true of the area of reproduction because in all cultures women's fertility and childbearing are subjects of social concern. Reproduction can be regarded as never simply an individual matter, or indeed a purely physiological or biological one. Women's individual

reproduction also stands for the reproduction of society, even in societies marked by a strongly individualistic culture.

In Chapter 1, for example, we will see that the Church in pre- and early-modern Europe took a strong interest in midwifery long before state registration, since it was concerned to monitor the moral aspects of birth. Each infant born needed to be baptized into the Church and the transitions of life and death to be overseen by religious authority. The Church was powerful and intimately concerned with regulating the reproduction of society. In modern Europe, the state has largely taken over much of this concern with social reproduction from the Church. Much of this is very routine, such as the registration of births and deaths and the provision of state maternity services, but there are also more authoritarian ways in which governments have done so, such as pro-natalist policies, designed to encourage growth of the population of a state, and eugenic policies intended to discourage births and reproduction that is considered socially undesirable (Unnithan-Kumar 2004; Van Hollen 2003). Such policies have been identified (ironically perhaps) in contexts as contrasting as Nazi Germany in the 1930s (Fallwell 2002) and Israel in the 1950s (Stoller-Liss 2002). This theme is also echoed in Chapter 7, as the social and political background to the recent re-establishment of community birthing and Aboriginal midwifery in northern Canada.

The main methodology used by anthropological researchers is ethnography, and this has changed relatively little since it was established by anthropologists such as Malinowski in the first decades of the twentieth century. Although ethnographic research is increasingly accepted now in studies of healthcare, and some classic examples exist, it is still greeted with some discomfort and is not always accepted as being able to produce generalizable knowledge. Ideas about generalization in health research, rather than being theoretically based are often centred on the idea of statistical generalization from a sample to a wider population. However, anthropology was always intended to be a comparative discipline, where ethnographic studies are theoretically informed and do not stand alone. Knowledge is built up and challenged by developing themes and debates across a number of studies and social or cultural settings. This counters the criticism that ethnographic research, owing to its detailed, in-depth and time consuming nature, is often small scale and may well focus on relatively easily bounded settings, even if the boundaries are more ideal than real. Ethnographic research may utilize a range of research methods and include both qualitative and quantitative techniques.

Qualitative studies in healthcare have become more common and accepted in recent years, particularly when they focus on health beliefs, attitudes and experiences, or on the organization and delivery of care. However, many of these studies do not share a key feature of ethnographic work in anthropology, which is to analyse small-scale and local beliefs or practices with reference to wider systems. This linking of micro- to meso- and macro-social levels is important to support a critically engaged analysis of healthcare systems.

The studies described and referred to in this book mainly use explicitly and self-consciously ethnographic approaches, or have much in common with ethnography. They provide case studies of maternity care, but also case studies in how ethnographic and related qualitative methodologies, such as narrative approaches, can provide fresh insights into the operation of healthcare systems. These not only add to knowledge, in a theoretical sense, but can be applied to developing and improving the effectiveness and experience of health care.

## **Outline of the Book**

Chapter 1 commences by tracing historical shifts in the reckoning, marking and management of time that have occurred worldwide, particularly in the modern era. The main focus is on European history, since it was that history which gave rise to biomedicine as a healthcare system, and to the globalizing trends that have led its forms of healthcare and forms of marking time to be spread worldwide. The chapter discusses the social and economic changes that have arguably contributed to changing conceptualizations of time, but it also touches on the historical roots of capitalism and the spread and dominance of biomedicine as the authoritative knowledge and practice of universalized medicine.

In Chapter 2, a sideways step is taken to look at anthropological ideas and studies pertaining to time, and their potential value for studying and reconsidering medicine and various forms of healthcare, with a distance or 'estrangement' that can help us to both see what may be very familiar practices and ideas in a different way, and to ask new questions and to engage in a constructively critical analysis. The chapter discusses relevant theoretical perspectives from anthropology and other social sciences to support such a critical analysis, looking at the work of key thinkers such as Marx, Foucault, Durkheim and Bourdieu as well as specific ethnographic studies relevant to time and/or childbirth. It also reviews debates in anthropology about the formative roles of culture and biology in cognition and ways of organizing the environment, including ways of conceptualizing and marking time, which are particularly pertinent to cross-cultural and interdisciplinary analyses of health and medicine.

Chapters 3 and 4 discuss and analyse obstetric theories and practices of time management in labour. Chapter 3 also describes and critiques the work of Friedman and the concept of the 'active management' of labour. This approach to managing labour hinged on tight control of time and progress, and was tested in a Dublin hospital in the 1970s. As is often the case with theories that resonate well with their times, this approach was rapidly and uncritically adopted in European and North American hospitals and thence exported, in the form of authoritative knowledge and practice, worldwide. The tight monitoring and control of time in the active management of labour is a well-established example of protocol-based care, which is being increasingly advocated in 'evidence-



based medicine' (EBM) and formalized by governmental bodies such as the U.K.'s National Institute of Clinical Excellence (known as NICE). The focus on EBM may have great value in questioning why certain practices or health interventions are used and whether they are effective, but the philosophy and methodology rarely acknowledges the situated nature of research, or the existence of protocols as social practices. This could be described as a project of rationalization which rests on notions of scientific evidence and rational decision making and action, but the analysis in Chapter 3 deconstructs this to show that scientific evidence itself may be highly contested, highly provisional and socially situated knowledge. Just as Bourdieu (1977) described the calendar as one of the most codified aspects of social existence, arguably the models of time and time management that childbirth protocols represent are social practices of a particularly codified form.

Chapter 4 then goes on to look at alternative theories and practices of monitoring the progress of labour used by a small number of independent midwives, mainly working outside hospital settings, and referring implicitly to more traditional forms of midwifery practice that involved watchful waiting and 'being with' the woman. This is also discussed in Chapter 8 in the context of rural Icelandic midwives who refer to 'sitting over' (*yfirseta*) the birth.

Chapters 5 to 7 continue the theme of contrasting models of managing time in childbirth, looking at changes and reforms developed recently in Euro-American birth settings that attempt to change the ways in which childbirth is managed. Chapter 5 looks at attempted reform of the way midwives' work is managed, to emulate a more traditional model of midwifery where the midwife works with and is accountable for the care of particular women, rather than working in a particular setting, accountable primarily to that service. For midwives, this change required a radically different time orientation, which can be characterized in some ways as either pre- or postmodern. Like the older midwives in history, and traditional midwives still working in resource-poor countries, the midwives had to learn to 'attend' the rhythms of women's pregnancies and labours, rather than the shift-system of clock time made necessary by hospital-based work. Stevens describes how this shift in time orientation led to reorientation in other aspects of their work, including a more woman- and community-centred approach.

In Brazil and Latin-America comparable reforms have been referred to as more 'humanized' as opposed to technocratic models of birth (Santos and Siebert 2001; Davis-Floyd 2001). Ironically, such reforms are taking place, albeit in a piecemeal and patchy fashion, in more resource-rich countries, while the models of obstetric management they attempt to reform are still being actively advocated and implemented in resource-poor countries as a form of development, despite their high cost and socially unequal spread, where healthy and wealthy women may be subject to routine active management of their labours while poor women lack access to sometimes life-saving healthcare. Similarly, models such as

'birth centres' as described in Chapter 6, refer to more traditional ways of attending<sup>7</sup> and caring for labouring women, while such knowledge and practices are being actively removed in 'developing' countries. Chapter 7, which looks at the reintroduction of midwifery and community birthing in a remote northern region of Canada, cuts across this apparent divide, set in a resource-rich country but in a situation where colonialism still has very strong and tangible bearing on the delivery of maternity services. Here, formally educated midwives in a setting where midwifery had been pushed to the social margins have begun to work with women who were dispossessed in more fundamental ways to bring back a sense of time and place in giving birth which is more appropriate to their sense of cultural safety.

Chapters 8 and 9 illustrate the value of using narrative approaches in health research. Chapter 8 sets out basic principles and values of using narrative approaches in research, and describes themes from narrative studies in Iceland and the U.K., arguing that a more 'storied' approach can better represent the nature of birth experience and birth care than more usually authoritative approaches to research. Chapter 9 illustrates this further with a case study of women's experiences of time in labour in an obstetrically-led birth setting in England, contrasting the women's embodied sense of time with the time management practices they encountered. This chapter also illustrates through narrative the experiential and embodied effects of the active management of labour reviewed in Chapter 3. In both sets of stories we hear reference to the ticking of clocks: by analogy, when the midwife's heart is described as 'not ticking', and quite literally when women described the imposed regime of actively managed labour as being 'against the clock'.

Chapters 10 and 11 shift the focus to the transition following birth, looking at issues of time and space in infant feeding and adapting to motherhood. Chapter 10 discusses the conflicts and paradoxes of the advocacy of 'demand feeding' in U.K. maternity hospitals, while chapter eleven looks at Japanese women's responses to the uncertainty of motherhood. Although Japanese maternity hospitals since 1945 have been run on a U.S.-inspired model, with highly restrictive practices relating to time and to infant care and feeding, Japanese notions of time and space support the women in living with uncertainty and adapting to their lives with a new baby to achieve a sense of being 'in tune'. In contrast, the 'demand feeding' policy in U.K. hospitals adopted as part of the UNICEF Baby Friendly Initiative, followed decades where women and babies were taught in Euro-American hospitals to adopt a rigid regime of measurement, by the clock and by other measures, of either the quantity of milk consumed or of height and weight plotted against time.

In settings that are in many ways both contrasting and similar, these chapters draw on critical theory to help to understand women's experiences. For example, Bourdieu's (1977) concept of habitus is used to explore the nature of embodied knowledge in a way that breaks down dichotomies between objectivity and subjectivity, knowledge and practice.

This book cannot, of course, cover all the work relevant to its themes, or all cultural settings, but throughout we refer to other work emerging in this field, much of which adopts a critically engaged perspective, and views women (as mothers or as maternity workers and carers) as active agents who negotiate the everyday reality of birth within its social and cultural context. We hope this book will make a contribution to the application of anthropology in the field of maternity care, and will also bring some useful material and insights to the discourse of anthropology.

## Notes

1. The term 'Western' is used in this book to denote countries, usually European and North American, which are relatively resource-rich and industrially or post-industrially developed or complex. The social and economic changes that globalization has entailed mean that it is not a literally accurate term – countries are infinitely more varied – but it is widely used and understood, and seems preferable to terms such as 'developed' which carry particular value assumptions. The term 'Western medicine' is sometimes used to highlight the association between biomedicine and the status and power of Western countries.
2. Biomedicine is a term used widely in anthropological literature to denote the form of medicine developed in Western countries. Although it developed in its cultural and historical context, as discussed in Chapter 1, it has universalizing tendencies: biomedical knowledge and practices are believed to be scientifically based, and so are considered to have universal applicability, rather than relevance to a particular culture. The universalizing claims of biomedicine have been analysed and critiqued in a number of anthropological studies, and case studies within this book add to that body of work.
3. This observation is primarily based on my experience of designing, conducting, reviewing and reading research within a health setting. It has also been commented on by a number of sociologists, anthropologists and epidemiologists.
4. Complexity theory draws on different disciplines, including mathematics, quantum physics and anthropology, to argue that systems which are inherently complex cannot be researched entirely through models based on linear or simple systems thinking (see, e.g., the writings of Bateson, cited in Chapter 2). Much of medical practice is highly complex and so cannot be understood by exclusive reliance on positivist approaches and forms of experimentation based on simple models. This has now been recognized by the U.K.'s Medical Research Council, but the randomized controlled trial, which is highly effective for testing the efficacy of specific interventions but less so for complex interventions, is still formally seen as the 'gold standard' form of evidence in U.K. health policy.
5. One might argue, of course, that this was equally characteristic of much of early mainstream anthropological and sociological work. Evans-Pritchard's writings on Zande witchcraft and magic (cited in Chapter 2) could, for example, be viewed in this way, but that work has also become a useful source and inspiration for anthropologists who have turned an analytic eye towards Western healthcare beliefs and practices.

6. For example, the World Health Organisation estimates that lifetime risk of maternal death in Africa in 2005 was 1 in 26, compared with a developed states average of 1 in 7300. Maternal and infant death rates tend to be highly correlated with income, within and between countries, and also with political factors such as structural adjustment or public health programmes and social factors such as women's status.
7. The historical and linguistic roots of the word 'attending' are salient, as they refer to a central theme in traditional midwifery of 'waiting on' birth, which may be contrasted with the active management approach of modern obstetrics and much of midwifery practice in obstetrically led settings.

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