

**'Giving birth in rural Malawi: perceptions, power and decision-making in a matrilineal community'**

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**Abstract**

This anthropological study examines the relationships, influences and power dynamics underpinning decisions made around childbearing in a resource-poor subsistence farming community in southern Malawi.

Local literature and relevant anthropological and technical sources are examined for childbearing themes, patterns of residence and relatedness, knowledge and power, health perceptions and risk. Methodological and ethical issues are analysed, taking a reflective approach toward the author's midwifery background. The study is founded in the view that understanding childbearing processes has inherent value for women's wellbeing, but also can contribute insights into wider social themes and contribute to anthropological debates.

A strongly matrilineal and matrilocal lifestyle is revealed with substantial power residing with older women. Men are heads of households when resident and responsible for the welfare of their own matrikin. This dynamic is examined indicating that childbearing women's older female matrikin make most decisions, at least for younger women, and men generally support them.

To understand decision-making, perceptions of health and childbearing, and concepts of risk are examined. Biomedical ideas are layered with ethnomedical, and local expressions of morality. Ideas of childbearing risk are grounded in this eclectic view, with biological problems often linked with causation, and resolution congruent with local cosmology. These include hot/cold imbalance, maintenance of the life-force, adultery in pregnancy, bewitching and pollution and taboo.

The development and legitimacy of knowledge used to make decisions is examined. Older women retain control; most young women remaining too ignorant for independent action, but all ages demonstrate acceptance of the knowledge of the formal health service.

The overall scenario is of generally benevolent control of younger women using a power base grounded in matrilineal relatedness and eclectic concepts, knowledge and notions of risk to make childbearing decisions. Choices are however ultimately pragmatic and dependent on circumstance with neither local concepts nor biomedical ideas prevailing.

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Appendix 3: Barber, G.D. 'To tell or not to tell? ethics and secrecy in anthropology and childbearing in rural Malawi', was previously published in Caplan, P. ed. (2003) *The Ethics of Anthropology: debates and dilemmas*, London: Routledge. Reproduced by agreement.

Map 1.3 with acknowledgement to Michael Kamuntolo.

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Use of names and pseudonyms:

Having planned to use pseudonyms throughout and disguise the locality as best I could, all key informants and local officials have now expressly requested that I use real names and places. Pseudonyms are used for all other individuals who took part in my enquiries.

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## Chapter 1: Introduction

### Introduction to the chapter and thesis

#### Three African births

I first met Dannis<sup>1</sup> when her baby was about three days old. At my next encounter ten days later, she collapsed in my arms as I tried to help her into my car to take her to hospital. She was feverish, bleeding and looked very ill indeed. I drove to the hospital as fast as I dared over dirt tracks and deeply pot-holed and rutted roads; Dannis lay slumped across the back seat supported by her mother and barely conscious. Her husband was away working.

Dannis had wanted to give birth with the help of Stella Kamuntolo, the local *azamba*<sup>2</sup> or indigenous midwife. She had however been referred to the hospital after spending a night in labour at the *azamba*'s home. This was her first birth and Stella believed her pelvis to be too small to be sure of a safe birth. Stella anyway followed local policy and did not normally take responsibility for women labouring for the first time.

Accompanied by her mother, Dannis started to walk to the hospital 10 km. away, passing along tracks and dirt roads through the scrub-land and maize fields. At least there was daylight but her labour progressed too rapidly and she gave birth at the roadside with the help of some women from nearby houses. She returned home at once with the baby, still on foot. She had appeared well when interviewed later as part of my survey but

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<sup>1</sup> Pseudonym.

<sup>2</sup> The term *azamba* is used for those women who are locally recognised as specialists in supporting others through pregnancy and childbirth (not for those who perform this service occasionally for kin and friends). Some are government trained and recognised. Internationally known as traditional birth attendants (TBAs), the role is expressed in a wide variety of ways. The term 'midwife' means only 'with woman' in its Anglo-Saxon derivation but is reserved by the laws of many states for those who have received a more extensive and government recognised education that is a mixture of practice and biomedical theory. Preferring to use 'indigenous midwife' rather than TBA, and 'professional midwife' for the more extensively educated I also recognise that most professional midwives may be 'indigenous' too if they are of local origin. This issue is a hotly contested domain and the easiest strategy is to use the local term *azamba* for most instances in this thesis.

bled soon afterwards and had complained to the other women of pain in her abdomen and an offensive vaginal discharge. They had told no-one of this for some days but Dannis did not get better so they asked for help from Stella who advised that she should be taken to the hospital immediately for medical care. At this point her mother talked to her own mother's brother's wife who disagreed with Stella, saying that there was nothing amiss in her opinion and that there was no need to go to hospital.

Her next visit was to a local healer who treated her by cutting her skin.<sup>3</sup> Dannis became increasingly ill and continued to bleed from her vagina. Eventually her mother's brother (who was the *mwinimbumba*<sup>4</sup> and responsible for the welfare of the women of the household) sought the advice of the Headman<sup>5</sup> who sent him back to Stella, suggesting she be asked to approach me for help to drive Dannis to hospital. My encounter with Dannis did not end with transporting her. At the hospital I had to negotiate on her behalf to avoid delays in being seen. This for me was a rare encounter with indifference, not normally evident when I was around, and I believe, unusual in this well-respected hospital. Once admitted Dannis underwent surgery and after antibiotics and a blood transfusion returned home, weak but recovering.

These events took place in a small community in rural Malawi, the location for my fieldwork and my temporary home. So Dannis's experience became a case study for me, providing information on relationships and residence patterns, household decision-making dynamics, and notions of normality and risk in childbirth. This was lived experience, the fear felt at seeing her condition, the anxiety trying to drive safely but quickly over dreadful roads, the helplessness in finding no-one willing to see her at first, the ignominy of abrupt communication from hospital staff. Yet I did not have to walk her there, and was an experienced professional midwife, accustomed to such surroundings. At

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<sup>3</sup> Cutting is often used to permit the entry of medication rubbed into the wound. This is considered further in chapter 5, case study 5 where Dannis's experience is further analysed.

<sup>4</sup> The guardianship of the women in a matrikin is invested in the *mwinimbumba*. The *mbumba* is the sororate. Translated as 'owner of the lineage' by Chakanza (1998a:27) the *mwinimbumba* is the member of the matrilineage responsible for the support of his female kin and is most often an older uterine or classificatory brother or mother's brother of a woman (see chapter 4). 'Matrilineage' denotes the corporate, localised group that traces its descent through the female line.

<sup>5</sup> The translation for Village Head is *mfumu* (pl. *mafumu*).



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the end of this incident, uppermost in my mind was the knowledge that I had been living in the community as her condition worsened, and had not known about it.

As I spent the evening hours writing my field notes by the light of a hurricane lamp I thought about Dannis and what had happened to her. Stella, who had been her first choice to look after her during the birth of her baby, had felt obliged to send her to the hospital as instructed. Stella is exemplary in her understanding of the formal teaching she has received and her compliance with the official parameters of her practice. On this occasion Dannis undoubtedly experienced more problems than she would have done under Stella's care – giving birth at the road side, attended by unprepared women, with all the inevitable opportunity for the introduction of infection.

The scenario reminded me of another woman I had met many years previously in Senegal – brought to me on the back of a bicycle, heavily pregnant and with bloated face and feet, high blood pressure and all the signs of pre-eclampsia, a dangerous pregnancy condition. That woman had been taken back home by her husband because he needed her to cook for him; whether she survived I will never know.

A final story illustrates how I came to write a thesis about decision-making around childbearing. This one, like the one about the woman on the bicycle, is directly linked to why I entered anthropology. Miriam, an indigenous midwife in Zimbabwe, was about to cut the cord of a newborn infant but was in a dilemma. The government trainer had told her she must never put anything on the cord stump as she might introduce infection. Her aunt, long dead and trying to 'whisper' to her now, had taught her that failure to do so would permit the entry of evil spirits. Whom should she believe? This fictional work by Taylor (1991) stirred my interest in both how choice is made and the forms of knowledge deemed to be authoritative. Already having developed an interest in why older women were apparently ignored by maternity care professionals in both the UK and Senegal, I was stimulated by challenges from writers such as Pigg (1997) for context-specific research on childbearing: reading Davis-Floyd and Sargent (1997:29) finalised the issue with their challenge to provide situated ethnographies, to

investigate the production, articulation, and (perhaps) the contestations of authoritative knowledge in specific areas of praxis, within specific communities, during specific events and interactions.

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A relatively unusual personal profile as midwife (with a long-term interest in maternal health in low-income countries), lecturer in midwifery, and more recently anthropologist would, I hoped, give me a specific advantage. Inevitably I would need to be aware of potentially unfavourable traits such as preconceived ideas and would have to reconcile differing imperatives. I also had a demanding job as lecturer around which I needed to manoeuvre. I was determined to follow the lead of my key questions as well as focus on Africa and draw together the varied facets of my personal history; I had to find a way to do it and this thesis is the result.

I went to the field not knowing what to expect. I found myself deep in the relationships of matriliney, and therefore needed to develop this area for the thesis. I also found myself drawn inexorably into the global debate around the place of indigenous midwives in contemporary childbirth although I avoid in-depth analysis of this complex issue. So the thesis has taken shape around these areas and I have found myself trying to contribute not only to local and global ideas about maternal health but also to anthropological knowledge and understanding on these themes.

This thesis, then, deals with the relationships, dynamics and influences behind decisions made around childbirth seen through the lens of my dual role as anthropologist and midwife. It has also become a study of relatedness and residence patterns that has relevance beyond the boundaries of this work and attempts to bridge gaps between childbirth studies and the whole arena of social anthropology. My focus can be pared down to the following specific questions:

- With a significant but not exclusive focus on place of birth and choice of supporter, what happens within households and communities to determine actions around childbearing?<sup>6</sup>
- How much agency do women have for self-determination?
- How is the knowledge needed for decision-making developed, legitimised and controlled?

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<sup>6</sup> I use 'childbearing' throughout the thesis in its widest sense, incorporating pregnancy, birth and the puerperium (the weeks following birth). I use 'birth' generally when I intend to focus on that time.

- What are the concepts that underpin such decisions?
- What are their implications for maternal health care policy?
- What do the answers to these questions contribute to wider anthropological debates?

Through this thesis, I explore how decisions are made by and for childbearing women and consider the influences that affect such decisions, primarily but not exclusively regarding the place of birth and the choice of supporter. I argue that older women in this matrilineal and matrilocal community are in positions of great influence and generally are the ones who make decisions about such matters as place of birth and choice of carer on behalf of younger women. Husbands largely step back from becoming directly involved although acknowledged as head of household when resident. Those women who have given birth previously have more freedom to make their own choices but primigravidae<sup>7</sup> are not expected to know anything about the processes of labour and birth. To some extent knowledge is guarded by these older women and its development and ownership became an area for enquiry.

Investigating how decisions are made involves considering premises on which they are based. Decision-makers work from pluralistic and layered views of the body and of childbearing that derive from both biomedicine and from local concepts of hot-cold equilibrium, and the importance of sexual activity for maintenance of the life-force. Such activity should be contained within moral boundaries and this is expressed through ideas of pollution and taboo. Risk and danger arise repeatedly, particularly in relation to breaking these taboos and through personalistic threats of witchcraft from envious others within the community.

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<sup>7</sup> Primigravidae are women who are pregnant for the first time.

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## **Situating the study: introducing the rationale**

This enquiry was initiated because of the neglect, evident within much of the international scientific literature, of the social and cultural contexts for childbearing and maternal health care and the apparent distance between the two paradigms. Policy decisions and judgements are made mainly on biomedical grounds and little weight is given to anthropological work on childbearing and the channel this provides for the voices of women to be heard or for greater contextualising of planning and policy making. Rather, the main interest lies in technical solutions and the provision of institutionalised or at least professionalised birth, not in indigenous forms of knowledge. Such knowledge is commonly seen as problematic (Pigg 1997). At the same time, the anthropology of childbirth is generally separated from the mainstream of anthropology as a discipline, as though the idea of childbearing as ‘women’s business’ and ‘medical’ carries over into academia rather than seeing childbirth as a life process that affects, reflects and is influenced by all facets of society. The contribution it could make to wider thinking is poorly recognised in the discipline.

Once in the field I realised the significance of the matrilineal context and that this environment for decision-making has rarely been addressed. This has implications for both policy and theory: global policy rhetoric needs to be informed by specific realities as exemplars, and anthropological theory can be enhanced by greater attention to childbearing as a social construct and indicator of ideology and practice. At the same time I had an interest in contributing to the polarised debate about the role of ‘traditional birth attendants’ although this must remain a supplementary issue.

This global rhetoric is considered first by explaining its contemporary emphases and approaches to childbearing and maternal health care before proceeding to explain the theoretical approach and situating the study in rural Malawi.

## **Current emphases in global maternal health policy and literature and the contribution of anthropology**

Competing interpretations that impinge on women’s experience of childbirth are at the heart of theory and practice around pregnancy and birth – most specifically ‘natural

experience' versus the 'technologically mediated' paradigm of birth as an unpredictable and risky business (Safe Motherhood Initiative 2002) that is normal only in retrospect. 'Every woman, every time' perhaps sums this view up. Such competing interpretations are central to contemporary debates around the best ways of supporting healthy childbearing and they involve powerful voices. Those involved in practice may see the issues differently from the theoreticians and policy makers. Meeting many people across the world of maternal health, I have been struck by the absence of the absolutism of the international rhetoric amongst those living and working in direct contact with women in resource-poor areas or locally responsible for managing services. Indeed Obermeyer (1999) similarly suggests that global agendas and values may actually be seen as 'other' by the people 'at the receiving end'. So practice and theory are separated by a divide that is rarely crossed.

While paradigms of birth have been contentious and often divisive, women's bodies and reproductive experiences are manipulated and challenged in the name of safety by those of us whose status and livelihood depend on women seeking support in giving birth. 'We' may be situated anywhere along a continuum of carers ranging from untrained (in formal terms) birth attendants or indigenous midwives through various levels of educational preparation and role as 'skilled' attendant, to graduates from university medical schools 'at the apex of the system' (AbouZahr 2001:402). It could be suggested that the continuum reflects educational and social status rather than usefulness to pregnant women; and the subjective nature of 'skill' makes it a generally unhelpful term that does not necessarily equate with training level.<sup>8</sup>

Today skilled attendance is nevertheless the new emphasis in global thinking – defined as health care professionals with the knowledge to recognise and deal with life-threatening emergencies supported by accessible, functioning and properly resourced emergency obstetric care (WHO 1999, 2003). This has been articulated as:

Skilled attendant + enabling environment = skilled attendance (after Graham et al. 2001).

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<sup>8</sup> I agree with Goforth who asserts ' "skill" ... is both ethnocentric and misleading in that it fails to take into consideration the iatrogenic effects of cosmopolitan medicine and accepts the biomedical notion of what constitutes competence' (1988:342).

The focus of attention now is toward achieving this for every childbearing woman through advocacy and sustained political determination, the prevalent moral discourse being about saving lives and framing local forms of knowledge as inadequate (Pigg 1997).<sup>9</sup> In the new order, success demands total commitment and prioritisation and leaves no room for continuing support of unskilled providers which, it is claimed, only prolongs the time needed to achieve universal skilled care for women (AbouZahr 2001 and personal communication, 2002). Nevertheless Graham et al. (2001) express caution and highlight the lack of evidence for the claim that skilled attendance and lowered mortality and morbidity are causally linked.

This new impetus rests on a foundation of successive waves of explanations<sup>10</sup> for and solutions to the problem of maternal morbidity and mortality, none of which appears to have made any lasting difference. Death and morbidity associated with pregnancy, birth and the puerperium are essentially preventable and clearly associated with contexts of poverty.<sup>11</sup> A significant turning point in development efforts was that 'Safe Motherhood' as a concept was 'born in the shadow of child survival' (AbouZahr 2001:399); this recognised that treating women as reproductive vessels alone disadvantaged them so maternal health needed specific attention. According to the WHO (1999) maternal mortality is a social disadvantage, not just a health one. All sorts of broad socio-economic, rights-based, gender oppression approaches competed at that time with 'vertical' programmes such as risk analysis and the training of traditional birth attendants. Yet none of these has been proved to be successful in terms of the usual statistical indicators of mortality rates and some are just too slow.

Nonetheless broader approaches continue to be proposed by global funding partners with newer emphases being placed on upgrading entire health systems, 'sector-

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<sup>9</sup> I note that Pigg demonstrates how the international development community and the WHO were still supporting the use of TBAs in 1997.

<sup>10</sup> A significant explanatory model for why delay occurs in receiving emergency care was proposed by Thaddeus and Maine (1994). The 'Three Delays' model demonstrates how delay in making the decision to seek care, in accessing care, and in receiving appropriate help in emergency facilities is linked with maternal death.

<sup>11</sup> Maternal mortality is defined as deaths occurring during pregnancy or within 42 days of the end of the pregnancy (through birth or abortion) resulting from a pregnancy related cause or mismanagement. Approximately 600,000 women die yearly in this way, almost all in developing countries (WHO 1999).

wide' approaches and directing budgetary support to central governments rather than specific programmes (Goodburn and Campbell 2001). Other policy advisers express concern that women will again become disadvantaged (AbouZahr 2001); the expectation of a trickle-down effect on services for childbearing women may be unrealistic.

Despite her view cited above, AbouZahr comments that it is notable how little evidence exists that such newer approaches will make a greater difference than former ones (AbouZahr 2001); Graham (2002) again cautions that credible means of testing have yet to be developed. Moreover there is substantial debate about many issues, one of the most contentious (as noted already) currently being the effectiveness of traditional birth attendant training in saving women's lives (see also Bullough 2000, Bergstrom and Goodburn 2001, Sibley and Sipe. 2002).

An important feature of these global emphases has been the widely accepted proposition that birth is only normal in retrospect and that every one has a risk attached. This, I argue, provides the opening for all kinds of interventions, strategising, scape-goating, persuasion and frankly coercive activities, most of which are carried out for the best of motives – to save lives. The risk approach is explored further in chapter 8.

Although some fifteen years ago Jeffery et al. wrote 'The normal delivery cannot be understood except in relation to the social world beyond the labouring woman's home' (1989:98) it remains remarkable how rarely the socio-cultural context of women's childbearing appears in the policy debates. Quality of care improvements and the need for services that are user-friendly, where women are involved in decisions and not deterred from using them by poor staff attitudes, neglect and incompetence, are nevertheless proposed as strategies essential to enhancing the utilisation of services and preventing maternal deaths (for example Gay et al. 2003). Such examples as exist do so mainly to improve compliance since women are seen as 'problems' (Ginsburg and Rapp 1991), and views of birth other than as a biomedical process the safety of which must be assured, hardly feature in the technical literature. There are a few signs that this deficiency could be changing. The WHO introduces women's stories to a work on statistics 'Beyond the Numbers' (Lewis 2003), but the tendency remains to ignore birth as socially marked and shaped (Jordan 1993). Indeed Campbell (2001) indicates a deliberate setting aside of women's status and living conditions by some as 'diluting' the technical focus of the Safe Motherhood Initiative.

Birth, as both part of women's lives and as part of gender politics, is largely the province of the anthropological and feminist literature, and of the natural childbirth movement, rather than of 'safe motherhood' literature. As suggested previously, even in anthropology it is situated mainly in the pages of specialist journals, as the literature review in chapter 2 demonstrates. Pigg (1997) confirms how rarely research into local practices is used effectively by those who plan maternal health programmes. Pigg furthermore identifies the need for context-specific work on the cultural understanding of birth. She recommends that anthropologists should focus on 'particular values, situations, and practices as they appear in specific contexts' and use holistic methods to develop understanding of birth rather than making generalised enquiry about traditions (1997:255). Jeffery et al. (2002) also identify the limited and universalised basis on which policy around birth is made.

Some more recent anthropological material does include work on these new imperatives emanating from the global thinkers and policy makers. As discussed in chapter 2, there is work on accommodation to change (such as Davis-Floyd et al. 2001) and on resistance and agency (Daviss 1997, Chapman 2003, Donner 2004).

Chapman (2003) examines women's vulnerability in resource-poor environments in Mozambique and highlights how (as appears to happen in Malawi) they delay seeking antenatal care until late in pregnancy as a strategy to avoid deliberate harm from bewitching. In her doctoral study of a Mayan community Goforth (1988) claims that previous studies on reproductive or medical decision-making addressed cultural ideology but not how structures and social interactions impinge on people's choices. Nonetheless the assertion of Browner and Sargent (1996) that few consider the interaction of biomedicine and ethno-physiology as concepts and how this affects decisions remains true today. Some anthropologists focus on such areas but not much has been done. The possibilities for further work are however endless; some I offer in the concluding chapter.

In short, then, these anthropological ideas and maternal health policy rarely come together in a constructive way. Medical and policy forums put forward solutions with the built-in authority of their provenance. The anthropology of childbirth meanwhile has remained isolated in two ways: the real contribution it can make to policy has been marginalised or perhaps never asserted. Moreover, it has scarcely moved out of isolation as a route to understanding birth in order to improve women's lot rather than to contribute



to wider realms of theory development within social anthropology. It has historically sat more comfortably with medical anthropology and women's issues (Caplan, personal communication, 2003). This thesis makes a contribution to bridging that gap.

### **Theoretical approach and assumptions adopted in this study**

This section provides me with the opportunity to capture the essence of the theoretical approach and assumptions from which I have written this study:

- Clarifying childbearing decision-making and practice and understanding why women act as they do requires the study of ideologies and social processes;
- Conversely, decision-making and childbirth practice provide an entry into understanding those ideologies, priorities and social processes;
- Decision-making is multi-level in its modus operandi, being pragmatically as well as ideologically determined;
- Women are subject to power relationships but also have agency;
- Such power relationships are linked to knowledge and its ownership and management;
- And finally but very importantly, I need to clarify my a priori assumption that biology and biomedicine provide the most adequate explanations for the physical processes of pregnancy and birth and for some emotional ones.

Understanding concepts and social processes, shifting though they are, provides some clarity about decision-making around childbirth. It became necessary for me to enquire specifically into concepts upon which decision-making processes are constructed in order to be able to make sense of what I was seeing. I needed also to dig deeper into confusing areas using specialist explanations from both persons and texts. One prime example of this is the vulnerability of pregnant women and the apparently simultaneous danger they pose to others. Only when I looked more specifically at the imperative for hot and cold balance and controlling the transformative but therefore dangerous power of sexual activity did I begin to see why people act as they do. A second example is relatedness and

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marriage and residence patterns. Without developing some understanding of these it would have been impossible to interpret events and situations occurring within the kin group and household.

Studying women's lived experience of childbirth and of decision-making conversely provides insight into ideology and social action and process. Women's bodies constitute a readable text on which are inscribed their circumstances, their own pre-occupations and ideals, indeed their whole world-view and that of those who influence them. I argue that the values of the society which I studied are clearly demonstrated by the way women in the matrilineal community are respected and treated, at least when mature, and the way in which moral precepts are set within boundaries expressed as a set of taboos and pollution ideas. Likewise, both the enduring nature of matriliney and matrilocality, and the gendered power relationships are revealed by the analysis of decision-making processes in this thesis.

Browner and Sargent (1996) similarly note how studies of reproduction inform anthropology in areas such as the position of women, the value placed upon motherhood and fertility, or women as sexual beings. In her Benin work Sargent (1982, 1989) shows up societal values just as much as she conversely demonstrates how values affect women. Sargent demonstrates clearly how political agendas, status aspirations, medical concerns and the virtues of courage, stoicism and self-sacrifice all meet in the context of birth in Benin, so demanding negotiation by women to reconcile such demands. Studying relationships can illuminate the links between a 'society's ... principles and its paradigms of maternity' (Browner and Sargent 1996:221). This needs to be undertaken in situated contexts to add life and concrete reality to the global rhetoric that so easily becomes out of touch. Allen (2002) specifically sets out to investigate these processes producing new insights into the reality of Tanzanian women's experience through her study of fertility and danger. The women with whom she talked expressed the importance of fertility for them, and how spiritual as well as physical risks affect their actions, so enabling her to understand better why their strategies might be incongruent with biomedical definitions of childbirth risk. The story she recounts of Samweli and her difficult labour (Allen 2002:206) foregrounds the link between infidelity and labour problems, an issue that arose repeatedly in my own fieldwork data.

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In exploring the pragmatic nature of women's action, Lock and Kaufert (1998) show how women will make use of whatever best serves their needs; they use examples provided by Kielmann about infertile women in Zanzibar (1998) and Lewin who studied lesbian women in California (1998). Ideology here is subverted by the impetus to achieve desired outcomes. The routes to such outcomes and the obstacles that have to be negotiated on the way are different in individual contexts, and shifting and variable there too. These factors, as with ideologies, need to be known to develop understanding of women's lives and to make sense of actions. Benin women might have objectives as prosaic as giving birth in hospital in order to acquire a birth certificate (Sargent 1982) and, equally pragmatic, some may give birth at home purely because of the prohibitive costs (Sargent 1982 and my own data). Malawian women may give birth in hospital because they believe it to be the safest place. Conversely they may stay in the village and seek the help of the *azamba* purely because there is no woman available to cook for them whilst in hospital. They may fear being bewitched by a jealous neighbour so leave quietly and alone for the hospital, or may set off alone because no-one can accompany them.

The final assumptions concern gender and power. A feminist approach would suggest that gender roles and relationships affect choices but that while women may be constrained they may also find ways of achieving agency to reach their desired ends. This is very evident in the work of Sargent and Allen previously described; both demonstrate how women inter-react with local systems to achieve their ends, but do not of course always achieve the desired outcomes. Allen (2002) describes the classic scenario of a woman failing to reach essential emergency obstetric care in time because of her husband's refusal to pay for it. Likewise in some (at least patrilineal) Malawian households, women may have to stay at home to prove their fidelity rather than use the hospital. Women may labour on unattended because they must await older kinswomen's agreement to leave, or while husbands seek to borrow hospital fees (Ashwood-Smith, personal communication, 2000). In contrast one of my informants strategised to avoid an *azamba* with whom she had a disagreement. Another chose a particular *azamba* because she knew she was less likely to refer her to the hospital. Sargent (1989) describes how women might choose to give birth alone even in a clinic, either to fulfil their view of stoicism or to protect their ability to dispose of babies they diagnose as being witches. These sources then demonstrate how decision-making is more than 'culture' or ideology

but is also pragmatic. In Malawi, circumstance may be as important as any conceptual rationale for choices when it comes to the 'crisis' of labour. As Goforth (1988:9) notes 'anthropological studies of medical decision-making usually emphasize cultural ideology' while social interactions are given 'only cursory recognition'.

It is very clear from the data that I present in this thesis that gendered power relationships are linked to the holding of knowledge that is necessary to determine action. It is also evident that the legitimacy of knowledge and power is important and socially ascribed and maintained. Most young women inexperienced as mothers cannot make decisions because they do <sup>not</sup> have the necessary knowledge tools. It is those in a relationship of power, mainly their older matrikin, who maintain that status of ignorance and so, whether deliberately or not, perpetuate their power.

In this thesis I will seek to tease out and understand the opportunities and constraints that make a difference to decision-making and women's agency. I start from the premise that not only practical considerations and cultural processes and concepts affect women but so too do the values, relational dynamics and power bases integral to the community. Such focussing on a specific environment in a specific time frame can add to wider understanding of the values and processes intrinsic to birthing decisions. It can moreover serve to underline the illegitimacy of the category 'woman' as universal and the tendency to generalise in providing technological solutions to the difficulties women may encounter in their childbearing.

### **Situating the study: introducing a rural Malawian community**

The fieldwork location and the people are now introduced. It is an area of rural poverty surviving mainly by subsistence agriculture, matrilineal and matrilocal and with a high proportion of female-headed households.

#### **Why Malawi, why here? A welcoming and suitable place**

Though very poor, Malawi was targeting purposefully the very high numbers of women who die through childbearing (see below) when I met the national Head of Midwifery

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Education at an international conference in Oslo in 1995. Lennie Kamwendo's descriptions of Malawian birthing (Kamwendo 1996) and her positive response to my interest started me on the road to carrying out fieldwork there. The choice of community was also the result of her initial guidance, but later through personal contact with the communities in question; these were chosen for convenience despite their rural nature and, above all, for the initial welcome I was given and enthusiasm shown for the project. To some extent the choice of Malawi was serendipitous but at the same time the country fulfilled the criteria I had in mind which included accessibility, English or French as recognised languages to reduce the language learning needed to local only, and an area with a fairly well-defined body of information available. I knew at that point that studying decision-making for childbirth would take me into diverse theoretical areas. It seemed then that a smaller country might simplify literature searching and make it easier to get to know the area. Illogical as this seems given the artificial nature of national boundaries, I did indeed find a defined body of literature due perhaps in part to a strong Malawian identity and focussed international and local research activity through well-established academic departments.

### **From colonialism to democracy, a short history**

The main ethnic groups of modern Malawi are all Bantu but arrived from different directions. The largest group is probably the aChewa, also known as the Nyanja people. Living mainly in the central area they have as neighbours the Ngoni, and the Tumbuka in the north. In the southern areas are Lomwe, Yao, Ngoni and toward the Zambezi, the Sena. The Ngoni, Yao and Lomwe have entered Malawi within the last 150 years. The southern Ngoni arrived in the 19<sup>th</sup> century, mostly from the direction of the Zambezi in flight from the hard regime of the Mozambique Portuguese (see map 1.1). These people were less war-like than their fellows from Shaka Zulu's bands who entered further north terrorising and conquering as they went in the 'Time of the Killing' (Briggs 1996). The patrilineal and patrilocal focus was gradually given up by these southern Ngoni as they integrated with local populations who gave them land whereas the more northern Ngoni settlers retained their familiar patterns. The Lomwe, often then despised but now the core group of the locality, had entered from the mountains to the east and north-east as had the Islamic Yao, traders in slaves and ivory for the Arabs on the coast.

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Assimilation appears now to be complete, but this history hides a tumultuous time of conflict and slave-trading culminating in the eventual colonisation of all groups by first the Portuguese then the British. There followed a time of, to use the words of Livingstone, 'Civilisation, Commerce and Christianity' (Wills 1985). Arab (and local) slavery in Malawi ended only very late in the nineteenth century.<sup>12</sup>

Years of conscripted wage labour followed, usually on estates and essential to pay British poll taxes. Resentment grew and rebellions followed partly led by some protestant church leaders such as Rev. John Chilembwe, now a national hero. Migration of men to gold and copper mines, to industry and plantations all over southern Africa then became a feature of life.<sup>13</sup> Many older men talked to me of their times as migrant labourers, usually leaving behind their wives to fend for themselves as groups of related women. This continues today with many men working away, sending remittances home when they can (or not) and visiting at intervals (again 'or not'). Female-headed households have become very much the norm, with, according to Davison (1995) an enduring proportion as high as 45% of households surviving on minimal or no support from distant men and running farms alone.<sup>14</sup>

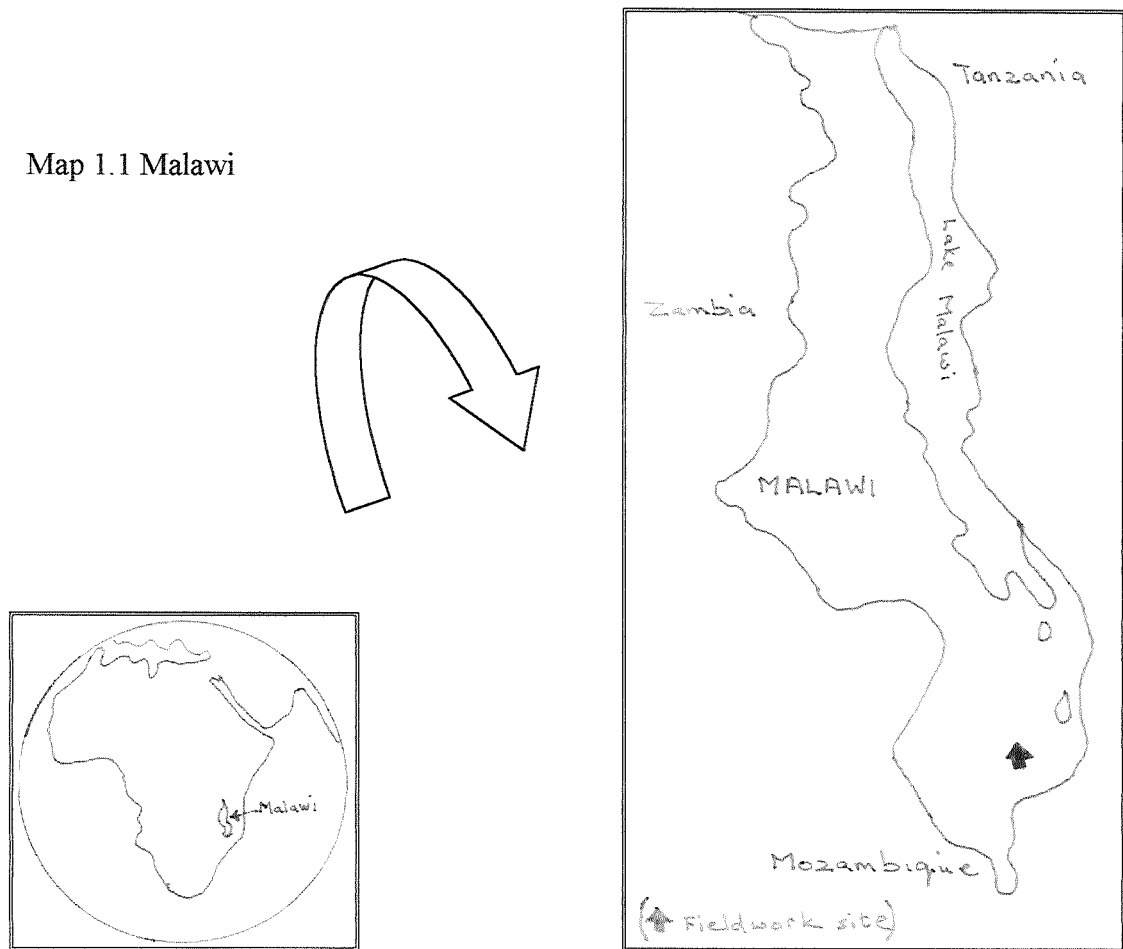
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<sup>12</sup> Mitchell (1956) and White (1987) provide comprehensive historical information based around specific southern village environments.

<sup>13</sup> This tendency to migrate for work continues to this day, either within or outside of Malawi.

<sup>14</sup> Survey of maize producers in Zomba, Southern Region. This percentage of female headed households would have been higher before ex-President Banda banned such migration following the crash of a plane full of workers.

Map 1.1 Malawi



### **Economics, politics and religion**

The people then were subject to years of exploitation and barriers to effective self-sufficiency. This continued through the colonial years, through conscription to the armies of World War II, and to land and labour exploitation as Malawi (previously Nyasaland) found independence and then republican status led by Banda. He encouraged the continued presence of settlers, the buying-up of land by local entrepreneurs, and state and personal interests in businesses such as agriculture, fishing, the press and food manufacturing (Mhone 1992, Dermann and Ferguson 1995). Banda also entered enthusiastically into structural adjustment programmes (Kaluwa 1992) so was popular with conservative governments elsewhere although shunned by many states. He was adjudged by Forster (1994) as a master at preserving culture as well as manipulating it for political ends.

Women remained disadvantaged through the years, in land, training, credit and, especially in patrilineal areas, in rights as widows. They continued however to be the lynch-pin of community and political activity, for their men and for Banda. The regime became increasingly authoritarian and repressive, with many dying or disappearing until Banda finally bowed to pressure for a referendum on multi-party democracy in 1993,<sup>15</sup> followed by elections in 1994. At this time a consortium of Malawi Congress Party (MCP) members (until then the only party) formed the United Democratic Front (UDF) party which achieved a majority against the MCP and another, Alliance for Democracy (AFORD).

Once introduced, democracy was accompanied by extensive civic education campaigns which went on through the next elections, after which the UDF continued in power. So during my fieldwork and earlier contacts between 1996 and 2000, people were feeling increasingly free to talk; they enthusiastically supported the elected President Bakili Maluzi whilst bewailing increasing poverty, lawlessness and AIDS deaths, believed to be consequences of 'multipartyism'. The subsequent years have involved extensive and often volatile debate about changing the constitution to allow for a third presidential term. This proposal has now been abandoned because of popular dissent and the country prepares for its third democratic elections. Political sophistication has grown but many challenges lie ahead. The continuing openness of the written media and frequent cartoons lampooning public figures is encouraging even if the national radio and television network can not shake off the image of being government propaganda organs.

Women are politically active, well respected and influential – but men tend to predominate at higher levels (Lwanda 1996). Morris (1998) emphasises the significant political power women may hold as Village Heads. He distinguishes, however, between local and wider level power exercised through party politics and government

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<sup>15</sup> Dissent was highly dangerous during the years of self-proclaimed Life President Banda and many intellectuals fled the country. The referendum on moving to multi-party democracy was only finally achieved after a group of Roman Catholic Bishops demanded change in a Pastoral Letter. The Bishops took the precautionary measure of copying it to the BBC for international broadcast simultaneous with its reading in parishes across Malawi but their lives were still threatened. Other factors influential in enabling change included international withdrawal of support in the face of poor governance and human rights abuses (Phiri and Ross 1998).



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appointments, again borne out by my data.<sup>16</sup> The role of the *mfumu* in ensuring the community's welfare was underlined by Morris (1998) who explained the political and ritual authority and the need to be seen as a 'male' mother striving to keep peace and harmony. I witnessed both reconciliatory activities and concern for the well-being of the people which emerges clearly in my data (most notably when Dannis became ill – see case study 1, chapter 5).

Women may hold such significant local roles but they may still be struggling to survive with their children on subsistence farming alone (Peters 1997a).<sup>17</sup> Many now support children orphaned through AIDS as younger adults die and many households are even led by children.

Inflation is severe, crop failure through drought and floods is frequent and commerce and services, schools and hospitals are on the point of collapse as workers fall ill. Malawi has one of the highest rates of HIV infection in Africa and this undoubtedly is damaging the economy further as people become unable to work or grow food.

Their faith is very important for many Malawians; almost all profess Christianity or Islam. Evangelical (often charismatic) churches draw large congregations in towns. There is, according to White (1987:256) a 'huge variety of practices and beliefs on offer'. In the fieldwork area alone I found Muslims, Roman Catholic, Seventh - Day Adventist and 'Africanised' churches such as the Abrahams and Ethiopians, and Presbyterians among hospital staff. The churches and mosques play an important role in assisting their members and the local population with education, welfare support and sometimes health care provision.<sup>18</sup> Mosques and churches provide advisors for young people and an important focus of community life. Mid-week prayer meetings may be held

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<sup>16</sup> I encountered women holding office as Deputy Village Head (usually being the sister of the Head), Head (having succeeded her brother), and as chair of the local political party committee. I did not encounter female office-holders at district or regional level, thus perhaps reinforcing the difference between domestic and public domains of activity of women described by Rosaldo (1974). Indeed I frequently read comments in newspapers about the slow increase in the number of women in government although a small proportion of Members of Parliament are female.

<sup>17</sup> Spring (1995) explores such issues further and others enter the debate about female-headed households and women's opportunity for self-determination through agricultural and household modes of production (for example Caplan 1995, O'Laughlin 1995, Peters 1995).

<sup>18</sup> The local secondary school is a Catholic establishment, as is a nearby teacher training college and the hospital used by most people. All these services are provided under the auspices of the government.

in homes and church events bring out women in their finest clothes. Faith for many is pluralistic and evidenced by visits to diviners, sorcerers, healers and prayer meetings in combination. The use of health care systems is equally pluralistic.

### **Reproductive and childbearing health and general services**

Throughout rural Malawi roughly painted signs are seen by the roadside marked 'Sing'anga' 'African Doctor'. Up a grass track will stand the often ramshackle home of a traditional healer. Many people use healers, herbalists, sorcerers and diviners as first choice or in conjunction with biomedical care. This I investigate further in chapter 7. Most however use formal health services too. A Chiradzulu District survey found that 97% of households sought health care from hospital or health centre facilities (National Statistical Office (NSO) 1998). The government provides services through local health centres, district hospitals and regional referral centres. Christian hospitals like St. Joseph's, Nguludi, which is situated about 10 km. from the study site, provide a substantial proportion of services under contract to the government which pays staff salaries. Government services are largely free of charge but many will choose to travel to a CHAM<sup>19</sup> hospital despite having to pay for care because resources are often more available, attitudes believed to be better, and surroundings often cleaner.<sup>20</sup> The costs involved in a hospital birth at St. Joseph's Hospital, Nguludi are detailed in Table 1.1 as equivalents of the purchase price of a 50kg. bag of maize:<sup>21</sup>

Table 1.1 Costs of hospital care

Normal maternity care including antenatal checks and tests, iron supplements, malaria and tetanus prevention, and care at the birth	just under 1 bag
Caesarean section	6-7 bags
Extra nights in hospital	2 bags each

<sup>19</sup> Christian Health Association of Malawi

<sup>20</sup> Staff - patient relationships have been the focus for recent media campaigns and surveys show user satisfaction with maternity services in the Chiradzulu District has improved substantially of recent years (Malawi Safe Motherhood Project 2003).

<sup>21</sup> Supplied by St. Joseph's Hospital Administration and Headman Malinga January 2004. I note that one bag of maize can feed two adults and three children for one month.

Village health workers provide support and public health information although in the study area the system has broken down (Headman Malinga, personal communication 2003). Health services are fairly comprehensive but always under severe economic and manpower constraint. Although government services are free it is evident from experiences of acquaintances that more advanced services, such as more expensive diagnostic ones and curative therapies, are unavailable unless private treatment is used. That might entail a journey to South Africa. Some hospice care for terminal illness is available from CHAM organisations. The burden of disease is heavy in Malawi with malaria, TB and HIV undoubtedly being the most serious problems. Child immunisation programmes have been particularly successful but malnutrition and lack of hygiene, coupled with the limited use of treated bed nets to prevent malaria means the child death rate is very high and many children have retarded growth.

Maternity services are very busy, but, as with general medical services may be severely under-staffed and often poorly supplied.<sup>22</sup> Inadequate hospital care has been identified as a substantial cause of maternal death in Malawi (Ministry of Health and Population (MOHP) 1995), a situation common in many poorly resourced countries. The maternal death ratio, always very high since records began, has soared from 620 per 100,000 live births in 1992 to the most recent assessment of 1127 (NSO and OCR Macro 2001).<sup>23</sup> Many deaths are HIV related but the classic causes of maternal death remain very important and interlinked in complex ways:

- infection
- retained placenta and post-partum haemorrhage
- obstructed labour and ruptured uterus
- pregnancy-induced hypertension

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<sup>22</sup> Neither of these situations appears to be as serious in the local mission hospital as in government establishments.

<sup>23</sup> With high fertility this becomes approximately a 1 in 11 lifetime chance of dying from childbearing. The rise in mortality to one of the highest in Africa may be linked to HIV infection which substantially increases a woman's chance of complications. Female life expectancy is now only 38 years (Engender Health 2002).

- unsafe abortion.

Many women survive childbearing problems but as a consequence are left with serious and often hidden health outcomes such as anaemia, infertility, and fistulae.<sup>24</sup> These can be debilitating and socially unacceptable and destroy women's lives.

Community outreach takes antenatal care to dispersed clinics and most women receive some professional antenatal care although usually not until about six months gestation,<sup>25</sup> far fewer using hospitals for birth, about 40% locally (Sichali, personal communication, 2000). No professional home care exists for birth. Some hospitals, including the local one, provide maternity waiting hostels (*chitando*) in which women may lodge in late pregnancy and such provision is to be expanded in future (MOHP 2003). Approximately 60% of birth care is provided in homes and birth houses by *azamba*, some of whom receive government recognition and supervision following a short training. Other women use untrained older kin but I found no evidence that this was a common occurrence in this community other than in emergency. Training and supervision of TBAs featured in the 1995 National Safe Motherhood Programme (MOHP 1995) and in its successor, the Safe Motherhood Operational Framework 2002-2007 (MOHP 2003). The Government of Malawi has made a considered response to the global push to reduce the role of TBAs with its decision to continue with their updating and supervision, but to review policy around their role and aim at maximum possible provision of 'skilled' attendants. Skilled attendance means hospital birth for all women as there are no plans for home-based provision (MOHP 2002). The provision of skilled attendants is newly emphasised as part of the 'rights-based' approach to maternity care and new ways of preparing midwives to meet the current emergency<sup>26</sup> are being explored. The standard means of training is as a registered nurse and midwife or a shorter more

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<sup>24</sup> An obstetric fistula is an open cavity between the vagina and urinary tract or bowel, often both, with uncontrolled leakage of urine and faeces. The usual cause is pressure of the fetal head on the birth passage when prolonged labour is neglected. Surgical repair is the only way to restore continence for such women.

<sup>25</sup> The Malawi Demographic and Health Survey 2000 (NSO 2001) states 91% of pregnant women attend one or more clinics but many doing so at a later than optimum stage of pregnancy. The national average for hospital birth is 55%.

<sup>26</sup> The staff emergency relates to the loss of workers through AIDS at a time when the system is already overloaded because of AIDS and TB.

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practical training of nurse-midwife technician. It is evident that the system would be unable to cope at present levels of resources and maternity care worker recruitment and retention if many more women chose hospital birth.<sup>27</sup>

There is evidence that the government is thinking beyond the technical to increasing male involvement in antenatal care and pregnancy education, and mobilising communities to prepare contingency plans for emergencies. This is especially important when women remain so disadvantaged and was discussed with me at local facility level thus confirming that national policy is reaching service level.

The Government of Malawi is seen as having strong maternal health policies but as less successful where quality of care, training of health care workers, and access to services are concerned (Policy Project 2003).<sup>28</sup> The intention is to renew efforts at provision of adequate services and provide better communications and transport facilities to avoid delays in reaching and obtaining the support needed in birth emergencies (MOHP 2002) (see fig.1.1). Without good support, called the 'enabling environment' in current global policy (WHO 2003), no amount of boosting levels or expertise of attendants will make a difference to women's and babies' health and survival. Nonetheless, contemporary data reveals that the decline in services and quality in maternity services were reaching breaking point by 2002. Despite efforts to increase training, supplies, referral systems, transportation and communications, decreasing numbers of births are being attended by 'skilled' personnel (Malawi Safe Motherhood Project Management Unit 2003).

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<sup>27</sup> Retention is becoming an increasing problem as many experienced midwives, nurses and doctors leave to work elsewhere such as South Africa, UK and USA.

<sup>28</sup> Post-abortion care, vital for improving women's safety, is rated particularly poorly while antibiotic and blood transfusions supplies, and transport are identified as causing real problems. Malawi achieves better ratings however than nearby countries on a number of factors such as professional care for birth (Policy Project 2003).

Fig.1.1 The road to Kalanje: main roads are good but village roads (where they exist) make vehicle transport very difficult.



Motherhood is given a central place in Malawian expectations of personhood and most women's lives follow a pattern completely subject to their reproductive capabilities and role. They often marry in their late teens, or become pregnant earlier and drop out of school. Many rural women follow a course from pregnancy to lactation to pregnancy, giving birth at around two yearly intervals and probably losing some children to childhood diseases. This leaves little opportunity for creating other roles for themselves until reproduction slows as they near the menopause. Twelve children was a common family size at one time; the average is now six.<sup>29</sup>

Given the resource constraints and population growth rate of 3.32% (NSO 2004),<sup>30</sup> it is perhaps unsurprising that services for those experiencing fertility problems are very limited despite the pronatalist environment. Family planning needs are however becoming better served as the general public increasingly expresses the desire for smaller families, one group of informants telling me '[when there are] many children [they] are

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<sup>29</sup> This is the observed fertility rate (children per woman) for the Southern Region. It is likely to be slightly higher in rural areas and lower in urban environments (NSO 2001).

<sup>30</sup> A population increase of about 33% is projected for the next ten years (NSO 2004).

not fed or dressed well and they become thieves' (Mithawa women 16 06 00).<sup>31</sup> It is vital for safe motherhood that pregnancies do not occur too young, too old or too frequently and services are provided by the government through agencies such as Banja La Mtsogola (BLM) and through hospital services. Extensive effort has been made in recent years to increase the accessibility and uptake of services and so continue the slight downward trend in fertility rates, standing during my fieldwork at 6.3 children per woman (NSO 2001).<sup>32</sup> Many barriers exist however to increasing uptake and a local Chiradzulu District survey indicates only 35% of women<sup>33</sup> had ever used 'modern' (that is biomedical) family planning services (NSO 1998). Services suffer from inadequate numbers of clinics, shortage of personnel and unreliable supplies, and people may refuse to use those facilities where quality and attitude is poor (Safe Motherhood Project 1998, Opportunities and Choices 2002a). Not least as a barrier is the increasing price of commodities, and even more important perhaps, local perceptions of family planning and contraception. Malawi is a deeply conservative country and the Catholic Church strongly influences peoples' activities. At St. Joseph's Hospital for example, family 'spacing' services rely on natural methods and nurse-midwives in training must go elsewhere to develop their family planning knowledge more widely. In the rural fieldwork community, reliance may still be on herbal methods and postnatal celibacy (see chapter 6 and 7). Hormonal contraceptive injections are popular but barriers to their use exist, not least being the need to travel to a clinic to receive them. The same applies to tubal ligation, 'to close oneself'; seen as desirable by many rural women but only once they have experienced a problem in a pregnancy or birth (Kamuntolo, personal communication, 2003).<sup>34</sup> Abortion is legal only when women's lives are threatened by pregnancy but illegal and unsafe abortions are common.

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<sup>31</sup> The Wanted Fertility Rate for the Southern Region of Malawi is 5.0 children per woman (NSO 2001).

<sup>32</sup> The overall (modern) contraceptive prevalence rate has more than trebled in 10 years to reach 26% of women (NSO 2001)

<sup>33</sup> Scanning a range of documents revealed minimal regard to male interests in contraceptive use, other than male reluctance to use condoms and the importance of male involvement in decision-making (Opportunities and Choices 2002a and 2002b).

<sup>34</sup> BLM provided minibuses at one time to transport women to hospital for tubal ligation. This fell into disuse 'because of shame', women did not wish to be seen going for 'the operation'. The nearest clinic is the BLM centre at Bangwe and women will walk the 15kms. to conceal their destination (Kamuntolo, personal communication, 2003).

Although disadvantaged in substantial ways such as lack of economic independence and limited education, women have some agency around childbearing and may seek out contraceptive advice with or without their men. It is expected that couples will make decisions about pregnancies together and couples which do this are more likely than others to use modern methods<sup>35</sup> (Opportunities and Choices 2002a, 2002b). Nevertheless, it is evident that women may choose injections because they are totally under their own control or hide their actions by other means. Women generally expect to become pregnant quickly after marriage and 36% of southern rural women aged 15-19 have experienced pregnancy (NSO 2001)<sup>36</sup>. However it is possibly only in patrilineal communities that women's status and wellbeing is so very dependent on giving birth.

Condoms are widely available commercially and supplies are provided to communities and distributed by someone such as an *azamba* or Village Head. However condoms are viewed as being for use outside marriage, by young men and adulterers (Kamuntolo, personal communication, 2003). They are not for use by couples.<sup>37</sup> Rumours also abound about their safety (Opportunities and Choices 2002a). Vasectomy is available, but the same source indicates this is not even considered in the fieldwork site.<sup>38</sup> Condom use is considered to be so important in Malawi for the prevention of unwanted pregnancy and the transmission of HIV that it now features strongly in the Safe Motherhood Operational Framework 2002-2007 (MOHP 2003), including major programmes in mobilising young people.

Reluctance to use condoms, both within marital relationships and outside of them (Bujra 2000), is common in Africa and constitutes a key difficulty in public health

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<sup>35</sup> 'Modern' methods of family planning encompass male and female condom use, diaphragm, hormonal oral and injectable contraceptives, intra-uterine devices, tubal ligation and vasectomy. Natural methods are timing intercourse through calendar and cervical mucosal observation, and lactational amenorrhoea. Local methods also exist which are described in chapter 7.

<sup>36</sup> Another source claims 63% of women have given birth by age 20 (Policy Project 2003).

<sup>37</sup> Advertising strategies do not help, often upsetting local sensibilities by their content or association as this story illustrates: during my preparatory visit to Malawi I noted a wall painting of a Zulu shield and silhouetted couple. I guessed this was a condom advert but was unaware until years later that the hotel wall on which the advert was placed was used as a brothel. So here condom use could be directly associated with sex work.

<sup>38</sup> Only 1.6% of married Malawian women use condoms and contraceptive pill use is not much higher. Depo-Provera use is 16% (Opportunities and Choices 2002b).



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campaigns. HIV is primarily spread here by heterosexual sex and mother-to-child transmission. Despite substantial support from external agencies for the government STI/HIV/AIDS<sup>39</sup> programme, poverty, unemployment, malnutrition and slow behaviour change interlink to leave a country devastated economically by deaths and illness, with a soaring general and maternal death rate, and countless orphans. All households are touched by AIDS deaths and the need to take in extra children. Many households are headed by children. The contemporary impact of HIV in Malawi can be seen in the following figures (NSO 2001, Save the Children 2002, UNAIDS 2002):

- Approximately 14% of Malawians aged 15 to 49 are sero-positive;
- The rate is 4-6 times greater in women aged 15-24 than amongst young men of the same age;
- About 10% of rural women are sero-positive;
- About 30% of urban women are positive (especially if living in city outskirts);
- 70% of commercial sex workers (assumed to be female) tested sero-positive in 1994;
- 30% of men reported using condoms with sex workers;
- The average Life Expectancy at Birth in 1999 was 38-40 (slightly less for men than for women).

A wide array of government and non-governmental organisations are active in the field of HIV and supporting those living with it or having AIDS. Support for orphans is a key area of activity. Nevertheless the epidemic continues unabated.

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<sup>39</sup> Sexually transmitted infections are increasingly linked with HIV infections, leading ultimately to AIDS related illness. This topic is so extensive that it minimally addressed here.

### The fieldwork locality – the place and the people

The main fieldwork community is a cluster of settlements spreading over some twenty square kilometres<sup>40</sup> in which live people of the Lomwe, Yao and Ngoni ethnic groups (see map 1.2 below). It is not obvious to the outside observer who belongs to which group and intermarriage is common. Most local residents are now matrilineal and matrilineal except for some of those posted there for work such as teachers and hospital staff. This is explored further in chapter 4. The local Ngoni people were originally patrilineal and patrilineal, and elsewhere in Malawi these ways of life still prevail amongst the Ngoni.

The area lies on the Shire Highlands plateau in Malawi's Southern Region (see map 1.1) and is thus relatively cool; the terrain is intensively farmed, sparsely wooded and undulating with flatter areas punctuated by conical hills of probable volcanic origin (see fig. 1.2).

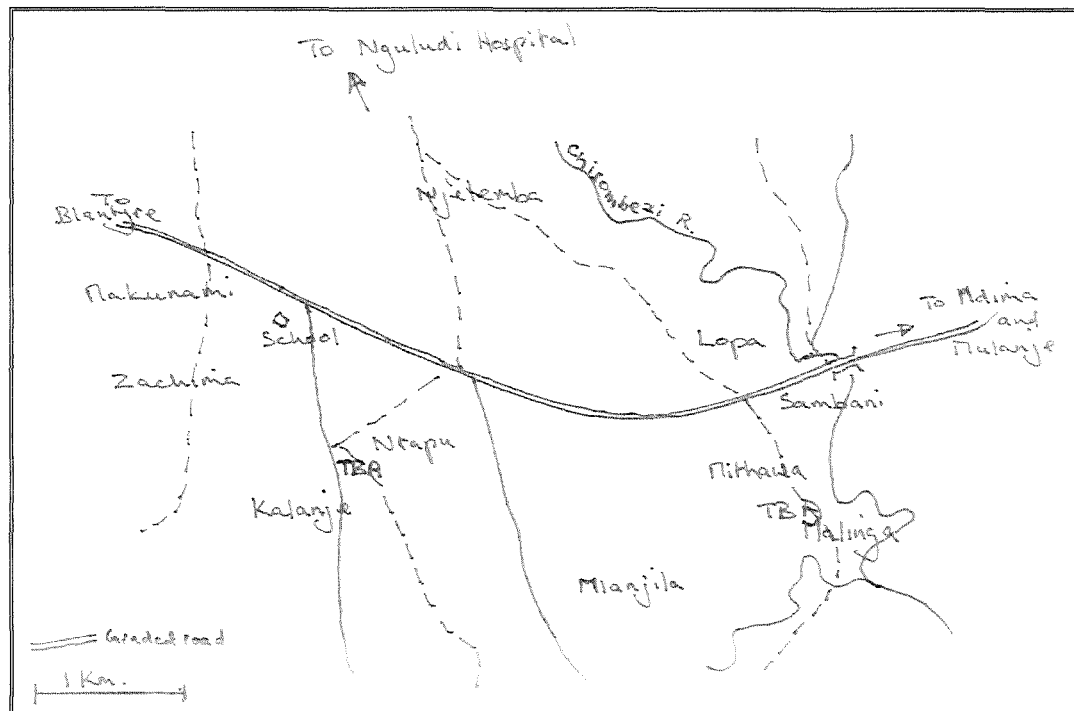
Fig.1.2 Fields around Nguludi: few areas remain uncultivated and trees are sparse



The area is not far from the commercial capital Blantyre and is served by a substantial dirt road with passing vehicles and informal fee-paying pick-ups (*matola*) providing some hope of transport (see map 1.2).

<sup>40</sup> This excludes the village and hospital of Nguludi, some 10 kms. North-west.

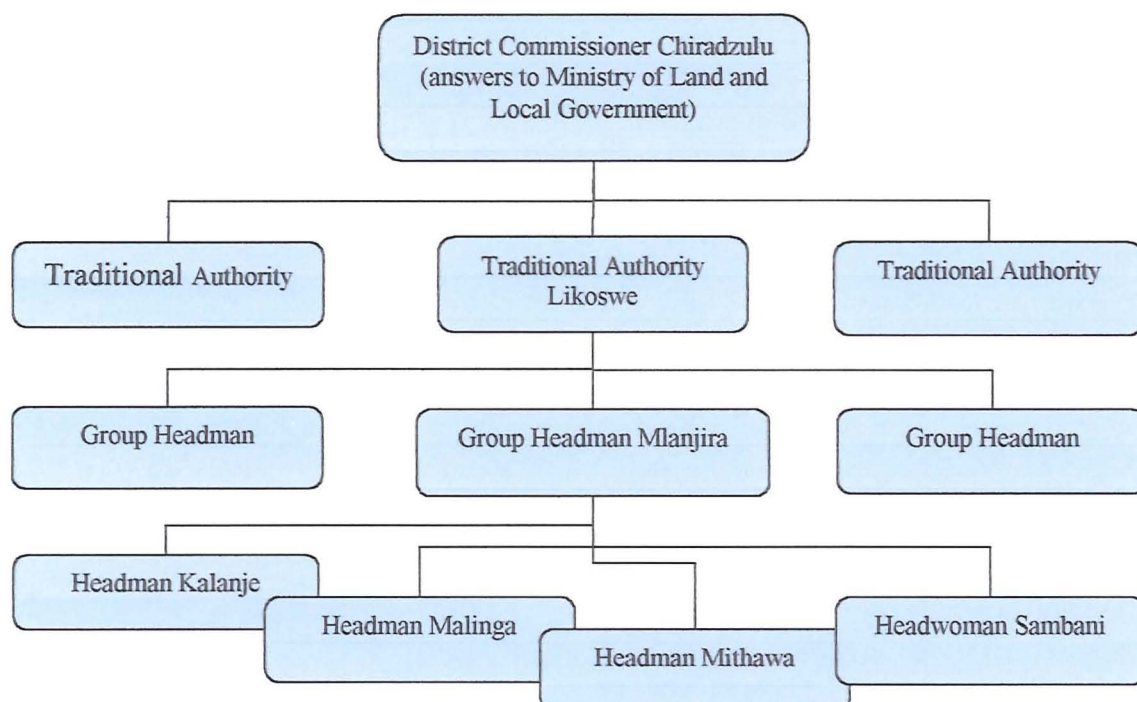
Map 1.2 The fieldwork locality



The area lies within the administrative District of Chiradzulu and Traditional Authority (TA) of Likoswe.<sup>41</sup> Local administration was at one time intensely political but is less overtly so now, its main concerns being local land affairs and use, civil processes amongst residents, registration of births and deaths, advocacy and ensuring appropriate provision of facilities. The system was set up by the colonial authorities loosely using old structures as a basis. For everyday community affairs, the people deal directly with the Village Head or Deputy. Although these are inheritable positions, residents have substantial influence over who takes such office. The organisation chart of authority is illustrated in fig 1.3.

<sup>41</sup> The Traditional Authority is both an area of civil jurisdiction and the person at its head – both office and office holder. It is defined as ‘The area of indigenous geo-political and socio-economic jurisdiction; an indigenous state (customary sovereignty) sometimes of a single lineage descent group that represents the source of authority of the Chief ... also a symbol of kinship unity and its responsibilities devolve upon its living representatives, the Chief and his councillors (*sic*)’ (Malawi Government, undated). Since democratic rule the responsibility has been civil only whereas during the dictatorship of Life President Dr. Kamuzu Banda it was invested with criminal/political powers and could impose the death sentence. Using villages under one jurisdiction as fieldwork sites made permissions easier to obtain.

Fig. 1.3 Organisation chart for Chiradzulu District



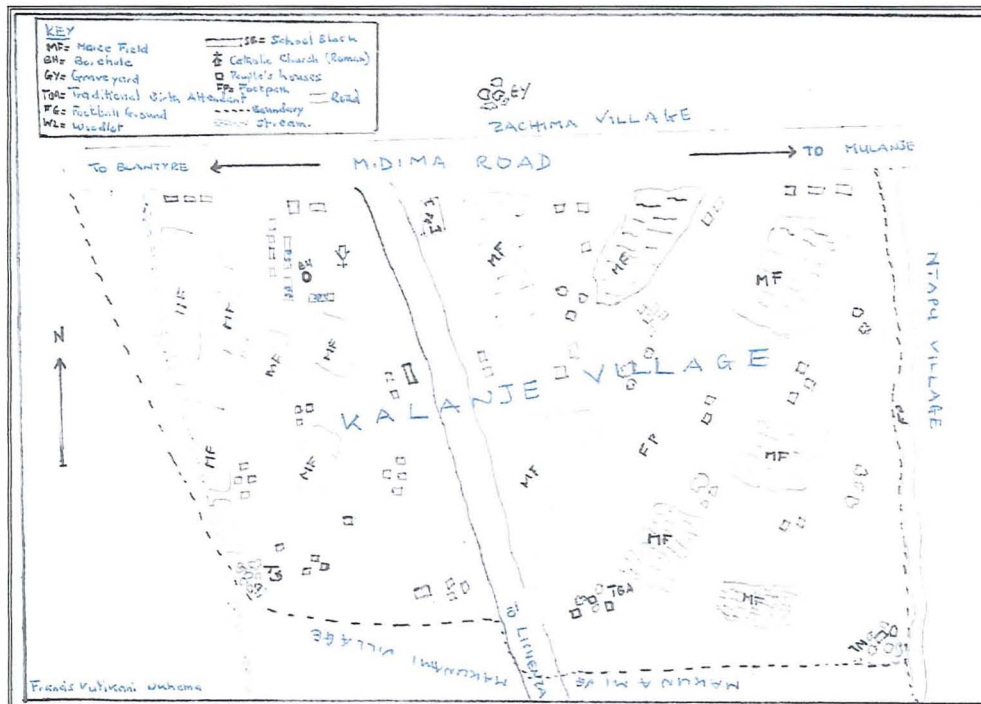
The locality is one of the most densely populated rural areas in Malawi.<sup>42</sup> Deforestation and erosion are serious as people constantly seek fuel wood, only sparing the sacred graveyard woodlands, in Malawian thought the home of ancestral spirits. The land is becoming increasingly overworked and infertile except for precious strips of *dambo*, riverside land where salad crops are grown, and a large unused tract of land nearby, the property of an absent land-owner. Clusters of homesteads are joined by networks of tracks that weave between the maize fields. Malawian fields prepared for planting look from the air like old and faded brown corduroy, with cropping ridges whirling around and over anthills and rocky outcrops, clusters of thatched houses and crossed by spidery networks of narrow paths.

The main villages featuring in my work are Kalanje, Malinga, Mithawa and Sambani (see maps 1.3, 1.4 and 1.5).

<sup>42</sup> 200-400 population per squ.km. (<[www.aidsmalawi.org/maps/popbydistrict.cfm](http://www.aidsmalawi.org/maps/popbydistrict.cfm)> accessed 21 05 03)







Map 1.5 Kalanje village

People live alongside each other in mainly matrilineal households with some degree of concentration of ethnic group, but almost all speaking the national language Chichewa<sup>43</sup> (the language of the Central Region and of the former President Banda) as well as, at least for older folk, their own tongue.

Most people live by subsistence farming growing the staple crop of maize and storing it in granaries after the harvest (see fig.1.4), with millet, peas, beans, green vegetables and some tomatoes. Some breed chickens, occasionally rabbits and guinea pigs while goats are herded by young boys on rough land. Chicken and goat are eaten on special occasions only. Dried fish may be bought for cash by those with higher incomes but fresh fish from the lakes is out of everyone's reach. Beef, also very expensive, is available at the nearby market although few people keep cattle. My hostess Stella, an *azamba*, was an exception, keeping two cows in a pen for cash income from their milk

<sup>43</sup> I use *Chewa* as an adjective and *Chichewa* as the noun to denote the language. Another term is commonly used as a noun to denote the ethnic group, thus *aChewa*. Similar terms may be used for other ethnic groups and their languages.

(see fig. 1.5). Most village residents eat *nsima*<sup>44</sup> with a ‘relish’ of beans, peas and vegetables such as pumpkin leaves and possibly tomatoes. Some have nothing but *nsima* and may go short even of that when harvests are poor. A few compounds contain fruit trees.

Fig. 1.4 Granaries, used to store maize and millet



Fig. 1.5 Milking cows provide milk for the household and for sale



<sup>44</sup> *Nsima* is a stiff porridge made of maize flour and is the staple food throughout Malawi. More liquid versions are used as porridge and as weaning and invalid foods.



Households usually have access to a piece of land inherited through the female line but this may be too small to support them for the whole year. Others, like the household in which I lived, have enough land to need help to farm it. Stella uses the labour of her sons. Her mother is too old to work in the fields so hires labour, as does her sister who owns too much to do all the work herself but has no sons and daughters living near enough to assist her.

Some people grow cash crops (tomatoes, tobacco) or cook or manufacture goods for sale such as bamboo mats and items from sheet metal. 'Locked in ... poverty' according to White (1987:257), women and men find their own ways of getting by but adults as well as children may be malnourished.<sup>45</sup> Survival is becoming increasingly difficult with frequent crop failure and with AIDS. At 11%, this area has one of the highest rates in Malawi of children who have lost one parent and 3% under 18 years who have lost both (NSO 1998, 2002).

Fig. 1.6 Self-employment and *ganyu* labour provide cash income for some



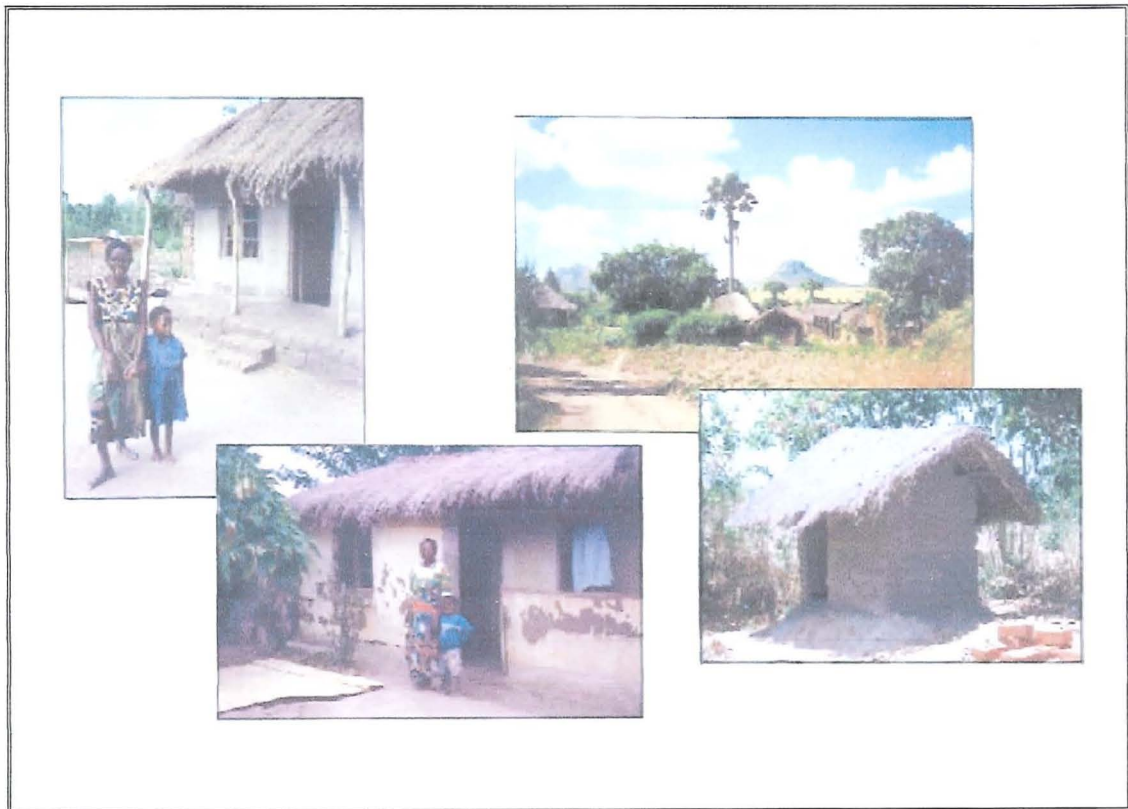
<sup>45</sup> 57% of pregnant women attending an urban (Blantyre) clinic were identified as anaemic. Inadequate nutrition is an important cause of anaemia which contributes to deaths of women (Van den Broek et al. 2000).



Women and men work from before dawn in their fields; few are in waged labour although casual (*ganyu*) labour, in the fields or households of others, is a way of life and a way of getting by for women and for men (see fig. 1.5 and 1.6). It is mostly men who make bricks for housing and construct them too; brick-making is a lucrative occupation. Women draw all the water for construction use as well as for the household and this can bring in some money.

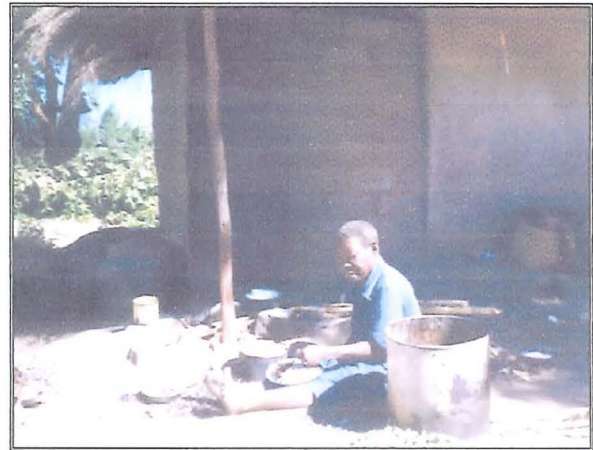
Houses are substantially constructed from dried mud brick, Blue Gum tree poles and untrimmed grass thatch, the 'untidy' thatch providing excellent shade. They may have a single space or a separate sleeping area; others like that of my hostess will have extra rooms and metal sheet roofs. Many people have no furniture and sleep on grass or bamboo mats, sometimes only on an old cloth. Most houses sit on mud plinths, often polished to discourage the entry of snakes. Fig. 1.7 shows such houses and a latrine.

Fig. 1.7 Houses and some pit latrines are of sun-dried mud brick



Women cook on hearth-stones in the open (fig. 1.8 and 1.9) or in purpose-built out-houses, such buildings all being clustered around well-swept unfenced courtyards. The screened pit latrines and bath-houses are normally placed discreetly behind.

Fig. 1.8 and 1.9 Cooking maize porridge (left) and beans (right).



Groups of houses are dispersed between fields and around churches, sacred graveyards and schools. The village and locality maps (maps 1.3-1.5) demonstrate the area's layout alongside the Blantyre city - Mulanje graded dirt road; some 20 kms. from the city, it is 10 kms. from the hospital and maternity unit of St. Joseph's at Nguludi. These maps also illustrate that no woman in the community has to walk more than about 2kms. to reach an *azamba*.

An overview of the local facilities can be obtained from table 1.2 below which is constructed from statistics available for Likoswe TA. The people living in these villages are at least as poor as the statistics suggest but the area is particularly clean and free from rubbish, everyone that I met having pit latrines, and most having access to safe water from deep and reliable boreholes. There were two boreholes in the cluster of

villages during my residence but the distance to them might be further for some people than to ordinary wells, streams or the river, so discouraging their universal use.<sup>46</sup>

Table 1.2. Statistical characteristics of the Traditional Authority Likoswe

Female headed households	33%
Access to safe water supply (tap, borehole or protected well)	36%
Sanitary facilities, usually pit latrine	90%
Households owning no livestock	45%
Farming households who do not buy fertiliser	45%
State inability to afford fertiliser as the reason	98%
Farming households who sell produce	52%
School attendance of household members: never enrolled	10%
	68%
dropped out	22%

Households n =11143

Source: NSO (1998)

Village Heads provided me with statistics to illustrate the characteristics of their villages which are tabulated below (table 1.3). Particularly of note are the high proportions of female-headed households in this locality although it is unclear how many of such households are permanently without men. I asked why Kalanje had such a high proportion of women without men. The reply was that many more women married very young there and then divorced (Deputy Head Kalanje, personal communication, 2003). Very few residents are in waged work and these have to travel unless employed at the school or hospital.

<sup>46</sup> Extra boreholes were provided during the writing-up period of this thesis, so reducing the walking distance for some women.

Table 1.3. Individual village statistics

	<b>Kalanje</b>	<b>Malinga</b>	<b>Mithawa</b>	<b>Sambani</b>
<b>Adults and children</b>	150	100	140	70
<b>Households</b>	80	30	50	15
<b>Houses</b>	120	80	110	40
<b>Female-headed households</b>	75%	25%	50%+	50%+
<b>Borehole</b>	yes	yes	yes	yes
<b>Nursery school</b>	In Headman's house	Shared, sited in RC Church but awaiting new voluntary teacher		No

Schools are within fairly easy reach and primary schooling is compulsory from age 6, although many children are to be seen herding goats and cattle in school hours. Primary schooling is free but a child without uniform may be sent home so poverty is still an issue. Secondary education is officially encouraged but attendance is poor and the cost may be prohibitive. Although an improvement on past figures, female secondary attendance is about half that of males and many drop out, often through pregnancy (Poverty Monitoring System 2000). Few educated young people remain in the community where there are no opportunities for them.

The people of these villages suffer the same range of health problems as elsewhere in Malawi, the chief among these being malaria, diarrhoea, tuberculosis and HIV. Unexpectedly, and repeatedly, I was informed that there had been no maternal deaths within these villages in living memory. This was confirmed by Village Heads and the Maternal and Child Health Coordinator (introduced below). The significance of this is impossible to determine in the context of this thesis but it was evidently considered by informants to be an achievement.<sup>47</sup>

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<sup>47</sup> Determining the significance of this fact for such a small area would involve complex statistical work. Finding explanations would be equally difficult because of the contextual variables. Some credited their *azamba* with this achievement. The good reputation of the local hospital undoubtedly made a difference too because of service uptake and quality, and there might be a relationship with other aspects of women's welfare (see chapter 9). I note also that maternal death is statistically rare in any given locality (Gay et al. 2003).

The large village of Nguludi provides an important focus for this area of Chiradzulu District. In 1950 the Daughters of Wisdom<sup>48</sup> founded St. Joseph's Hospital and School of Nursing which provides almost all the formal health services used by the community.<sup>49</sup> In Nguludi are a market, schools, large Catholic Church and convents. A Montfortian teacher training college, school for the deaf, rest home for retired nuns, workshops and agricultural supplies centre are situated nearby. The area has a central place in Malawian history, featuring in the Chilembwe uprising, and Nguludi was itself a centre of slave trading. A building called 'The Slave House' (now a national monument) still exists in the centre of the village.

### Who's who?

The *azamba* of the village cluster, along with their Headmen and women, are key contributors to this thesis. The former are government recognised and supervised at regular intervals by means of monthly visits by *Mai*<sup>50</sup> Sichali, the Maternal and Child Health (MCH) Community Outreach Coordinator from St. Joseph's Hospital, Nguludi. I introduce these individuals next.

*Mai Regina Clements*<sup>51</sup> is now nearly 80, born in Kalanje where she still lives, she was apprenticed to her grandmother, also a midwife. She has practiced for many years and eventually received government training. She is losing her sight now but remains highly respected and popular as a midwife and herbalist. She has taught her daughter her skills. Widowed, she shares her house with a granddaughter and has many friends amongst the elderly women. Regina is now reducing her commitment to delivering babies; whether this is a result of increasing disability or difficult mother-daughter relationships remains unclear.

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<sup>48</sup> The Daughters of Wisdom and the Montfort Brothers belong to the Montfort foundation, a Roman Catholic missionary order of European origin.

<sup>49</sup> Annual Report 1998: St. Joseph's Hospital and St. Joseph's School of Nursing, by courtesy of the management.

<sup>50</sup> *Mai* denotes 'Mrs.' and *Bambo* denotes 'Mr', the standard forms of address in chiChewa. *Amai* and *Abambo* are used as honorific greetings without names. I do not continue to italicise them except in headings.

<sup>51</sup> Actual names are used throughout for those who feature in this section, used by 'insistent' permission of each individual.

*Mai Grace Kamba* is Regina's daughter, married for the second time and about 50. She has no children. Grace worked at one time as a nanny in an English household so speaks some English as well as all local languages. She is her mother's assistant and has received government training. Every week she helps the team that sets up an antenatal and child care clinic in the Catholic Church, and has in the past acted as secretary to the local political party.

*Mai Stella Kamuntolo* is in her 50s and has been right through secondary school. Stella was chosen as apprentice by a professional midwife who retired to the village, then later selected for government training. Stella holds several offices in the community and district such as Vice-President of the local branch of the Red Cross, is active in supporting the poor and children orphaned by AIDS and is appointed as youth and marriage advisor by the Catholic Church. At the time of the fieldwork Stella was divorced and head of her household. She has eight children, some single, some married and others at school. One plans to commence nursing training soon. Her mother, step-father and sister live in adjacent houses. Stella understands some English.

*Mai Winnie Sichali* is a qualified midwife and nurse who lives with her children and several orphans; at the time of my fieldwork she also lived with her husband who has since died. Based at St. Joseph's Catholic mission hospital, she is responsible for organising the mother and child outreach and vaccination clinics for the area served by the hospital. Mai Sichali also runs revolving credit schemes to encourage crop diversification into groundnuts and soya bean to improve child nutrition.

*Bambo Malinga*<sup>52</sup> 'inherited'<sup>53</sup> the Village Headship by popular request instead of it passing to his brother. He works in town and lives there with his wife and children, visiting the village weekly to deal with community affairs and whenever emergencies occur. Bambo Malinga speaks good English. His mother lives in Malinga and his sister deputises for him.

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<sup>52</sup> *Bambo*, *Mai* and even 'Mrs.' are attached to village names to address or denote Head men and women.

<sup>53</sup> Village Headship is inherited by custom and practice but local people have some influence over who takes this position. Headship inheritance is a complex matter beyond the scope of this thesis and is explored by both Mitchell (1956) and White (1987).

*Bambo Kalanje* owns a busy roadside tea room and grocery shop and lives there with his wife and children. He has gathered a reputation for wisdom over the years and is very active in local administrative affairs.

*Bambo Mithawa* lived in the village of his wife's matrikin during my fieldwork some 3kms. distant from where he held the position as Headman. He also owns a small grocery shop and, like the other Heads, shows great hospitality. He has since built a house in Mithawa at the residents' request.

*Mai Sambani* has been Headwoman of her village for some years having inherited it from her brother. She lives alone with her daughters. Most of the village residents are female; there is a great shortage of adult men. Mai Sambani was a valuable and vivid informant and regularly gathered groups of women to talk with me.

## **Summary of the thesis and main arguments**

Having provided scenarios and a brief description of the thesis, I now outline the body of the thesis in more detail.

This *first chapter* sets the context for the research in various ways. The rationale is explained and issues around the well-being of childbearing women, the global policy environment and the anthropological contribution to maternal health thinking are outlined. I indicate the theoretical aspects and assumptions that have influenced the approach I have taken. The fieldwork is then located in its rural Malawian setting, touching upon historical, economic and political contexts, and on geography, religion, health and culture. The field area is located in southern Malawi in a resource-poor community of subsistence farmers. Malawi has a very high rate of maternal death and illness; this forms an ever-present background to the research. Key people featuring in the thesis are introduced.

In *chapter 2* I review the contribution of the literature to issues relevant to the thesis. The literature review encompasses three areas, treated separately but inevitably interlinked. At its most basic, this chapter is about the gendered nature of power and the way in which culture and childbearing illuminate each other. I note that the ways in which childbearing is viewed is influenced by how women are viewed. This emerges as a



significant domain for the interplay of dynamic relationships of coercion, compliance, agency and resistance. Authors such as Davis-Floyd, Jordan, Laderman, MacCormack and Sargent (to name only some who work specifically on the anthropology of birth) have all demonstrated how culture is inseparable from women's experience and have contributed to debates around knowledge, power and influence as well as to the wider socio-cultural context of birth and the values that affect it.

In this chapter I also examine work on knowledge and power, and indigenous and biologically-based medical systems, their social production and their congruence with cosmology. Legitimacy and authoritative knowledge are strong themes in the literature as are power and gender, and the ways in which they affect role and practice. Of note too is the variability of expression of the category 'birth attendant' such as *dai*<sup>54</sup> and the importance of this in global policy where they are often taken as forming a homogeneous category. I follow this up by considering knowledge development for women and the community, and finally for indigenous midwives, outlining the importance of congruence between paradigms of childbearing and health in spite of the privileging of biomedicine on the world stage.

Notions of risk and danger emerged as clear categories for analysis in fieldwork data so the literature, both from the social sciences generally and anthropology in particular, are analysed for their contributions. Three areas of risk talk emerge from my data – childbearing difficulties related to moral expectations and the maintenance of hot and cold balance, fears congruent with biomedicine, and personalised malevolence arising from envy and greed. Congruent issues are explored through the literature on strategic responses to the need to express and symbolise, and perhaps enforce the moral order in the matrilineal group through pollution and taboo, and witchcraft beliefs.

*Chapter 3* provides space for explaining the conduct of this research and how I worked toward producing a credible ethnography. Fieldwork involved community residence, participant observation, individual and group interviews, archival work and

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<sup>54</sup> *Dai* are local women who provide birth assistance in the South Asian sub-continent, with varying responsibilities that range from labour support and delivering the baby to performance of 'polluting' actions only, such as cutting the umbilical cord and dealing with body fluids and the placenta. As in Africa and elsewhere some receive government training and supervision, and cannot be seen as a homogeneous group.



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meeting with key external informants. A male, then a resident female interpreter, and independent translators of audio recordings supported fieldwork. I describe what happened in the field alongside an exploration of how my background and assumptions impacted upon the conduct of the research, the kind of evidence gathered and its subsequent interpretation. I indicate how the adoption of a holistic and woman-centred approach supported the vital interpersonal and communication skills required and helped me deal with the potentially competing dilemmas of anthropological and biomedical research ethics, such as issues of confidentiality, secrecy and whistle-blowing.

*Chapter 4* explores relatedness and local marriage and residence patterns as the context in which choices are made by and for pregnant women. The enduring practice of matriliney and matrilineal residence results here, I suggest, in a relatively supportive attitude to pregnant women's welfare. In particular the notions of relatedness characteristic of this way of living place a specific emphasis upon female standing and autonomy in the community. It is also apparent that the long history of de facto and permanent female-headed households which have developed as a result of male mobility brings autonomy as well as, very often, poverty to women. I engage here with relevant material on matriliney and relatedness such as that by Carsten, Douglas, Holy and Schneider, and on Malawi by Peters and Morris.

I address who makes decisions in this matrilineal and matrilineal context in *chapter 5*. The dynamics of decision-making at household level are described, drawing on the findings described in the previous chapter and using interview, observation and case study data. Those women who have already given birth have considerable opportunity for self-determination but younger women do not. These findings significantly emphasise the influence of older women in the matrilineage and also the important role of the woman's mother's brother or *mwinimbumba*. Men are heads of households when resident and are responsible for the welfare of sororities but older women make most decisions on behalf of younger women and men generally support them. Evidence clearly emerges that some men would appreciate greater involvement, and there is potential for tension between the agency of women and the authority of the male as head of household.

Having considered who makes decisions, I move on in the next three chapters to discuss the basis on which they are made.

*Chapter 6* features knowledge formation, ownership and power. Here I consider how ideas about health and childbirth are developed into knowledge for action, looking at both contemporary and older forms of life preparation and socialisation, and their resulting influences on power and decision-making strategies. I argue that the increasing dominance of the biomedical paradigm and the concurrent use of village healers indicate acceptance of apparently incongruent paradigms and also ambivalence and reluctance to show lack of respect to members of older generations by setting aside their knowledge. I illustrate how biomedical diagnoses of childbearing difficulties may be integrated with indigenous concepts of causation, although possible solutions may be drawn from either or both. What counts as knowledge governing action and the potential conflict arising from making decisions with alternative paradigms is explored from the viewpoints of both lay members of the community and the indigenous midwives. My case studies indicate the essentially pragmatic nature of choices, suggesting that Jordan's work on authoritative knowledge may be over-simplified, although Last's work on knowing and that of Lewis on layers of understanding prove useful in analysis. I also address the notion of legitimacy of forms of knowledge and how this is demonstrated and reconciled in the way people use the support on offer.

The basis for decisions and consequent actions is likely to be congruent with prevailing representations of the body, health, illness and childbearing therefore local concepts are addressed in *chapter 7*. This analysis is supported by comparative and theoretical material from writers such as Douglas, Feierman, Janzen, Jordan, Laderman, Lewis, Lock and Strathern. Important contributors to an understanding of Malawian cosmology and illness causation theories include Forster and Morris. Very strong themes emerging from my data relate to sexuality and its powerful role in the maintenance of the life force, and oppositional concepts of 'hot' and 'cold' states of being. Antipathy toward mixing 'hot' and 'cold' and concern for the upholding of moral values emerge as ideas about taboo and pollution, and there is significant layering of these ideas with both biomedical concepts and with notions of jealousy and witchcraft. The evidence provided by the indigenous midwives themselves constitutes an important element of this chapter, clearly illustrating not only the degree of integration of biomedical and ethnomedical ideas but also the strength of symbolic links to notions of acceptable, particularly sexual,

behaviour. The way they accommodate potential dissonance illustrates how dynamic is the practice of childbirth.

Risk and its management is a significant emphasis in the technical literature on birth as has already been shown in this introductory chapter yet perceptions of risk and the resultant actions may differ when mediated by alternative views on health and childbirth. Ideas of risk emerging from the evidence are examined in *chapter 8*. Such risk ideas include those featuring overtly biomedical concepts. They also incorporate those congruent with the local cosmology featured in the preceding chapter, hot and cold theories and the personalisation of blame such as its connections with childbearing difficulties. Writers such as Beck, Bujra, Caplan, Giddens and Lupton are reviewed for material pertinent to a context which might better be categorised as pre-modern or one of rural 'scarcity' rather than 'modernity'. Here bewitchment and banditry may be seen as greater risks than giving birth at home, despite the evident fear of birth complications that people acknowledge can be better dealt with in hospital surroundings. Local ideas of risk and danger in childbearing are therefore grounded in this eclectic set of views, which, while focussing on specific biological problems, also seek causation and resolution congruent with local cosmological ideas. At the same time older women, and particularly established mothers, demonstrate general acceptance of the knowledge base of the formal health service.

*Chapter 9* brings together the foregoing analyses of local relationships, agency and power dynamics, concepts of health, childbearing and risk, and knowledge and power to synthesise the main arguments about decision-making. The apparent benevolence of this matrilocal community toward women's welfare is stressed although the agency of younger women is still very limited. My main conclusions relate to the influence of older female matrikin in making decisions on behalf of younger women and the apparently integrated, but layered and blurred nature of the concepts underpinning childbearing knowledge and choices despite their distinct origins.

This concluding chapter situates the arguments within the wider context of safe motherhood, considers their implications for policy and practice and addresses their contribution to anthropology. The demonstration of the enduring local expression of matriliney and matrilocal residence and its impact on female welfare is one such contribution. It also raises questions about the male outlook on matriliney. The work adds

to existing information on conceptual systems within Malawi and beyond, and how these link to decision-making both in relation to childbearing and outside of it. In terms of policy implications, the importance of involving older women rather than ignoring them is demonstrated, as is the positive nature of the contribution made by well-supervised indigenous midwives when involved with and respected by the formal services.

The overall dynamic identified is one of usually benevolent control of younger women in the matrilineage with older women making use of their structural and symbolic power base and their knowledge based on eclectic concepts and notions of risk to make childbearing decisions. Choices in any given situation are ultimately pragmatic and dependent on immediate circumstances with neither local concepts nor biomedical ideas necessarily prevailing.

## **Conclusion**

In this introduction I have set the scene for the thesis by situating it both in terms of contemporary emphases in international thinking around maternal health and in relation to theoretical approaches in anthropology. I have explained the rationale for the study and identified specific questions I am trying to answer. I have also identified four overlapping theoretical perspectives that are important to the study. These theories relate to dual aspects of understanding: how understanding birth can contribute to knowledge of wider social processes, and how understanding such processes and ideologies can assist in the explanations of childbirth ways and concepts. Decision-making is a pragmatic process but the fact that women's childbearing experiences are also embedded in power relationships, provides further theoretical underpinning for the study.

In this chapter the study has been set into the local context in terms of socio-economic, historical, religious and political contexts, the way the site was chosen explained and the people and area introduced. I have also briefly described the health care systems relevant to childbearing women and introduced some key informants.

The next step is to review the substantial anthropology literature around three key areas: childbirth itself, knowledge and power, and risk and danger.

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## **Chapter 2: Childbirth, knowledge and risk: anthropological literature reviewed**

### **Introduction**

This chapter explores themes in the anthropology of childbirth that are relevant to the thesis, and other material on knowledge and power, medical systems as forms of knowledge, and risk and its relationship to childbearing in the Malawian context.

### **The anthropology of childbirth, theory and practice**

Specific strands of thought can be identified in the anthropology of childbearing of the last forty years, extending from Mead and Newton (1967) to contemporary work. Publications, writers and themes are many. Authors come from a variety of fields within anthropology, and from diverse professional backgrounds, both academic and applied. Their ethnography covers many diverse environments and stretches from 'high tech' to basic birthing scenarios.

It is evident from this literature that investigating childbearing brings rewards on different levels. 'Other' practices have intrinsic fascination but people's actions can have greater significance in indicating the way they conceptualise childbearing processes; they also provide insight into socio-cultural contexts.

### **Birth ways and practices as entry points to understanding culture and values**

If studying childbirth and its rituals has value for learning from how women 'do' pregnancy, birth and becoming mothers, it has particular potential for understanding culture and the priorities and values of society, especially for revealing how women and their reproductive powers are regarded. Given that the anthropology of childbirth addresses what people do and why, it also demonstrates status, moral norms and adaptive

strategies. Childbirth is a powerful means of signalling fundamental ideologies and preoccupations whether these be local or global.

The western world has benefited for many years from anthropological contributions to understanding childbearing. Mead and Newton (1967), writing about cultural patterning of perinatal behaviour, claimed that taken-for-granted modern practices benefit from comparison with 'traditional' ones, so emphasising a theme continued by such authors as Jordan (1993, 1997) and Kitzinger (1994). Western women, and particularly the profoundly influential natural childbirth movement, learned about the role of emotion within physiological birth processes (Mead and Newton 1967) and ritual birth incantation (Kay (1982), Sargent (1982, 1989), Laderman (1987) and Jordan (1993)) have all highlighted the importance of the presence during birth of familiar supporters.

MacCormack focuses upon change (1994:ix) highlighting the importance of avoiding the study of birth 'without an attempt to relate ['customs'] to particular adaptive strategies of a population that is managing to survive in a particular environment'.<sup>1</sup> Mead and Newton (1967) also argued that activities need to be understood in context, revealing a pragmatic and functionalist explanation for pollution beliefs around birth as grounded in women's need for rest and seclusion. The successful introduction of new ideas depends for Mead and Newton upon compatibility with the context and 'total pattern' of society as well as with health and survival, an issue which remains pertinent now as service providers strive toward 'safer motherhood'. Laderman (1983) likewise progresses beyond collecting birth ways and investigates ecological contexts, laying out conceptual foundations for pregnancy activities and focussing upon nutrition and postpartum diet. As Kay (1982) and later MacCormack (1994) suggest, the need exists to interpret 'folkways' and social behaviour rather than providing 'lists' for curiosity value only.

Few consider the interaction of biomedical and 'ethno-physiological' concepts according to Browner and Sargent (1996) although MacCormack (1994) and Jordan (1993) are exceptions, Jordan highlighting how understanding local concepts facilitates decision-making and providing appropriate education to indigenous midwives. Her 1997

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<sup>1</sup> The contributors to MacCormack's text respond to this challenge by examining situated adaptive strategies. Cosminsky (1994) for example, compares highland and lowland Guatemalan beliefs around birth and the impact of Western medicine on them. Furthermore Cosminsky addresses the importance of compatibility of midwife education programmes with belief systems and socio-cultural frameworks.

work provides plentiful evidence of adverse impacts on the effectiveness of teaching and women's care when learners' concepts of bodily processes are poorly understood by trainers.

As well as understanding what people do, the reason why they act in certain ways is a constant thread running through anthropological sources but the emphasis tends to be upon 'otherness': indigenous ways and the apparently (from a western perspective) disadvantaged woman of the resource-poor world. Some, notably Martin (1987), Davis-Floyd (1992), Jordan (1993) and Kitzinger (1994), do focus on well-resourced areas and what birth practices signal about society, biomedical hegemony and the meaning of birth for women.

Jeffery et al. (1989) writing on rural North India, confirm the symbolic importance of birth ways: 'People's evaluations of the physiological processes involved and the procedures adopted speak volumes about how women are regarded. Childbirth carries heavily loaded meanings' (1989:98). Seclusion and the inability to obtain the birthing services of any but ritual pollution specialists such as *dai* provide a clear indication to the women of North India of societal views of their reproductive powers (Jeffery et al. 2002).

Ritual may symbolise or signal a change in status (Homans 1994) such as to motherhood, or to a state of pollution – or both. Institutional birth may be accorded higher, if not necessarily safer, status, but there too childbearing women's low status is signalled by neglectful treatment and the use of low-paid menial workers for polluting activities (Van Hollen 1998). Birth is of such low status that Jeffery et al. (2002), and Unnithan-Kumar (2002), among others, see little possibility of developing the *dai* role and enhancing their potential to become respected workers like their counterparts elsewhere in south-east Asia. However some *dai* see their merit and expertise to come from the very uncleanness of the work they do and their contact with the unseen inner world and life-force of women as they deal with the precious but polluting placenta (Chawla 2002, Rozario 2002). Here Chawla addresses women's agency in the face of great disadvantage. Thus it can be seen from these sources how easy it is to look upon one element – the pollution of birth - in very different ways. While female reproductive powers are 'dirty' and endangering, yet they are also powerful and spiritual, with the provision of assistance to women seen as meritorious by the very women labelled unclean.

Exploring childbirth and related practices then informs us about what matters and a society's 'cosmology, social, psychological and spiritual contexts' (MacCormack 1994:10). Bariba women in Benin are expected to be strong in the face of pain and gain respect from solitary birthing (Sargent 1982, 1989). Birthing practices may be indicative too of views of health and illness and wider social organisation, McGilvray (1994) connecting them in his paper on Sri Lankan fertility, birth and sexual power. There female power and 'ferocity' relates to pollution beliefs and risk to men; without menstruation to drain away excess power and heat, men believe they would have no control over women despite their own good health grounded in sexuality. So women are seen as dangerous although McGilvray, usefully for this thesis (see chapters 4, 5 and 8), also shows how childbearing women in matrilineal groups may be better cared for than those living within patrilineal systems because of the importance of lineage continuity.

A final example of how birth (and here fertility) can indicate the values and priorities of society comes from Cameroon (Feldman-Savelsberg 1999), fertility being integral to Bangangté group identity and status. Their concern with childlessness, perceived as empty and robbed wombs, reflects contemporary uncertainty and 'illness, vulnerability and decline exacerbated by the loss of political autonomy' (1999:2).

The anthropology of pregnancy and birth thus contributes to understanding how people live and what their values are, as well as informing practice. It is not merely an archive of disappearing birth practices collected for curiosity, despite the incontestable importance of data banks for historical 'survival' and stimulating enquiry (Odent in Vincent Priya 1992).

### **Relationships of power: agency, resistance, compliance and control**

Childbearing is an arena for power and control within the household and amongst kin, between women and their carers, and between carers themselves. It is also a site for agency and resistance and for women to optimise their circumstances.

Much of this power is biomedical hegemony, for example that described by Sargent (1989) for Benin, and Daviss (1997) for Canada. Even western women, despite their comparative advantage, are held down by the power of obstetric technology (Chalmers 1990). Although, as Jeffery and Jeffery (1993) suggest, the western world is setting the agenda, yet understanding indigenous practice can improve the lot of western



women and encourage appropriate care for women in resource-poor areas (MacCormack 1994). Nonetheless knowledge is inevitably used to improve compliance with biomedical hegemony as Steinberg (1996) proposes.

Ram (1998) takes issues of agency further and demonstrates the influence of class, race, gender and caste, justifying a focus on the politics of reproduction in a world of anthropology which, she says (following Ginsburg and Rapp 1991), has marginalised maternity through masculine assumptions.

Whereas Ginsburg and Rapp, and Ram accuse anthropology of marginalising maternity, Rice and Manderson (1996) accuse medicine of marginalising its local meaning and expression. They comment on how women's own beliefs and socially determined meanings are ignored when childbirth is appropriated by medicine and indicate how easy it is to assume that agency is universally the same. Such a tendency could, I suggest, apply to both medicine and anthropology. Rice and Manderson argue that modern ideas of individuality, intention and self-determination may not be pertinent in such contexts.

Birth is used for maintaining power according to Davis-Floyd who addresses American birth as a symbolic enactment of beliefs, arguing that 'ritual is a powerful didactic and socializing tool' (1992:9); 'symbols are loaded with cultural meaning' that is internalised often subconsciously to align the recipients' beliefs and values with the dominant paradigm. For Davis-Floyd this involves messages of subjugation for educated American women.

Pragmatism and agency amongst women and the ways in which they contest biomedical hegemony or express ambivalence about the best care for them emerges from studies in both technocratic and resource-poor environments (for example Martin 1987, Jordan 1993 and 1997, Davis-Floyd 2000, Rozario and Samuel 2002). Women negotiate their experiences and reject or accept what is on offer for varying reasons, their agency and resistance often being motivated by pragmatism (Lock and Kaufert 1998). Nonetheless Ram and Jolly (1998) demonstrate how control is exerted over women, claiming that the changes they currently are experiencing as globalisation are linked rather to 'civilisation' and attendant processes of modernity.

Expressions of power and agency are key elements in the literature. From the time when Davis-Floyd, Jeffery, Jordan, Martin and those they inspired began to focus on

these topics, the emphasis has been on how women and their midwives operate within gendered constraints, whether in the kitchen, workplace or birthing room. Such situated manoeuvring as they employ demonstrates adjustment to domination but equally how women optimise their circumstances. Nevertheless agency often remains limited; high maternal mortality and morbidity rates indicate that many birthing women still encounter insurmountable obstacles in obtaining appropriate support.

Such power issues and their undeniable consequences do not appear to have benefited from substantial anthropological enquiry. Similarly anthropology does not generally use birth to investigate broader concerns, such as the consequence of the use of power – gendered inequalities, strategising, resistance and compliance. There is, however, a new way of looking at birth that brings together historical analysis with anthropology that I consider next.

### **‘Rescuing the ignorant’: colonialism, modernity and development in the anthropology of childbirth**

‘[T]ransformation and possibilities traceable to western, scientific epistemes and know-how’ is how Lukere (2002:197) defines modernity, likening this to ‘traditional’ in its ambivalence. Many of the transformations in the way women and their carers have dealt with childbirth can be attributed to modernising and development imperatives and reactions to them. Some anthropologists have employed such historical aspects to inform wider political issues around the effects of colonisation, evangelisation and development. They have also demonstrated how the language of development has reflected older emphases on rescuing the ‘ignorant’.

The use of maternity in this way, for example by Ram (1998) brings maternal health into the wider world of anthropology rather than sitting on the sidelines. Ram and Jolly’s edited text (1998) examines how ‘civilising’ processes historically exerted control over women, and investigates their responses to medicalisation. Hunt (1999) examines similar processes in the Congo and Vaughan (1991) analyses wider colonial discourse on illness in Africa.<sup>2</sup> The colonial influence on women is evident also in White’s historical

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<sup>2</sup> Vaughan includes Nyasaland, now Malawi in her analysis.

portrait of a southern Malawian community (1987). His assertions about the missionary imposition of external views of femininity match those of Ram (1998) who explores how western institutionalised models of maternity were imposed.

The literature shows that women's options may have been limited should they have wished to resist, and their own meanings and ways of expressing them may have been marginalised. Moreover, the colonial and modernising imperative left many women with stark choices between a hegemonic biomedicine stripped of humanity, and customary birth without benefit of emergency support when needed. This situation is little different today.

Modernisation and women's responses are features of many anthropologists' work on childbirth although not necessarily articulated as such (see Davis-Floyd, Jeffery, Jordan and Sargent above and Daviss 1997). Substantially more conscious are the recent emphases on modernising processes of writers such as Ram and Jolly (1998) and Lukere and Jolly (2002). These authors demonstrate how the language of development is merely a continuation of the colonial one, with 'the other' being shown as ignorant and helpless. Western agencies continue to be pre-occupied by certainty and safety in childbirth, seeing women as downtrodden victims as did their colonial predecessors (Jolly 2002). Lukere and Jolly (2002) focus on oppositional aspects of birth: hospital and home, professional and lay, foreign and familiar, biomedical and indigenous, technocratic and natural.

Contemporary anthropological work considers how change impacts on agency. Choosing to use biomedical services may involve further reductions in women's control over birth. Furthermore, women's bodies are contested domains onto which are inscribed the pre-occupations of those who influence and affect their agency as well as their own (Jeffery and her collaborators 1988, 1993, 2002, Davis-Floyd 1993, 2000, Jordan 1993, 1997, Daviss 1997 and Van Hollen 1998). Change desired by women in New Caledonia has removed childbirth from female control, bringing husbands into the hospital birth room, putting women's wisdom out of reach and leaving fear of doctors and procedures in its place (Salomon 2002).

Anthropologists have been concerned with explaining birth and understanding culture while change is the constant undercurrent and inevitable pre-occupation of agencies responsible for maternal health service reform. Rarely however have the two come together with much consistency. As Lukere (2002:201) writes when reporting on

the relative silence of women such as the Pacific islanders she studied ‘Biomedicine, high anthropology, and demography do not always converse’ and they need to do so. MacCormack (1994:vii) likewise asserts ‘most of medical and health planning literature ignores detailed studies of culturally appropriate fertility and birth care’.

Change is being driven by new global imperatives for maternal health service reform that may set cultural issues aside. Moreover contemporary systems approaches potentially remove the debate from the birthplace, even from medics, to politicians. It is not only women who may resist. Some of the most recent anthropological literature addresses, perhaps for the first time, how midwives can accommodate change in practical ways and satisfy both women and development imperatives for safety. This literature examines ways of accommodating change, articulating and developing the identity and role of those who care for women, finding pragmatic ways of meeting women’s needs while satisfying developers, negotiating what Geurts (2001:379) calls a ‘critical midwifery grounded in pragmatism’.<sup>3</sup>

Satisfying developers – policy makers, funding partners, leaders of global thought – will not be easy. The biomedical imperative is reinforced by maternal mortality that is rising instead of falling, and its confidence is supreme. The prevailing and determined policy rhetoric is to do away with ‘unskilled’ indigenous care for childbearing women (AbouZahr, personal communication, 2002) and moral and rights-based arguments are powerfully persuasive.

A third way is however emerging: of midwives as ‘articulate defenders of traditional ways as well as creative inventors of mutual accommodation’, of ‘postmodern’, politically-engaged midwives moving easily between domains and using both biomedical technologies and holistic philosophies, of midwives who challenge authority and ‘engage in the most radical of cultural critiques’ (Davis-Floyd and Davis 1997:319-320). Matsuoka (2001) describes flexible, community-based Japanese midwives who engage with the whole childbearing experience and are prepared to go beyond or ignore classical boundaries. Similar postmodern midwives collaborate with Canadian women to achieve desired outcomes, their clients, if still few in number, joining with them in the ‘collective struggle for midwifery in Canada’ (MacDonald 2001:252).

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<sup>3</sup> I note that male writers are virtually absent from this the field.

Such women negotiate with medical technology to achieve their desired ends. Professional and 'traditional' midwives in Mexico faced doctors together, inhabiting 'a tiny cultural space perched precariously on the shifting ground between the disappearing traditional midwives and the expanding biomedical system' (Davis-Floyd 2001:233). Davis-Floyd et al. (2001) describe the postmodern midwife as having relativistic and respecting attitudes to local forms of knowledge.

Nevertheless such situations are relatively rare and this literature reflects mainly the views of midwives within anthropology rather than those of women (and, notably, not those of obstetricians). Do they represent women, or are they speaking for themselves as they too contest medical hegemony? Despite the new emphasis on political engagement and collaboration with women in achieving mutually desired ends, such an emphasis remains poorly developed. Nevertheless, earlier studies largely featured only indigenous midwives and childbearing women, so professional midwives have remained unheard. They may need to assume a greater role in making space for women's voices, perhaps through anthropology, as the global policy emphasis shifts to complete marginalisation of 'unskilled'<sup>4</sup> birth attendants who might thus become less accessible. Women, their carers and anthropologists need to collaborate and identify ways to ensure policy makers listen, simultaneously moving away from the gendered and marginalised status of childbirth within academic anthropology.

Throughout this overview of the anthropology of childbirth, gender, knowledge and power have underpinned the literature. In the end, I suggest that the anthropology of childbirth can be reduced to these categories. Knowledge and power is a central theme in this thesis and occupies the next part of this chapter.

### **Key ideas on knowledge in anthropology and related literature**

Knowledge emerges as a substantial, although often incidental, theme in literature which crosses the interface between anthropology, history and gender. Thought-provoking authors on knowledge include Gordon, Jordan, Kleinman, Last, Lewis, Lock,

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<sup>4</sup> I return to this when reviewing the anthropology literature on knowledge.

MacCormack, Martin, Sargent, Vaughan and Vitebsky. I work from the principle that knowledge brings status and power, and its definition and acquisition is controlled by those who know. As the work of Foucault demonstrates (1977), knowledge *is* power. The first issue to be explored here is that of forms of knowledge, specifically biological/biomedical and indigenous/ethnomedical knowledge. This sets the conceptual foundations for discussing anthropological literature on knowledge and power related to childbirth.

### **Biomedicine and indigenous knowledge: paradigms of health and childbearing**

In this section I review some of the ideas around biological and biomedical, and indigenous and ethnomedical forms of knowledge. I set this out to avoid the assumption that biomedicine's supremacy as explanatory theory is taken for granted. I use 'biomedicine' to denote the paradigm that is based upon the biological explanations of body structure and function that emanate from mainly European sources (Rhodes 1996).<sup>5</sup>

Indigenous knowledge is used as a 'catch-all' term to denote forms of thinking about health and childbearing that derive from local cosmologies. I use 'ethnomedical' specifically to denote the therapeutic and local, noting the emphasis of Rubel and Hass (1996) on cultural contexts within ethnomedicine which, according to Rhodes (1996:171), are largely 'bracketed off' in biomedicine. This form of knowledge is mainly handed down verbally and by experience between practitioners.<sup>6</sup> Significant differences are that biomedicine can explain cause but, unlike ethnomedicine, does not attempt to provide reasons for the timing of illness or explain who is behind it, and tends to act independently of social context. Biomedicine also focuses on the individual whereas indigenous ideas tend towards a community and household focus and location for health problems (Kleinman 1995). Perhaps as a consequence of this, or for reasons of pragmatism, people use biomedical and indigenous services together, or consider the healer-family relationship in addition, so compensating for the inadequacies of the dyadic doctor/patient approach (Kleinman 1986). Birth likewise cannot be detached from its

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<sup>5</sup> Alternatives, such as 'cosmopolitan', 'allopathic', 'western' and 'modern' all suffer from restrictions on their usefulness that are not discussed here (as indeed does biomedicine).

<sup>6</sup> This is unlike Ayurvedic, Islamic and Chinese medicine that may be written down.

social moorings (Jeffery and Jeffery 1993) as biomedical approaches tend to do. Daviss goes further, describing the importance to Inuit elders of birth as a 'community, social and spiritual act' (1997:441) and reporting their shock on learning that doctors believed it to be a medical act under their ownership, with Inuit women meanwhile seeing birth as personal.

Many authors address the dual use of biomedical and ethnomedical specialists. Some propose that this depends on initial interpretations and categorisation of problems and how people endeavour to make sense of things (Janzen 1978, Lewis 1975), Janzen using the phrase illness 'of God' or 'of man' (1978:67). An alternative view proposes no sequential or simultaneous pattern, and either selective choice depending on perceived cause, or a pragmatism that overrule categorisation (Sindiga 1995). Samuel (2002) underlines such pragmatism, explaining how biomedicine may be considered best for difficult cases but that hospital environments and poor staff attitudes may be real deterrents.

Good, a medical anthropologist, addresses belief and its meanings which I look at in chapter 7. Relevant here is what he has to say about medical knowledge: 'constituted through its depiction of empirical biological reality. Disease entities are ... [seen to be] biological, universal and ultimately transcend social and cultural context' (1994:8). He contends that the biomedical paradigm makes no allowance for variety in knowledge and that theory reflects apparently unalterable or 'correct' facts (1994:9). Its validity is embedded in biological cause and function, and variations exist in ecological and sociological contexts only. Good also notes how non-written 'folk' models are discounted as 'belief', biomedicine positioning itself as universal and scientific in its accounting for the body and illness. This ignores how biomedical ideas, like any other, change over time, particularly as new certainties replace old. Good (1994:21) argues that anthropology's greatest contribution to society is its view that 'knowledge is culturally shaped and constituted in relation to distinct forms of life and social organization'.

One of the clearest characteristics of the principles of biomedicine that differentiates it from indigenous knowledge is the depiction of the body and its processes as a machine (Martin 1987, Davis-Floyd 1992). This principle is demonstrated clearly in obstetric and other medical texts and is commonly gendered. In contrast a supreme example of indigenous knowledge is the concept explored in this thesis that prolonged or obstructed labour is related to marital infidelity, with confession or herbal medicine

providing solutions for such dangerous circumstances. Biomedicine categorises prolonged labour as malfunction and obstructed labour as a matter of mechanics, these circumstances being treated with intravenous hormones and surgery respectively.<sup>7</sup> Yet the principle that I witnessed in the field was a mixture, with the cause (immorality) being congruent with the indigenous knowledge set, positioned alongside the biomedical procedure of caesarean section as the solution (see chapter 7). Furthermore this case demonstrates how separately evolved knowledge forms overlap: the age-old herbal remedy used by some of my informants to stimulate labour has similar but less controlled action to the oxytocin used by obstetricians for the same purpose. Such remedies are available not only in Africa (see for example Bullough 1980 for Malawi and Veale et al. 1998 for South Africa) but all over the world with the origins of their use lost in time.

The principle of congruence between knowledge for practice and local cosmology being necessary for acceptability is an important one addressed by writers such as Pigg (1997) and Jordan. Jordan (1993) believes that systems and ways of doing birth must be internally consistent and match local definitions of birth. If these are incompatible, women will use biomedical resources only as a last resort, a situation that leads to failure. Lewis however suggests that 'people are more concerned with efficacy and practical considerations than with explanatory consistency or logic' (1993:212).

Disparate knowledge forms are increasingly becoming integrated but the incorporation of biomedical ideas into ethnomedicine tends to prevail rather than the reverse. Nevertheless northern Nigeria exemplifies the integration of 'aspects of competing knowledge bases' (Pearce 1993:150) into pluralistic services. Indigenous knowledge also incorporates ideas from across the diversity of African practice, Vaughan (1991) providing examples to demonstrate the resilience and adaptive powers of local systems.

Afro-Caribbean medicine borrows from biomedicine to form a continuum of local 'folk' practice which fills gaps and is used by elites and biomedical practitioners for themselves despite being rejected and marginalised as deviant (Laguerre 1987). Pluralistic systems and loose boundaries have always existed and oppositional explanations make

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<sup>7</sup> I note the way I was taught the 'mechanics of labour' as a student midwife by rote in the classroom. Later I learned by observation to understand the impact of the process on women, and women on the process, an insight which was given no academic credence at that time.



poor models (Stoner 1986). Furthermore, Stoner maintains, indigenous midwives commonly combine ideas, especially following training. She recommends acknowledgement of the plurality of therapeutic techniques rather than insisting on mutual exclusivity and divergence. The lack of unity of ideas and practice in ethnomedicine and the way it is tacked on to biomedicine makes its status as a system doubtful. Last (1981) argues, admitting nonetheless (as Lewis 1993 above for congruence) that this is no deterrent to users in northern Nigerian.

I have noted that the anthropology of childbirth addresses issues of power and gender, role and practice through both indigenous and biomedical ways of dealing with childbirth and understanding it. At no point is any challenge that I can identify offered to biomedicine as explanatory paradigm for the basic physical processes of pregnancy and giving birth – what Jordan (1993:xi) calls the ‘universal physiology of birth’. Biomedicine remains the gold standard for policy makers, anthropologists and professional health care workers alike when ‘the chips are down’ with no alternative offered and relativism making no appearance. Lewis (2000) argues that biomedical precepts are reasonable ones but must be understood as assumptions alongside the constructed nature and individually mediated concepts of normality and disorder.

For Lock too, biomedicine with its meanings and values is socially produced knowledge. No analytical viewpoint is value-free despite scientific facts being commonly considered ‘pristine and beyond the realm of social analysis’ (1988:3). Lock challenges anthropologists for having failed to examine biomedicine as though it were beyond analysis. Although indigenous medicine remains the main topic of enquiry I suggest that substantial redirection of interest toward high-technology obstetrics has occurred more recently, exemplified by Davis-Floyd (1992), Jordan (1993), Browner and Press (1997), and Georges (1997).

Biomedicine is a tool of modernity for Hodgson (2001) with services, facilities and expertise imposed on people as a modernising mission and rationality emphasised by the use of quantifiable indicators to mark achievement. Likewise, biomedical training and compliance with regulations is used instrumentally by Nepalese TBAs to enhance their status as ‘modern’ and act out the language of development. Pigg (1997) claims that this is officially encouraged in order to move the modernisation project on.

These writers are some of the most significant ones to consider the power issues around childbearing knowledge, issues which are discussed next.

### **Influencing practice: legitimacy, power, gender and authoritative knowledge**

Knowledge and power are linked in numerous ways and together determine action provided they are deemed to be legitimate – a status conferred and conveyed by various means along a continuum from usage by popular practice to statutory legitimacy provided by official recognition, for example by certification. A variety of issues arises and many authors have specifically addressed such legitimacy; I consider some of these issues and writers now.

Legitimacy can be assumed or assigned. Consumers may provide legitimacy for healers, their mutual relationships and perceived moral standing and trustworthiness being more important than legal status (Last 1996). Indian *dai* are ‘cultural repositories of ... body knowledge/practice’ and specialists in women’s wellbeing, according to Chawla (2002:148). Rozario (2002) describes Bangladeshi *dai* strategies to counteract their lowly reputation and give meaning and legitimacy to their work by claiming spiritual sanction and taking pride in their expertise. Sindiga acknowledges the importance from an African perspective of community recognition of knowledge and of those who hold it (1995). Familiarity alone maybe enough for legitimacy with the ‘other’ being distrusted (Lindenbaum and Lock 1993). Healers and Malawian *azamba* have specialist knowledge which alone confers legitimacy. This is not a universal situation as Jeffery et al. (2002) demonstrate: the advice of rural north India *dai* may be ignored. Their degrading role in dealing with pollution renders them equivalent to menials rather than conferring legitimacy and their knowledge may be common amongst older women rather than unique. Unnithan-Kumar (2002:110) proposes likewise that the ‘socially diffuse nature of birthing knowledge’ produces a lack of respect for its specialists in Rajasthan.<sup>8</sup>

Performance of speciality is to some degree self-perpetuating however. ‘Doing birth’ may ensure the performer is given special status but such performance demands

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<sup>8</sup> Van Hollen (1998) found that *dai* in Tamil Nadu were viewed more positively than those in Uttar Pradesh described by Jeffery et al. (1989). Their advice was valued and considered alongside other allopathic practitioners and local Multi-Purpose Health Workers (who provide community-based reproductive health care in India).

props. These might be certificates, birth registers, birth kits or special places for giving birth, possession alone conferring legitimacy. Technology, whether complex or simple, is symbolic and Greene (1995) notes the legitimising value of improving birth rooms for traditional midwives, made evident by increasing client numbers.<sup>9</sup> Technology may however be a resented 'gauge' of legitimacy as Newland found in Indonesia (2002) where indigenous midwives refused to wear rubber gloves for birth when out of the supervisor's gaze. Technology may be employed for its symbolic value only, Mayan indigenous midwives, for example, using biomedical technology such as sterilisation of scissors in ways that obviate its usefulness. These women use the symbolically powerful technology but might reject the imposed knowledge base, preferring their own situated knowledge (Jordan 1993). Conversely I argue that the Mayan midwives' actions might have been more to do with misunderstanding the principles behind the taught techniques, new ideas having been internalised without the foundation needed to avoid partial understanding.

Training sanctioned by powerful others such as the state, and the conferring of office must be ultimate legitimisers. Jordan (1993) illustrates the symbolic value of equipment with a 'graduation' photograph of Mayan rural midwives holding simulated and empty birth kit boxes. The level of training matters too, with legitimate cadres of indigenous midwives commonly being supervised by more highly trained (often younger) others as in Indonesia (Newland 2002) and Sierra Leone (MacCormack 1981). Customary midwives hold office there, often high office, in the Sande women's sodality as specialists in gynaecology and surgery such as genital cutting. Yet they are still legally subordinate to younger, professional midwives. Conversely, the professional midwives may need initiation into the society in order to achieve the respect of the community and those older Sande midwives for whom they are responsible. Such local acceptance is vital as Laderman (1983), Unnithan-Kumar (2002) and Jeffery et al. (2002) demonstrate for Indian auxiliary nurse-midwives who may be seen as incomers – under-resourced, overworked and delegitimised because of their government family planning role.

In Weberian mode, MacCormack (1981) believes that midwives' status is mainly achieved rather than ascribed, so creating difficulties for inexperienced ones who have rational/legal legitimacy only, which may not convince childbearing women. I

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<sup>9</sup> Such an expectation was also expressed to me by the *azamba* Grace, and the symbolic nature of equipment is explored too, both in chapter 6.

would add charismatic legitimacy as a feature they may lack. Furthermore, Sande Society midwives achieve legitimacy by deftness in practice. These confident and ‘towering figures’ are ‘eager to learn new therapies and new preventative techniques in order to enhance their reputation and social standing’ (MacCormack 1994:108) and to integrate biomedical ideas with existing knowledge whilst retaining witchcraft as a causal mechanism for biomedically mediated birth problems.

Authoritative knowledge clearly links with power and is the focus for strategies, often competitive ones according to Foucault (1977) and Whittaker (2002), to build and retain it. Biomedicine and indigenous ways are undoubtedly competitive and perhaps inevitably gendered. However, competition may relate to status rather than incongruent concepts of childbearing as Jeffery et al. (2002) demonstrate regarding *dai* and older household members.

Legitimacy then may be structural, functional and symbolic with ‘expert’ judgement legitimated over lay (Kleinman 1995) and, importantly, expert defined in international policy as professional (WHO 2003).<sup>10</sup> As Foucault proposed, scientific statements have their own politics (Foucault in Rabinow 1984). The WHO argues from a population and clinical evidence-based standpoint, not from women’s life experience. Nevertheless movement towards the professionalisation of indigenous medicine has arisen with healer associations campaigning for recognition (Last and Chavunduka 1986). Vitebsky (1993: 114) identifies a deliberate move for dominance:

Ignorance is knowledge denied or denigrated, and its apparent ‘growth’ is really a growth in the knowing party’s power to denigrate other knowledges and to refuse to engage in dialogue with their knowers.

For Vitebsky, the dominant paradigm (whichever this might be) is considered to be universal and sets out to teach and ‘missionise’ the ignorant, as noted previously in historical literature and also in cross-cultural nursing studies (Callister 2001). As knowledge becomes concentrated through regulation or diminished confidence in the newly ignorant, lay people become passive receivers, those in the know increasingly defining knowledge and what matters. Again quoting Vitebsky ‘abandoned ideas ...

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<sup>10</sup> ‘Global Action for Skilled Attendants for Pregnant Women’ is an influential WHO strategy document produced in 2002.

appear later as hills of burnt-out knowledges which are then seen merely as 'beliefs' (1993:104).

Cosminsky (1994) explores the foundations of Guatemalan indigenous midwifery – an example of this process. Birth practices are based on concepts of the body that reflect cultural themes and values including social relationships; these are reflected in ritual practice in which the midwives are specialists. Such knowledge is fading under biomedical influence: herbal knowledge is declining and views of the body as separate from the self and social environment are replacing Mayan holistic and personalistic birth ways. The social and emotional balance once considered vital, with midwives mediating roles in this, are vanishing – exemplified by the reducing demand for them to provide postnatal hot baths for restoration of the hot and cold balance. This is being replaced by the proposition of a diseased pregnant body in need of medical attention with inevitable consequences for midwives' status.

People may not accept this scenario quietly. While the Inuit appeared initially to accept the disappearance of their distinctive childbirth culture and knowledge, later they moved into resistance and increasing activism (Daviss 1997), understanding the preservation of their knowledge as political activity and re-affirmation of their culture (O'Neill and Kaufert 1990).

Knowledge must govern action to be authoritative, rather than just being the knowledge of powerful people (Jordan 1993, Davis-Floyd and Sargent 1997 and colleagues). Authoritative knowledge development is a consensual social process that builds sanctions and perpetuates power relationships (Jordan 1997). Hierarchy matters and the devaluation of that not seen as authoritative contributes to its construction. This perhaps tautologous argument reflects the potential both for self-perpetuation of those recognised as authoritative and for reducing the agency of others. In Foucauldian terms, knowledge and power are self-preserving, even self-perpetuating and inter-dependent (1977).

The knowledge that counts provides a foundation and justification for decisions. It can disempower both lay and professional people, at least those in subordinate positions. Jordan (1977) indicates how women might 'know' (that they are pregnant) before entering the doctor's office, and lose this certainty once inside. She observed hospitalised American women being deliberately excluded by doctors who worked to

confirm clients' ignorance and their own privileged positions. Both women and nurses appeared 'inert' and colluded in presenting themselves as ignorant, here regarding women's readiness to give birth. Women's 'body knowledge' became diminished; their doctors' legitimising rationality being mutually created as the knowledge that governed action, so perpetuating the legitimacy of the dominant paradigm.

It is a short step only for legitimacy, authoritative knowledge and power, features of work by Lindenbaum and Lock (1993) and others, to become the coercion demonstrated when Canadian government 'colonisers' captured birth from Inuit women and created a monopoly (O'Neil and Kaufert 1990)<sup>11</sup>. Treichler (1990) suggests that linguistic capital, the power to impose and enforce specific definitions, has led to the redefinition of childbirth as a medical event. So knowledge has directly become power.

Newland (2002: 272) shows how surveillance systems have trapped Javan women in the medical gaze described by Foucault, and coerced them into accepting biomedical contraception. The meeting of biomedical and 'village' knowledge has proved to be a contested domain with 'capacity to transform notions of the self and body, community and cosmology'. In the same text Unnithan-Kumar (2002:110) found the poor women of Rajasthan seeking hospital birth

caught in a bind between the power and hegemony of medicalised institutions which are prone to alienate their bodily and social experiences ... and the oppressive nature of kinship institutions and the requirement of the domestic economy.

Home birth is helplessness for these women. It illustrates a potential fallacy that has grown with the efforts of western women to reclaim a form of birth that is seen as 'traditional' and 'natural' and equates with woman power, while biomedicine is associated with subordination. Morton (2002) suggests that the early anthropology of childbirth tended toward this outlook, Martin (1987) for example demonstrating female resistance to high technology and hospitalisation. Jeffery et al. (2002) challenge illusory romantic notions of birth and Lukere (2002) confronts the equating of 'natural' and 'non-

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<sup>11</sup> This story is part of midwifery lore, the profession's illegality in Canada being finalised by the apparent ending of the need for midwives in the far north thereby constituting an example of the capture of the profession by others (medical men). This area in which doctors had largely refused to practice had been one of the last strongholds of midwifery in North America. The situation is however moving on as midwifery becomes again more accepted in the USA and legalised once more in some Canadian states despite substantial opposition from other health care professions.

intervention' with 'traditional', and 'intervention' with biomedicine, as being too simplistic. From my midwifery experience and anthropological fieldwork (see chapters 5, 6 and 7) I can confirm this as a relevant challenge.<sup>12</sup> The arena of birth continues nevertheless as a contested domain and a powerful expression of gendered resistance and power.

This power is almost everywhere gendered just as, I note, has been much of my own discussion. Treichler (1990) sees hospitalised women as subjects in male territory. I argue likewise that the maleness of high-technology settings is understood virtually as a given by many British female midwives despite increasing numbers of female doctors and male midwives, low-technology settings being largely female. The powerful colonial medical discourse described by Vaughan (1991) would largely have been male with expatriate (usually female) midwives and nurses as subordinate.<sup>13</sup> Jolly (2002:1) offers an even stronger critique of gendered power claiming that childbirth literature is 'suffused with a feminist sensibility that bemoans the increased male power apparent in the medicalisation of birth'. Caplan nevertheless demonstrates that women need not be passive victims of men even if subordinate, her female informants on Mafia Island not seeing themselves in that way (1995).

### **Knowledge development within communities and amongst women and their midwives**

In preparation for considering knowledge that affects decision-making and how it is developed in chapter 6, I examine here some of the literature around how this happens, omitting education theory and practice literature. I concentrate on indigenous and biomedical systems as they affect first the community, and then indigenous midwives, arguing that much of what is written about knowledge development in indigenous systems has universal relevance.

As already noted, for new ideas to be incorporated into a person's knowledge set, they need to be congruent with existing frames of reference. Laguerre (1987) describes how cognitive body maps are formed from personal experience and are the

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<sup>12</sup> and so does Fiedler for Japan (1997).

<sup>13</sup> Although local nurses (if not midwives) might often be male in colonial times.

product of knowledge gained through socialisation, represented as impressions held in the mind. Such explanatory devices and underlying cosmologies guide understanding and influence strategies, although not necessarily representing reality. Pearce (1993) expresses this differently as medical truth construction being dependent upon environmental sources and personal experience, the Yoruba integrating different forms of knowledge freely to handle health matters.

Next I consider how community members, especially women, develop what they know.

### **Knowledge development within communities**

Many societies convey culturally appropriate and locally selected knowledge to their young in formal ways. Some education is 'just in time' for marriage, pregnancy or birth as observed by Bascope (Sargent and Bascope 1997). Just as I describe in chapter 6, instruction and information may be given to Mayan women (and their husbands) only while they are labouring. Primigravid women may know very little about what to expect since, according to Jordan (1993), they will have observed no births previously.

Ritual initiation may be intended to develop the (often secret) knowledge considered necessary for functioning as part of the society. This is often the knowledge needed to behave in acceptable ways, commonly for women, according to La Fontaine (1985), to do with compliance with sexual norms and expectations and pleasing husbands. Similarly, core beliefs and values may be conveyed through symbolic messages (Davis-Floyd 1992). Initiation also legitimises new members of the community, or indeed secret society as with Sande in Sierra Leone (MacCormack 1994) and marks or creates life transitions by conferring of knowledge. Much of this is relevant to my fieldwork site and, with literary sources on Malawian initiation, is discussed in chapter 6.

Knowledge that perpetuates the life of the community and its expectations and values is thus passed between generations. Most people in such communities will have undergone some formal educational process as part of initiation; this applies no less to those who act as midwives to the childbearing women. Their common early life-preparation is supplemented by other forms of knowledge development; this literature is reviewed next.



### **Knowledge development amongst indigenous midwives**

Several literary themes emerge on knowledge development amongst indigenous midwives – apprenticeship to elders, biomedically mediated government training programmes, and inherited or spiritually endowed knowledge and skills. The appropriateness of the preparation they receive for their task, and particularly its effectiveness in helping with the achievement of measurable improvements in maternal morbidity and mortality rates is the subject of intense controversy within the global maternal health field.<sup>14</sup> This issue is fuelled by what Jeffery et al. (2002:91-92) call a ‘tendency to universalise birthing’ that I believe raises generalised and unrealistic expectations of indigenous midwives who are infinitely more varied as a cadre than the literature suggests.

Those responsible for supporting such knowledge development are usually professional staff of one kind or other. They may have little notion of local realities or may be inexperienced. As Davis-Floyd (2000:13) writes

Very seldom do “trainers” enter a community and spend time there learning about indigenous birthways before they try to intervene. Rather, they attempt to educate traditional midwives in biomedical ways of thinking that are often totally inappropriate to local circumstances and realities.

Conversely other trainers share the background of lay counterparts, having been exposed to similar initiation processes with biomedical constructs of childbearing introduced later. While the latter are influential, not least through instilling confidence in positivist science, this may be little more than ‘skin deep’ as Hunt (1999), Salomon (2000) and Vaughan (1991) found when studying colonial and development agency activities.<sup>15</sup> Nevertheless I assume here the dominance of biomedicine in professionals’ and trainers’ backgrounds.

Knowledge develops in different ways. Some believe it to be esoteric: indigenous midwives in western Java claimed mystical origins for the knowledge situated ‘in the heart’ that was both learned and gifted or inherited (Newland 2002). Mayan midwives claimed supernatural help and guidance and attributed their calling to God or

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<sup>14</sup> The debates are not reviewed here but are comprehensively reviewed by Bergstrom and Goodburn (2001) and Sibley and Sipe (2002).

<sup>15</sup> Good and Delveccio Good (1993) note that conflicting voices, discourses and perspectives exist even within biomedicine itself, and that it is steeped in cultural meanings.

spirits (Cosminsky 1994), Bariba women likewise claiming divine guidance and learning some elements of the work in dreams and night-time voices (Sargent 1982).

Such supernatural support may be important for the confidence of midwives and women. Cosminsky, however, finds the divine mandate is being sidelined by biomedical influences and might be subverted by formal training schemes such as those provided to inexperienced Mayan women by mission nurses. These bypass the old spiritual calling and legitimacy required for older women.

Inheritance is a declared means of knowledge acquisition for some such as Malaysian *bidan* (Laderman 1983). A talented learner must have inherited the necessary character traits from an ancestor. Some however learn by personal experience only (Camey et al. 1996); even apprenticeship mode learning cannot be assumed.

Jordan is perhaps the most prolific anthropologist regarding indigenous midwife knowledge development (1993, 1997) having herself learned for some years by being apprenticed to a Mayan midwife and ultimately acting as consultant to government training courses. Jordan often learned by touch, her tentatively examining hands being covered by the midwife's own to impart the sensations of correct techniques. Similar techniques have been reported elsewhere such as in Malaysia (Laderman 1983) and the 'modelling' of the Inuit (Daviss 1997).<sup>16</sup> Empirical learning and practical feedback contrasted with formal training courses observed by Jordan where didactic teaching, based on written materials, resulted in lack of interest and limited application of new knowledge by illiterate midwives.<sup>17</sup> They acquired 'competence in the privileged discourse of biomedicine' and became accomplished actresses who could employ the right words to satisfy trainers and supervisors (Jordan 1993:183). This is the language of development described by Pigg (1997) that renders indigenous knowledge invisible.

Van Hollen (1998) takes up the theme of moving toward modernity through knowledge. Tamil Nadu *dai* learned the language of allopathy, comprehension of its principles being assumed once they could speak the language of 'science'; the *dai* became

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<sup>16</sup> Such learning by observation and labelled informally as 'sitting by Nelly' in UK, has a long history of supreme utility for an occupation where art is deemed to be important as well as science. Relevant to legitimacy is the drive in UK to gain academic recognition for practice experience in midwifery education.

<sup>17</sup> Jordan's vivid portrayal of Mayan midwives 'waiting out' boring lectures (1993:172-3) has been profoundly influential on my own teaching practice.

people 'who knew' and spoke of being converted to knowing (1998:274). Yet Van Hollen witnessed contradictory forms of language amongst qualified nurses which illustrates how training programmes may mask actual understanding, and how the dominant, usually biomedical paradigm is proposed as knowledge just as the indigenous is rendered as 'other' and 'ignorance'. Ineffective or inappropriate training programmes may indeed produce collusion with hegemonic structures, or conversely lead to strategies of resistance when existing ways of knowing are denied (Jordan 1993).

Mayan midwives described by Jordan were considered as ignorant by doctors they encountered. Conversely, these women considered as ignorant those who did not know 'ethno-anatomy' and 'ethno-physiology' and believed operating to be dangerous in the absence of such familiarity. This extraordinarily lucid example of contested ways of knowing demonstrates how lack of understanding, assumptions and poor communication can cause barriers to collaborative working, and how strategising for ascendancy might work.

The construction of biomedicine as the dominant paradigm, and indigenous ways of knowing as inconsequential or harmful, is a significant concern of Jordan's. She coined the term 'cosmopolitical' to emphasise the nature of globalised biomedical knowledge (1993), arguing for its comparative irrelevance whilst it remains incongruent with belief systems. It may, moreover, be dismissed if indigenous midwives detect a mismatch between biomedically grounded practice and their experience. Taylor's fictional account (1991) presented in chapter 1 vividly portrays an encounter between a Zimbabwean indigenous midwife and government trainer, each defending her practice from positions of certainty about the validity of her knowledge.

Developing indigenous midwife knowledge toward dominant biomedical concepts is an important issue that needs further study; its omission constituting perhaps one of the greatest gaps in global 'Safe Motherhood' research. I note also that many clinical techniques taught to these experienced indigenous midwives, described (and often questioned) by authors such as Jordan (1993) and Cosminsky (1994), are changing anyway in the countries that exported the techniques as a result of women's protests and

(largely) midwifery research.<sup>18</sup> It is also evident that didactic biomedical messages may be distorted in their translation into practice and when they appear to be incongruent with observations.<sup>19</sup>

In short the anthropology literature describes a system by which biomedical precepts are taught to indigenous midwives with a view to legitimising and regulating what they do. This generally follows the model used to train professional midwives, often didactic and assuming understanding of the body that is congruent with what is being taught. Usually preceding this is a period of learning by the apprenticeship model by which they develop skills, knowledge and attitudes appropriate to local cosmologies, and expected and appreciated by local women. Both approaches may combine easily in the mind of the learners, but they may not do so and it has been demonstrated that knowledge and understanding may remain layered, accessed depending on circumstance and on who is asking. Such multi-layered knowledge is not confined to lay people, as with forms of language just discussed – some Tamil Nadu nurses holding views of ritual practice which are as contradictory as their language (Van Hollen 1998).

A final twist in the debate about forms of knowledge does not appear to feature yet in the anthropology of childbirth. Having constructed the ‘other’ (lay knowledge of childbirth) as inadequate, dangerous or even criminal (Van Hollen 1998) and attempting to impose ‘safer’ hegemonic biomedical ways of seeing birth by training indigenous midwives, global opinion strikes the final blow finding that

Training of TBAs alone, in the absence of back-up from a functioning referral system and support from professionally trained health workers, is not effective in reducing maternal mortality (WHO 1999).

While acknowledging the inadequacy of current mortality statistics as indicators of success (Graham et al. 1996), and knowing that back-up and referral deficits cause professional workers also to fail, the knowledge of lay workers is now consigned to being

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<sup>18</sup> Examples of such research are flat positions for birth, breaking the fetal membranes, perineal cutting and umbilical cord treatment.

<sup>19</sup> A supreme example is the universal and probably justifiable condemnation of the use of herbal uterotonics by biomedical practitioners. Indigenous practitioners and women observe that their use achieves its purpose despite occasional severe problems. (Emergency facilities presumably see failures only). Meanwhile a variety of ‘professional’ ‘skilled’ practitioners use synthetic oxytocin injections in often inappropriate and equally dangerous ways to speed labour (Van Hollen 1998, Jeffery et al. 2002, Newland 2002).

good for little more than understanding cultural needs and supporting public health efforts (WHO 2003).

### **Social science risk literature and its relationship to childbearing in Malawi**

This review of literature is included because of the emphasis on risk emerging from fieldwork and contemporary policy. I consider major theoretical work and relevant ethnography then address risk and blame, pollution and taboo, and witchcraft, progressing from general to regional and, where appropriate, to local sources. This prepares the ground for discussing fieldwork data in chapter 8 and adds to the biomedical view of risk noted there and in chapter 1.

#### **General social science risk literature**

Risk has grown as a social science theme, with Douglas, Beck and Giddens providing reference points for others such as Lupton (1999a) who have shed light on difficult concepts, and anthropologists such as Gabe (1995) and Caplan (2000) and their contributors who have given substance to theoretical propositions and assessed their contextual relevance.

The risks Giddens and Beck describe tend to be new and more appropriate to industrialised and richer contexts than to subsistence farming environments like Malawi. Beck's (1992) scenarios are man-made, high consequence and irreversible. Beck neither addresses the culturally specific notion of what it is to be safe, nor discriminates on socio-economic grounds but, as Lupton (1999a) notes, does acknowledge that risk may be socially constructed. Caplan (2000) asserts that risk society with its pre-eminent scientific knowledge base does however allow for individualism and reflexivity as evidenced by its critique and challenge of scientific claims.

Unlike Skinner (2000), Bujra (2000), and Shaw (2000), Beck does not confront natural phenomena like volcanoes, AIDS, genetics, and reproduction so his ideas should not be applied out of their technological context; some ring true nevertheless in the present context. Wealth may provide a way out: poverty is a key determinant of maternal

death. People tolerate habitual risk: poorer women continue their lives regardless, not appearing to be any more ruled by fear of death than do richer ones. Technological development can pose new risks: the caesarean section rate has soared inappropriately worldwide despite its inherent dangers. Rationality demands ascendancy: the dominant paradigm that defines risk and safety is usually biomedicine, and this brings huge profits to some professionals and organisations such as drug companies.

Giddens (1991) explores the globalisation of risk and how modern society becomes obsessed with a 'logic of safety' that energises action. People attempt to control and colonise the future but distrust scientific knowledge despite scientists' efforts to define risk and to have their knowledge unquestioned. Such lay scepticism entails the loss of protective cocoons, a situation evident in western childbirth where challenging professional power and knowledge means making new choices with often inconclusive information. As Caplan notes (2000), people have to make their own lifestyle choices but for poorer women (such as those featuring in this thesis) these may be determined by their place in the community as much as by hypothetical consequences.

New risks replace old for Giddens. However, for women, childbearing's ancient anxieties persist while global mobility adds that of HIV. Giddens and Beck provide helpful insights but overall the childbearing experience remains personal and local and features little in the social science risk literature. Lupton's (1999b) proposition that western pregnancy is seen as a perilous journey requiring eternal vigilance applies not only to modernity, indeed *woyembekezera wapita wamimba wadwala*: 'pregnant women at the crossroads of life and death' is a Malawian saying.

All societies actively select risk for attention (Rayner 1992) as can be seen in chapter 8. Furthermore, risk is often socially constructed and reflects institutional and group values rather than individual phenomena; such risk 'survives or disappears because of its usefulness in the social system' (Krimsky 1992:20) rather than because it is right or wrong. However this argument ignores the individual agency that I suggest arises even within close-knit communities and works by subverting or ignoring customary ways.

Pre-existing values and interests can prevail over apparently objective hazards such as mortality, especially over the contemporary artefacts of mortality rates (Wynne 1992). Moreover, it is not possible to take into account all elements at once, according to Douglas and Wildavsky (1982) so social principles provide useful assistance in guiding

behaviour and the choice of which risks are worth taking. They assert that societies have different culturally determined nightmares, culture lying between private belief and public science. They emphasise the social; I suggest pragmatism and convenience are important too in the crisis of birth, alongside local perceptions of problem and remedy. In the end the way risk is constructed and acted on is more important than whether precipitating notions are real or false (Lupton 1999a).

### **Birth as risk: the perspective from anthropology**

A key issue around birth is the use of risk as a weapon, knowingly articulated and manipulated. A flood of the 'risk' word threatens to overwhelm western women with information and options expressed as moral choices and statistics. Techniques offered are mainly professionally owned, their presentation sometimes implying that women who refuse them are deviant or guilty of risking their babies' health. Despite the high probability of unnecessary surgery,

recycled stories and rumors – danger, safety, fear, pain, blood and the imperfect child are easily-fanned embers ... Fear is quite enough to sweep the majority of [Italian] women willingly and obediently into hospital (Szurck 1997:293).

Choices abound but may be reduced to conforming, or rebelling and foregoing other benefits. Inuit resistance to institutionalised birth involved defying those later responsible for child welfare whose good will they needed to preserve (Kaufert and O'Neill 1993).<sup>20</sup> Likewise birth certificates may be withheld following home births (Sargent 1982, Harris 2002). Risk quickly becomes social control thus conforming to Foucault's disciplinary proposition (1977, Smart 1985).

Daviss (1997) describes people having their own favoured logic of normality, risk and decision-making that competed with alternative views and ignored their potential significance. Such logic determines how birth is approached and encourages selective use of evidence to justify action. The language of risk was used to articulate opposing views of Inuit women and doctors and to express power relationships and vulnerability with no

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<sup>20</sup> My own choice of birth environment involved a similar such coercion.

meeting of minds. Doctors used disaster scenarios constructed from limited evidence when statistics failed to gain women's compliance (Kaufert and O'Neill 1993).

Women may see risk beyond the physical, again as chapter 8 demonstrates. In Sierra Leone it concerns mind, body, spirit and society (Jambai and MacCormack 1997) and as in Malawi includes fear of jealousy. Pregnancy language is one of shame in North India; risk is articulated as vulnerability to spirits and the evil eye, and contact with women's own birthing fluids and others' menstrual blood (Jeffery and Jeffery 1993). Risk incorporates danger to the husband and others too, from her touch, her cooking and her presence. Only pollution specialists, the *dai*, should deal with the defilement of birth and, according to Chawla (2002), with female reproductive power which demands specialist knowledge to protect others.

These are ancient and enduring risk perceptions but just as birth has been transformed by modernity as noted above, so has risk. Longhouse births in Sarawak are now contested activities, domestic space producing fear in some women and security in others (Harris 2002). Poorer women derive strength and vitality from customary space and practices and expect rapid recovery there, while fearing relocation and possible roadside birth. Wealthier women use state and professional discourse to position longhouse birth as a dangerous practice of poverty. As Allen (2002) suggests in her Tanzanian study of managing risk, the context of birth allows for the expression of differing realities and principles.

Ways of modernity may be embraced willingly, for example in Lombok, but there professional midwives work from local clinics, reinforce local ritual and enable families to provide the support they are themselves unable to provide (Hunter 2002). Elsewhere the benefit of institutionalising birth to reduce risk may be illusory.

The growing literature on birth demonstrates how varying contexts, concepts and practices come together around risk, and how this topic clearly illustrates differences in situated perception. It also demonstrates the contested nature of risk in childbirth and its place as a focus for politics and power.

Whereas Beck and Giddens pay little attention to the local, Douglas's cultural approach is perhaps more dynamic (Skinner 2000), each society needing its own risk scheme to control or explain the unexpected. For Douglas (1994), pollution and taboo provide effective controls while blame can be attributed either to breaking these or to



malevolence. Such social constructions of risk are considered next, firstly examining pollution and taboo then the personalised risk that is witchcraft. These have proved to be important in the light of my research findings.

### **Risk, an instrument of blame**

Risk can be analysed from an instrumentalist stance such as that of Douglas (1994). Dangers to groups are moralised and blame attributed to others such as outsiders, the unpopular and deviant. Linking danger to undesirable behaviour legitimises established orders and contributes to the negotiation and management of instability and change. Moreover, danger is used selectively as a bargaining weapon; a community 'signposts the major moments of choice with dangers' in its search for 'cultural homogeneity' (Douglas 1994:26-27) and to reach consensus for acceptable behaviour. Power is a central issue here. Individualism and innovation present substantial threats to confidence, authority and certainty. Other threats such as the poor, the marginal and the different are identified for discrimination; responsibility for harm may be imposed on them. Such attribution of blame also arises in witchcraft although often as a threat from within.

Douglas describes a forensic aspect of risk, communities seeking explanations and evidence for events. Misfortune may result from sins committed, from active adversaries or outside enemies (1966). Risk for her is political and about protecting society from anything that will 'wreck it' (1994:4) and its norms and values – as it is claimed to be in Malawi (see chapter 8).

Attribution of blame may be particularly strong in societies that do not accept happenings as natural. The Lele of the Congo (Douglas 1994), and the Nuer (Evans-Pritchard 1976) expect to identify causes just as do the modern societies called litigious by Caplan (2000). Each society has its own nightmares and risk portfolio chosen on social and structural criteria; common values plus common fears provide a choice of risks and ways of living. Values, morality and politics are made visible by considering the way risk is dealt with (Caplan 2000). Fathers in Tanzania, for example, are blamed for women's problem labours (Allen 2002) as happens in Malawi (see chapters 7 and 8).

Key organising principles emerge from literature on risk and danger although idioms are locally constructed and expressed. They can be understood from symbolic and instrumentalist positions, expressing and explaining, and being manipulated to specific

ends. A straightforward aspect of relativity weighs up one consideration against another, effectively contributing to choice and decision-making, and thus to the focus of this work. So risk may also be perceived to:

- highlight key principles and important activities
- express potential problem areas
- indicate boundaries, providing means of protecting them and ensuring compliance
- indicate when infringement has occurred
- explain why and when things go wrong.

Much of what is said around the moral discourse and instrumentality of risk applies to pollution and taboo, and to harm at the (ill) will of others.

### **Pollution and taboo: power that contains**

Society selects those risks for attention that it assesses will do most harm; these are often sexual and gendered, pollution beliefs reinforcing social pressures for conformity (Douglas 1994), for example by holding woman within their marriages by taboos. The 'ideal order of society is guarded by dangers which threaten transgressors' and 'good citizenship' is mutually enforced by groups (1966:3). An adulterer's touch brings contagion and illness, perhaps to the children; sexual fluids are substances of danger and symbolic impurity. Such substances may be singled out for attention when 'out of place' or defying normal categorisation, then becoming polluting, dirty and subject to taboo (Okely 1983).

Douglas uses Radcliffe-Brown's formula that 'rules express the value of marriage in that society' (1994:133) although often functioning loosely. She also provides a more specific framework (based upon Nuer beliefs) than the previous one:

- Rules can provide focus for action when there is confusion over moral principles
- Infraction of moral codes may be identified retrospectively by the presence of some problem

- Belief in harm from pollution can reinforce ideas when moral indignation is low-key
- Taboos can provide sanctions when moral indignation is not reinforced by punishment.

Rules thus express public conscience for Douglas and provide a means of control when open chastisement is inappropriate. They may keep boundaries intact but Lupton (1999a) argues that Douglas's model provides limited explanation for change. She proposes the body as a model bounded system and takes Douglas's ideas about contamination and pollution further, order and disorder serving as controls and maintenance strategies for values and moral order. Breaking down boundaries is more common at the margins and Malawian matrilineal society is one such case with many husbands being relatively marginal as is shown in chapter 4. Feldman-Savelsberg (2000) likewise explains pollution as body politics and policing body boundaries: pollution, dirt and hygiene again are instrumental, or conversely symbolise good order.

Health-related functions have been ascribed to taboos such as postnatal sexual abstinence, a common regional practice expected of couples. Gray (1994) grounds this in child survival and the deleterious effects on lactation of another pregnancy, linking the taboo with mortality when short birth intervals lead to early weaning and failure to thrive.<sup>21</sup> So for the Enga, two year sexual abstinence has much to do with child survival.

The overall topic of taboo and pollution relates closely to Malawian concepts of health and imbalance that are explored in chapters 7 and 8. Zulu (2001) explains Malawian postnatal sexual taboo similarly to Gray but attributing harm caused to a breastfeeding child to sharing fluids with the unborn sibling. Becoming pregnant before the ritual 'warming' (*chisaula*) ceremony brings disgrace.<sup>22</sup> Some older women judge parental compliance with this abstinence by the health and weight of the child – a splendid example of the forensic use of taboo. This, I suggest, illustrates how reified

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<sup>21</sup> If a woman becomes pregnant, the breast milk for her older child diminishes, and she may wean that child rapidly especially if there is a taboo that suggests the fetus will harm the suckling child. This is raised for Malawi in chapter 7.

<sup>22</sup> *Chisaula* is the ritual strengthening and 'warming' of the child involving coitus interruptus by the parents with the child between them. This is explained further in chapter 7.

boundaries and taboos may become out of step with reality; the contemporary experience described by Zulu is of verbal and physical abuse of wives by husbands and, as people reported to me also, the fear of husbands returning from extramarital affairs with HIV infection.

Van Breugel (2001)<sup>23</sup> addresses pollution and taboo in detail in his thesis on Chewa religion, especially regarding female vulnerability to male infidelity (pollution from without) explored further in chapter 7 and 8, and explains that Chewa men are invariably blamed if wives die in childbirth. Van Breugel describes societal expectations of couples as checks and controls, and supernatural sanctions – a ‘basic law governing family morality’ (Van Breugel 2001:170). It may be supernatural but is impersonal rather than religious and punishment is automatic according to Marwick (1965).

The right use of sex is vital in Chewa codes with anything harming fertility seen as a crime against the group, not just the couple. Van Breugel demonstrates how the rules ensure optimum conditions for reproduction and benevolence of ancestral spirits on whom fertility depends.<sup>24</sup> He claims moreover that ritual hot/cold statuses are not moral categories but that disregarding taboos is a moral matter and ‘selfish individualism’ (2001:208).

Breaking of taboos then is a key reason in literature for attributing responsibility for problems and blaming some group member, often resulting from contact with a polluting ‘other’. Blame can also be attributed in other ways and in other directions than the sexual ones of many pollution ideas and taboos. Malevolence is a powerful threat, whether deliberate or unintentional, and relevant literature on this will be the final topic.

### **Bewitching and sorcery: the personalisation of blame**

The issues around witchcraft have similarities to pollution and taboo regarding symbolic, explanatory and instrumental rationales. Blame and scape-goating, control, dealing with

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<sup>23</sup> Van Breugel is a Dutch priest who carried out doctoral fieldwork whilst living in pre-democracy Malawi but could not publish it safely. His 2001 editor, Martin Ott, comments on the continuing relevance of much of the work despite the enormous changes occurring in Malawi in the meantime. With some differences, mostly related to religion, his work is highly pertinent to my thesis.

<sup>24</sup> I observed no sign that ancestral spirits are given any thought now in the fieldwork community and this was confirmed on direct questioning (Kamuntolo, personal communication, 2003).

internal conflict and explanation for the unattributed – from ill health to, in this case, material and political gain – all apply. African witchcraft deals with explaining ‘why now’ and ‘who’, questions ignored by biomedical theory and practice.

I consider first the work of Evans-Pritchard, Geschiere and other relevant writers on Africa before moving to localised sources.

Witchcraft and sorcery beliefs involve adversarial action, both intentional and otherwise, distinction sometimes being made between witchcraft as malevolence stemming from any person being a witch, perhaps unknowingly, and sorcery as deliberate manipulation of evil perpetrated by anyone wishing ill, often using substances.<sup>25</sup> Nevertheless ‘sorcerer’ appears mainly to denote specialists, ‘witches’ being anyone. Connection with jealousy, greed and conflict is universally assumed; this rapidly became apparent during fieldwork before reading the literature in any depth.

Determined attempts may be made to identify the cause of unexplained events or misfortune. The Azande use witchcraft in this way, Evans-Pritchard arguing ‘witchcraft beliefs ... embrace a system of values which regulate human conduct’ (1976:18). It provides alternative explanations when no breach of taboo, failure to observe moral rules or incompetence is identified. While accepting physical causes witchcraft provides reasons or answers to such questions as why a granary damaged by termites fell just as someone was sitting under it, why a boy stumbled just where a root stump was situated, why a thatch burned just when the hut was full of stored beer. Witchcraft is an idiom of misfortune, causing annoyance to the Azande rather than fear, and resulting from enmity, spite, uncharitableness, envy and greed. It can kill but even unmannerly, unsociable and offensive behaviour may be attributed to it.

Janzen came to similar conclusions, the baKongo seeing witchcraft as the ‘disastrous consequences of unbridled envy, anger and injustice’ and ‘a recurring theme in the exploration of causality of illness’ (1978:24). Ill will, envy, gossip and backbiting – all violations of social precepts – are enough to cause illness in the baKongo view. Papua New Guinea witchcraft is also related to jealousy and resentment, Strathern and Stewart noting ‘Such an idea may act to restrain people’s behaviour and hence support morality’

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<sup>25</sup> The general view for Malawi however is that the distinction there is a false one with the terms used interchangeably.

(1999:100). Witchcraft is implicated in infertility in south western Ghana, jealousy causing the witch's own reproductive powers to be transformed to 'eating' children instead of bearing them (Ebin 1994). Aowin matrilineal bonds are so significant that bad behaviour and jealousy threatens the whole community and people are specifically warned against envy.

The notion of reversing norms pervades literature with incest, nakedness, necromancy, riding animals, leaving excreta in inappropriate places (Mayer 1982), all being both 'witch' and polluting and taboo-breaking activities. Animal appearance may be read as witch presence, or used instrumentally (Morris 2000).<sup>26</sup>

Witchcraft emerges throughout African literature related to unexpected events, weakness and power struggles as well as jealousy, (Poole 1994 for Cameroon) and situated in insecurity (Ashforth 2001 for Soweto). It is a 'force for both levelling and accumulation of power' (Fisiy and Geschiere 2001:227) and rarely the act of strangers but of bitter familiarity and human frailty, say Moore and Sanders (2001).

Ancestors who are usually considered to be benevolent and mainly interested in being remembered through reproduction (Schoffeleers 1968) cannot easily be blamed for misfortune except when they have been wronged (Mayer 1982). This, according to Mayer, is when witchcraft beliefs tend to emerge. Attributing blame this way may be more comfortable than questioning accepted practice – health beliefs, medical techniques, agricultural practices – and punishment can be instituted (Mayer 1982). Society creates witches and pins the image to individuals. Feldman-Savelsberg (2000) demonstrates adaptive strategies, threats of harm to childbearing women through adultery replacing the now illegal sanction of killing the guilty.

The Maka of Cameroon attribute wealth and power to witchcraft as an accumulative force or 'eating' of the substance of others (Geschiere 1997). It is for them a discourse of secrecy and human agency, of inequality and suspect power, the dark side of kin relationships and a conservative force for maintaining equilibrium. Geschiere takes this beyond the local to macro-politics, criticising Mitchell, Turner and Marwick for

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<sup>26</sup> My first interpreter explained to me how witches may use medicine to transform themselves into wild animals or take their form after death, for example a snake might be used to kill someone. Animals other than domestic ones are of the wild and dangerous woodland 'outside' the homestead (Morris 2000).

addressing only social control and micro-politics. The Ibibio similarly shift responsibility for disparities between aspirations and success to bewitching, an aspect Offiong (1991) believes to be increasing with modernity and insecurity. They scapegoat those who transgress their model of a good person – hospitable, generous, honest, brave, dutiful, and no more successful than others.

Themes of unexplained circumstance prevail, alongside deliberate malevolence and unintentional harm from jealousy and greed. The ‘local boy made good’ who one day becomes a politician must have been a witch, maybe even bewitching others to ensure his own success. This is not so different perhaps from envy felt by those left behind by the social, business or political climbers of modernity.

Historically, the manipulation of technical aids, psychic acts and spells has long been common practice in the west (Thomas 1982). Thomas quotes Francis Bacon describing the tying of knots centuries ago to prevent the consummation of marriage – a remarkable similarity to the tying, untying and untangling practices around labour and birth found all over the world including in Malawi.

Marwick (1965 and 1982) differentiates between inherent personal witchcraft power, and sorcerers’ magic, setting out a social theory of witchcraft amongst the aChewa of mid twentieth century Northern Rhodesia (now Zambia). He argues the beliefs and practices act as social strain gauges, indicating tensions and change and providing means of manipulation and control. Marwick offers alternative uses for sorcery when access to judicial procedures is denied, such as when competition for headships or resources, wealth accumulation or deviance within matrilineal groups raises tensions. Fear of accusation and attack is also an effective sanction to ensure compliance and limit change. Breaches of the code can be categorised according to Marwick (1982). Drunkenness, promiscuity and breaking taboos are the realm of ‘non witchcraft’ sanctions, perhaps spirit punishment, but certainly *mdulo*.<sup>27</sup> People accept ritual symbolism at face value with an ‘uncomplicated, ingenuous and yet shrewd appraisal of social life’ (Marwick 1965:233). Conspicuous gain, sexual jealousy, meanness and greed, aggression and failure to discharge obligations are subject to sorcery. The emphasis on sharing is marked

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<sup>27</sup> *Mdulo* is an expression, local to Malawi and Zambia at least, describing a form illness; this is addressed further in chapter 7 and 8.

in Malawi; envy, malice and meanness have no part in the makeup of an ideal person according to Morris (2000) who, like myself, experienced constant dilemmas as a consequence.

Bad will and disturbance are internal but group cohesion must be maintained. Marwick cites avoidance and joking relationships between kin as assisting change by making tension visible but ‘Smouldering hatred (nevertheless) flares up from time to time in acts of sorcery’ (1965:294). Witchcraft accusations can rationalise the need to move on and break up over-large communities, so simplifying the disengagement of close matrilineal links.

Backbiting, Marwick reports, is dreaded especially by Heads and the *mwiniumbumba*. Senior members of the lineage receive complaints, public confessions and declarations of good. Such declarations are particularly used to ease difficult births as malice is especially dangerous to pregnant women and others in liminal states. ‘The womb has heard these bad words’ he quotes (1965:138), thus linking directly with the fears expressed by my own informants (chapter 8). Morris (2000) asserts that witches have a marked preference for producing reproductive illness, unsurprising when witchcraft concerns envy and insider tensions.

Van Breugel articulates a powerful rhetoric of people gripped by fear and subject to witch beliefs often emerging alongside their Christian faith in times of real trouble. Both he and Morris (2000) propose Chewa views of a good person as powerful models, acting as incentives for social compliance and leading to an ‘exaggerated form of meekness and courtesy’ (Van Breugel 2001:230). Aggressiveness is seen as a foreign attribute.<sup>28</sup>

Marwick’s opinion of matrilineal systems as having inherent tensions is matched by Van Breugel but neither explains why matrilineality should be more ‘strained’ than patrilineality. Rather I would argue the inescapable possibility of a gendered view, as I find Morris does also (1998). Van Breugel’s discussion (2001) of the advantages of egalitarian aspirations in a small-scale society is however helpful for explaining the fears around accumulation and success. The use of medicine, human material or incest (to gain

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<sup>28</sup> A more contemporary feel for ‘meekness’ is provided by ‘respect’ or ‘shame’ in the positive Malawian sense (see Morris 2000:64-5).



the life force of the 'victim') and other witchcraft activities for profiting at the expense of others are suspected whenever drive and ambition are observed. People can, however, bring harm upon themselves according to Van Breugel's informants by arousing jealousies, working too hard, or not avoiding quarrels. The anger and envy may be another's, but the one harmed is responsible. Whatever the attribution, kin group harmony is so important that accusations or the fear of them lead to restraint, compliance and reconciliation.<sup>29</sup>

Perceptions of danger, taboos and threats of bewitching and witchcraft accusation provide powerful symbols of both right and wrong and substantial means for maintaining control. They also, it seems, all relate back to the prioritisation of community interests over individualism. Pollution ideas represent moral, often sexual, standards. Bewitching represents envy and greed. In the presence of such possibilities, accusations and practices, group boundaries are maintained, otherness providing a powerful symbol of blame for misfortune, the unknown and unexpected, and leaving the familiar intact.

## Conclusion

Diverse strands of thought within anthropology contribute to understanding the processes of childbirth and women's lives while, conversely, analysis of childbirth concepts and practices can help with understanding culture and societal values. The ways in which childbirth is manipulated are particularly indicative of how women are viewed and who defines what matters. The anthropology of birth not only identifies women's situation but is beginning to address adaptive strategies for global change. Knowledge and legitimacy are important themes in relation to who controls childbearing processes. The knowledge that matters, however, is often pluralistic and layered. Biomedicine, though powerful, is by no means hegemonic, and resistance and agency may arise in different ways. Nonetheless, such agency may not always be attainable for women especially as control of the knowledge essential for action is part of the strategising for power. Likewise, those

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<sup>29</sup> See chapter 4 on relatedness and residence and 8 on risk.

in power can define what is risky and dangerous, so symbolising the concepts that underpin values or perhaps providing for means of control.

Concepts of risk are important to decision-making so this literature has been reviewed, focussing on the constructions of risk and danger that emerge from the data – biophysical notions, the symbolism and instrumentality of attributing blame through moral pollution and the personalisation of blame through witchcraft.

Women's agency as child bearers and as supporters of others is context dependent. The context for the women who feature in my evidence is explored from chapter 4 where I begin by considering the relationships and household dynamics that affect them and their decision-making. First however I explain how the research was carried out and examine some of the influences on what I achieved.

## Chapter 3: Methodological and ethical issues

### Introduction

In this chapter I explore the way in which I conducted the research and what happened. I address the methods used, including preparatory work, and then consider issues of reciprocity. I move on to explore the ethical issues that I anticipated and experienced, using anthropological and midwifery ethical codes to support the analysis. I focus also on disclosure of secret knowledge and ‘whistle blowing’.

My aim is to make explicit the way in which I went about the fieldwork enterprise and how I handled eventualities so that readers can make individual judgements about credibility. I take a reflexive and autobiographical stance in response to the challenges of, for example, Okely (1992:24) who suggests that reflexivity forces us to think through the consequences of our relationships to others. It is also taken in response to the belief that the life histories and assumptions of fieldworkers necessarily affect the way research is conducted, responses received and the knowledge that is developed from the data gathered. For this reason it was important that I should attempt to recognise my own biography and resulting worldview, both as potential barriers and as contributing factors. Gardner calls this background ‘historical specificity’ (1999:50). It is becoming increasingly apparent however that developing such awareness is an ongoing process that does not cease with the closure of the notebook and switching off of the tape recorder. A continuing challenge for analysis and for writing is the recognition of the influence of preconceived ideas on the meanings and significances derived from notes and transcripts.

A parallel stance taken throughout is the deliberate attempt to provide space for the voices of women to be heard, effectively constructing a feminist methodology that is an attitude of mind toward the researched and their world rather than a separate form of activity. So while classical ethnographic methods of participation, observation and informal interviewing were used, it was from the viewpoint of women, with neither researched nor researcher being seen as mere tools for the extraction of data. Nevertheless, the research project emerges from my own long-term interests, not those of my informants, namely a concern for safer motherhood. This probably indicates an

assumption, both ethnocentric and bound up in my profession of midwifery, that maternal death is viewed everywhere in the same way; this may not be so. I am mindful of Scheper-Hughes (1992) who had to deal with differing views of death and suffering when Brazilian infants died. Hall and Stevens (1991:17) suggest that 'Feminist studies are designed, implemented and disseminated with the goal of providing for women explanations that they want and need about phenomena that affect their lives', but Malawian women might have more urgent priorities. Loudon (1992) notes that we continue to drive despite the risk of fatal road accidents, so maybe death in childbirth is equally low in people's priorities. I therefore retained what Chambers calls the 'power to define' (1995:23) but tried to leave participants space to 'co-determine the outcome ... constructing knowledge and interpreting reality' (ibid). Neither was I providing explanations for women directly – rather adding to esoteric knowledge and attempting to act as advocate by sensitising policy makers.

Before addressing methods and ethical issues, I discuss the ways in which I prepared for fieldwork.

## **Preparing for fieldwork**

### **Planning ahead**

I wanted to investigate the notions, knowledge, systems and dynamics that determined action around childbearing in rural Malawi; I had a husband and an academic job neither of which I could leave for long periods despite the support and goodwill they offered. It was vital to find a way to conduct anthropological research that would accommodate my responsibilities without compromising the credibility of my work. After considerable discussion with my supervisor a plan was devised for four periods of two months each in the field preceded by a preparatory and exploratory visit of three weeks. I proposed a short follow-up visit and this has now been achieved. I anticipated that short periods in the field would have inevitable disadvantages in the degree to which I might be accepted and the insights I would be able to develop. Conversely I planned to use intervening periods in Britain for archive work and early analysis, and not least, reviewing progress with my supervisor to avoid going off track in the field. In the event, it was hard to use the

time in Britain to best advantage because of increased work pressures caused by being away. More positively, both the community and health service staff received me warmly each time I returned and I was able to resume my work again rapidly having completed formalities such as greeting the Village Heads. On one occasion only, the low key welcome in the household worried me. On reflection, I realised that people commonly go away to work so the passage of time and distance I travelled may have been less notable than it was to me.

### *The preparation visit*

Having met the Director of Midwifery Education for Malawi in Norway (see chapter 1), I then talked with one of her lecturers in London. They facilitated my entry and saved me substantial time. Once in Malawi Lennie Kamwendo advised about procedures and people I needed to see and provided introductions to several rural maternity units.<sup>1</sup> She put me in touch with the Director of the Centre for Social Research, Chancellor College at the University of Malawi, who would play a central role in enabling me to gain research approval. Dr. Khaila provided encouragement and agreed to support me, explaining the importance of affiliating to the Centre. My research proposal would be submitted to the Ministry of Health Ethics Committee, a supervisor would be provided and I would have full access to library and information technology facilities in Zomba, some 80 kms. from my fieldwork setting. The library proved to be a valuable source of work carried out in Malawi; the Information Technology Department I used less, relying mainly on my own resources.

I learned that the Government of Malawi expected a return of 10% of the research budget to the community which took part in the research. The assistance which the *mafumu* and the *azamba* requested was to re-roof one birth house (in Kalanje) and construct one in Malinga where no birth-house existed. Mai Kamuntolo used a room of her own home, or if full, a clean out-house. I approached this project as a necessary distraction; it caused many hours of extra work as it developed way beyond the initial plans as well as becoming an increasing financial burden. However, as shown later, it provided substantial insights, not least into local politics and relationships.

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<sup>1</sup> I noted that no government hospitals were included in her selection.

Hospital visits made during this preparation period resulted in two invitations with the offer of temporary accommodation and the support I needed to locate rural communities for study and residence. However it was quite clear that I would have to retain some distance from hospital personnel once in the field. I had to avoid being seen as 'one of them' by those with whom I would later live, despite needing also the hospital goodwill and facilities. The opportunity for participant observation in St. Joseph's Hospital was on offer. This was tempting but I remained convinced of two factors – the need to maintain separation from hospital staff, and that my questions primarily concerned decision-making in the community. It was there that I needed to be.

### *Language training*

The preparatory visit enabled me to streamline the planning process and entry into the field. The other essential element of preparation was language training before departure. This was less easy to arrange. Malawi has two national languages, Chichewa and English, as well as Ngoni, Yao, Lomwe, Tumbouka and Sena. Most, I was told, could speak Chichewa. Finding no evidence of formal courses I finally located a Malawian student in London who was prepared to teach me, and acquired a set of old language tapes which proved to be helpful if intensely uninspiring.

In Malawi I took daily lessons from my first interpreter and gradually improved although progress was limited by periods back in UK. I always used an interpreter for interviews, and for anything more than basic activities. I could understand enough, however, to detect when my interpreter had misunderstood me or my informants. The effect on my work and the measures I took to ensure the validity of my data is explored further when considering strengths and weaknesses of the work.

### *Selecting the setting*

I chose the setting for reasons of convenience. I received a welcome from the St. Joseph's hospital management and staff and the Dutch Medical Director demonstrated an understanding of social anthropology that boded well for the progress of my work. Public transport was available at least during the dry season and there was a network of villages linked by the Traditional Authority of Likoswe and visited by Maternal and Child Health (MCH) team. I planned to take up residence first in a hospital staff house with a view to identifying an outlying village to which I could move at a later date.

## The methods

In this section I shall explain the methods I used and describe what happened. I also explore areas of confidentiality and anonymity, and reciprocity and dependency.

My first move was to meet the Coordinator of the MCH outreach programme (Mai Winnie Sichali) and to make myself known to the maternity staff although I deliberately spent most time in the initial stages with the community team. I needed the introductions and the wealth of information Mai Sichali could provide while avoiding continuing and excessively close identification with the hospital. She became a key informant after having introduced me to all the eleven trained *azamba* in her area and provided information about the gatekeepers of the community. Specific invitations for residence were received from neighbouring *azamba* and approved by the Village Heads, these *azamba* becoming hostess and key collaborators.

The first two periods of fieldwork involved residence in staff houses as described. During the first period, investigation was concentrated around the pregnant women staying temporarily in the nearby maternity waiting hostel<sup>2</sup> or *chitando*, and those who accompanied them, their 'guardians'.<sup>3</sup> My interpreter and I spent time with them most days and talked with them about many subjects including their life histories, marriage and residence patterns, ideas about birth and reasons for choosing to give birth in hospital on this occasion (see fig. 3.1). A schedule of topics was devised but used informally and interviews were conducted with both individuals and groups of the constantly changing occupants.

Here I encountered my first ethical dilemma when expectations of advocacy were made of me. My help was requested by a woman who appeared to be destitute, alone and unable to contact her husband<sup>4</sup> who was in South Africa. I promised to ask

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<sup>2</sup> The hostel comprises a large brick-built room, latrine and outdoor space for cooking over open fires. Women, who may have travelled several miles, sleep on a mat or cloth on the cement floor. Here they await the onset of labour, sometimes for several weeks.

<sup>3</sup> Food is not provided for women in the hostel or for patients in the hospital unless they pay extra. A female relative or friend is expected to stay to provide food and all personal care. Cooking fuel and foodstuffs are expensive in the market and some women remain hungry.

<sup>4</sup> I make no assumptions about the status of male partners of women when using 'husband' but have chosen this term because it is the one used always by interpreters, translators and others when speaking in English. Continues over

hospital staff about special funds rather than give in to another of the frequent personal requests for money, the consequence being that she was reprimanded for having told me she had nothing.

Fig. 3.1 Pregnant women and their guardians at the *chitando*



I recorded time budgets, reported by women about their home lives, and observed in the *chitando*. I mapped water and firewood collection points, and river bathing facilities on site to gain an understanding of life in the *chitando*. During this time also I began to visit villages with the MCH outreach team. This had a dual purpose, to familiarise myself with local communities, and them with me, and identify a suitable place to settle. At first I observed clinics and the team at work, sometimes helping out a little. Later I would sit outside on the ground with the women and children who were waiting, just watching and making occasional notes. A diary entry reads: ‘A large group of children watched me from as close as they dared. Mai Sichali was amused and commented to them ‘look it walks and talks just like us’.’ By now I was already practicing the art of impression management (Goffman 1959, Shore 1999) and specifically not taking an active part in

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‘Partner’ would not have been understood in this deeply conservative society. The chiChewa term is *mwamuma* or *abambo* / father as an honorific.



consultations. I was getting to know Mai Sichali as a friend and key informant as well as gatekeeper. Nevertheless I tried to reduce such contact within village environs once this initial stage of visits to the surrounding communities with her team was completed.

I carried this avoidance of all but essential contact with hospital midwives right through my research. When living in Nguludi and focussing on the *chitando* and the local community visits I restricted socialising largely to my neighbours and some older teachers. Looking back on the case study of Dannis with which I open this thesis, I realise that the way I was treated by a nurse who did not recognise me provides evidence of some success in this respect. This must have been obvious to those accompanying Dannis.

Such deliberate avoidance of being associated more closely than necessary with the hospital did mean that I could not spend time in observation in the maternity unit, or take time out from my host community to interview hospital midwives. There seemed anyway to be a limit to the extent to which they could help me develop my understanding of the context for decision-making at village level. I wanted to concentrate my limited and precious time on learning about life in the village. I have been able to make up for this deficit to some extent during my recent return visit.

So the setting for my work was to be the villages and my residence (for the time being) the hospital. By the second visit, when I transferred my main focus from the *chitando* to the villages, I commenced spending nights in Malinga and hanging my mosquito net in Stella Kamuntolo's spare room, collecting my new interpreter by day from where she was then living. I relished the half understood 'chats' with my hostess's mother and sister who came in each night, if not the sleepy attempts to write by a single candle on the edge of my bed after the household had gone to their sleeping spaces, and the trip across the dark compound to the latrine. By the third visit I took up full residence with Stella. Here was my first example of reciprocity. A half built grocer's shop was attached to the house. This became my room with a tiny cooking space attached once I had paid for its completion. It was to become the shop where Stella would sell soap and matches, rice, salt, combs and razor blades once I no longer needed it.

### Participant observation

From then on I became a temporary member of the Kamuntolo household, with interpreter and her baby.<sup>5</sup> I was around all day and involved in the life of the household (see fig. 3.2).

Fig. 3.2 *Kucheza*: chatting on the back step



I cooked some of the time but shared in many household meals. This is a comparatively well-resourced residential unit, domestic help<sup>6</sup> being employed for fetching water, some cooking and general household duties. I was never permitted to carry water from the borehole and my attempts to cook local food were greeted with amusement. Jane washed my clothes in the river and the oldest son ironed them. He would not permit me to use the charcoal iron that had a gaping hole in the side – I might burn my clothes, and it was anyway considered disrespectful for me to be permitted to help with the chores. I was soon given the role of providing transport. I suppose that collecting chicken feed from

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<sup>5</sup> From the third visit, Jane's (her real name) husband was away studying and she and her son Joseph lived with me.

<sup>6</sup> For a time one of these helpers was a woman who was repaying Stella for helping her during birth. On my recent visit Stella was employing a young man.

town, driving the heavy maize sacks to the mill and providing lifts to the hospital when required was far more useful than spilling buckets of water everywhere or cooking lumpy *nsima*. I could also help to prepare vegetables, a highly social activity sitting on the ground amongst women, toddlers, scavenging chickens, and the occasional wayward goat. Two diary entries describe a common scene:

I sat on the veranda with the other women and stripped maize cobs into a large pile ... I then helped to fill the grain sacks, discovering in the process a large wet patch where Joseph had [urinated whilst] playing. The women just laughed. During this time Joseph happily played with the maize and a cup, filling and emptying my lap. Who needs toys?

And also:

I have been sitting in the storm gutter watching and sewing. In front of me Stella is sitting on the ground winnowing the maize flour we brought back from the mill. In front is a large basket and there is flour all around her. Just now I shouted 'no' to Joseph<sup>7</sup> and he obligingly stopped modifying my hired car with a heavy saucepan. He was in trouble too with the older boys for moving their goalposts of bits of brick, but they patiently replaced them each time as they played with their ball made of plastic sugar bags.

But life was not always easy. Although the household was prosperous by village standards, maybe because Stella as its head was so organised and resourceful, still they were (and are) very poor. In comparison I was wealthy beyond their imaginings. I was complimented within the village on the way I presented myself, my clothing, my attitude, the way I did not make my wealth obvious, but still I had a car and a camera, tape recorders and handheld computer, solar power panel and borrowed satellite phone. I rarely ran out of matches and paraffin, or money to buy more. It was hard to refuse requests for help thus creating a self-perpetuating dilemma that remains unresolved.

Another dilemma concerned my status. I felt I never progressed beyond being an honoured guest and was always referred to as 'Madam' or Mrs. Barber, or even 'Mummy'. Eventually I understood this to be equivalent to the British use of surnames between friends in my grandmother's day, and 'Mummy' and 'Madam' as direct translations of '*Amai*' and '*Abambo*', the honorific terms used to address older females and males which I had rapidly adopted.

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<sup>7</sup> Jane's son was a baby at the commencement of my field work and was by now a toddler.

Meanwhile the life of the village went on around me. I seemed to miss funerals, and apparently no parties, such as for weddings, were held until I provided one when leaving. I was unaware of any birth celebrations although the older women demonstrated dancing with hoes for boys and with pestles for girls. Village meetings are solemn occasions with the *mafumu* and advisors sitting around, men and women separate. I did not try to attend but came upon one by accident one day. I walked quietly by with Regina who bobbed into a crouch as she passed and cupped her hands together politely.

My farewell party provides an example of formal customary proceedings, chairs in a circle for the male Heads and officials, seats on the birth-house veranda floor for their wives and female Heads, the ground for others (fig. 3.3) – but with dancing to finish (see fig. 3.8). As village guest and party hostess I was given a place among these women and was obliged to add to the many speeches. Formality, courtesy and deference were automatic features of meetings, whether they were between the *azamba*, *mafumu* and me, between the *azamba* and women, or in the clinic setting.<sup>8</sup>

Fig. 3.3 A formal farewell



<sup>8</sup> The clinic was the only place where I observed women kneeling in obeisance other than at a roadside meeting between the older midwife and the local Group headman. In some areas it is common, for example in front of the husband or older relative and amongst the young in educated families when serving a visitor with food.

I have no doubt that much was concealed from me. This would have been easy as adult household members had their own space, even to the maid sleeping on the storeroom floor with her baby. I often understood more than people perhaps realised but they only needed to speed up to baffle me completely. Lomwe, Yao and Ngoni languages are commonly used and even in Chichewa there are colloquialisms, so inevitably I heard mostly what people chose to reveal. Nevertheless I often knew something was going on and would check my understanding against my interpreter's version of events when we were alone.

An early intention had been to get to know pregnant women and follow them through their pregnancies, if possible being present at the birth (in hospital if necessary) and monitoring choices along the way. The reality is that women rarely reveal their pregnancies until they become obvious and even those who consulted my hostess usually arrived with the birth imminent. I was often elsewhere or had group interviews booked. These could be difficult to arrange with everyone busy in the fields and even more difficult to change at short notice without inconveniencing some who then would not come again. Ultimately I had to make difficult choices. Presence at the birth might give me insight into birthing customs and let me see first-hand the decision-making processes such as regarding hospital transfer when problems arose. However it was almost inevitable that my presence, and with a car available, would influence that process so I would not see normal practice. The insight I was gaining from arranged interviews was so valuable that I gave them priority over waiting around in case labouring women should arrive. This information was retrospective; decisions had already been made and it was inevitably coloured by the impression my informants wanted me to develop. Nonetheless I could cross-check information from different sources to improve the validity of my findings, as I did deliberately for Majami's case study (see chapter 5). I carried out such cross-referencing throughout fieldwork to improve my confidence in the findings.

Compromise was needed too around night births in the other villages. Robberies were common and ritual murders of six women had occurred nearby between my visits<sup>9</sup>.

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<sup>9</sup> Such murders are very unusual in Malawi and these had caused intense media interest. Although local people were reluctant to discuss them, they insisted that the killings were linked to the acquisition of body parts such as breasts and genitalia for ritual purposes. Some women were seized from busy daytime tracks and attacked in the tall maize. One woman survived but was blinded. A group of men was arrested and the chief suspect died in custody. The attacks did not continue.

My hostess did not want me to leave her home at night, let alone stay with the Kalanje *azamba* because of their vulnerability living on a through route. Neither could my interpreter accompany me because of her child. I did not argue. I was also not called for night transport for security reasons. Even the local Catholic Brothers would no longer drive women to hospital at night because of a recent armed hijacking on the Nguludi road and so, Stella insisted, neither should I.<sup>10</sup>

Notwithstanding some drawbacks, I soon found people being more open in what they let me see than I had dared to hope. Three examples from my fieldwork illustrate this and confirm Holloway's assertion (1997) regarding opportunities for casual conversations and more planned in-depth interviewing emerging from participant observation.

### *Example 1*

We were walking along a narrow track when Stella pulled branches down from a tree and gleefully tied up a few seeds in the corner of her *chitenge*.<sup>11</sup> I longed to ask what she used them for but these were early days. Could this be the medicine used to speed up women's labours that was apparently responsible for many maternal deaths? Would Stella fear I might report her? This was my first test. I decided to wait and no more was said.

Much later I did indeed discover what these seeds were. We were in Regina's hut talking about her knowledge and grandmother's teachings and with great merriment she described the use of the oils from these same seeds for making the genitalia more sexually attractive. Returning home, my interpreter amused the women of the household by telling the story (she was of course supposed to be bound by confidentiality) and Stella asked me if I wanted some. I laughingly declined saying I was happy as I was and was not sure my husband would be too keen. Having a husband could be useful and I exploited the fact often. I knew then that I was gaining access to privileged knowledge and later Regina demonstrated seed preparation and openly talked about the knowledge of women.

### *Example 2*

Regina marched off one day, bare foot, hoe over her shoulder, Jane and I trying to keep

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<sup>10</sup> Unbeknown to me until my recent visit, my presence and security had caused concern at administrative level: Headman Malinga had been required to report my arrival to the police each time I returned.

<sup>11</sup> Skirt cloth.



up behind. We climbed a hill through high grass in search of medicine to ‘strengthen the blood’ (see fig. 3.4). We then searched her deceased mother’s garden – completely overgrown around a tumbledown house<sup>12</sup> – to find the roots she needed. I was amazed at being given this information when she hardly knew me and pondered on the potential symbolic nature of the medicines, which I was told produced red and black liquids or ‘iron’.<sup>13</sup>

Fig. 3.4 Regina Clements, *azamba*, digs for roots to make medicine



### *Example 3*

I was privy to some of the secret knowledge of women and was offered more. Discussing preparation for childbirth one day, a regular member of a group of older women offered to tell me the secrets of the old style initiation of girls and provide a demonstration. Wavering on the edge of uncertainty about the ethical issues around anthropological curiosity, and being unconvinced that the other women in the group were as keen, I finally did not take up the offer. In retrospect this constitutes a substantial lost opportunity. However I remain convinced that my decision was the appropriate one in view of the apparent lack of enthusiasm shown by other women in the group.

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<sup>12</sup> Houses are not normally occupied following death as spirits are thought to inhabit them. It is less common now for land to be abandoned although it was allowed to revert to woodland in the past (Morris 2000).

<sup>13</sup> The possible significance of colour is addressed in chapter 5.

Ellen (1984) suggests that only physical actions can be observed, the meaning has to be deduced. He also comments that if social actors can comprehend their own meaning it should be possible for the researcher to get at it. I tried this in various ways and quickly began to develop the antennae of an anthropologist. I soon realised I was never off duty, whether in the village, visiting friends, waiting endlessly somewhere, at church or in the bank. My curiosity had been aroused.

A key area of concern prior to commencing fieldwork was about how I should act if there was a crisis with a pregnant woman. The reasons for this are explored in more depth later but I wanted to avoid influencing decisions where possible. Early on Stella asked me to see a woman in late pregnancy who she believed to be seriously anaemic (case study 1, chapter 5). I was reluctant to be seen as an advisor but Stella was not going to let me refuse, and should I anyway? Seeing Dalita, I agreed with Stella's judgement. What did she think should happen to her? 'I think she should go to hospital' she replied, and would I please drive her there. Relieved because Dalita would receive treatment without me having to intervene, I readily agreed.<sup>14</sup>

I found this combination of co-operation with requests for help, and judicious questions about what the *azamba* wanted to happen, was a useful strategy. I had not interfered but neither had I refused help. Their judgements were sound – a woman in slow labour, another with an open breast abscess, one carrying a breech baby. Transport was requested each time and I always agreed, asking that an *azamba* should accompany me when women were labouring strongly. When carrying the woman whose fetus was 'breech' we arrived just in time with the woman across the back seat, female relative squeezed in beside her and Grace in front. Grace returned pleased with herself, having been commended by the doctor for taking her in. I will never know whether she did so because I arrived; in any case walking in such advanced labour would probably have led to a roadside breech birth.

As expected I found that being in the right place at the right time demanded flexibility, adaptability and acceptance of disappointment. At the same time, fieldwork could not be completely casual and a deliberate element of choice – of purposive

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<sup>14</sup> Severe anaemia is very common in Malawi; it puts women at increased risk from even normal blood loss during birth and reduces their chances of resisting other problems such as infection.



sampling of participants and events – was needed to make optimum use of limited time. Formally ‘arranged’, but informally conducted, interviews contributed hugely to my ability to gain what Holloway calls ‘a sense of the setting or ‘feel for it’ and (to) understand what’s going on here’ (1997:63). Interview participants too had busy lives and, although some chance opportunities arose, people could not normally stop to talk without an element of prior ‘booking’. Punctuality was expected and people always knew what time of day it was by the sun if they did not own a watch. Nevertheless, I would often wait for an hour or two.

## Interviews

### *The mother and baby survey.*

Stella, Regina and Grace were the main organisers of interviews. They knew the areas of current focus and at first I was almost totally in their hands. Our first organised activity within the villages, which lasted through two visits, was to talk to mothers of young babies. This gave me a picture of a whole range of issues: marriage and residence, who decided on place of birth, and family size and spacing. I had devised a schedule but talk was informal and altered depending on circumstance; for example I refused to interview a woman with a very sick baby because I thought it to be inappropriate and insensitive. Another (only one) was very unwilling and I refused to continue despite pressure from Stella who scolded her for not talking to me.

We talked to 76 mothers through the cluster of villages, including those with babies up to one year of age. I noticed that Regina and Grace were only taking me to women who had given birth with them, not in hospital, and not to those who had given birth alone or with untrained female supporters. I worried that the picture might be muddied by the selection bias of these *azamba*. Repeated casual enquiries suggested however that women no longer used untrained supporters or gave birth alone other than by accident.<sup>15</sup> Women walked for several kilometres from distant villages to give birth in the Kalanje birth house rather than with closer *azamba*. I eventually recognised that I was developing a clear enough impression of what was happening anyway. Many of the women, and those from whom I took life histories, were including details of former

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<sup>15</sup> I was unaware at this time that this was uncommon in this area.

pregnancies when they had given birth elsewhere. I might not have seen women with whom there was some dispute or where serious problems had arisen. Nonetheless Mai Sichali appeared to have a clear knowledge of events at village level, through regular visits and information from the community health workers. She expressed confidence that she always received information when serious problems arose and did not believe anything was being hidden from me.<sup>16</sup>

### *Group interviews*

I had several topics that I wanted to discuss and so I selected female and male group interviews as the method of choice, in some cases using active participatory techniques. Fig. 3.5 show the yellow card discs used for devising the Venn diagrams (see chapter 5) and three of the groups involved. Such techniques worked well with the women, less so with male groups which were more formal.

Fig. 3.5 Discussion groups working on Venn diagrams



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<sup>16</sup> Asked how she knew what was happening in the villages for which she was responsible, Mai Sichali explained that both Village Health Workers and Heads would report incidents to her. The area was well-populated and it would not be possible to conceal a serious incident for long. Village Health workers are responsible in Malawi for community health promotion and education.

For each discussion topic I devised a schedule of areas to discuss, and refined this with Jane's assistance. Deliberate attempts were made to keep the sessions as discussions and to avoid leading the answers. Despite the language barriers, I found it fairly easy to see when Jane's own ideas were beginning to intrude and we learned together how to conduct ourselves as partners. I could also use these group events to follow up questions that had arisen from observation and casual talk. The chosen topics were:

- Patterns of marriage and residence;
- Decision-making in households;
- Marriage;
- Pregnancy and fertility;
- Birth;
- Education and preparation for childbearing;
- Choice of birth place and attendant.

Marriage and residence, then decision-making discussions were each conducted with separate male and female groups in four villages. The sessions on marriage processes and childbearing were mainly conducted with women as some men started to demand payment. Some extra sessions were added at the end as more groups wanted to take part and one Village Head criticised my hostess for using the same people repeatedly. The gendered groups were very different. Women would meet casually, often sitting on the ground under a tree and chatting loudly. The groups were lively, often noisy and full of laughter. No children above the age of about four, or young unmarried women, would be permitted to stay for subjects such as sex, marriage and birth which were deemed unsuitable. I would place the microphones on the ground amongst the group of women and generally obtained good quality recordings despite the outdoor environment. Only once or twice did chaos follow when we had to move to a tin-roofed house because of heavy rain. Recording was particularly easy in the Kalanje birth house. Men were always more sober, sitting in a circle on chairs and speaking more moderately and formally with the odd chuckle as light relief. The men proved to be much more difficult to audio-record.

The formal arrangements distanced them from the microphones and their deeper voices were harder to pick up.

I compromised successfully on audio equipment, taking no sophisticated facilities with me for reasons of convenience and theft. I used a battery powered handheld personal stereo with a tie microphone, and always carried reserve equipment. I later acquired a pair of miniature boundary microphones which performed admirably. In the evenings I would copy the tapes for security. I recorded singing and dancing inside and out of doors in the same way with surprising success.

Participants were both self selected and invited by the *azamba*. From these groups I identified people for individual interviews. I conducted several life history interviews with women and men, talked to Village Headmen and women, and explored particular situations from the perspective of different actors to create case histories. Particularly successful were the interviews with both male and female Heads regarding safer motherhood. They proved to be an excellent source of information, ideas and indicators of community concerns.

A range of other informants agreed to contribute, often in English. The secondary school headmaster provided valuable information, as did a Scottish religious sister who worked in the maternity unit and focussed specifically around her hospital-based practice. I interviewed three more hospital midwives during my recent return visit, signalled in this thesis as Midwives A, B and C. A Malawian anthropologist working for the UK DFID-funded Safe Motherhood Office in Blantyre clarified several issues that I struggled to understand. I was able to talk also to her colleagues: a British anthropologist, the medical director and her successor, a public health physician. They provided information and reports about their extensive project activities.

A four day academic conference at Chancellor College, to which I am affiliated, brought together local and foreign researchers and academics from history, anthropology, religious studies and geography. All of these people had worked in Malawi or continued to do so and meeting them broadened my knowledge substantially.

## **Ethical issues, encountered, addressed and analysed**

A variety of ethical issues was encountered, some anticipated and some not, some considered at length and some addressed as seemed best in the heat of the moment. Areas of confidentiality and anonymity, of reciprocity and dependency were encountered as must happen to all field researchers. Less universal perhaps were those that arose from being a midwife as well as anthropologist and the way in which I reconciled differences in expectations resulting from this. I also anticipated dilemmas around intervention and encountered some, if fewer than expected. Nevertheless revealing secret knowledge became an issue for me. I consider these issues and the way I responded to them next.

### **Confidentiality and anonymity**

Confidentiality and anonymity had to be key areas for decision-making about how to act. It would be almost impossible to conceal identities of some informants and anonymity was not promised, but for others it was promised as far as could be controlled. Most were illiterate and consent forms were not used.<sup>17</sup> I would tell the group that what they said was confidential, I would not reveal what they said within the community and their anonymity would be guarded in publication. The Ministry of Health Ethics Committee had made no demands of me so I was free to act as I saw fit whilst avoiding unnecessary invasions of privacy and exploitation. Power differentials were not a problem as no one needed to turn up to group sessions and individuals could easily find ways of evading me and my tape recorder, or leaving midway.

Confidentiality did not end with the avoidance of broadcasting what informants said to me; there were more complex issues that arose around secrecy and conflicting demands on me. Before explaining how I overcame such dilemmas, I examine the everyday issue of how I acted in the context of my dependency on those who helped me, and their need of resources to which I had access. Although often difficult to describe I choose to examine these issues in some depth because my attitudes and behaviour had an undoubted effect on successes and disappointments.

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<sup>17</sup> The use of consent forms is a standard device within UK midwifery research and my decision has been challenged by UK colleagues from outside of anthropology.

### **Reciprocity and dependency, a methodological conundrum**

Before leaving for the field I had read material on feminist research and expected the need for an element of reciprocity in the interview encounter. I had read Ann Oakley (1981) on interviewing women, Callaway (1992) on gender in ethnography, and Judith Okely (1992) who discusses the mutual exchange of life histories and personal knowledge. I found that I needed to answer questions and give information less than I had expected from reading Oakley; perhaps I was just successful at emphasising the learning aspect of what I was doing rather than the teaching. I found ways of sharing knowledge and techniques with the *azamba* and normally did not describe my own midwifery practices unless they had indicated their interest alongside telling me theirs. It probably helped that I could be critical of some areas of UK practice (which still persist in Malawi as a result of years of European teaching). The situation was as I had anticipated with the first interview group members who did appear to expect me to teach them. Over the years they had received a variety of Malawian and foreign advisory workers, especially in health and agriculture,<sup>18</sup> but they quickly responded to explanations of my role. With the women, talk was distinctly 'female' as described by Oakley (1981). The women wanted to know about me, and the photographs of my husband and children proved to be important tools. They wanted the sharing of lives described by Coffey (1999:130). This became even more pronounced when my daughter married between fieldwork visits so I had wedding photographs to take back. These proved to be immensely popular and initiated many useful conversations.

Attendances at births were a more contested area of reciprocity. Persistence was needed to persuade Stella that I should not be delivering the babies instead of her. She wanted to watch me, but I believe was sorely disappointed in what she saw when I relented; my practice was probably inadequate from her view. She had been taught by a Malawian retired professional midwife and delivered babies in the manner I had used when I first trained, while I now practiced in the less interventionist manner growing in favour among UK midwives. Inevitably though, some of the non-intervention was a cover

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<sup>18</sup> At the time of the fieldwork, the area appeared to have only four foreign hospital-based health personnel and a construction engineer, mostly Roman Catholic missionaries. Only Malawians were to be seen in the villages e.g. nurse-midwives teaching at the Mother and Baby Clinic and the Village Health Worker.

for ineptitude, since I had been too long in a university environment and felt rusty and inadequate beside Stella.

Reciprocity around interviews was also at work when I decided early on I would offer no payment. I provided soft drinks and offered to take photographs of all interviewees. This was popular, eventually causing significant problems with later group interviews when they suddenly became huge, some women arriving as we finished, probably in order to be photographed. For most people a photograph was a treasured possession.

I repaid household members for their hospitality by completing the construction of my accommodation instead of rent. Other requests were made which I never really learned how to handle; undoubtedly I did not always react with good grace especially when I was criticised for acting inequitably, or was asked for more. Living within the village environment and a large, relatively educated household with very limited resources, I was constantly aware of need. I found this hard and did not know where to draw the line between fair reciprocity and dependency.

To an extent I was constantly under obligation as I needed help. My hostess arranged everything for me. Her older son, Brian, managed the work needed to make my room habitable and more importantly, supervised the birth-house project introduced earlier in this chapter, putting in many days of unpaid work. He assisted me in many ways but the need to maintain some element of surveillance and to expect accountability inevitably altered the relationship.

I learned about Malawian ways of conducting business through Brian and building the birth-houses, but it was all too easy to resent the time spent on it. It also appeared to me as a living example of what my first interpreter calls the 'demon of dependency' that he believes delays his country's progress.

The lack of a waterproof roof on her birth-house in Kalanje was causing problems for Grace who wanted to replace the picturesque but inconvenient thatch with galvanised sheets. I was unsure what her mother wanted to happen, being unaware at that time that they disagreed over many things and that the birth-house actually belonged to Grace. Regina usually helped women to give birth in their homes as she had always done. In Malinga, Stella's lack of a dedicated birth-house caused problems for her, some older

women suggesting there was no point in sending their young women to her as she had no better facilities than did they.

The birth house saga is a long one; suffice it to say here that as the project grew way beyond the original plans – for a new roof for the old Kalanje house and a simple building in Malinga – I became increasingly concerned at the lack of support from community residents who, I had understood, were to make bricks and provide labour. Even worse, conflict arose in my absence in the UK. On my return I learned of accusations that one person involved had perpetrated a late night attack on the *azamba* of Kalanje to steal stored building supplies; a labouring woman had been slightly injured. Frustrated and confused I talked to the Village Heads who dismissed the accusations and put them down to the jealousy of those who wished to control the funds. Later the accusers claimed to have been mistaken in the darkness, the attacker had been a stranger, and the furore subsided.

Finally the houses were successfully completed and equipped but the problems would not have happened, I was informed, if I had just given the money to a village committee or to the hospital to manage. My main error appears however to have been to assume that the community wanted the birth houses too. Because the *azamba* charged for attending births, the houses that were seen as their property would help them to make more money. I had thus only helped the *azamba*, I was told, not the community. Nevertheless it was satisfying to see the completed buildings despite the departure from the original plans.<sup>19</sup> The original Kalanje birth house and the new ones are shown in fig. 3.6. 3.7 and 3.8.

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<sup>19</sup> These buildings were finally furnished (if reluctantly on my part) with beds, mattresses and curtains. The request for beds led to one of the midwife to midwife discussions I so much relished but so often avoided, provoked by my misgivings about beds encouraging women to remain static and poorly positioned for labour and birth. Eventually I complied with the requests believing I had no right to determine what was appropriate about the ways in which the *azamba* provided their care.





Fig. 3.6 and 3.7 Kalanje original birth house (above) and the new (below)

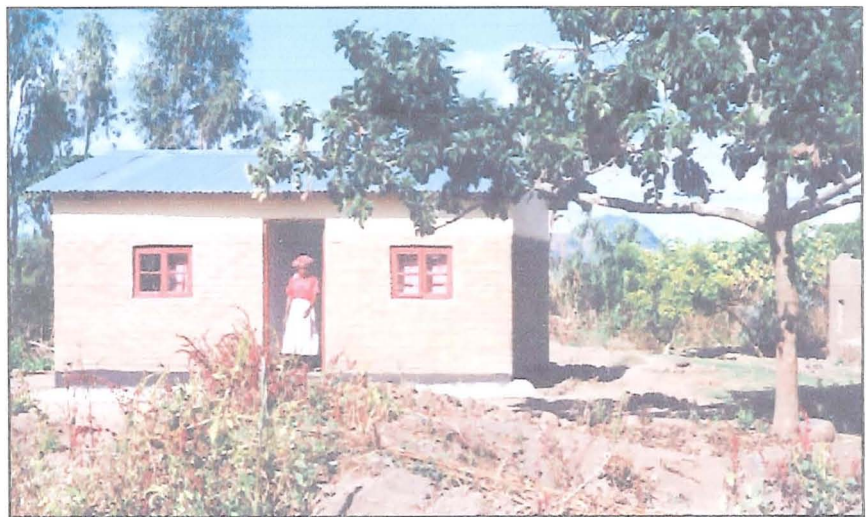


Fig. 3.8 Women dance outside of the Malinga birth house with the three *azamba*



The rights and wrongs of my attempt to comply with government expectations are difficult to identify. Undoubtedly I was manipulated but probably laid myself open to this. Should I have refused to go beyond the initial agreement with the Village Heads and *azamba* to purchase roofing materials with the community providing labour, making bricks and cutting wood? It was hard to refuse to extend assistance when the evidence suggested the project would just stop and all investment would be wasted, with materials probably disappearing into private use. Did other researchers comply with these requirements? After all no one checked on my compliance. I will never know whether assisting the community in this way served only to perpetuate dependency. So where does reciprocity end and exploitation begin? That perhaps is impossible to determine without an appreciation of what is usual, and considering how they are intangible notions of personal constructs and vested interest.

Reciprocity was involved also in the encounter between midwives and in interviewing women. As noted earlier, I specifically avoided what I saw as teaching. I had made a conscious decision to suspend my professional role as much as possible. Whether this could be maintained is considered in the next section. As the fuss over the birth house attack settled another situation came to light that was to bring up all my pre-fieldwork fears about how to reconcile my two roles as anthropologist and midwife. Issues of secret knowledge and its ownership arose, of the right of respondents to choose what to reveal, the right of research subjects not to suffer because of the researcher's presence, and most acute of all, when to intervene. These dilemmas are explored next.

### **Reconciling differences, anticipation, reality and ethics**

Before leaving for the field, I experienced qualms about how I would act if a pregnancy emergency or birthing situation arose that disturbed me and moreover, anticipated conflict regarding expectations of me in this regard. In this next section I first address the dilemmas that I faced and how I reconciled the differences in my two worlds.<sup>20</sup>

What was I to do if I did not like what I saw happening to birthing women? This question, loaded with assumptions, demonstrates my attempt to integrate the potentially

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<sup>20</sup> Such dilemmas as mine were encountered also by Lewis as he worked as an anthropologist in New Guinea after qualifying as a medical doctor, and are explored 32 years later in Lewis (2000).

dissonant personae of midwife and anthropologist. How confident was I in biomedicine as explanatory paradigm for every human experience including pregnancy and birth? I expected local birthing practices to be different and knew that evidence for making judgements might be unclear. I must 'think on my feet' and work out what was my own 'bottom line'.

To an extent, my anxiety indicates another assumption – that my position is different from that of other anthropologists. They too would wish to intervene if a woman was in trouble and provide the assistance needed, even perhaps acting against what they saw happening. Childbirth is a normal life event; this is the philosophy of many contemporary western midwives. However it remains impossible to ignore the extreme events that can occur, and are considered to be more likely when women have a history of too many babies too often, too young or with inadequate food supplies, or inappropriate interference and poor hygiene. Women can bleed to death in minutes, can suffer convulsions or get infected with fatal consequences. The unborn child can become badly positioned or the woman's pelvis may be too small to allow it through. The woman struggles hopelessly to give birth until she dies of shock, dehydration and infection, or survives with permanent internal damage. Perhaps the difference between me and most other anthropologists is that I know all this. My midwifery training prepares me to predict and recognise situations that others may not, and above all I am 'programmed' to act. Any person would do their best to assist but more is expected of me. I too expected more of me, so I carried baggage into the field that had the potential to hinder my search for the local reality of childbearing and the concepts and knowledge of the 'other'.

In more anxious pre-fieldwork moments then, I confronted how I might act if intervention appeared necessary. Worst-case scenarios were witnessing internal manipulations and pulling on the unborn baby, application of substances such as cow-dung to the genitalia of women or to infants' umbilical cords, and pummelling on the woman's abdomen to speed up the birth, all known practices in Malawi. Less anticipated at the time was being privy to secret knowledge and what I might do with it but I recognised the need to be circumspect regarding the authorities. I needed their cooperation but was wary of losing informants' confidence if they suspected I was reporting back, and then there was a straightforward ethic of confidentiality. I had also to take responsibility for the ethical conduct of my interpreters. News travels fast in a small

community and I knew attempts at manipulation of my interpreters were possible, especially for Jane, living on site as she did.

I was aware of the potential for harm to my informants and took account of Homans who warned that social researchers could be held accountable for harm, 'only at their peril - proceeding without reckoning the likely consequences and implications of their work' (1991:176). Demands for information might come from authorities and Plummer (1983) believed exploitation and betrayal of subjects to be a crucial ethical issue. Conversely non-intervention could itself be exploitative, here of childbearing women, if my reluctance to help was grounded in a fear of damaging relationships.

Ultimately I found people appeared not to see me as a potential troublemaker, rather they had unrealistic expectations of my relationships with health officials – advocacy was expected even to government level. Nevertheless it was confidences and privileged information which eventually caused me more worry than the need to intervene.

### *Two systems of medicine:*

Before considering what actually happened, I need to explore the reason for anticipating such predicaments and locate myself in the two worlds, my familiar world of midwifery and 'the other' as an anthropologist in the field.

I trained when home birth was still an easy option in the UK although hospital birth and interventionist medicine was on the ascendant. I preferred the relative freedom and rewarding relationships of community practice and relished two years working with refugees in Senegal. Returning to the UK I settled back into a junior hospital post with difficulty. Pregnancy concentrated my mind and I realised I did not want the sort of birth many of my clients were experiencing. Attending natural childbirth classes and selecting my midwife carefully I soon went on to become 'radical' as a midwife and a natural childbirth teacher myself. So I was poised uncomfortably between two ways of knowing and the scene was set for a dilemma in the field. Raised in the confident atmosphere of the western biomedical paradigm, I knew that alternatives existed, might be preferable and that Malawians may well prove to 'mix and match' despite some practices being dangerous (Kamwendo 1996). If Malawians could reconcile difference and move freely between forms of health care, could I also reconcile different ideas and professional ethical demands?

*Two codes of practice*

Both anthropology and midwifery have codes of practice and guidelines. As a UK registered midwife I am accountable for my practice in whatever environment I find myself. 'In all circumstances, the safety and welfare of the mother and baby are of primary importance' state the Midwives Rules and Code of Practice (UKCC 1998: Code section.1). I would not be entitled to practice in Malawi and was not there for that purpose but people might not see it that way and authorities would no doubt still hold me accountable. The UK Code of Conduct (UKCC 1992) (Appendix 1) with its emphasis on beneficence and accountability was familiar to Malawians (Msowoya, personal communication, 1999), and the International Code of Ethics for Midwives expects the same standards of midwives anywhere (International Confederation of Midwives 2000) (Appendix 2). The ICM code encourages respect for cultural diversity whilst 'working to eliminate harmful practices'. The interests of mothers and babies could never be subordinated to research interests or even to the reputation of individuals such as indigenous midwives. But what would be the best interest of mothers and babies, and what were harmful practices? This was not so easy to answer.

Still concerned about these issues I talked them through with the supervisor designated by the University of Malawi who advised me that the Ministry Ethics Committee approval safeguarded me for whatever action I chose. Yet I still felt that these midwifery codes and the promise of support for decisions I made could not determine appropriate action for me. Could the anthropological codes help?

The Ethical Guidelines of the Association of Social Anthropologists (1997) articulates the primacy of the interests of research subjects and the need to reconsider the project if these could not be ensured. Yet sensitivity to potential for harm and disturbance was not really my difficulty, I had plenty of that. Confidentiality and anonymity were addressed, as were the honouring of trust and protection of research subjects. Furthermore, like the codes for midwives, these guidelines were inevitably general and so I must trust my own judgement in the circumstance – situational ethics. Thus as Lewis (2000) found, the point of intervention cannot be determined before the watershed is reached. For me the problem was identifying the watershed itself.

I identified both differences and similarities in the codes, as is inevitable when philosophies are shared: of utilitarianism and duty, principles of beneficence, autonomy, and avoidance of harm and exploitation. Themes of exploitation are most evident in the

anthropology guidance, perhaps with good reason. Research will often serve the interests of the researcher or sponsors more than that of subjects. There is such a strong emphasis on the duty of care in midwifery and nursing codes that exploitation hardly features except for a brief recognition (RCN 1993), and the avoidance of abuse of privileged relationships and exploitation for commercial gain (UKCC 1992). Unsurprisingly, 'doing good' is the strongest emphasis.

The RCN (1993) acknowledges potential ambiguities and dissonance between research and caring roles and recommends confining researcher intervention to protection or rescue alone, unless employed as a carer. Nothing is said about reporting malpractice but the emphasis on anonymity and the confidentiality of privileged information is strong. The potential of research for revealing 'deviations' from normal practice is recognised, recommending remedial rather than punitive action and condemning efforts to determine concealed identity. The UKCC (1998) ambiguously advises disclosure as sometimes justifiable 'in the wider public interest' and supports the reporting of circumstances that 'jeopardise standards of practice'.

In the end, issues of intervention hardly arose until I learned of Grace's 'accident'<sup>21</sup> that I describe in detail in Barber (2003) (Appendix 3). Grace and Regina were both very popular as *azamba*. Part of this undoubtedly derived from their reputation for safe and kindly care, and from their position on the route to the hospital. Labouring women often got no further. Later I recognised their willingness to help women considered unsuitable by Stella (such as first time mothers) as a factor. Grace however lived life at the run, and was known as unpredictable; she was supposed to work under her mother's supervision although conflict was common and Regina complained she could no longer teach her. I already knew from Grace herself and from the supervisor that she used herbal oxytocic substances to strengthen uterine contractions. These can work very powerfully but unpredictably (see chapter 7) and their use is condemned by the health authorities.<sup>22</sup>

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<sup>21</sup> Terminology of her supervisor.

<sup>22</sup> Bullough (1980) studied such herbal medications and found Malawian TBAs used them extensively to speed labour. Used globally in a synthetic form in hospitals, oxytocin can be dangerous there too. The danger lies in forcing the uterus to work hard when the baby is badly positioned, or is too large to pass through the mother's pelvis which may in turn be small or deformed. The uterus eventually tears and, without blood transfusion and antibiotics both woman and baby usually die of haemorrhage, shock and Continues over

On this occasion Grace had given several doses of herbs and the woman in her care had come close to dying (Majami's story is described as case study 5 in chapter 5). My dilemma was that Grace had now told me she used the medicine in question for pain relief, denying what we both knew – that she used the herbs as uterine stimulants. Pain relief was, as far as I knew, not the usual use for them and I was unsure what to do about it.<sup>23</sup> I could inform the supervisor of what I had been told, I could maintain silence, or tackle Grace's practice myself.

### **The anthropologist's dilemma, the politics and ethics of whistle-blowing**

#### *Observing ethical codes*

Anthropologists live their research. It must be the supreme example of embodied knowledge and dilemmas cannot be switched off at the end of the day. For me a dilemma existed because of competing paradigms of practice, not so much between anthropology and midwifery, as I had expected, but more because I believed that no one form of childbirth knowledge had all the answers. I also knew that my decisions could have significant consequences, both for local women and for the midwives who were my main informants and collaborators.

It was important to get it right but codes of practice are designed to guide and alert the reader to the issues at stake, not to act as rules of conduct. Codes provide an alert to the language of responsibility (Kellehear 1989) and support ethical reasoning without removing individual judgement. Ethical principles can be taught; moral reasoning is learned by experience and practice judgements have to be made in the light of the moment. In the end, attitude is all-important. 'Ethical conduct derives from a way of seeing and interpreting relationships' (Kellehear 1989:71). Codes can do little but indicate a profession's view of desirable attributes and, as Strathern (2000) argues, relate individual actions to it. This is especially so when, as in anthropology, there are limited

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infection. Obstructed labour is one of the main immediate causes of maternal death in Malawi, (MOHP 1995), and in Zambia 85% of women who died had taken such medicine (Nkata 1997). Toxic effects are common too.

<sup>23</sup> Further reading since that time has clarified the fact that several herbs are used and often for different purposes including for pain relief in labour, 'stomach troubles', and as abortifacants (Bullough 1980, Morris 1996).



sanctions available. Conversely a midwife can be called to account under threat of withdrawal of registration which, in most countries, makes continuing practice illegal.

### *The anthropologist as interventionist*

A long history of the anthropologist as advocate exists and it can be a highly political activity. I could have tried to deal with Grace myself but felt I had no right or mandate to do so. Maybe it would have been an effective strategy to have shared my disquiet at her activities with her, but I wanted to conform to my earlier determination to avoid such intervention. Giving my opinion might however have been seen as reciprocity, could have kept her out of trouble in the future and helped to protect the women in her care. With hindsight perhaps I was too sensitive to my status as enquirer, and too precious about what Grace thought of me. Dealing with the issue myself might have been an effective compromise that avoided involving others.

The dilemma was to tell, or not to tell. The consequences of not telling might be continuing dangerous practice, but of doing so – no experienced care at all. I knew that a possible outcome was that Grace might be removed from recognition but continue to practice, now unsupervised and unchecked. I was convinced that her care was otherwise far preferable to the untrained ‘grannies’. Leaving aside such consequential reckoning, the *azamba* had provided information in a private setting but with the tape recorder running, notebook in hand and with no promise for them of anonymity because I knew how easily identifiable they would be. Grace, Regina and Stella knew I was planning to write. However they gave me information for a specific purpose, which did not include reporting on them.

### *Confidentiality and keeping secret knowledge secret*

It can be seen then that ethical decision-making in anthropology is a dynamic process. The researcher must engage with it in the context of guidance from those who have been before, but with an eye on the consequences for those concerned in the specific scenario. To an extent I had to act as agent for these actors and alone make decisions that affected their lives. It is not as straightforward as the apparently simple ‘do good and do no harm’ of the health care professional. Certainly it complicates matters when the anthropologist carries the baggage of another label like ‘midwife’ and inherent self-imposed and public expectations. I also knew that some disclosure was made inevitable by the very public act of writing notwithstanding the guarding of identities which I had originally intended.



The issue of secret knowledge and confidentiality is more complicated when informants may have limited insight into the potential for trouble. I had moved in from another world, experienced in both one-to-one and group encounters, made friends, and with the help of a local interpreter succeeded in getting people talking in ways they would never normally do. At times I wanted to warn 'you shouldn't be telling me this' as people volunteered information I had not deliberately sought but I never did so. Did Grace realise how dangerous I could be? Was Stella really so safety conscious and conforming to what the authorities wanted of her to the detriment of her own income, or did she just have more insight into my potential? At the same time I am perhaps guilty of paternalism in thinking Grace may not have understood what she was doing in both talking to me, and declining anonymity.

There is another item too on my personal agenda regarding disclosure of information. I believe firmly in the potential contribution of indigenous midwives in the context of limited resources and the unreality of expecting rapid change however much money is invested. I believe too in their importance in providing culturally sensitive support that is so often lacking in professional care. I remain unconvinced about the impossibility of educating and supervising them adequately. Could my revelations about Grace, a well-supervised 'trained' indigenous midwife, just serve to reinforce prejudice and deprive women of these trusted companions?

Finally I return to whistle blowing. I have analysed the background to my uncertainty how to act, considered the available guidance and described what happened when I reached my 'watershed' (Lewis 2000). The codes and literature about the ethics of intervention or about secret knowledge contribute little, just some case studies (AAA 1998) and examples from the past, enjoinders to consider the public good (UKCC 1992) and the overall emphasis on confidentiality. In the end Grace was really doing nothing very new and her supervisor's awareness of the need to watch and educate her got me off the hook.

## **How then did my autobiography and circumstances affect my success in the field?**

Inevitably my limited language fluency was a drawback and partly a consequence of contemporary conflicting demands on time. Ellen (1984) recognises the need for realism where language learning is concerned in the era of restricted research funding. However I was able to work around this deficit in several ways. I almost always took contemporaneous notes when talking to people with the help of my interpreters, or made them very soon after. I was usually able to pick up when there was some anomaly in the interpretation; answers were unexpected, or did not make sense, or someone who knew some English would redirect the conversation, or I would understand enough chiChewa. My first UK-based teacher, Kondwani, gave reassurance by commenting that early audio tapes demonstrated how I identified misunderstandings between myself, the interpreter and my informants. She noted how I double-checked when unsure by seeking the information from a different angle. Stella and Grace both had some understanding of English and were tactful in doing the same if Jane mistranslated. Following my first period working with Jane, audio tapes were translated at the University with a specifically commissioned remit to check the accuracy of our work together and alert me to problems. Jane was not a trained interpreter, but she was able to stay with me, was a mother, and her skill rapidly improved. A female interpreter was essential as topics became more sensitive. Without a baby much of the information would have been tempered by the fact that women should know nothing about pregnancy before experiencing it and women would have been less willing to talk. Indeed the baby, later a toddler, acted as a real 'ice breaker' for me when meeting with groups of women. Research assistants and interpreters on offer from the University would have had none of these qualities. Three Malawian translators were used in UK, Suzie Forster taking the main load. Suzie provided highly encouraging feed-back by informing me that it was rare for people to talk as openly as they had done to me, and that my interview techniques were very appropriate resulting in credible information.<sup>24</sup>

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<sup>24</sup> Suzie Forster is very accustomed to such work having supported her husband, the anthropologist the late Dr. Peter Forster, in interviews and translation for many years.

My status as a midwife must have made both positive and negative differences. Much good will and interest in my project was expressed when I explained it to informants as 'writing a book about having babies in Malawi'.<sup>25</sup> This strategy is commended by Agar (1996) as is the importance of the presentation of the self. My profession gained me entrance to the field with no local or national problems. Some people viewed me as a religious 'sister', others just as a white woman whose husband appeared from time to time. This latter fact was very important, as was my motherhood, although many were disturbed that we only had two children as Caplan (1995) experienced in Mafia. I am certain my grey hair also helped me to gain acceptance but I did not ever feel I was assigned a position as honorary male (Ellen 1984).

Potential effects of the limited timescale and fragmentation of the fieldwork were mitigated by my previous experience in making rapid and empathetic relationships with strangers and people from different cultures. I had experience in informal interviewing and approaching sensitive topics, perhaps with unwilling respondents, and sensitivity to making waves. If anything I would perhaps hold back too much to avoid upsetting someone but such awareness appeared to be appreciated. I was very touched to be told by a group of older men, when discussing residence and marriage patterns, that no one had ever talked like that to them before. Moreover I always tried to avoid progressing too fast; Bernard (1995) points out the unreliable responses that may result from trying to learn as much as possible in a short time.

I must of course not underestimate the effects of my skin colour, nationality, comparative wealth and midwifery training on my relationships. I had little contact with hospital midwives but visits there, perhaps when transporting labouring women or sick villagers, were the least comfortable of my encounters. This awareness is particularly important in relation to the *azamba* as is seen in the story of Grace Kamba. I may never know how selective was information-giving. All three *azamba* had healing knowledge, Regina and Grace at least being used as healers. This I suspect may be the main area where a substantial gap almost certainly exists between information I gathered and the reality. Stella was openly critical of others but I would expect her in particular to have a keen sense of which therapies I might be expected to disapprove. Regina and Grace may

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<sup>25</sup> Some informants understood well the notion of doctoral research and theses, for example Mai Sichali's husband (since deceased) had a PhD in chemistry.

have been less acutely aware of this but I am uncertain that more intensive probing would have produced significantly greater results.

In a more general sense, my presence did not appear to make much difference to the community – what Bernard (1995:141) calls ‘low reactivity’ that makes for greater validity of data. A few children would call out after me *jambuli, jambuli* (photograph, photograph) but people did not take much notice as Jane and I went around the community despite a white face being a rarity to the majority who did not often (or even ever) go to town. A wave and a greeting were welcome but no hoards of following children appeared. Household visits were special and always a chair or mat would be brought for me but even there people only rushed to get out of working clothes for photographs. I remained an honoured guest but so too did my interpreter and the *azamba*.

My need to return to UK at intervals inevitably limited immersion; in no way could the methods used amount to classic long-term anthropology. However some unexpected insights did arise, in some ways similar to the unusual experiences described by Coffey (1999:33) if less dramatic than instances she gives such as seeing spirits. The incidents were distinctly counter-intuitive to me from my rational biomedical background and Christian philosophy. Bewitching is a constant fear for many Malawians. A situation arose where a village *mfumu* was telling me that I had gone about a certain activity in the wrong way and it would have been better if he had been in control. I offered to put matters right but he warned me that this would put him in danger of being bewitched so I did nothing – I was learning to follow village norms – almost as though I also had to protect people. I also learned to stay indoors at night, few were about who had good intentions although this for me was a fear of robbery – not the spirits. Nonetheless, it was not difficult to understand the fear that prevented labouring women from walking to the hospital, or even the village midwife’s house, at night.

The final example was curious. New grandparents are expected to abstain from intercourse to avoid harming the baby while they are ‘hot’ from sexual activity. This applies too to those who hold babies and is explored further in chapters 6 and 8. What was I to do when my husband arrived? This was not rational but a confusing mixture of not knowing what was expected of me, fearing what others might think if they thought I had broken the taboo, and almost an actual unwillingness to do so. Later I asked my hostess if this was important for midwives – did they have to turn women away if they had had sex?

No was the reply, this was not of concern nowadays. Fleeting though these doubts were, they were real enough and perhaps are an example of embodied knowledge.

The project then was designed and carried out with the intention of using a considered approach to the effect I had on the results and the people. However my own agenda was being served. For the work to fulfil criteria for the feminist paradigm (Hall and Stevens 1991), the patriarchal (if benevolent) concerns of the health care worker to find out why women are not compliant with their advice is not enough. Even though I wish to find out more about the constraints on women from their own vision of reality, that is probably fulfilling my midwifery agenda and anthropological curiosity. I believe however that the reflexive approach that causes me to 'explicitly scrutinize' my 'history, assumptions, motives, interests, and interpretations' (Hall and Stevens 1991:18) helps me to be aware of whether I am seeing the world purely through my own eyes as I create the ethnographic text, or am achieving some degree of the experience and interpretation of the other.

A last quotation from Hall and Stevens (1991:21) illustrates the importance of reflexivity. They say, 'It is the deliberate, thoughtful assessment of how researchers themselves participate in creating and interpreting research data that is the mark of adequate feminist enquiry'. I knew that this would have to continue to be explored in greater depth both while writing my thesis and in publication.

## **Conclusion**

In this chapter I have described the methods I used to gather information that would support the development of my thesis and demonstrated how I prepared for and managed fieldwork. Using a reflexive and autobiographical approach, I have given an account of how I used my dual background of midwife and anthropologist and other aspects of my personal circumstances to advantage. I have also considered how these might have affected what happened and the information available to me.

The particular circumstances raised several ethical issues; of secrecy and whistle-blowing, confidentiality and anonymity, potential good and harm. It also raised issues of reciprocity and dependency, and of reconciling different roles and expectations in order to foreground the anthropologist in me, while accepting and understanding the

midwife. The next chapter takes me forward to considering what proved to be a vital element to understand, the residence and marriage patterns that prevail in this community.

## **Chapter 4: 'Marriage is not for one person but is a family thing'; the local dynamics of residence, marriage and inheritance patterns**

### **Introduction**

A matrilineal kin group is ... a group of ... men and women ... who are culturally linked by descent through the female line (Morris 1998:96).

This chapter focuses on the way people live, in particular on matrilineal inheritance and matrilocal residence in the group of villages studied. I quickly became aware of how important these concepts are, both for identity and sense of belonging and as foundational ideology, processes, and structures. This is confirmed by Holy (1986). The way of life has specific meaning and links with notions of common ancestry and clan-ship,<sup>1</sup> and sharing of substance, particularly breast milk, blood and semen (Lawson 1949, Morris 1998, 2000). Carsten (2000:21-23) calls this sharing of the 'substance of relatedness'. Here it is specifically transmitted as cultural links through the female line from a common clan ancestress and shared breast (see quote from Morris 1998 above).

It became increasingly evident that I needed to understand how the dynamics and meaning of matriliney and matrilocal residence influenced the welfare of women, as there appeared to be significant potential for effects on decision-making for childbearing.

For this reason I offer a description and analysis of this topic using fieldwork findings and literature and present matriliney and matrilocality as a way of life and mind set as described to me by informants. I discuss the commencement of partnerships, the

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<sup>1</sup> No attempt will be made to address the issues of clans although of importance to Malawians, especially Chewa/Nyanja. I was unaware of the subject arising on any occasion.

choices couples face, where they live and how they work together, the ending of relationships and bereavement.<sup>2</sup>

I address the ways in which people provide for themselves, land ownership and control, and consider the roles of the various agents who support and possibly control the daily lives of men and women. I propose the possibility that the control of land, the relative freedom of women to reject unsatisfactory relationships, and the generally beneficent and supportive environment are all foundational to female autonomy and women's welfare at times of vulnerability like pregnancy. The gender politics of matriliney will be explored further in chapter 5 in which relational aspects of women's lives will be brought into exploring agency, who makes decisions and how.

By focussing on relatedness I do not imply a view of kinship as bounded entity; relationships are an integral and fluid part of the context and meaning of lives, as are history, economics and politics to those who live them. The expression and construction of matriliney may be very different in other settings and times as described by Vaughan (1983).

It became increasingly evident that the prevalent inheritance and residence processes and patterns are of prime importance to local people whose lives are consciously organised around them, and about which they are very willing to talk. Using Barnard's phraseology (1994), kinship here is 'transparently structured' and appreciated, informants expressing the 'naturalness' and lasting importance of the system to them. This accords with other writers on Malawi such as Peters (1997a) and Morris (2000) who note the resilience of this way of life despite pressures for change. Some informants, both male and female, made explicit comparisons with the patrilineal and patrilocal way of life in other areas of Malawi, thus matching Peters' (1997a) report of her informants' conscious differentiation of themselves from patrilineal people.

So the rationale for the inclusion of this chapter is predicated on its effect on childbearing decisions; kinship emerges as lived relationships, for being and doing and thus as stage set, script and performance.

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<sup>2</sup> I saw no evidence of the formation of alliances through marriage but do not rule out that it may still happen as described by Mitchell (1956) among others.



Key literature is discussed first because of the contested nature of kinship material and the debates around matriliney which Holy (1996) suggests do not go away. The main discussion of the evidence collected and the analysis of the implications for childbearing women makes reference to these sources where appropriate.

### **The literature on matrilineal inheritance and matrilocal residence as ways of living**

Whilst preparing for my second visit I read foundational literature on Central African residence and inheritance patterns and was intrigued by the debates around matriliney and matrilocality and how many ideas appeared incongruent with the limited information gathered to date. Meeting Pauline Peters back in Malawi set me on track for identifying more contemporary literature once I had returned to UK. Meanwhile I continued a naïve questioning of relationships and their importance for informants.

I read Radcliffe-Brown's (1950) theories of the social function of bounded and structured descent systems and the legitimising aspects of marriage, and Richards (1950) identifying the 'matrilineal puzzle', the contradictory demands on men by virtue of fatherhood and marital partnership in one community and sonship in another. This debate appears to have been dominant until challenged by cultural, feminist and later interpretive thinking that transforms the field from mere structures and function into meaning and lived experience (Schneider 1961, Poewe 1981, Carsten 2000).

The debate took many turns with challenging new ideas culminating in a collection of articles in *Critique of Anthropology* addressing what Peters (1997b) calls intentionality and agency in strategising. Such strategising is key to the adaptability that enables matriliney to be as resilient as Morris (2000) suggests, and as it appears to be both from my fieldwork and Brantley's reworking of Read's data (1997:165), in Brantley's words 'accommodating and borrowing' one system from the other.

Early emphasis by commentators who were mainly from patrilineal backgrounds themselves explained why such a system should have existed in the first place. Writers had moved on from seeing matriliney as a primitive response to circumstance with patriliney as a superior evolved form. Rather, it was seen as a

response to the demands of female-led hoe agriculture and male mobility through hunting, trading or labour migration, and dependent on a gendered division of labour (Schneider 1961). Men could travel and return to settled agricultural bases, women could rely on matrikin in their absence. Matrilineal descent and inheritance, and matrilocal residence, was characteristic of low-income groups with minimal technology for cultivation (Gough 1961a).

Writers such as Richards (1950) and Gough (1961b) believed such ways to be dying out with people moving toward patriliney and patrilocal residence. Alternative explanations for their demise were offered such as change in economic circumstance (Douglas 1969). The system was blamed for the fragility of marriage and considered incompatible with waged economy and Christian values. Both Mitchell (1956) and Phiri (1983) describe mission efforts to undermine matriliney, female land access and control of children. In the strongly Catholic and Muslim area of this study, however, church, mosque and people appeared to have reached a stable accommodation.

More recently men are reported to be rejecting matriliney and matrilocality, wishing to leave their possessions to their own offspring (Holy 1996) and take wives into patrilocal living. It is proposed that men are pulled by opposing responsibilities to wives and their matrikin, and to their own lineage. So too are women confused by duties and loyalty to husbands and to the brother or older male relative charged with their care, the *mwinimbumba* (Schneider 1961, Phiri 1983, Holy 1986). Schneider emphasises the problem of dual authority over women. Few mid twentieth century writers show much optimism about the future of matriliney and matrilocality in a capitalist world economy. Most articulate these patterns as dilemmas, full of contradictions and disadvantages, always, I note, from the male perspective. Conversely Peters (1997a) challenges these writers asserting that the emphasis on strained relationships, woman and husband, and mother's brother, implies inattention to gender relations and an undue emphasis on notions of bounded groups and division.

A key feature throughout the material is the expectation that men in such systems still hold political and jural power and household control. Yet Holy (1986) describes powerful matrilineal Iroquois women, holding political authority with males. Dissonance between inheritance and decision-making powers is a key feature of analysts' critiques of matriliney. It could be seen as an inability to accept women having

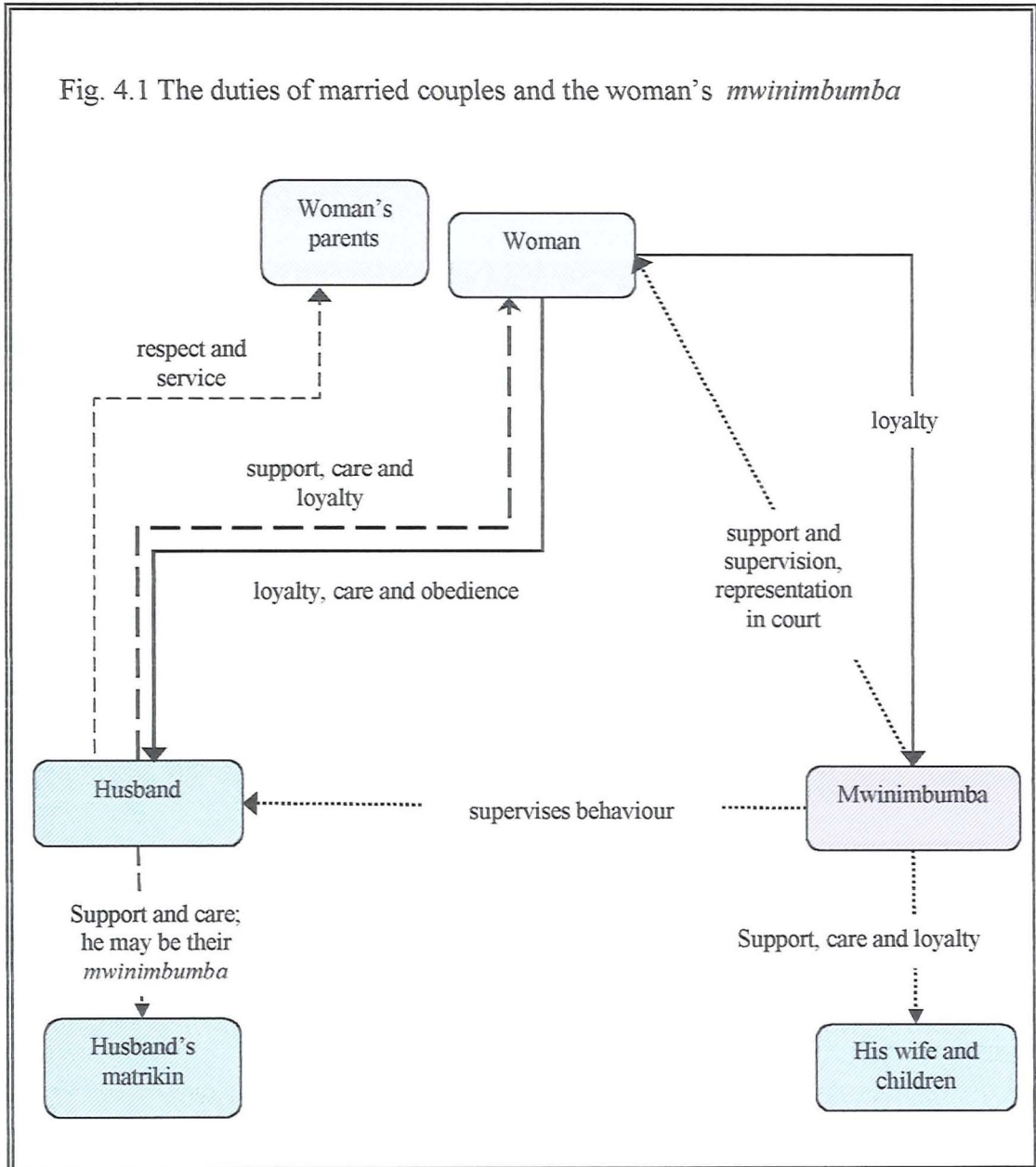
enough economic control and rights over children to be able to leave an unsatisfactory relationship. In Peter's view Malawian women have authority and scope for independence because of the inheritance patterns but not necessarily gender equality in the wider realm (1997b). Peters agrees that contemporary elite households tend to consist of man, woman and their children but that they remain embedded in matrilineal relationships.

The androcentric and Eurocentric stances taken by writers such as Richards (1950) and Read (in unpublished research reports) are challenged by Brantley (1997). She found that Read emphasised male interests and spoke from the male-oriented view of the patrilineal Ngoni with whom she had lived. Patriliney was unquestioned and male voices predominated. Even in 1981, Meillassoux, for example, still provided evidence of analysis and expression from male perspectives, with women seen as objects of exploitation and protection.

Male interests are commonly central in the literature. If men are disadvantaged by matriliney, one could question why they let it continue when the evidence demonstrates the potential for advantageous transformation. In another gendered argument, Phiri (1983) describes male strategising to counteract the effects of matriliney while (like some of my informants) choosing not to reject the way of life. It has to be assumed that men are still comfortable enough to remain within the system, although making adaptations to their advantage. Gender enters the equation more significantly with the work of Poewe (1981) and Yanagisako (1979) as feminist discourse becomes more audible and gender blindness less prevalent.

The main dilemmas described in the literature can be summarised as a three-way pull between key household members which puts men apparently at a disadvantage. This is illustrated in fig. 4.1. The literature does not appear to recognise that the *mwinimbumba* will reprimand the woman if she is neglectful, abusive or adulterous. He aims to preserve her marriage as well as defend her.

Fig. 4.1 The duties of married couples and the woman's *mwinimbumba*



Men have limited control of their own biological offspring (who 'belong' to the wife's matrilineage) but may have control of their sisters' children, who are of their 'blood' through their matrilineage. Many writers consider this to be untenable, apparently assuming that male interest is invested primarily in their own progeny (Peters 1997b).<sup>3</sup> Similarly the land control issue, of farming property coming from the wife's matrikin, is seen as economically untenable when men have no long-term financial interest. This

<sup>3</sup> For example Schneider (1961).

ignores the immediate benefit men gain from food grown there, and that their sisters are in control of the land of their own matrilineage. The view emerges that the only way to success is through patriliney.

These sources assume that direct genetic ties are foundational to the understanding of what it means to be related. Carsten (2000) takes other routes to considering relatedness in the light of a variety of global expressions of kinship. She emphasises the incongruence of universalistic categorisation when there are so many ways of determining who is kin that the supremacy of biology can no longer be assumed. Nor can we expect to find the same symbolism and interpretations everywhere – as is evident if the Malawian notion of feeding the fetus with sperm through intercourse is compared with the Karembola father giving life to his child through *couvade* and caring for his wife (Middleton 2000).

Beginning to perceive that the processes related to the prevailing systems were important to the welfare of childbearing women, I enquired specifically into local expressions of marriage and residence which I consider next.

### **Gathering evidence in the field**

People were keen to explain to me how they lived and its importance to them. Life history and key informant interviews were highly productive in helping me to develop a coherent understanding of the patterns and dynamics as people consciously constructed them, and clarify what I was observing and learning casually.

I consider the marriage, residence and inheritance patterns as organising principle and practice, founded upon descent from female ancestors and being ‘of the same breast’. These are important to situate women within the environment of marriage and childbirth, seen as ‘family things’.

### **Matriliny and matrilocality, a way of life and a way of thinking**

The importance of bringing in men to marry the women of the community became obvious immediately I commenced the mother and baby survey. Although many young mothers appeared to have no man around, as noted in chapter 1, they live

with their mothers and uterine and often classificatory sisters. Married women were careful to explain their men's absence,<sup>4</sup> and visiting women to explain their own presence. Often they were daughters who had moved elsewhere returning for the birth or to visit.

I commenced collecting residence and marriage pattern data by talking to pregnant women in the Nguludi *chitando*. Those who agreed were mainly the experienced pregnant women and the guardians (older kin responsible for cooking for them). Women pregnant for the first time are not supposed to know anything about birth and were generally reluctant to talk. Of nine women from whom I collected residence data, two lived where their husbands worked, one's residence was patrilocal and five lived matrilocally. One had married a Tonga and lived patrilocally until he married again and rejected her; she then returned to her matrikin. These women were not necessarily representative of the immediate locality as the hospital's reputation draws women from a wide area.

The survey of seventy-six women with babies under one year demonstrated the situation in the cluster of villages around Malinga, clearly indicating strong matrilocal residence of women despite figures that do not add up accurately. Fifty-nine were in matrilocal residence, living with their mainly incoming husbands and their own matrilineage. Five were living with their husband's kin within the village having themselves come from elsewhere, two commenting that they awaited the completion of houses at their own homes and would return there, so then becoming matrilocal too. They were, I was told, 'engaged'. Four were in the village because of their husband's work (e.g. teacher and pharmacist) or because they had acquired land there. Eleven were single or separated. This group was a convenience sample, women who were known to the *azamba* with babies younger than one year. I was unable to identify reliably those who were missed because of residence elsewhere, or to follow them up. However the cross-section of origins that emerged of those actually resident gives me confidence in the survey's adequacy for assessing residence patterns. One of these

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<sup>4</sup> Despite it being very common for women to live without resident men, many informants appeared to be uncomfortable about it.

survey interviews ended with the opportunity to photograph a formally posed matrilineal household group (fig 4.2)

Fig. 4.2 A matrilineal household



Matriliny and matrilocality appear to be less a casual continuation of a customary way of life, or a convenient way of managing affairs (Poewe 1981); rather they are an expression of the organising principles of my informants' lives. Groups I met were overwhelmingly in support of the matrilineal system although with some male reservations, as is demonstrated later. Only one elderly man expressed grave reservations about coming in as a stranger; his second marriage is more difficult than the first (also matrilocal) which ended only with his wife's death. His second wife shouts at him but he has nowhere else to go. Some men, he said, travel north or far south to find wives from patrilineal people who are prepared to leave their homes. That however might cost money in *lobola* or bride price.<sup>5</sup> He alone suggested that men continue with matrilocal residence because of custom, not because they like it.

Other male informants saw the way of life as 'only natural; it's the way we do it here'. Problems might arise for them if the wife's family are drunkards or abusive but the 'one who comes from away', *chikamwini*, translates as 'the one to be respected

<sup>5</sup> Men from matrilineal groups would not have access to *lobola* brought in by out marrying sisters to use to pay their own *lobola*. No money or goods change hands with marriage in the community other than perhaps a dress or soap given as a gift by the man to his new wife.



as he belongs to another'. They explained that they normally receive this respect but have the right to pack up and go if poorly treated. No longer must they work for years for wives' parents before finalising the marriage. However both men and women listed various tasks, such as building houses and latrines, which respectful husbands should do for their wives' mothers. According to Phiri (1983) Malawian men are seen as work-horses and according to Marwick (1965) bride service buys new husbands access to their wives' services but not ultimate control over the children.

Respect is all-important, between man and woman, generations and sexes, and for those in authority like Village Heads and clinic midwives before whom women still kneel. Nevertheless older women are anything but subservient. The avoidance of first name use reported in chapter 3 is part of this respect, evident between generations and sexes. Avoidance practices<sup>6</sup> are detailed by Radcliffe-Brown (1950) and Marwick (1965) and fear of mothers-in-law by Bruwer (1948). Avoidance no longer appears to be so important at least within more educated households<sup>7</sup> such as that of my host family but may of course be hidden. A male informant suggested that women need daughters as confidantes saying:

If the mother has a lover the girl<sup>8</sup> can know it but it will be bad for the son to know because he can reveal it to the father (Kalanje men 25 11 99).

Some young women approach their mothers about intimate matters but mothers' mothers and mothers' fathers are often seen as the main confidantes, for example to talk about sex.<sup>9</sup> Some elements of a joking relationship as described by Radcliffe-Brown (1950) emerged in an encounter I observed between the elderly *azamba* Regina, her grand-daughter and young men requesting condoms. The teenager was shy and embarrassed and spoke to Regina with downcast eyes. Suddenly there was

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<sup>6</sup> Classic avoidance is between men and their wives' mothers, or between immediate generations.

<sup>7</sup> Household is used in this thesis to denote the group of people with a common residence. It may be synonymous with a shared hearth but multiple cooking and eating groups may also exist. It may be one economic unit but more often there would be several women, each having control of a piece of land and owning separate granaries.

<sup>8</sup> 'Girl' and 'boy' were consistently used by interpreters and translators up to the age of marriage.

<sup>9</sup> I am unaware whether the mother and father of a person's father (who would probably live elsewhere) also have such joking relationships, or whether joking and confiding relationships may be a function of age differential rather than relatedness.



laughter and full eye contact as they talked and joked together, the grand-daughter still kneeling respectfully at her grandmother's feet.

Just as respect is of great importance, so is the continuation of the matrilineage. Both men and women expressed an equal desire for sons and daughters. There is absolutely no evidence of the son preference indicated by Vuyk (1991)<sup>10</sup> and the birth of either is, they said, celebrated with dancing and ululating. For female babies, a mortar and pestle is taken to the dancing ground, for males an axe and hoe. Informants pointed out that young men marry out so are of limited long-term usefulness; their contribution is seen as short-term only. Boys might work as goatherds, then later while still in residence, help in the garden, build houses, dig latrines and construct coffins. Roberts (1964) suggests this is essential preparation for providing for future wives and in-laws. Girls are essential. They pound maize, cook, draw water from very young, look after the mother when sick and help in the garden but their chief role is to bring men into the village and produce children for the lineage.

The system appears to demonstrate a practical logic. Women and children live in comparative security, not moving out unless the matrikin are confident of their welfare. The domestic group has the use of male labour brought in by women. Married men invest energy in ways that are of no help to their own lineages, but those are maintained through the reproductive powers of their uterine sisters. Through the *mwinimbumba* system they may still have considerable influence over these sisters' well-being as explained below. Although of limited direct benefit to a lineage, sons are replaced by the daughters' incoming husbands. Provided men and women are exchanged within the same general area and social system, reciprocity prevails and appears to be at the heart of the system of *chikamwini*.

Inheritance has similar logic. Land has a pivotal role (Yanagisako 1979) and remains within the matrilineage unless a deliberate decision is made to sell. Men keep few of the goods resulting from their investment of energy but their children benefit directly, or at least daughters do. Land will be distributed to them on marriage or bequeathed to them when wives die. Sons may share other property. Husbands can

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<sup>10</sup> National child survival statistics confirm this with slightly more girls surviving than boys as should be expected.

make decisions about land use when resident and their wives are alive. If there are no surviving children, however, the land reverts to the control of the *mwinimbumba* and is re-distributed in the family. I found no evidence of inheritance through the woman's mother's brother when there were surviving children. The children were always described to me as the beneficiaries on death or separation of the parents.

A man is unlikely to take accumulated property back to his lineage except for that earned specifically by his individual effort, and may encounter problems in giving assistance to his matrilineage while resident with his wife. Meanwhile back in his place of origin his matrilineage retains control of property through their women, his mother and uterine sisters.

Matrilocal residence and the associated principles of living together then go some way to ensure the group survives. Women and children are cared for, and courteous and mutually beneficial relationships help to gain and retain the services of incoming males. Men meanwhile achieve power through political and household headship and by being responsible for female welfare in their matrilineage. Women mark continuity of relatedness through inheritance mother to daughter. Men achieve such continuity by descent through to sisters' children.

### **Marriage and relatedness**

'Marriage is not for one person, but is a family thing' I was told when interviewing a group of (mostly older) women in Kalanje (23 06 99).

After six months I remained confused about marriage and its formalisation, about the constitution of residence and relational groups, and what constitutes the group labelled the *banja*, or 'family'.<sup>11</sup> I had seen 'white' wedding processions by the roadside and had attended a large reception in town for a professional couple. At the same time I was told couples just move in together. I knew many had religious ceremonies, I had heard of the marriage guarantor (*nkhoswe*) and of throwing chickens into houses but was unsure of the significance of all this. I also could not work out what the much-used word '*banja*' meant. So to help me to sort out this confusion

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<sup>11</sup>'Family' was constantly used by interpreters and by informants when speaking in English.

which persisted even after the group discussions on marriage and residence, I searched through interview data, particularly life histories, and talked at length with Stella and one regular group of informants. I gradually developed the following picture.

*Becoming married: customary proceedings for establishing marital relationships*

When a man decides to marry, he generally asks his father's brother (his *mwinimbumba*) to approach the mother's brother of the woman of his choice (her *mwinimbumba*). The two meet and appoint either themselves or another as marriage broker, the *nkhoswe*,<sup>12</sup> whose role is to ensure the smooth start and continuation of the marriage. He is a guarantor of good behaviour. Once agreement has been reached between the *mwinimbumba*, the couple are technically married, although the word 'engaged' was often used in conversations with me. The chicken throwing, or exchange according to Morris (1998), would occur at this point but appears to be less common now. Parents have an insubstantial role in the proceedings. Arranged marriages are uncommon now; the initiative comes from the couple or, according to the older Mithawa women (16 11 99) the man. They believe that a divorced or widowed woman may find herself in some difficulty<sup>13</sup> since she cannot initiate marriage proposals. She may have to remain single and without male support and company although living with her matrikin. Nevertheless some element of arrangement surfaced in the following exchange which took place in Kalanje when discussing parents' duty of care for the behaviour of daughters, and the women's regret that many 'go with boys'<sup>14</sup>:

G<sup>15</sup>: If they have a daughter or granddaughter, how should it happen if it is time to marry? If I have a daughter who isn't going [out] with boys, how does she get a husband?

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<sup>12</sup> Some writers such as Power (1995) use the term *nkhoswe* to represent the sorority leader, here called the *mwinimbumba*.

<sup>13</sup> There was no evidence of levirate or sororate unions. Indeed Roberts (1964) reports these as being the subject of strict prohibition by the Lomwe people, one of the main groups in this community.

<sup>14</sup> This is a universal euphemism for premarital or extramarital sex, and implies promiscuity although technically meaning just meeting up. The statement at the head of this chapter about marriage being for the family was followed by criticism of 'bad girls' who just get men and 'sleep with them' or 'follow boys'. This is often assumed to be intended to obtain money for clothes. Morris (2000) explains that 'to wander around' (*kuyendayenda*), is the term used for adultery which explains the translation into English and inference of extramarital sexual activity as 'going around with boys/girls'.

<sup>15</sup> I use the following convention for such exchanges: Respondent (R), Gillian (G), Interpreter (I).

Group: In the culture of Malawi, if she wants to get married, you ask a man, do you want a girl? You get the elders from the village and parents to discuss among themselves, the uncles discuss about the girl and boy. They do *chinkhoswe* and get married later. Everyone has to agree (Kalanje women 23 06 00).

The couple can move in together once this agreement has been reached and commence a sexual relationship.<sup>16</sup> Their life together may start at the home of the woman's parents, then progress to a house built by the husband, the eventual aim of all couples. They may live virilocally for a time if he has a house there, and while he gathers funds and material to construct the marital house. Having a house in the woman's natal village is synonymous with marriage; no house, no marriage, only engagement. The availability of land for the couple to cultivate is a common pre-requisite for the existence of a marriage according to some male informants.

The couple may choose to have the marriage blessed in church at some point and a celebration party may be held although many can no longer afford this. Catholic and CCAP churches will give a blessing at any time even after the birth of a child, but Seventh-Day Adventists are apparently stricter. Others may expect church marriage before sexual intercourse commences.

The Kalanje women expressed their expectations clearly. 'Engagement' does not necessarily happen at once, there may be a waiting period but the couple may have sexual intercourse once the engagement is formalised; before the engagement this must be done secretly. Having been asked the difference between engagement and marriage one woman replied:

*Chinkhoswe* is when they pay a small amount.<sup>17</sup> parents and uncle have had discussions. They ask the girl, 'Do you love the boy? And the girl can say yes or no. The boy goes to the parents of the girl to say that he wants her ... he is told to go to the uncle ... his parents come and discuss arrangements for marriage. Some people see *chinkhoswe* seriously as marriage. ...

*Chinkhoswe* is just a traditional thing; it is just advice, how things are. Marriage is when you go

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<sup>16</sup> I was given 'sleeping together'. Morris (2000) points out that there is no specific term for sexual intercourse in *Chichewa*, and that phrases such as 'sharing a mat', 'sleeping/lying together', even 'knocking together' are used which explains the translations used by my interpreters. Moreover, Jane commonly used 'doing sex' and 'doing their thing'.

<sup>17</sup> The only mention of payment and probably here it is a payment to advisers.

maybe to the church ... and you say 'I will not have another man till I die'. There is a ring for the wedding but not for *chinkhoswe* (Kalanje women 23 06 00).

The others agreed,<sup>18</sup> and confirmed that Muslims have their own ceremonies. This group was composed mainly of Yao (usually Muslim) and Ngoni (usually Catholic). The Ngoni women explained their old custom of paying cows or money, the goods moving from the man's kin to those of the woman, and of children consequently belonging to the husband.<sup>19</sup> Effectively his lineage bought the right to the offspring of the partnership.

There appears to be no sanction now against couples who have sexual intercourse before engagement but have a stable relationship. Casual sex is viewed negatively but parents are reluctant to act; informants expressed fear that young women might drink rat poison if criticised or punished. Young women with 'bad attitudes' are however less likely to obtain support in time of need. Single women who become pregnant normally continue to live with their matrikin, sharing household food and tasks. They may be given land for supporting themselves and their children – a property transfer that normally only takes place on marriage. They may nevertheless encounter difficulty in making good marriages because of damaged reputations.

No sanctions are used against men who make women pregnant without making a commitment although some pressure to marry emerged. Stella provided more detail about the problems of unmarried mothers suggesting that men might deny responsibility and 'chase them away' if proper *chinkhoswe* has not occurred. This suggests some contractual status to *chinkhoswe* which is missing when couples move in together without, as she said, 'following proper procedures'. Roberts (1964), writing of family law in Nyasaland, similarly places the agreement in prime place as legitimisation of the marriage and resultant children, a Lomwe woman having no right to support from her children's father without it.

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<sup>18</sup> This discussion was rather dominated by one person in particular so this may be less than representative of general views.

<sup>19</sup> The Ngoni have adopted the matrilineal ways of their host communities as explained in chapter 1. Already by 1949 Lawson had identified the Ngoni move toward matriliney, perhaps tellingly using the phrase 'succumbed'. Taking on the local expression of relatedness was perhaps the surest way of assuming local identity for vulnerable and indebted incomers.

Throughout these conversations (with mainly older women) there was an emphasis on being chosen by men rather than having much opportunity for choice themselves. Younger women may have had a different view.

***Banja: relatedness as sharing space and one breast***

As noted previously 'family' is commonly used as the translation for the Chewa *banja*. Determining the real meaning was difficult but I eventually concluded that it is used loosely with alternative meanings. It may be used for wife, husband and children – the male-headed nuclear family that writers such as White (1987) and Phiri (1983) report as the ideal of British colonisers and early Christian and Islamic missionaries. Alternatively, and I suggest more usually, it signifies the above group plus the wife's female kin (her mothers and sisters),<sup>20</sup> their male partners, children and unmarried males shown in fig. 4.3. *Banja* can also be used as 'household' or 'hearthhold' and involve others such as myself and a housemaid living with the group and sharing food.

Defining this group can still be difficult, as no easily identifiable boundary exists such as fenced compounds. This nicely illustrates the way in which relatedness is not a bounded entity despite lineage being so foregrounded in local expressions of kinship. Nevertheless, the boundaries of the sorority group tend to be more clear as is shown in the chart in fig. 4.3. This illustrates the relationships of Stella Kamuntolo and her sorority group comprising a mixture of people who are resident and working or studying away.

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<sup>20</sup> 'Mother' can be classificatory signifying any older female relative as can 'sister' be those of her own generation: 'little mother' might be a woman's uterine mother's younger sibling; 'sister' might be the daughter of her mother's sister.

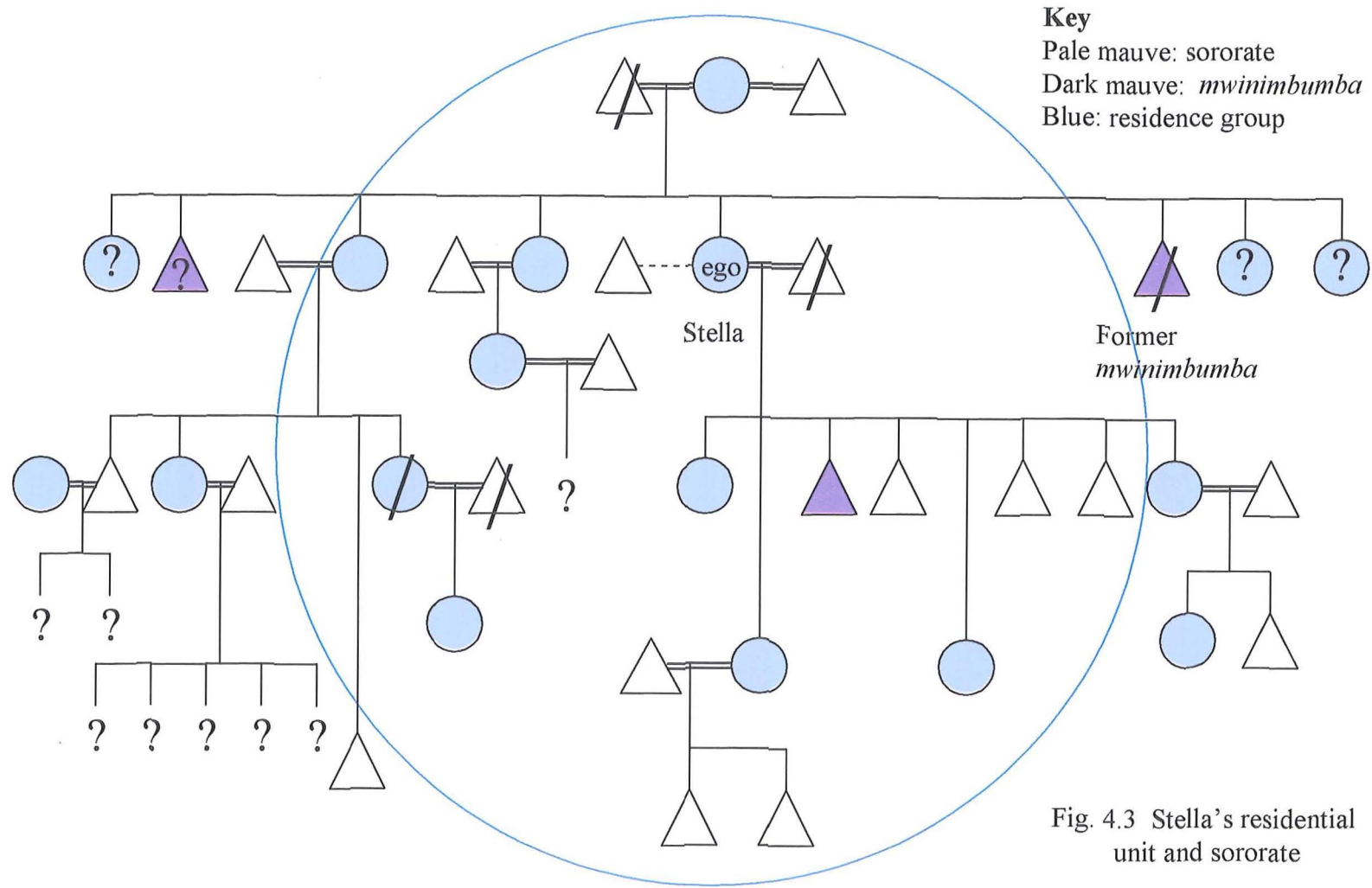


Fig. 4.3 Stella's residential unit and sororate

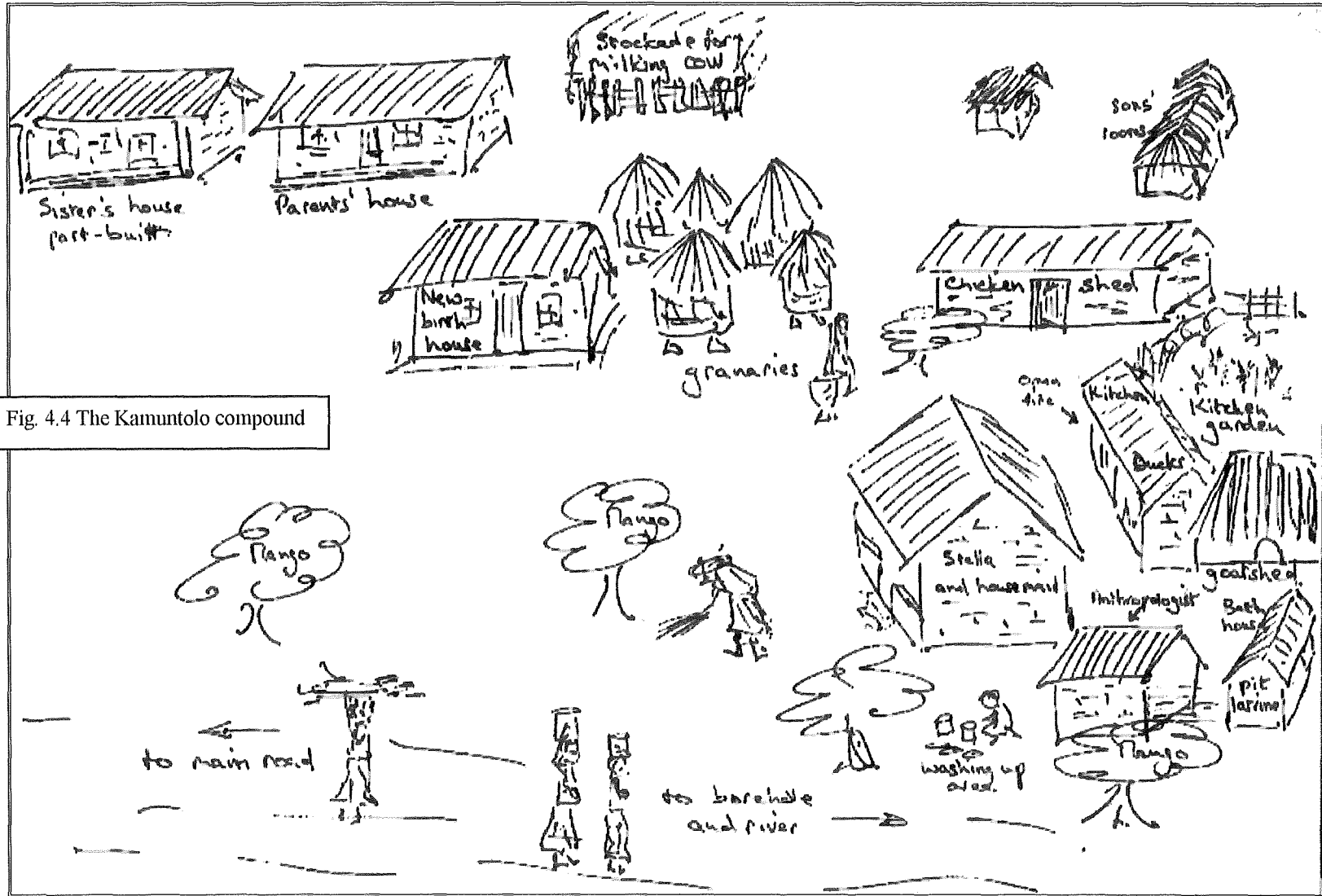
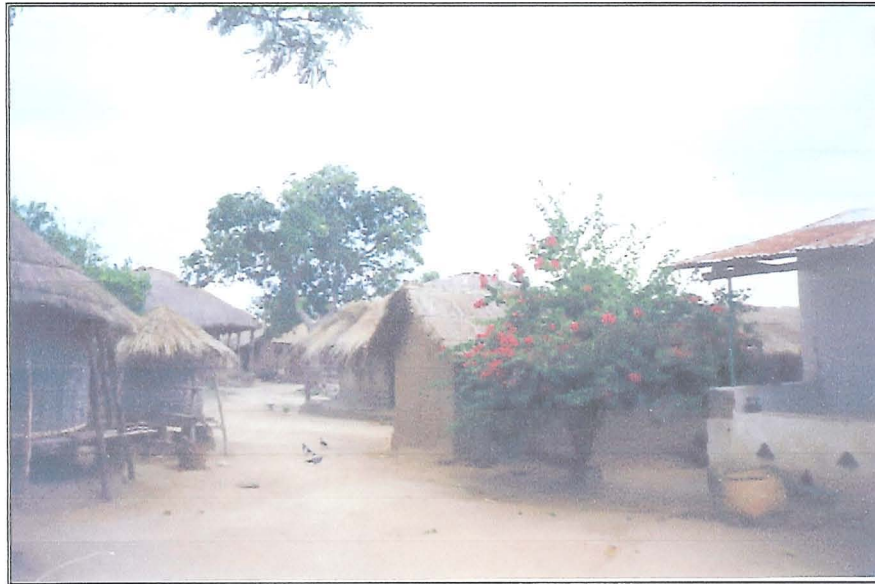


Fig. 4.4 The Kamuntolo compound



I lived right next to the house occupied by Stella, and her maid who slept in the storeroom. Her younger, and adult but unmarried sons, occupied single-roomed sun-dried brick houses nearby or lived with her mother and stepfather, or the married sister whose husband was away working (see figs. 4.4 and 4.5)

Fig. 4.5 The Kamuntolo compound



*Banja* was used at times to include Stella's daughters who had 'followed' their husbands who worked away as well as being used for the immediate group, as Peters says (1997a) rather as the British use 'family'. So the word might signify a limited, or extended and fluid residential or lineage group depending on circumstance.

The garden<sup>21</sup> given to a woman on marriage by her mother or mother's mother is cultivated with her husband, and left to her daughters, or to her *mwinimbumba* to distribute if she dies childless. Some, such as Stella and her sister who lived nearby, have the use of fairly large areas; others have much smaller gardens. Some women have no land or very little and try to gain cash through *ganyu* (casual)

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<sup>21</sup> 'Garden' is consistently used in translation to denote the small plots of land used for cultivation by an individual.

labour.<sup>22</sup> The ideal is to control land in varied environments to use for different crops, the best being streamside gardens (*dambo*) where valuable salad and tomato crops are grown for sale. People universally complain that the land at their disposal is becoming ever smaller because of population increase. No wild land remains although I was surprised to observe tracts of land that appeared to be uncultivated such as that belonging to Regina's late mother. In her case this surrounded her derelict house. Houses of the dead, I was told, are rarely occupied for fear of ancestral spirits but in this case so too was the surrounding land.<sup>23</sup>

A couple cultivates land alone unless they have unmarried sons and daughters, or are elderly when they may receive assistance. I was amazed at the advanced age at which I observed some such as Regina hoeing. I was informed that sisters would help each other. I saw no evidence to either support or disprove this assertion unlike Vaughan (1983) and Peters (1997a) who investigated the economic aspects of matrilineage groups elsewhere in the Shire Highlands. If the land-holding is large and some cash is available a woman might employ *ganyu* labour at busy times thus providing the temporary employment and source of cash for poorer residents described previously. Those who live away from the land such as Stella's sister, and my former neighbours at Nguludi, the laboratory technician and his wife may do the same.<sup>24</sup> The ability to return, particularly to keep a check on affairs and to pick up the harvest is important for those living away. My former neighbours had a complicated and expensive 80 km. journey by minibus or taxi and a long walk to endure, on the return carrying 50kg. sacks of maize or other crops such as sweet potato and manioc grown on the land given by her matrikin.

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<sup>22</sup> I gathered no information about how some come to have access to so much more than others other than through division between daughters discussed below.

<sup>23</sup> I also enquired about the large tract of apparently unoccupied land bordering the cluster of villages. This, I was told, was a cattle ranch belonging to the Member of Parliament. I remembered that colonial authorities had taken large quantities of land in the past, and much had been re-distributed to those considered worthy by Banda after independence. The land was labelled as a tobacco ranch on older maps.

<sup>24</sup> This was her land given by matrikin. In the early days of the marriage he had lived there with her until his work took them away.

The choice of where to live is determined largely by the custom and practice of the matrilineal group but freedom to relocate exists. These choices are explored next.

### **Where to live? Staying put and moving away**

A substantial number of village residents had moved away for work – for example Stella’s sister and the Headman of Malinga. *Bambo* Malinga works and lives with his wife and children in Blantyre, the nearby commercial capital, and visits the village about once every fortnight or more frequently if called by his sister, the Deputy. Stella’s sister was temporarily resident during my fieldwork, to care first for her newly widowed sick daughter, then subsequently her daughter’s daughter, orphaned when her mother too died. She has a ‘good’ house some 35 kms. away where her husband works as a teacher, as well as the one she occupies next to her elderly mother and stepfather. This house was being renovated and improved so confirming the importance to her of retaining a house in her lineage community.

Moving away, and the circumstances that might provoke it, I raised deliberately in group discussions in order to determine whether socio-economic circumstances are indeed believed to affect matrilocal residence patterns as suggested in the literature. Life history interviews also provided valuable information and examples as had the early survey of new mothers. I asked what might cause couples to move away from the woman’s matrilineage. Both men and women blamed conflict and excessively demanding relationships. This could indicate that wealthier residents are unwilling to share their property. Some authors propose that men wish to retain property they have acquired for themselves and bequeath it to their sons. Unwillingness to share with wives’ kin is leading to the demise of matrilineal inheritance (Goody in Douglas 1969, and contested by Douglas). In this view, capitalism and matriliney do not mix. Douglas suggests poverty is more of a stimulus than wealth for the retention of property for male offspring. Holy (1996) reinforces this although none of these writers suggests why it should be inheritance only by male offspring that forms the focus of male aspirations. Few people have much to share in this community and reasons for moving elsewhere appear to be more to do with immediate economic survival than with greed.

Several people revealed a different explanation. Much as conflict within the wider group and excess demands for support may lead to marriage break-up, some couples seek to remove themselves together from such situations. These explanations came from informants:

- If in the home there is someone who always likes to shower bad words to the others [you can move] (Sambani women 15 11 99);
- If you respect the others you can stay with them for ever (Malinga women 17 11 99);
- If the wife and husband love each other, the wife talks [with] the husband to find some [other] place to stay (Mithawa women 16 11 99).

The danger for separation is very real however as the wife might be caught between the demands of her kin and what may be seen by them as her husband's meanness or 'stinginess' and reluctance to provide for them. This does not affect the principles of the matrilineal inheritance pattern in people's minds.

Unable to find evidence of moving away being considered as a sign of the decline in the importance of matrilocal residence I asked about it directly. A simple solution was provided. Those women leaving with their husbands to seek work are not seen as leaving. They are still 'living' at home and have moved away temporarily. This is permitted only once the husband has gained the confidence of his wife's kin and a house should be built to which they will return one day. Indeed some of my town-dwelling professional acquaintances talked of retiring to their home villages and some local residents had spent many years away and returned – such as a retired policeman and teachers. The government-trained midwife who taught Stella her skills was one such retired resident. So matrilineal residence patterns continue according to local people. There may in fact be no greater mobility today than in previous generations when many worked in far districts or other countries. Stella's late father had been a tailor on an estate in Zimbabwe where her mother (the 'granny' in the household who often chatted to me) and their children joined him. Another man had worked in the

South African gold mines while his wife continued to cultivate back home. This place was still home to such migrant workers.<sup>25</sup>

Much as families prefer to see daughters continue in residence, one man pointed out the advantage of having a son-in-law who finds waged employment elsewhere because of the flow of money 'for the man to give to his in-laws'. Children of those living away continue to be part of the woman's matrilineage. Even if the husband and wife live virilocally, the children revert to her family if their mother dies or leaves her husband. An alternative scenario was rare but, I was told, could occur when a man from the matrilineage paid *lobola* to his wife's parents and effectively 'bought' the rights to the children. This was more common if the woman was from a patrilineal area such as Chikwawa, Nsanje or northern Malawi, and was referred to by elderly Ngoni informants as part of their old ways.

Despite the emphasis on matrilocal residence in this community, one very real change is taking place. Village Heads have little land left to distribute and property is becoming more and more divided; those with several daughters are experiencing real problems. There is no apparent element of preferential distribution or primogeniture, and the smaller plots are becoming increasingly worked out as scope for leaving land fallow diminishes. A couple might move away to rent better land,<sup>26</sup> but again their real home remains the village. Informants considered this continuation of lineage membership important despite neolocal residence. Nonetheless, moving away must effectively put the interests of the couple before that of the matrilineage and perhaps confirms Holy's view (1986) that the development of nuclear families contributes to the demise of matriliney. However, remittances sent home would nullify this effect of self-preservation and abandoning the matrikin.

Ultimately the continuity of matrilineal inheritance and matrilocal residence as defining elements of local identity is a construct that may mask a different and

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<sup>25</sup> Mass recruitment for international labour migration was stopped by Banda after a plane crash killed many workers. It is unclear how much international migration of poorer workers there is now although many educated workers move to countries such as South Africa, UK and USA.

<sup>26</sup> Land rights and acquisition in the villages did not feature in my data however Morris (1998) explains the common ownership to which gardens revert when unused. Area chiefs and Village Heads used to have legal control of customary land but this right appears to have diminished.

evolving reality. Undoubtedly my respondents may have been creating a scenario that reflected their aspirations rather than describing a situation they preferred to conceal. Relatedness however, can only be what people see it to be, and to my informants, it is vital that matrilineal community and reciprocity prevail.

### **Making a living, pulling together**

Despite the reputed fragility of matrilineal marriage, a strong emphasis emerges on pulling together and reciprocal action. Obligations were presented in a way that suggests a general sharing of the load and observation confirmed this. During group interviews, women and men quoted the same gendered range of responsibilities for themselves and countered this with equivalent lists for the opposite sex. This is illustrated in table 4.1.

Table 4.1 Gendered household responsibilities

<b>Female responsibilities</b>	<b>Male responsibilities</b>
‘To meet men’s needs’	Look after his wife and her matrikin
Cook	Buy food
Sexual intercourse, to ‘please’ husband	Sexual intercourse – provide children, ‘feed’ the unborn
Draw water	Dig a latrine
Collect firewood and make fire	Build a bath house
Heat husband’s bath water	
Wash his clothes	Buy clothing
Wash plates	
Keep house and grounds clean	
Clear, plant, weed & harvest the garden	Clear and cultivate the land
Prepare harvest for storage	Build and maintain the granaries
Take maize to the mill or pound it	
Community activities	Community activities
Caring for children and elders	Buying medicine and taking sick relatives to hospital
Income generation: baking, brewing, marketing of cash crops	Income generation: basket- and mat-making, tinsmithing, brick-making, wage labour

Women's overall responsibility is to fulfil husbands' needs and care for children; childcare was not mentioned at all by informants, but was very evident nonetheless. Some women included caring for parents in their responsibilities.

Universally female tasks listed were drawing water to heat for husbands' baths, cooking and being available for sexual intercourse when required. Sambani women said 'You can stay without it but if he wants it you respond' and

When they finish their work in the afternoon the husband can call his wife to go inside the house to do their thing there. If friends ask her 'what are you doing in the house?' she can say 'I was drawing water for my husband' (Sambani women 15 11 99).

The women went further than this saying 'If the wife needs it [sexual intercourse] she can call her husband; if he fails she must help him'.

Although women are expected to respond to husbands' sexual demands this is not total. Women can initiate sex as demonstrate above and withhold it too, for example if the husband is lazy, drunken or abusive. They said 'There are some husbands who when they get drunk beat their wives. If he does that you cannot make love at night' (Sambani women 15 11 99).

Male groups discussed cooking at some length suggesting that cooking is what men seek wives for although they can manage it themselves – women believe men are unable to cook but they have to learn when young. This was confirmed by seeing goatherds collecting their ration of maize flour from Stella every morning before taking the goats from their shed. They must, she said, collect wood to make a fire, find water to boil and make up their own *nsima* with the flour. Cooking is a clear example of the gendered division of labour which is visible around the house if not in the fields although, on my recent visit I found a young man had replaced the housemaid and was cooking for Stella.<sup>27</sup> I saw few men taking part in child care although school boys often did so.

The male role is primarily to provide for wives and children and supply clothes and 'necessities', and to help his parents-in-law. The provision of children for the woman's lineage was frequently cited as a prime duty; the male is expected to have

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<sup>27</sup> Restaurant and roadside stall cooking appeared to be almost entirely a male occupation.

sexual intercourse expressly to make his wife pregnant. Moreover he should feed the unborn baby with semen until the eighth month of pregnancy when he should stop to avoid 'making a hole in the baby's head'. As will be seen in chapter 7 intercourse should then be avoided for several months after the birth to prevent hot-cold related illness in the husband and the infant. I asked what happens if there were no man around to feed the foetus in this way, would it suffer? The response was that the woman can ensure adequate feeding of her unborn baby by eating porridge instead of having sex. The evidence obtained does not make it clear what 'feeding' the unborn child means or whether this is in fact related to the tracing of links of relatedness and the importance of substance in Malawian thought. Morris (2000) however speaks of the activation and strengthening of the blood of the child by food and semen becoming flesh and bone, blood being associated with the kin group and *moyo* (life force) as is semen.

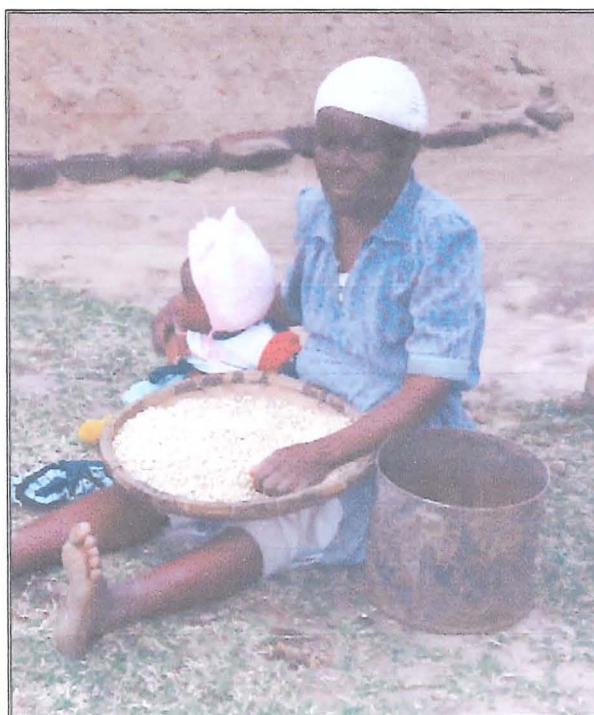
The other duties of husbands, centring on cultivation, building work, care for families' health, and income generation, are also listed in table 4.1. The declared emphasis is on bearing equal loads but one group of older women mentioned female overload more than once. They described how men come from the fields with their wives, then sit in chairs while the women cook for them, first collecting firewood and drawing water often from some distance. Men and women appeared to complete equal tasks in the fields although some mentioned clearance of old crop debris as a male responsibility. No longer do men take on initial land clearance as described by Morris (1998) since there is no unused territory nearby, neither do men now hunt. There is little edible wild life left in the almost treeless landscape unlike the situation a few years ago when men would hunt some five miles away or further afield around Mulanje Mountain where game was once plentiful.

Both male and female farming responsibilities are very onerous but who takes final responsibility for farming is unclear. A constant round of clearing, tilling, sowing, fertilising, weeding, watering and harvesting takes place. At busy times such as preparing for planting, men leave around 4 a.m. for the fields while women prepare the children for school before joining them. In Stella's household, the labour of her two older unmarried sons is essential to supplement her own on her substantial holdings. Only when the land is ready for planting and awaiting adequate rain, or following the end of the harvest does some rest come. Women then must prepare the crops for safe



storage through to the next harvest. Little allowance is made for pregnancy, only children and the very elderly are spared cultivation responsibilities. One elderly regular contributor to group interviews in Kalanje sat on the floor clutching her walking pole, laughingly declaring 'I don't work, I just sit and eat'. Stella's mother too is unable to work the fields now, and depends on hired labour.<sup>28</sup> but despite her age still contributes by caring for babies and preparing food (see fig. 4.6).

Fig. 4.6. Older people continue to play a role



In the past much of the heavy work would have been undertaken for older kin by the incoming male as part of the period of bride-service before marriage. Although such service is no longer expected, the demands made of sons-in-law are nevertheless high as is explored below.

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<sup>28</sup> The welfare of the elderly (like orphans) is of increasing concern in Malawi as the active middle generations die of AIDS. Many older people would of course be unable to afford to hire labour.

### **Responsibility within the household**

If the incoming son-in-law has a duty to serve his parents-in-law and support his wife and children, he also is considered to have a leadership role alongside the more welfare oriented role of the *mwinimbumba*. These men's actions and attitudes have a strong bearing on the welfare and agency of women, especially on those who are pregnant. These are explored next and in some detail because of their significance, and to add to locally specific knowledge on matrilineal households.

#### ***Chikamwini: the institution of the incoming stranger***

An incoming husband is known as *mkamwini*.<sup>29</sup> This was variously translated for me as 'the one who comes in from outside' as previously described and as 'someone's property', 'comes from somewhere and marries', and 'it's not mine'. The stranger status is thus strongly emphasised and linked to the imperative for respecting someone who has been given by others (his lineage). He might not stay yet is needed for labour and for providing children for the lineage, so should be respected and looked after.

The incomer may be considered more helpful than resident kin, especially than sons who may or may not maintain supportive contact with their parents when marrying away. Some spoke more favourably of him even than of the *mwinimbumba* whose specific role is to help his female matrikin. The *mwinimbumba* might also be *chikamwini* and therefore of limited usefulness in crisis.

The husband might not be a total stranger; it was evident in survey and life history interviews that some originate from the same village as the woman or from close by. They move in space and in status, hardly in locality and may in the past have been cross-cousins.<sup>30</sup> Stella suggested men should come from further away; this was the point of *chikamwini* in her view:

Yes that is the meaning of *chikamwini*. Men leave their home to stay with their wives ... people these days do not understand the meaning of *chikamwini* but in those days it meant that ....

Let's say for example my [uterine] brother marries you and brings you to stay with us at home,

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<sup>29</sup> The person is a *mkamwini*, the institution or status is *chikamwini*.

<sup>30</sup> Mitchell (1959) indicated that this allowed a man to remain in his matriliney on marriage, so greatly simplifying taking a Headship.

let's say from Chikwawa and bringing you here you are called 'mkamwini' but these days we just use it as a mere name while in those days it meant 'It belongs to someone, it has just come. Stay well with it'. It is the same when a man comes and marries here and stays here, he is called 'mkamwini' as well. *Mkamwini* is not only a man; a woman can also be *mkamwini* so long as she is staying with the spouse at his home (Stella Kamuntolo 23 10 99).

Stella (S) explained her concerns about cross cousin marriage in the following exchange:

S: At one time cousins could marry but not any more. It is because a cousin is considered to be your [classificatory] brother. If you want to have a strong marriage it is better to have someone you are not related to.

G: What is a cousin?

S: Cousin[ship] [*chisuwani*] is like for example my mother has a [uterine] brother and my cousin is her brother's child.

G: So would you say the same with your father's brother's children?

S: No they are [classificatory] brothers.<sup>31</sup>

G: Does that mean that anyone from the father's side is a [classificatory] brother or sister?

S: Yes.

G: So father's [uterine] sister's children would be [considered as classificatory] brothers and sisters too?

S: Yes (Stella Kamuntolo 23 10 99).

So the offspring of brothers and sisters, however defined, rarely marry in this community now because they are all seen as classificatory siblings according to Stella. This appears to apply to both matrilineal cross cousins<sup>32</sup> (those whom Stella, the interpreter and translator all called 'cousins' and who used to marry) and matrilineal parallel cousins who have long been considered as classificatory siblings so unable to marry.<sup>33</sup> I asked why classificatory brother/sister marriage is seen as undesirable.

<sup>31</sup> Because the father's brother is a classificatory father.

<sup>32</sup> The offspring of a brother and sister within a matrilineage, known as *masuwani* (pl.) or *msuwani* (sing.). Stella appeared to make no distinction between parallel and cross cousin relationships. Neither did UK based Malawian friends who used *chisuwani* for both cross and parallel cousin status.

<sup>33</sup> Morris (1998) notes that the offspring of two uterine sisters (parallel cousins) never marry. He reports an emphasis on cross-cousin marriage but comments that this may not be between 'real' cross-cousins. Even fifty years ago, Mitchell (1959) noted that cross-cousin marriage was recommended but loosely defined amongst the Yao of the Liwonde area to the north-west, and less common than might be expected from the rhetoric. Peters believes all marriage between the offspring of siblings to be rare now in the Zomba area some forty miles distant from this fieldwork site (1997a). The situation is less clear for patrilineal kin.

Through complex examples Stella conveyed concern about incest as they could well have been brought up together.

The marital role of the incoming husband emphasises companionship as well as the provision of goods, support and semen. As is indicated by the pressures on partnerships from demanding in-laws, wider expectations of the *mkamwini* are of sharing what he and his wife have, and on helping her parents in many ways. This is often expressed as burdensome but is probably no different from the pressures a woman living virilocally would experience from her husband's kin. As one informant said, she (the woman living as *mkamwini*) might have some fish and have trouble concealing it from her mother-in-law. The dutiful or kind son-in-law will dig latrines, re-build houses, granaries and bathrooms for in-laws (specifically expressed as for the mother-in-law) and will buy clothes, medicines and food for them especially if they are poor.

Pressure may be experienced by a man to fulfil his first duty and complete the marital home. If progress is slow and they are living too long with his kin, he can enlist their help to assist with construction. Only then can he take his wife away to live elsewhere, for example near his work, once he has proved himself a trustworthy son-in-law.

In contrast, my interpreter and her husband originated from patrilineal/patrilocal groups and she was explicit about the differences she observed while working for me. She is a Sena from Chikwawa living then at Nguludi where Francis was a nurse-midwife. Jane and the baby relocated to live with his family when Francis commenced training as a lecturer, visiting her parents occasionally and returning to work for me when I needed her. When he could get away from university Francis was building a house for them at his parents' village despite the fact they were likely to live away for much of his working life.<sup>34</sup>

Respect and duty of care to incomers is a feature of the system. Should the husband be taken ill, the wife's relatives must inform his kin or his father's brother so they visit and decide with her *mwimbumba* what action to take, themselves bearing

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<sup>34</sup> Francis has since died and Jane, having been dispossessed by his kin of all but her son, returned to live with her widowed mother.

the financial responsibility. Such respect and care extends to his welfare as a widower provided his relationships with his children are amicable. On the death of his wife he would expect, according to customary practice, to return to his matrilineage with no more than his blanket, and maybe a few personal items. The same occurs if he wishes to remarry after bereavement. He might however be given a year to continue to till his late wife's land before going off to look for a new woman and live with her. Nevertheless, children often undertake to support an elderly man for the rest of his days so avoiding the need to uproot, maybe after a lifetime in this one place.

Men moving into wives' homes is a key feature of the way of life and closely interlinked with matrilineal inheritance as rights to property, most specifically land, remain within the lineage. The exogamous system allows a family to capitalise on their women's reproductive powers, bringing in men who produce children for them, forging alliances, and also providing labour and income generation. Provided men come in, sons can leave to find a wife elsewhere. Women are vital to the lineage as they cannot be replaced, so for the matrilineal and matrilocal community, the welfare of their women must be paramount. This is reflected in the *mwinimbumba* system, considered next.

#### ***The mwinimbumba: sorority head***

The role of the *mwinimbumba* can be clearly deduced from the explanations of support for women that emerge from the primary data. However this alone is inadequate as an explanation for the system: women resident with matrikin ought to be in a fairly strong position without this senior male who usually lives away, being *mkamwini* himself. There may be symbolism and meaning in ascribing responsibility for the sororate to a male lineage member who has shared the same breast and thus substance. The power issues around the insider, the absent sorority head, and present (but outsider) husband are full of potential conflict but the evidence suggests that flexibility and peaceful accommodation to separate roles generally prevails. The *mwinimbumba* may occasionally be a respected female. Still, the overall situation is one of women needing males to take responsibility in domestic, judicial and political domains despite female power as 'owners' of the children and the land. Morris (1998) asserts that gender equality and matriliney are not synonymous. The limits to female power appear to be finally set through the Traditional Court system. No divorce or court case

involving a woman is valid without the presence of her *mwinimbumba* or deputy. Neither may a Village Head take action related to her without his presence and must inform him if problems arise.

The *mwinimbumba* is usually, but not always, the older uterine brother or mother's brother of a group of sisters and has the role of ensuring the welfare of the women in the *banja*. The women select him and merit looms larger in their thinking than age, status or wealth. The three generations of women of Stella's household chose her eldest son as their *mwinimbumba* on the death of the previous one even though he was then only 22 and unmarried, and despite there being older male kin who could have taken this responsibility. His position and the extent of his responsibility can be seen in fig 4.3 which also shows that his predecessor was of an earlier generation.

Asked what has to be done for the *mwinimbumba* in return for his support, most informants only mentioned respect. Providing food, shelter or clothing was rarely cited and obedience did not come into discussions at all. This is at odds with the view of conflicting loyalties and obligations, and diminished rights of husbands, offered by writers discussed earlier.<sup>35</sup>

The *mwinimbumba* is generally spoken of as one who must be informed and consulted about occurrences and dilemmas rather than one to whom all decisions must be referred. He acts as go-between for marriage negotiations as described earlier and generally facilitates action – perhaps to help find transport and finance when medical attention is needed as happened with Dannis (case study 4, chapters 1 and 5).

Although the *mwinimbumba* will take action to support a household through difficulties if the husband fails to do so, the latter's role, and that of older females, appears to be just as important. No-one talked of conflict between these men and I heard no suggestion that children were controlled other than by the father, thus corresponding with Phiri's 1983 assessment. A particularly strong responsibility is that of peacemaker in disputes and both husbands and wives can appeal to the *mwinimbumba* if discontented with the other's behaviour and bring in the husband's own *mwinimbumba* if required. Several informants referred to the husband's own as

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<sup>35</sup> Richards 1950, Schneider 1961, Phiri 1983, Holy 1986.

being a brother of their father and that he would intervene, or at least expect to be notified if a man is sick or in trouble of some kind.<sup>36</sup>

The position of *mwinimbumba* is not seriously affected by *chikamwini*. Most move away on marriage or will do so later as will probably happen with Stella's son. Two alternatives exist. If he lives at some distance a deputy may be appointed to assist in his absence and make decisions but is expected to keep the *mwinimbumba* informed. Alternatively the *mwinimbumba* may bring his wife and children to live in his natal village.<sup>37</sup> Men elected as village Heads may do the same.<sup>38</sup>

The woman continues to need her *mwinimbumba* throughout her life, not just as peacemaker or to order out her husband if he is found wanting, or as representative and negotiator before the Village Head or local court. He finally will make a speech at her funeral. It is a lifelong commitment.

The role of *mwinimbumba* exemplifies the respect given to men. However, informants insisted that the *mwinimbumba* does not oust the husband as head of the household and that a woman's first duty is to her spouse. This concept of head of the household is considered now.

### ***The head of the household***

Despite the frequent mention of separation, the expectation of relations between spouses is of mutual respect. I asked each group and several individuals what it meant for a man to be 'head of the household' as I understood that this was expected. Everyone agreed that men should be honoured as the main decision-makers about household matters, some providing biblical motivation and saying that husbands should be obeyed. Respect however is not seen as automatic, it needs to be mutual and working hard is a key attribute of a respected husband. The status is not necessarily

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<sup>36</sup> The *mbumba* specifically denotes a group of sisters, apparently both uterine and classificatory, sometimes just women of any relationship (Banda liked to call all women his *mbumba*) but the same term can be used for groups of males.

<sup>37</sup> Children however still 'belong' to their mother's lineage and would return there if the marriage were to end.

<sup>38</sup> A uterine sister deputises for the Malinga Headman who lives and works in town. The Mithawa Headman fulfilled his duties from his wife's nearby home, until recently when he moved with his wife to Mithawa at the request of the inhabitants.

permanent. The Sambani women progressed from obedience to throwing their men out, putting it this way:

RI: [the man] is the one who controls the family and you are to obey -- let's say he says that you shouldn't go out to chat and you must obey him.

R2: It is written in the Bible.

I: They are saying that the head of family is the husband because he is the one who chose you and the husband can say anything to the wife. If the wife wants to go to the garden he can say you must not go to the garden. ... He can decide everything in the house and she said that he is the head because they heard from the Bible that the husband is the head of the family.

I: Most of the things in the house are done by the husband.

R2: There are some husbands who when they get drunk beat their wives.

I: If he does that you can not make love at night (15 11 99).

This is similar to the suggestion by Poewe (1981) for Zambia that the reality of gender relations did not match the rhetoric about the male head of household proposed by Roman Catholic ideology.

The reasons given by men for this male supremacy despite their vulnerable position in the household relate less to the biblical injunction described by women than to their contributions:

[He is in control] because he leaves his home to find a wife and also the things that a man does are for the good of his wife. If he is working, the money is to be used by the wife. He controls the family (Kalanje men 25 11 99).

These men asserted moreover that women are unable to manage alone. This is contrary to my experience with acquaintances such as Stella, a self-reliant and capable (at that time divorced) woman with many varied roles who then had four boys between the ages of 23 and 8 still at home.

Despite the rhetoric about males as head of household, it is evident that many households are female headed. Poewe (1981) found the Zambian reality to be different from that proposed by Catholic ideology and as Peters noted in 1995, the de facto position of Malawian men as head of household depends on their presence and many are not around. A substantial number of women are alone through labour migration or divorce. Women might be heads of household for a short time with absent males or between partners, or permanently. Women might be seen as household heads even in the presence of male partners. Regina said it could be the 'grandmother [who heads the



household] because it is her home, not [that] of her husband nor her daughter's husband ... because the grandfather is the one who follows the wife' (16 06 99).

A husband is considered to make the household complete (Morris 1998) and it appears that major decisions are made by man and wife. The position over land use is more confusing. Most agreed that men and women decide together what to do with the garden but some men emphasised that they were in control, their wives 'followed'. Morris (1998) however indicates that matrilineal Malawian subsistence agriculture was always centred on females, with in-marrying males supplementing female labour. Male rights to rent out the wife's land are uncertain but an evident moratorium exists on selling land without her agreement or that of her *mwinimbumba*. Stella provided some clarity, also indicating her understanding of comparative ways of handling property:

S: It's up to you to choose; if you want to shift the crops there is no problem.

G: So who controls the garden? Is it the wife or the husband?

S: Both

I: If a woman marries and her mother gives her a piece of land, can the husband have control over it?

S: Yes he can. For example here I have children who are staying along the road and I gave them pieces of land and they have control over it with their husbands. They can decide to buy fertilizer for the garden, it's up to them and also this other one who is [near town], I gave her a garden there and another one along the road and I don't have control over them. They control with the husbands. They can rent more land if they feel it's inadequate or they can decide on their own to share the land with the children.

G: Right. So is it usual that the husband is in charge of the garden?

S: He controls it by deciding that they buy fertilizer, they should go to work in the garden. If they divorce the garden is left with the wife.

G: So ... can not sell it and run away with the money?

S: The husband can not do that. He just came and married. (To the interpreter) We are different; in your area a woman follows a husband and full control is with him while here a husband follows the wife and if they divorce he just goes back home. He can not sell the land. It is the wife who can decide to sell the land and she just seeks permission from *mwinimbumba*.<sup>39</sup>

G: So if they sell the crops whose money is it?

S: For the family because you do all the garden work together. You agree on how to use it.

(Stella Kamuntolo 17 06 99).

<sup>39</sup> On a later occasion Stella commented that women only need to inform the *mwinimbumba* of their actions, rather than seek permission.

The interviews on marriage, inheritance and residence made it clear that many women expect to follow their husbands' lead on household matters and that men expect to provide for their women, and to be obeyed by them in relation to all activities. Others talk more of a sharing relationship and making decisions together. Although Malinga women (17 11 99) described husbands as at the forefront of all activities, as leaders and providers, everyone knows also that many women do not have male household heads and the position is anyway contingent on 'good behaviour'. Furthermore they have the *mwinimbumba* to keep an eye on affairs; they are able to withdraw sex as a sanction and retain the ultimate solution to the inconsiderate, drunken, rude or violent man. He has to go.

### **The end of marriage**

Writers such as Marwick (1965) commented on the historical fragility of marriages within matrilineal systems yet often described this as a new phenomenon as do my informants. It is difficult to see why breakdown should relate to matriliney or matrilocality other than in relation to excessive demands from kin or because women can send their men away without serious threat to their own welfare. Nevertheless life is usually tougher for single women than for those who share the workload with men. The buffer against hard times is more limited, and the availability of cash, needed for substantial commitments such as school and medical fees, might be severely diminished. The Kalanje women commented that they could grow food but not do duties like house building and buying clothing as they had limited means of earning (25 11 99). However women would be with their matrikin, or accepted back if living away, and have the same access to land as when married. They would be less likely to be destitute than if rejected by husbands' families in patrilocal communities, especially if then faced with rejection by their own kin.

Serial monogamy appears to be expected and accepted but some men (mostly Muslims) have more than one recognised wife or other women with whom they conduct long-term relationships. A key informant living with a daughter and other female relatives in Sambani, a village now almost devoid of men, had married aged sixteen to a man who was 'attracted to her' and 'asked for her hand in marriage'. He was 'nice' but started to beat her and eventually returned to his ex-wife. Later she

revealed that the other relationship had continued throughout her marriage, she had been his second wife. Another informant had sent her husband away to a woman with whom he had developed a relationship; she was not prepared 'to be two'.

Older Sambani women argued the proposition that men are untrustworthy and not motivated to stay in a marriage because there are so many women available; they do not need to work at relationships. This following dialogue took place:

G: There seem to be many separations. Can you tell me why you think this is?

R1: Due to disagreements within the family. If he is harsh on you, you chase him away.

R2: If you chase him away he says there are many women out there: I will get another one.

Informant 3: The truth is there are few trustworthy men and the rest would have as many [women] as they want (Sambani women 15 11 99).

Early in my fieldwork I had visited a young Sambani woman with a newborn baby. She had just been deserted. As we continued on we passed a man identified to me as her husband as he walked off down the road with a young woman in school uniform.

The frequent break-up of relationships is regretted by most people. Learning how to 'live with the husband well' and obey him so 'you can be with him a long time' were given as examples of advice given to young women about to marry. Some informants had remained with their spouse over many years and had grown old together. Criticism was expressed by both older and younger mature women of the way 'girls move around with boys nowadays'. I heard less comment on the behaviour of young men other than their possible denial of paternity and refusal to support those whom they impregnated. Indeed the incident discussed earlier when two young men approached the Kalanje *azamba* to request condoms from the government supply revealed attitudes to sexual activity between young people. Much hilarity followed, especially because they were too shy to approach Regina in my presence and sent her giggling granddaughter to make the request.

The emphasis on harmonious partnerships and faithfulness is discussed by Morris (2000) who points out the importance of sexual activity for the wellbeing of Malawians. He notes too that serial monogamy was more common among his acquaintances than long-term partnerships.

A remark, made in a male discussion group about living in an environment that lacks respect for sons-in-law, revealed an apparently relaxed attitude to

relationships. 'The solution is divorce because you should not be troubled because you married' (Malinga men 17 11 99). This was quite different from earlier female comments that the couple could move away if they loved each other. The marriage could be made to work despite difficult kin relationships if the will was there.

Lack of respect for men also appears to cover excessive demands made on them. They might move out if unreasonable expectations of providing for in-laws persisted. Women do not always see it that way. I was told:

Some husbands are fond of beating the wife and others are so stingy that they do not want to share anything with your relatives and if the wife is tired of this they can separate (Mithawa women 16 11 99).

Women might find themselves caught between husbands and their own kin; equally trapped might be the men.

Differing gendered attitudes surfaced around why relationships do not survive. Women described unfaithful, drunken or violent men who may abuse the mother-in-law as well as the wife. The *mwinimbumba* may intervene but is often unsuccessful in bringing about reconciliation; sending the man away might be the only solution. They discussed the promiscuous behaviour of young women but did not address the adultery of mature women. Men on the other hand talked almost exclusively of adulterous women as the cause of marital breakdown. They expressed distress at leaving children behind despite often retaining some role in caring for them. Comparison of their status was made by some with men in patrilocal areas where the children would belong to male lineages. Their own matrikin would provide refuge but rejection might follow for men who had not maintained support and relationships with them over the years. One male informant commented on the need to keep his matrikin happy in case he ended up separating from his wife. No substantial expectation emerged of lasting partnerships.

Despite occasionally portraying cavalier attitudes the men nevertheless described being alone as problematic. The returning son has no freedom to make the demands of his parents that he might of a wife, nor would he have her as sexual companion. He might soon seek another woman to cook and provide sex, and of course provide a place to build a house, and access to land to control and cultivate. He

would have no land entitlement at his parents' home, as land passes only to daughters, sons being expected to have access to land through wives.

Men may find it necessary to leave the marital home and children even when it is wives whose infidelity has caused a rift. There was great feeling conveyed in the statement

When the wife starts going out with other men it is a sign she no longer needs you – it pains you a lot [so] you can reach the point of killing the other man – so to avoid that you go back home (Kalanje men 25 11 99).

Regret was also expressed by a female informant who commented that a woman might miss her husband 'especially when she feels like making love' (Kalanje women 25 11 99). She could survive but would 'miss his touch'.

Separations may be temporary and there is evident will to make marriages work. However, men suggested that they could not return without an invitation from the wife; one woman reported this same fact almost gleefully. The woman reports the separation to her *mwinimbumba* who makes efforts to resolve the dispute. The *mwinimbumba* from both sides may be involved in negotiations. A woman might be taken to task by her *mwinimbumba* as might the husband by his. There are limits to the degree to which a woman will be supported. If she is advised to leave a drunken or abusive partner and insists on remaining with him, her *mwinimbumba* may wash his hands of her and accept no more responsibility.

If the breakdown is considered to be irretrievable, the Village Head is informed and provides a letter for the Traditional Authority's Court. This constitutes a divorce. Whether this same procedure is followed when the marriage has not been legally formalised was not determined.

The older residents saw change as profound. I was told 'A long time ago people used to stay together for a long time while nowadays it's not like that' (Mithawa women 16 11 99). The reasons for the change, if accurately perceived, must be as many and complex as in any society, but they are changes in behaviour, not changes in the social system. To some extent a self-fulfilling prophecy appears to be at work; lack of confidence in the potential for prolonged partnerships inevitably contributes to the apparent fragility of marriage if men see little reason to invest in its maintenance. Furthermore the historical and continuing mobility of men must have

increased the incidence of foundering partnerships but, contrary to the memories of these men, there is ample evidence that Malawian marriage has long been seen as fragile (Mair 1952).

The counter-argument relates to what men said about needing to avoid neglect of their own matrikin. They may have no satisfactory 'bolt-hole' having spent many years in the woman's community and are therefore more likely to work at the partnership. These informants did not appear to see their freedom to leave as an asset.<sup>40</sup> Women too see life without a man as problematic and might look for a husband. The imperative for women to remarry appears to be less however than for women from patrilineal communities who have no choice but to leave the marital home and return with nothing to her own kin.<sup>41</sup>

It is evident then that marriage break-up is common but has significant consequences for both women and men. For women life might become very hard as they bear the burden of children but some support is usually available from matrikin even if they are blamed for the estrangement. Women have relative freedom to divest themselves of burdensome husbands. Men are free to leave but normally do so without the children, and soon seek another companion and the land and sense of belonging she provides. He might be welcomed back to his former home but, with no land entitlement, this is hardly satisfactory. Systems of support are activated to try to prevent separations; these might involve both groups of kin, the *mwinimbumba* and the original marriage guarantor, the *nkhoswe*.

Before concluding this chapter, I will return to the literature for an analysis in the light of my findings and then consider the implications of these findings for childbearing women.

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<sup>40</sup> Regrettably, the need for newly single men to marry again to find a new place to belong also becomes very important in the contemporary context of HIV and AIDS and a possible factor in the currently high rates of prevalence in Malawi.

<sup>41</sup> Such women may be stripped of all property and the children on divorce as reported earlier for bereavement. Again this is more likely when *lobola* has been paid to a woman's father by her husband's kin. At least on bereavement, this is now illegal but very difficult to control (Mbewe, personal communication, 2003). Such practices are heavily criticised in the national press (for example 'The Nation' 12 November 1999).

## Returning to the literature

This fieldwork data supports a lively co-existence and accommodation between old ways of life and new. The contemporary patterns of inheritance, residence and marriage that I encountered in this small geographical area are strongly matrilineal as far as land use is concerned, and also matrilocal with marriage bringing men into the larger residence group. With children belonging specifically to the wife's lineage and men being introduced, this both strengthens the lineage and ensures the availability of male labour. Men guard the continuity of their lineage by ensuring their sisters find suitable husbands and are well looked after by them. The *mwinimbumba* supervises the welfare of the *mbumba* on behalf of absent male siblings. This relates to Schneider's noting of males' interest in their sisters' procreative powers (1961) but it may be deeper than that with the role (as matriliney itself) having a meaning related to group identity, and, moreover being used to negotiate and express a sense of belonging and difference. Vuyk (1991) among others notes the privileged and lasting relationship between (uterine) brothers and sisters; this honoured and influential position may then be symbolic of the 'sharing of one breast' and being 'of one womb' that is important in Malawian relatedness. Despite this, it was the functional aspects of the *mwinimbumba* system that were emphasised by informants as I have demonstrated in this chapter.

My continuing interest in the *mwinimbumba* system caused amusement but I find it to be worthy of specific attention. From a functional point of view, why do women who already have the advantage of residing within their own *mbumba* or sorority group need such protection? The safer motherhood literature generally appears to assume women move away from their kin on marriage so may be at risk of neglect or abuse. Such assumptions relate to patrilocal residence and patrilineal inheritance. No protective institution appears to be in place for women in the potentially more vulnerable position of being incomers in patrilocal households. Similarly, why is it not deemed necessary to provide such a protection for men? I have not yet found any evidence in the historical or contemporary literature of an equivalent to the *mwinimbumba* system for men in patrilocal communities. I have to assume that an inherent assumption exists about female vulnerability that is only recognised when women are the focus for a group and its reproduction. Meillassoux (1981) suggests that women are highly valuable as a childbearing resource as the matrilineage cannot

replace them in the way that can be done when inheritance is through males. Douglas (1969) similarly points out the danger to a matrilineage of losing its females. From the point of view of the research into decision-making dynamics, the emphasis on female welfare would appear to be beneficial. Furthermore, this may provides answers to my questions, the institution of *mwinimbumba* itself indicating the value put on women in matrilineal societies that may be less pronounced in patrilineal ones. The potential for influencing safety in childbirth is an intriguing possibility.

Collier and Rosaldo (1981) raise another issue of pertinence to the stability of a matrilineal society in their discussion of brideservice. They point out that husbands can do little to retain accumulated goods and the main benefit of marriage is to obtain the services of a wife while she is prepared to co-operate. A man must impress those who can influence her continuing interest in him. Thus he has good reason to be dutiful to his in-laws and to remain on good terms with the *mwinimbumba*. Clearly, the *mwinimbumba* of both man and woman normally work together to reconcile differences provided attitudes are seen as 'good'. This may not always follow when a new wife is easy to find as is suggested by some female informants. Power (1995) demonstrates another strategy, describing a man who had accumulated enough wealth abroad to seek a wife from a group that practised patrilineal inheritance and would permit him to take her away, a desirable aim in the view of a few male informants.

In some areas in the central African matrilineal belt such as amongst the Goba there is an emphasis on male attempts to earn the right to remove his wife to his home as soon as possible (Lancaster 1981). This was not apparent in this community where relatively few families reported daughters who had gone away. The expectation appears to be lifelong matrilocal residence rather than aiming at removal and most men who talked to me seemed to accept their status as respected incomers. Little evidence was revealed of them feeling like providers merely of food, labour and babies. Some men enjoyed considerable prestige and respect holding leadership (such as Headmen for their nearby home communities) and advisors. However I have to recognise that these self-selected groups and interviewees may have represented only the more established, fulfilled and content male residents.

A similar contradiction exists regarding the statement of Poewe (1981:15) that 'virtually all matrilineal societies are riddled with predictable interpersonal



conflicts'. The assumption appears to be that men cannot accept any other than their sons inheriting the fruit of their labours. This appeared to be quite the opposite in this environment and the country as a whole, which has a reputation for striving for peaceful relationships, rooted, Morris says, in matriliney (1998).<sup>42</sup> Again, there may be alternative explanations in the limited opportunities for accumulation in what is a subsistence community. Maybe men would be more concerned to look after their own sons if they had much to pass on but this still makes ethnocentric assumptions about the primacy of father-son over sibling relationships, and a pattern of male dominance. Such dominance appears to be limited despite the articulated emphasis on man as head of the household. This agrees with what Poewe calls the 'fantasy' and 'fiction' of universal male dominance (1981: 23, 25). Mature women here are respected, valued, strong, and know it.

Finally, the debate about the survival of matriliney in the face of the market economy, which ignores the element of female autonomy that prevails at least at local level,<sup>43</sup> is challenged on paper and by performance. The local reality is a resilience and ability to adapt and accommodate to changing circumstances and modernisation, to waged labour and movement, to education and the neolocal, probably two-generation, household. The last is a challenge of urbanisation indicated by Chakanza (1998a) that appears to be less problematic than predicted especially with wealthier neolocal households remaining involved and interdependent with their matrikin as noted earlier. The contemporary norms of Christianity may also pose less threat to matriliney than predicted, at least in comparison to other multitudinous changes that Malawian society is encountering. For these people, matriliney is seen as 'the way we do it here' and perfectly 'natural', and, as will be shown, for childbearing women there are distinct advantages in the concern for their welfare.

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<sup>42</sup> This desire for peaceful relationships overlays a society afflicted by fears of witchcraft and jealousy (see chapter 8) and subjected to a reign of terror by former Life President Banda's secret police and military youth group members. Few of these people have ever been brought to account.

<sup>43</sup> Women are still in a minority in public life although well respected and, as Davison (1997) reports, increasing in influence since the beginning of democracy in 1994. Davison significantly comments on the greater degree of control exercised by rural women than urban.

## **Marriage and residence patterns, the impact upon women's welfare**

Morris suggests that 'absence and mobility of husbands ... was a crucial aspect' of the matrilineal system (1998:45) and it could be said that the system was an ideal way of protecting women and children left behind. Whether or not this was a response in the past to constant labour migration, or men leaving to hunt, it still applies now. Many women live without men in female-headed households but generally benefit from secure continuing relationships and residence with matrikin. Whether concerns for their welfare are altruistic, or because of their status as bearers of the children who ensure the continuance of the line, makes no difference.

Women have access to land for feeding themselves and their children, and usually retain control of it. To have a stable partnership is much desired and life can be very hard without, but these are not generally vital for survival. Moreover, despite the emphasis on harmony and the efforts of kin and village authorities toward reconciliation, women are not usually compelled to endure abusive relationships. In normal times they are unlikely to be alone and hungry if they choose to send men away.<sup>44</sup> Women generally choose their mates and are not subject to widow inheritance or property seizure when bereaved provided they do not marry into a patrilineal group.<sup>45</sup> If they choose to move away with husbands, the matrikin continue to maintain an interest in their welfare. This protection, the power, influence and agency of women will feature again in chapter 5.

## **Conclusion**

In this chapter I have demonstrated that the matrilineal and matrilocal way of living remains active and consciously appreciated by most residents amongst the groups studied, some of whose ancestors originated from patrilineal areas as refugees but

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<sup>44</sup> It has to be noted that the very high rate of HIV related illness and death from AIDS is increasingly disrupting society. By early 2003 the usual level of poverty and food insecurity was deteriorating into hunger through drought, crop failure, economic inflation and management failures.

<sup>45</sup> Like the media, community members are highly critical of such practices.

became integrated. These residence, marriage and inheritance systems are as much a way of thinking as a way of life and incorporate emphases upon respect and reciprocal benefit. Inherent in this is a concern for the welfare of women upon whom the future of the lineage depends and through whom the substance of relatedness passes. 'Being of one breast' is a substantive element of the symbolism of lineage and belonging. Matriliney and matrilocal residence are processes not just structures, and meanings as well as functions; they are identity and security.

Substantial elements of androcentric and Eurocentric analyses are evident in literature but for just a few men, matrilocal residence entails being used and sometimes abused as provider of labour, children and goods as suggested in such sources. Excess demands on those accumulating personal wealth may inevitably lead to change. Female perspectives however bring a different view of a system that enables women's agency and sustainable ways of living. Women who have some control over their circumstances, own land, can access food, reject unsatisfactory partnerships and still survive, must be safeguarded to an extent at vulnerable times such as pregnancy. The way in which the system works when decisions need to be made around childbearing processes is considered next in chapter 5.

## **Chapter 5: Childbirth 1: Decision-making dynamics amongst kin and household members**

### **Introduction**

This chapter addresses the question of who makes decisions related to childbirth and how they do so, building upon chapter 4 in which I explored the structures, dynamics and meanings of relatedness. The consequences of such dynamics for who decides what happens to women are considered before investigating who has the knowledge to make decisions, and the basis on which they are made, in chapters 6 and 7.

Four key areas emerge from the data that are, I argue, especially significant for decision-making around birth. The first three are the specific roles that exist within lineage, household headship (already addressed in chapter 4), and the relative power of women according to their age. The fourth is dependent upon these, being the accommodation reached around male roles and the power of older women.

I present evidence collected from participant observation, key informants, life history interviews and group discussions with men and women separately, some being presented as case studies. Data is drawn from discussions on marriage (and sexual activity to a limited extent), pregnancy, birth and preparation for it, and specifically on decision-making for birth. The evidence is illustrated by Venn diagrams constructed on the ground by groups to indicate the relative importance of various actors in the decision-making process.

Observing and talking about birth presented particular challenges. It is a relatively infrequent event even in an area of large families. It is also enveloped in secrecy for fear of being bewitched, and a reluctance to talk about all things sexual. Women often conceal their pregnancies and in the past would give birth alone in the fields, partly so men could not hear any sounds they might make. So it was necessary to supplement observation and participation with deliberate enquiry, both about childbearing and areas such as women's autonomy from which ideas might be extrapolated. Having done that I

will consider my evidence in the light of the secondary sources and explore issues that arise for women's agency.

Before presenting the research evidence I provide a short review of secondary material relevant to the topic of decision-making around birth.

### **The literature on decision-making dynamics around childbearing**

Literature around decision-making is the main focus here; most sources cover broader areas than birth alone but still contribute useful insights. I first consider the evidence of Lewis from New Guinea then the ideas of Janzen on Bakongo therapy groups, and move on to Sargent's evidence from Benin about strategising, autonomy and coercion around birth. I consider relevant work from other writers including Goforth (1988), who specifically studied decision-making, and Van Hollen (1998), and finally focus on Malawi with the work of Peters (1995), Spring (1995) and Morris (1998).

#### **Managing therapy**

Approaches to decision-making appear from the literature most often to be ad hoc but some are more organised. Lewis (2000) focuses a whole text on how a New Guinea Gnao community unsuccessfully sought to find a cure for one person's illness. Lewis describes the 'theatrical' rites (called 'sitdowns of sympathy' 2000:183) observed to comfort the sick person and to reach a consensus on action. Brothers' opinions counted, so did those of the sick person, but the outcome normally reflected overall opinion and belief. No one authority or group held sway. Lewis is careful, however, to point out that such rites are out of the ordinary, most therapy occurring briefly and in private with no such spectacular ways used to reach decisions.

More organised were the decision-making activities of the Bakongo studied by Janzen (1978) who, he demonstrates, had developed a relatively formalised system of collaborative decision-making and determining, seeking and managing appropriate therapy for the sick. The kin group was the main group involved but with some inclusion of the wider clan and others such as religious leaders. One person would lead as 'therapy

manager'. The group sought solutions and planned ahead using a characteristic 'multi-episodic' pattern of activity.

Janzen's work has produced both interest and challenges. Feierman (1985) suggests that Janzen's view reifies the therapy management group rather than allowing for flexibility. Furthermore, Feierman asserted that a loose network of relatives coordinated treatment choosing between varieties of options for their kin. Not only might choices move between therapists and treatment alternatives but some individuals might take decisions independently of the group.

Janzen appears to claim a pure process of decision-making, independent of influence by the patient. This assertion could be challenged in that only the unconscious might have no influence or, as he says, babies who are not competent to have a say. When dealing with childbirth and women who are normally competent, they are likely to have some effect on choices made. His work features illness, not childbearing, so the relevance of his work to a normal life event can be questioned, bearing in mind however that any notion of the normality of birth may be a western view constructed in an era of relative safety in childbirth. The impression emerging from my data is nevertheless one of birth approached as a normal part of life. Women really did stop work in times past to give birth in the field then carry on, and many women still give birth with minimal support. Women do nevertheless fear birth and speak in terms of danger so work on illness such as Janzen's can be helpful.

If indeed Janzen's work is relevant, the organised and systematic therapy management system he describes might still not be appropriate for childbearing women. The multi-episodic and prolonged nature of the process may be too drawn out for pregnancy, and the unpredictable climax of labour and birth would not accommodate a planned gathering, nor the broad range of therapies noted by Feierman.

It is clear from Janzen's work that the Bakongo collectively sought the best solution for the circumstances. In Benin, Carolyn Sargent found evidence that while women strategised to achieve their aims they were subject to coercive government policies and to powerful members of the kin group.

### **Female control in Benin**

Sargent's fieldwork in Benin included both rural and urban Bariba people (Sargent 1982 and 1989). She found multifactorial reasons for choices related to childbearing in rural areas (1982), some of which related to beliefs and midwife authority and some to the authority of women in households. She discovered that those with the greatest authority such as husbands' mothers, and fathers' sisters and mothers, would be involved and that formal group discussions to determine a course of action were rare. Men were not normally involved either. She contrasted this with the findings of Janzen amongst the Bakongo. A key finding for Sargent was that 'The domain of reproduction represents one of the primary arenas in which women control decision-making' (1982:17). Such space for autonomy is however limited; women were seen as never growing up. They were expected to be fully subordinate to their husbands except in the reproductive domain where they had almost complete control and a means of enhancing their status. This is in stark contrast to the women of matrilineal areas of Malawi, at least the women of the study community, whose influence and decision-making powers certainly extend beyond the reproductive arena if not necessarily beyond the domestic.

Sargent found a different situation in urban Parakou (1989) when studying socio-political constraints and how belief and behaviour articulated. Women here would be subordinate to husbands and to husbands' female kin, but also were subject to the imperative to protect their positions in the town and workplace. Husbands who were nurses, civil servants or military police would insist on hospital birth because of the coercive nature of rules against home birth, the punishment for which might be fines and reprimands for husbands in public service and withholding of family allowances. Wealthier townswomen also maintained appearances by giving birth in hospital where they could make an ostentatious bedside display of belongings thus promoting the elite status of themselves and their men. This affected poorer women too; they might resist institutional care because they could not follow suit. Birth place provided women and authorities with a further opportunity for contesting control as hospitalised women were constrained from diagnosing newborn infants as witch-children and taking action by killing them. So decision-making was highly politicised and manipulated for socio-cultural and financial ends, issues of which I detected no sign in Malawi.

Planned resistance was evident to Sargent (1989). Women who refused to attend hospital because of shame and a perceived lack of privacy might use cost or problems with access as excuses. Such strategising was used mainly by less well educated women and husbands, perhaps because they had fewer alternative ways of evading pressure. So for these urban Benin women, choices would be made by either the husband or themselves but under the coercive influence of his kin and both government and social incentives and disincentives. Ways around such strictures could nevertheless be found.

### **Other sources**

Some other writers on the anthropology of birth address decision-making specifically, if only amongst other considerations. Jordan (1993) argues that Mayan women may no more be free agents at home than in hospital and that older women and indigenous midwives hold the power. Likewise, Jeffery et al. (1989) demonstrate how women take little part in making decisions for their labours; older kin and *dai* discuss what to do between themselves, perhaps permitting some choice only in finding comfortable positions for birth. Even *dai* may be directed by senior women and have limited influence on decisions made. Jeffery et al. (1989) identify too the social changes that have produced both positive and negative effects for childbearing women and their autonomy. Rice and Manderson (1996) consider agency and how societies may view this differently but, like others, do not examine decision-making processes in depth. Gardner (1991) describes Bangladeshi women's position in their husband's natal households as one of both protection and exploitation indicating, however, that women might use this to their advantage. Goforth deals specifically with decision-making processes for birth in her thesis on birth attendant choice (1988), like Jordan amongst the Yucatec Maya. However she proposes socio-economic factors as central influences rather than cultural ideology, with an obstetrical managing group taking responsibility through its control of resources. She also takes this further into practice theory and investigates the effect such choices have on the system.

Most recently, Van Hollen (1998) has examined the way in which modernity affects decisions made around childbearing by women and their families. Van Hollen particularly considers women's responses to allopathy and the way in which they procure the reproductive health care they need from a basis of multiple understandings.



None of these writers find substantial change to decision-making at the level of the kin group and community, and underline the continuing subordinate position that many women hold in relation to their own reproductive lives.

### **Dependency, autonomy and gendered power relations in the matrilineal community**

The issues around gendered power relationships are inextricably linked with the residence and marriage patterns, and household formation explored in chapter 4, and are foundational to decision-making. Such gendered relationships are addressed in both Malawian and regional literary sources.

Gendered power relations are potentially complex in matrilineal contexts. The apparent freedom within the domestic domain of women who have some control over resources may, however, be less evident outside of it and may, according to Davison (1997) apply more to rural women than urban. Davison points out the disadvantage caused by the gendered nature of commercial and development projects with men usually being given control or labour opportunities and thus gaining access to household finances. This process has been perpetuated throughout the 20<sup>th</sup> century since early colonial practices caused the erosion of female autonomy reported by White (1989).

I contend that such changing relations of production are also likely to have far-reaching effects on female autonomy in the realm of reproduction in circumstances of uncertain access to resources. However some women undoubtedly benefit from judicious manoeuvring whatever their circumstances, perhaps losing in the power relations struggle but gaining in material comfort and security while relationships last. They maintain a degree of agency as Caplan (1995) found on Pemba Island where, she notes (referring to the work of Sen 1990 on cooperation and bargaining), the Pemba women accepted constraints on their lives for their own ends. So also for Malawian women changes are not necessarily disadvantageous and while some will suffer if alone, others will prosper.

Malawian women may move in and out of marital relationships, periods of male-headed or dual-headed household being interspersed with times when they may be the sole decision-makers. Furthermore, they may be household heads and in conjugal relationships simultaneously; as Morris (1998) commented, a common assumption can be found in literature that men will inevitably lead when present. Alternatively, they may remain married but with husbands away working for long periods. Households may be

effectively dual-headed with no one person making all the decisions. Spring (1995) found that the concept of the female-headed-household was manifested in differing and changing ways, the women she studied being at least semi-autonomous and, like their husbands, having their own strategies for survival.

Serial relationships are common and women might be heads of household only for relatively short periods between relationships (Peters 1995). Morris (1998) noted such serial monogamy amongst many of his acquaintances; this surely militates against secure positions of headship for men when women have spent substantial periods of time carrying sole responsibility. It seems unlikely that women give up this status easily when their circumstances change, and a degree of female strategising is likely to ensure the retention of control. Moreover I assert that such scenarios would occur as much in pregnancy as outside of it; change in relationships may occur at any time and women therefore need to remain flexible and capable of self-determination.

O'Laughlin (1995) confirms the misleading nature of assumptions of universal male dominance, finding men and women to have separate allocative priorities and commitments beyond the conjugal boundaries but maintaining links into each other's networks. O'Laughlin warned however that severe poverty might just as well follow a separation as might independence and autonomy. Nevertheless the safety net of the matrikin appears to be relatively secure for the women featured in my evidence, perhaps better than that for men.

Morris (1998) underlines the importance for women of access to their own land, and control of their labour and its products – such as the contents of the grain bin. He thus confirms the mythical nature of male dominance within matrilineal communities, an assertion supported by my findings about the control held over young men's labour by older women described in chapter 4.

These scholars all contributed to understanding the dynamics of decision-making that I was observing in the field. I feature these next.

## **Fieldwork data**

Here I present five short case studies that illustrate decision-making around childbirth. I then examine decision-making dynamics related to specific relationships and roles, pregnant women as decision-makers, and the role of men and of older women. I then explore the subject of delays in decision-making because of its known relevance to maternal morbidity and mortality, and finally consider the evidence for female autonomy.

## Case studies

### *Case study 1: Dalita: did she conceal her labour? (fig.5.1)*

Dalita<sup>1</sup> was Stella's sister's daughter and lived nearby. She had difficulties with her pregnancy that might have caused problems in labour but gave birth safely at home while waiting for her mother to return from the maize mill and accompany her to hospital.

I had met Dalita previously when Stella became concerned about her and asked my opinion. Dalita was known to be very anaemic because of repeated attacks of malaria and also schistosomiasis infection, diagnosed by laboratory tests. She was also short with a small pelvis, a warning of potential difficulty in labour. The fetus however was also small, caused, according to Stella, by a refusal to eat properly in pregnancy. I quickly realised that Stella wanted to refer her for hospital birth because of her anaemia and status as a first-time pregnant woman and really only needed agreement from me.<sup>2</sup>

Dalita eventually commenced labour while her own mother was at the maize mill some 10 kms. away. She was unlikely to have a rapid labour so Stella decided it was safe to await her mother's return so she could escort her to hospital, 10 kms. in the other direction. However Dalita progressed faster than expected and she gave birth before her mother's arrival. I had continued with a planned trip into town and expected her to be around still on my return, perhaps then asking for transport. We were both taken by surprise and I missed the birth.

I asked Stella about the problem of Dalita's mother's absence when decisions needed to be made; Stella replied that she was entitled to make decisions as Dalita was of her matrikin. She expressed her annoyance that Dalita had 'concealed' the start of her labour and covered up her contractions for so long, and reported she had 'shouted' at her for doing so.

The decision-making process is illustrated in figure 5.1 as a decision trail and appears straightforward, but did Dalita conceal her labour? Was she scared of the

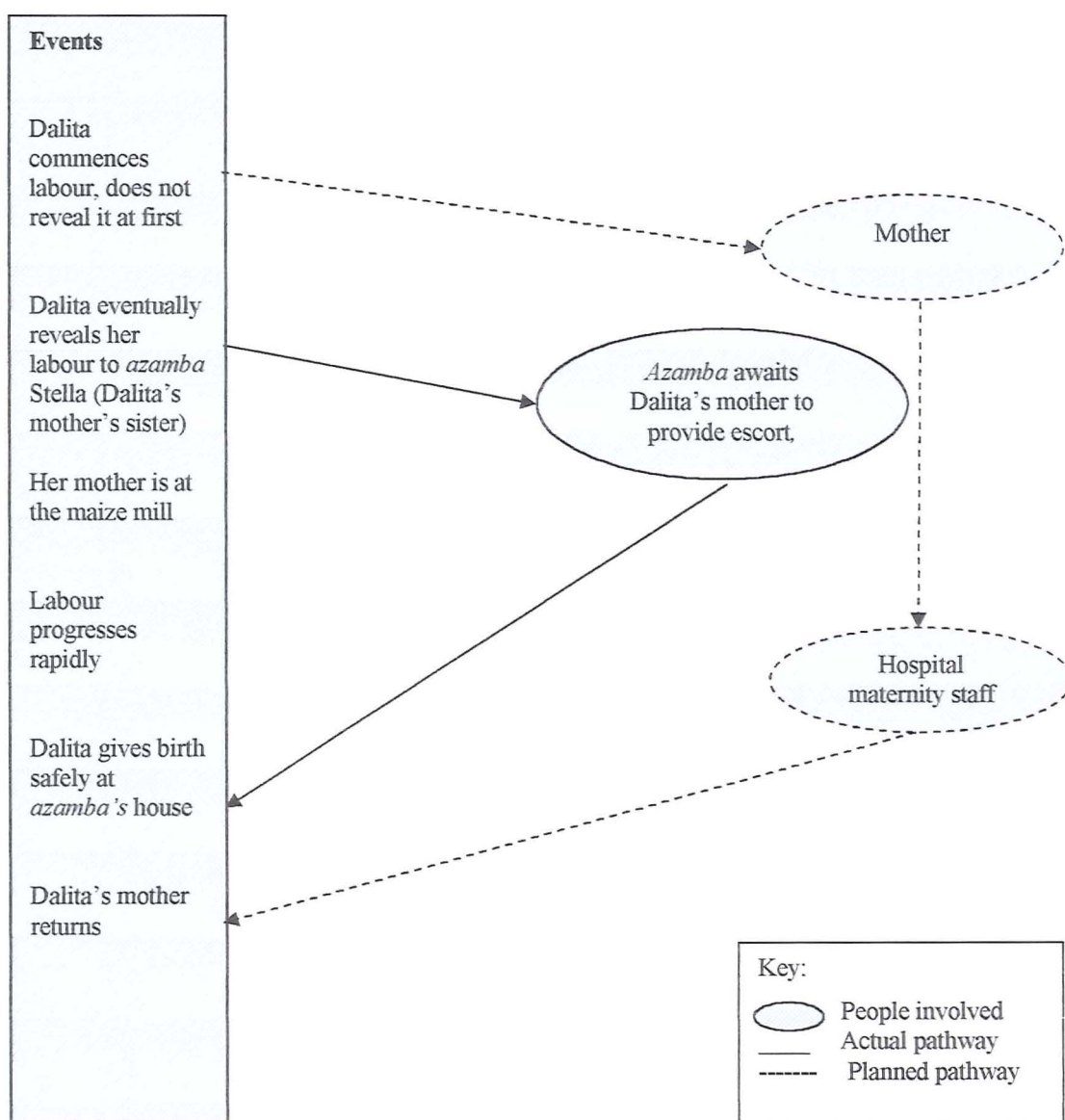
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<sup>1</sup> Pseudonyms are used for the subjects of each case study.

<sup>2</sup> Anaemia is associated with an increased risk of haemorrhage in labour and the woman has less ability to withstand such bleeding if it occurs. Women giving birth for the first time in Malawi are advised by professional carers to give birth in hospital because of a perceived increased risk.

hospital? Was she aware of what was happening but was too ashamed to tell her mother's sister, Stella? Was she perhaps frightened of Stella, or did she not recognise her contractions for what they were? The explanation may be as simple as waiting for her mother to return, and getting taken by surprise at the speed of her labour. After all, Stella had been taken unawares too despite her experience, and without examining her vaginally as I might have done at home, so was I.

**Fig. 5.1 Decision trail, Case study 1. Dalita: did she conceal her labour?**



*Case study 2: Valestar, the Headman's daughter (fig. 5.2)*

A local Headman's daughter, Valestar, arrived in strong labour at Stella's house very early one morning.

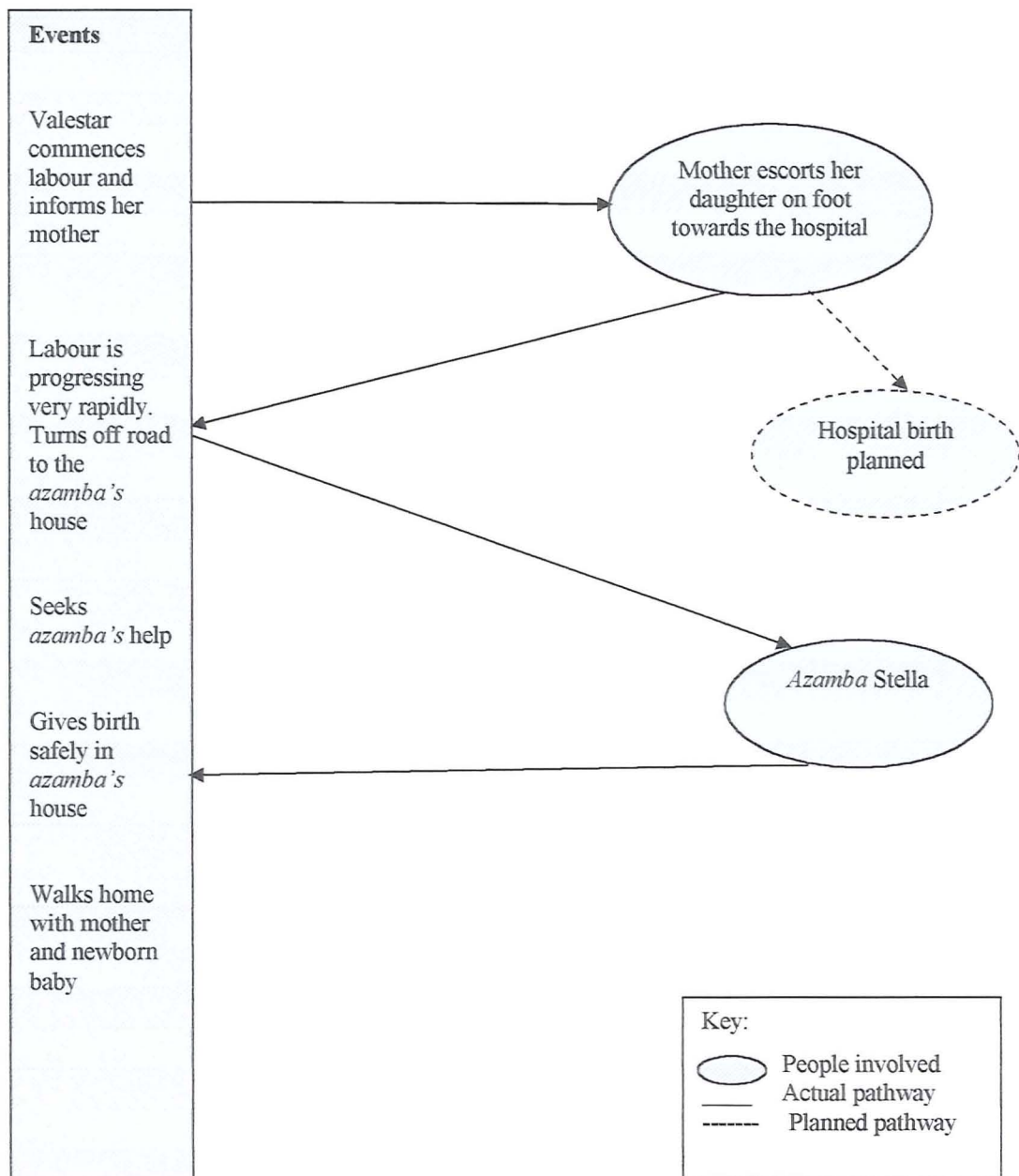
I first knew something was happening from the commotion outside of my room as Valestar arrived. She was escorted rapidly to my interpreter's room and gave birth without a problem and almost at once on a bamboo mat on the floor. Having no time to argue (as I usually did) I agreed to deliver the baby, I suspect inexpertly in Stella's view as she took over from me several times. Valestar and her baby were both well so her mother packed their things and, carrying the infant wrapped in cloth, they walked home in the high morning sun.

Two days later I visited Valestar and her baby at home and she told her story. She had given birth to most of her children at Nguludi Hospital and believed it was important to go there for this birth because of the increased risk of haemorrhage. The clinic staff too had advised her not to give birth at home. She chose to comply with this and commenced walking with her mother in the early morning hours but was contracting strongly; it quickly became apparent that she would not get that far. They turned aside to Stella's house, and arrived just in time.

Valestar's father now entered the mud-brick house and greeted us warmly; we had paid a courtesy visit to him as Village Head only days before and had left clutching gifts of rice and a live chicken. Her mother remained outside; I did not then know why. Later I learned that she did not enter because another daughter had also just given birth, but the baby had died and she had handled the body. She could not enter without endangering Valestar's healthy baby because of this contact with death. Later we heard of the worry Valestar's unmarried sister had caused by 'going with boys'. Valestar and her baby remained fit and well and she passed out of my view.

So for Valestar events turned out well and she gave birth in the security of Stella's room, even if this had not been her intention.

**Fig. 5.2 Decision trail, Case study 2: Valestar, the headman's daughter**



*Case study 3: Mafewa, whose baby was born too early (fig. 5.3)*

I first encountered Mafewa during the survey. She had come to the village two years previously, following her husband who lived there with his matrikin. They did not yet have a house in her natal village. Mafewa had given birth at home helped by Stella and her husband's mother but the baby was born dead. After one year Mafewa had given birth again at home with Stella's help.

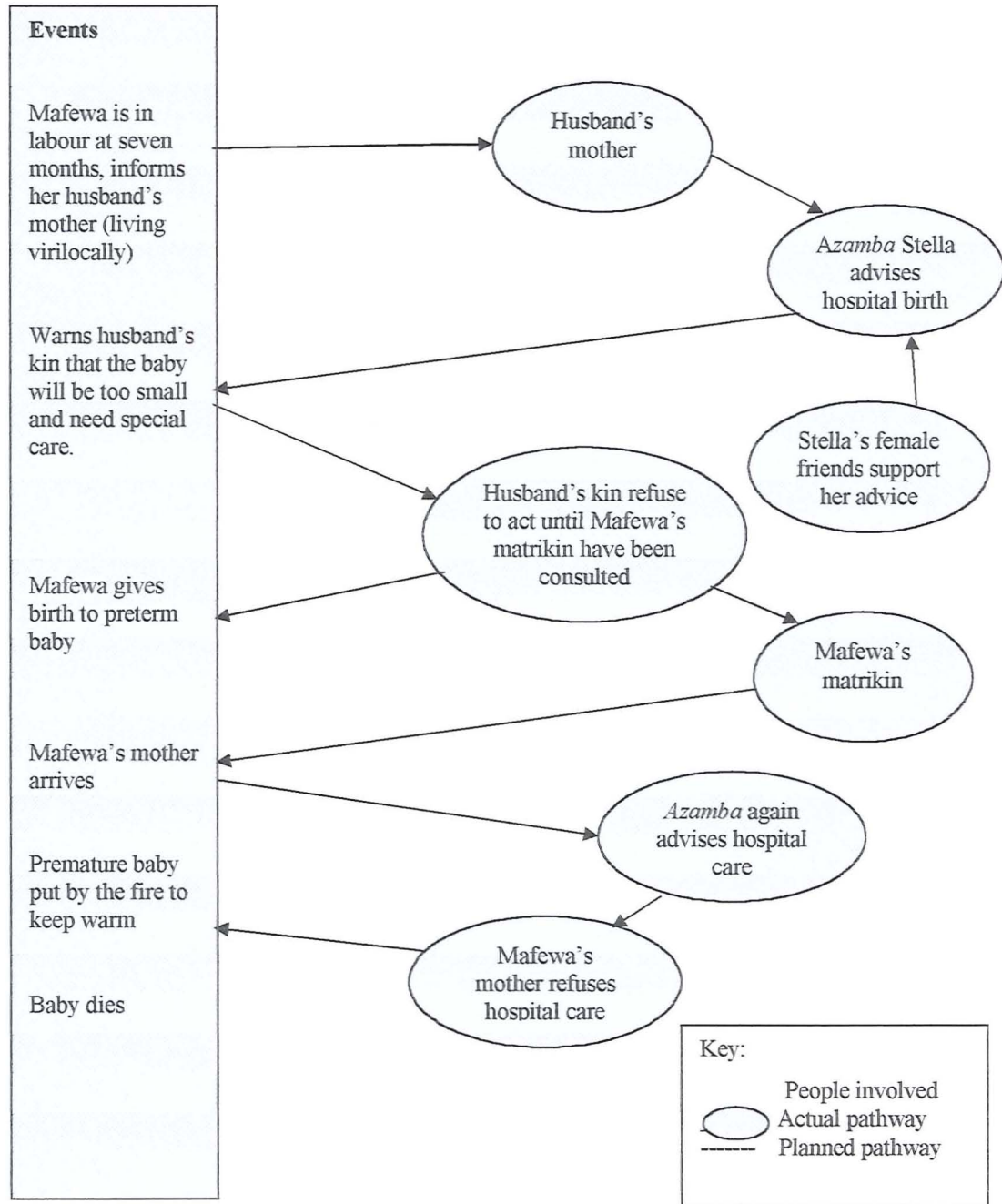
Later I heard a different scenario from Stella. Mafewa had commenced labouring two months early at seven months gestation. As indicated in fig. 5.3 the husband's mother and father had come to get Stella who said the baby would be too small and would need special attention; they must take her to the hospital where special facilities were available. The husband's parents refused to do this despite her best efforts at persuasion. They insisted on waiting until permission to move had been received from Mafewa's own parents. Stella did not see them again until they called her to say the baby was born. She advised them to 'keep the baby thoroughly covered' and take Mafewa and her baby to hospital. Again they refused. Once Mafewa's mother arrived, she insisted premature babies could survive at home but the baby quickly died despite being kept near the fire.

Talking later to Stella I learned more as we discussed the possible reasons for the refusal. Stella attributed their 'intransigence' to the successful premature birth the husband's mother had herself experienced and her resultant confidence that the baby would be safe if kept warm. She also blamed their refusal on limited understanding rather than unwillingness to use hospitals and attributed the death to the delay experienced while awaiting Mafewa's own mother.

So prior experience was more important in the mind of Mafewa's mother than was Stella's knowledge, and so was the need for permission from her parents to act more important to her husband's kin.



**Fig. 5.3 Decision trail, Case study 3: Mafewa, whose baby was born too early**



*Case study 4: Dannis, an infection follows a roadside birth. (fig. 5.4)*

At the commencement of this thesis I introduced the story of Dannis and how I met her first when her baby was about three days old. I described my next encounter when she collapsed as I tried to get her into my car to take her to hospital, and how very ill she became after giving birth at the roadside on her way to hospital, developing an infection in her uterus and then bleeding heavily some two weeks later.<sup>3</sup> I also outlined the pathway taken as her mother and other kin sought to find help for her, first ignoring Stella's advice to seek help at the hospital and then only listening to her after they had consulted a traditional healer instead.

Stella was deeply upset by this incident and complained later to me that people often did not follow the advice given, saying 'due to their illiteracy ... they underrate TBAs ... saying we can help ourselves ... [until] they fail ... and later they come'. On this occasion they had chosen instead to get medicine from a healer and to cut the sick woman's skin. She showed her exasperation to me saying 'You know us Africans; we just cut, cut, cut'. Stella did not explain 'cutting' but used the phrase 'black medicine' repeatedly and said how anaemic the woman was. She had lost a lot of blood.<sup>4</sup>

I had to wait some time to investigate further without appearing to pry or be making official enquiries. Dannis recovered and I was able to talk to her mother and to her mother's sister, neither of whom showed any misgivings about using hospital treatment. It appeared that they just did not understand what was happening and decided to try local medicine first although other evidence (Mithawa women 12 7 00) suggests hospital medicine is seen as less powerful than indigenous for postnatal infection. Fig. 5.4 shows in bare facts a near tragedy unfolding, called internationally a maternal death 'near-miss'.<sup>5</sup>

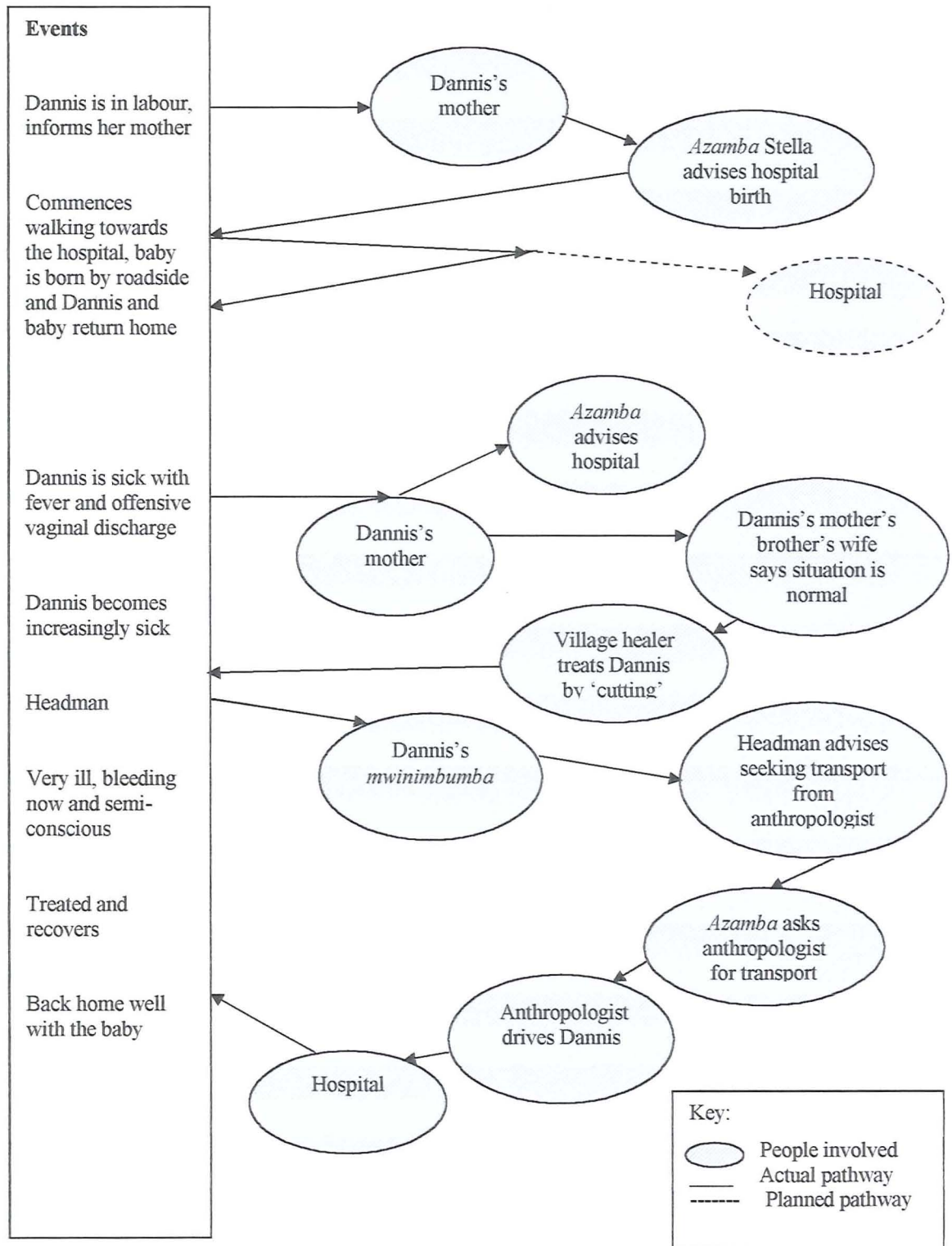
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<sup>3</sup> These are classic signs of an infection of the uterus which is life threatening, both because of the toxic effects of infection and because serious bleeding can occur.

<sup>4</sup> Turner (1968) and Ngubane (1977) address blackness as signifying darkness, pollution and often death in Zulu and Ndembu medicine, a possible explanation then for cutting being the letting out of pollution. They suggest black can also signify good, auspicious (Turner) and black medicine being used to expel the bad and protect from further harm (Ngubane). Van Breugel (2001), writing of Malawi, describes cutting as allowing for the rubbing in of protective medicine against poison when a neighbour is suspected of evil intent. He also notes red is the colour of life.

<sup>5</sup> 'Near miss' is a technical term that signifies a life-threatening problem that a childbearing woman survives.

**Fig. 5.4 Decision trail, Case study 4: Dannis, the woman with a postnatal infection**



*Case study 5: Majami escapes death, or 'Grace's accident' (fig. 5.5)*

Majami had given birth to three children, all born normally in the mission hospital, but wished to use the *azamba* this time. She told me she chose Grace Kamba as she lived nearer and it was night and 'I wanted to try the TBA, I was told it was nice, with more help'

One morning she started pains soon after attending the antenatal clinic. Majami (M) confided in her sister that evening then started to bleed. Her words tell the story of her labour:

M: I went inside Mai Kamba's house and met her mother, who is also a TBA. I was given medicine in a cup; she didn't ask if I wanted medicine – I thought it was treatment. When [Mai Kamba] came, she told her mother that she shouldn't have given this, but rather another medicine. Mai Kamba gave me the other medicine. She said that she knew what she was doing. It was 8 o'clock at night. In the morning my sister was saying that I must go to the hospital. Mai Kamba was refusing, saying you should respect her work, she knows what to do. I stayed the whole day there.

G: Did [you] have more medicine?

M: I was given another medicine the second night - in addition to the other two.

G: So how many altogether?

M: I was given three types of medicine. I was given another medicine, like a stick – I should chew it so that the labour should start again.

The picture at this point becomes confused with versions differing between informants, but with an argument between mother and daughter *azamba* evidently taking place and some conflict between Grace and Majami's sister. After a further night Majami's contractions recommenced, they were, she reported, painful but 'ordinary'.<sup>6</sup> Then she received more medicine and her condition worsened.

M: When I was given the medicine to chew at night I woke up at 4 o'clock. I failed to move and stand up – I started to lose blood, after that I could not walk. Then they sent a message to get a car. They saw I was not all right.

G: Do you remember at all?

M: When losing blood, I fainted. When taken to hospital I wouldn't know – but in the early days of labour I knew what was happening. I didn't even see in the car to hospital – I could just hear

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<sup>6</sup> *Azamba* are expected to refer women to professional help if labouring longer than between sunrise and sunset (or sunset and sunrise) without giving birth.

people talking. I didn't know what was happening, I was unconscious ... my sister said she wanted to take me to hospital. I didn't want to argue with the TBA. When I went to the hospital I didn't know who had taken me. When I signed consent to the operation I did not know what I was really signing. Afterwards I regained consciousness and asked my sister why I was found there.

G: Do you know what they have done inside?

M: The hospital told me. The baby was born but was dead. They said that the baby damaged the uterus. The medicine that I took was not good. The baby broke the uterus. -- They told me that they had taken away the broken uterus ... [but] ... Mai Kamba is doing good work. She was just unfortunate. Many go there [to Grace] and are helped.

I learned from my interpreter whose friend had been involved in the incident that Majami's 'brother'<sup>7</sup> had intervened and over-ruled Grace, organising the car to take her to hospital. She was treated with blood transfusion and caesarean section, her uterus being removed as it was irreparably torn. Her infant was found to be dead and had been lying crossways hence the obstructed labour.<sup>8</sup> A hospital midwife later informed me that Majami had sustained not only a ruptured uterus that was beyond repair but moreover her bowel narrowly escaped damage. She had needed the hysterectomy in order to stop the bleeding and save her life; she would of course never become pregnant again.

Her sister later provided another version of the story when chatting to my interpreter. Majami had selected Grace because of her popularity<sup>9</sup> and she believed her to be less likely to insist on a hospital birth than Stella. Stella lived nearer but would, she anticipated, comply with government guidance to refer women of high parity such as Majami.<sup>10</sup> Grace was renowned for her use of herbal medicines, particularly the one used to stimulate contractions of the uterus and this was probably a factor in Majami's choice. Grace had boasted to me of her knowledge, but even the Deputy Headwoman of her

<sup>7</sup> 'It is unclear whether Majami's 'brother' was her uterine brother or the husband of her sister.

<sup>8</sup> Ruptured uterus is a major cause of maternal death in poorer countries such as Malawi and anywhere without good access to emergency obstetric care.

<sup>9</sup> Grace's popularity appeared to be partly because of her willingness to use herbal medicine to hasten births, but she also had a genuinely good reputation as did both Regina and Stella.

<sup>10</sup> An inconsistency exists between the reported number of Majami's births and the label of high parity which suggests miscarriages and perhaps stillborn babies had not been included.

village condemned its use to me<sup>11</sup> and discussed the potential for women to be charged with murder if they gave it to procure abortion or caused the death of a woman. ‘It is killing’ she said.

Grace’s actions did not go unnoticed. Majami reported that the hospital staff asked for her TBA’s name. They then sent a car to collect Grace, and Majami became aware that they were ‘scolding’ her. Later again, a meeting was called by the District manager of all registered *azamba* to remind them about the limits to their activities.

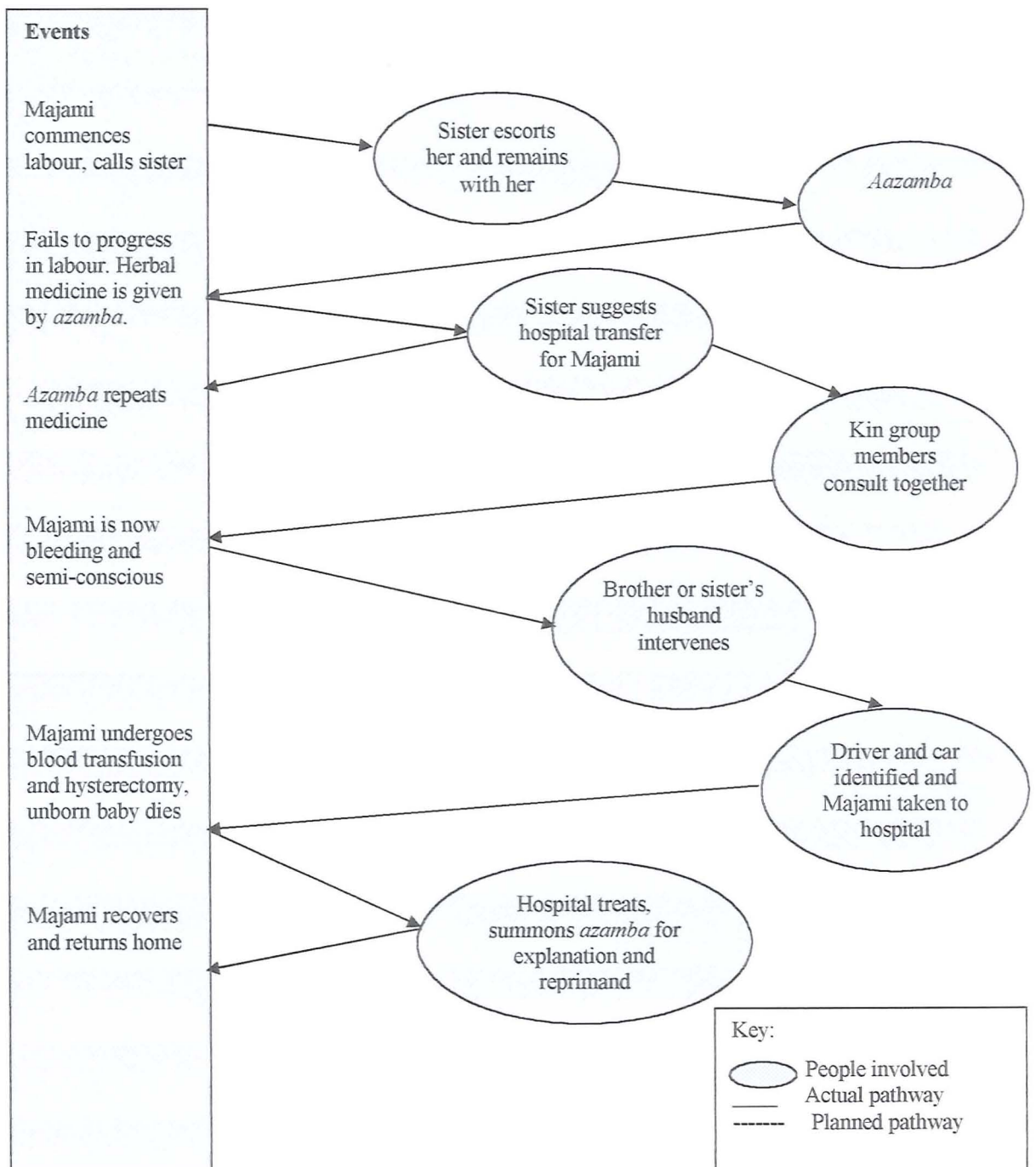
When I interviewed Majami later she was making a good recovery after coming so close to death.

The decisions made are shown diagrammatically in figure 5.5 and I explore the incident and the role of the *azamba* further in ch. 6 and 7. This is a story of agency that went wrong – a woman who made her own choice and did not (maybe would not, or even could not) change her mind before she became too ill to make choices any more. She was then at the mercy of an *azamba* with a vested interest in keeping her rather than admitting defeat, but benefited from kin who eventually intervened and ignored the one with the specialist knowledge. This was another ‘near-miss’ for maternal death.

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<sup>11</sup> Such prohibition exists because of the very powerful and uncontrolled way in which the uterine stimulant acts, as can be seen in Majami’s story, with the risk of toxicity to the mother as well as of damaging the over-stimulated uterus if the birth passage is too narrow or the baby badly positioned.

**Fig. 5.5 Decision trail, Case study 5: Majami: the woman in obstructed labour**





### **Kin relationships: organising principles for decision-making**

It is made clear in chapter 4 that kin relations and the matrilineal and matrilineal system are the principle organising frameworks for the lives of the women in the study communities. The co-resident female kin group, the household and in-marrying husband all have potential for making decisions on a woman's behalf. The husband's kin may be involved if the couple is living virilocally, but not without consultation with her kin.

The only other agents who feature in this study are Headmen and women, local political officials and the *azamba*. Heads may advise and support relatives in finding transport, or men to carry a woman to hospital. This is demonstrated in Dannis's story (case study 4). The role of the Head and the political functionary (female in Malinga) is evident from the words of one of the men's groups:

If they find difficulties with transport or they don't have any money, we report to the (ruling) party chairman and he is the one who ... finds some men who make a wheel chair so that they can take the patient to the hospital ... he and the Village Head work together (Mithawa men 23 11 99).

The men confirmed that these officials have the power to persuade people to help, again as happened with Dannis. This persuasion appears to be the limit of Heads' powers and influence regarding pregnant women, having no jural responsibility unless a complaint arises, for example from a woman about the neglect of her husband.

A clear chain of consultation as far as the Headman emerges in Dannis's story (case study 4). Van Breugel (2001) notes that such a chain of consultation must be followed starting with the least 'senior' person. If that individual cannot solve the problem, then he or she must escort the sick person to the next in seniority.

*Azamba* may be influential regarding decisions but are not in authority within the household or community. They are 'an' authority by virtue of their knowledge base; but are 'in' authority only with regard to their own kin as with Dalita (case study 1). Authoritative knowledge and power differentials arising from it are explored further in chapter 6. It is true that power relationships within the kin group are also dependent on knowledge as well as status. This can be particularly clearly seen with the situation of young women experiencing their first pregnancies discussed below.



So who does make necessary decisions for a childbearing woman? From the evidence and case studies presented here, the key people are demonstrated to be:

- The pregnant woman herself when ‘experienced’
- Her mother or mother’s mother, their sisters and her own sisters if older than herself<sup>12</sup>
- Her husband
- Her *mwinimbumba* (who would also fulfil this role for the older female kin).

### The pregnant woman

It is clear that younger, and more specifically, first-time pregnant women are not expected by older generations to make their own decisions about childbearing and not even to know what will happen in pregnancy, labour and birth until very close to each stage. They have neither the status for autonomy, nor the knowledge (see chapter 6). Various groups and individuals indicated they did not believe it to be appropriate for young women to make their own decisions because of their lack of experience (Mithawa women 4 6 00). This dialogue with a male group confirms this:

G: What happens if the woman herself disagrees, like if she wants to go to the hospital and they say no, or she is told to go to the hospital and she does not want to go, can she make a decision herself?

Group in chorus: No

I: Can’t they allow her?

Group in chorus: No

R1: She can not decide on her own because she is the patient. She just goes where the women take her to.

I: They are saying ... she does not know what will happen and she must understand what everyone is saying to her (Malinga men 27 11 99).

Groups sometimes produced differing views about female autonomy as the following lively exchange demonstrates:

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<sup>12</sup> Both uterine and classificatory sisters and mothers

G: What happens if the husband wants to take her to the hospital but the woman does not want to go?

Group (chorus): It cannot happen that way

R1: She is feeling the pain and cannot refuse to be taken to the hospital.

G: Because the husband wants it?

I: Yes, if the husband wants.

G: What if the woman wants, or does not want, to go to the hospital, and they do not want what she needs, can she do anything?

I: What happens if she wants to go to the hospital but the other women do not want her to go?

R4: It cannot happen that way.

Group (Chorus): You can just go alone.

R2: But it cannot happen that way.

R1: You just go and they will find you there because you are the one feeling the pain.

I: They are saying that they cannot say that you must not go to the hospital – but if it is like that, the patient herself must go to the hospital (Malinga women 27 11 99).

The final evidence around women's autonomy relates to the case histories described. Majami (case study 5) made her own initial choice of place of birth and attendant, preferring to use Grace rather than Stella. Of the other four, three certainly followed the lead of other people although it has to be noted that Dalita (case study 1) who was in her first pregnancy concealed her labour for a time, either deliberately or from ignorance. This could of course have been her way of maintaining some control.

Those women who already had children were much more likely to make up their own minds about choice of place of birth and choice of carer and this was very clear in the survey. Having told me that a young and inexperienced woman would inform an older woman that she was in pain, the Kalanje women said 'If it is the third pregnancy, when in pain, they bathe, pack clothes and go because they are experienced' (11 7 00).

There are however indications that the inability of younger women to make choices is changing. Younger Malinga women claimed that even in their first pregnancy they would make the decision whether or not to use the hospital as advised by the antenatal clinic staff (15 07 00). They claimed the right to make their own choices and underlined the difference education makes, as this further dialogue with them demonstrates:

G: Who decides? Someone else or do you decide alone?

R: Nobody makes the decision, you decide alone.

G: Is that for the first or second babies?

R: For the first pregnancy you do not know how you are going to give birth. You think by yourself that you should go to hospital. There can be complications.

The Deputy Head of Malinga expressed his view that women should be free to act as they considered appropriate and conveyed their fear of placenta problems:

R: Some will give birth on their own. They are very strong women, they have courage. Also a woman should know to go to hospital on her own when in labour. When the baby is born there can still be problems with the placenta. What people fear is the placenta, most of the time – it doesn't come out. They can manage to have the baby but the placenta can be a problem.

G: The fear about the placenta, does this make them go to hospital?

R: Yes. Even the TBA can find that a problem. Many want to go to hospital because of the fear of the placenta. Even TBAs sometimes fail to take the placenta out (Malinga deputy Headwoman 15 7 00).

Mai Sichali confirmed how things were changing saying:

Decisions are different now; those who go to school know more. The decision belongs to the pregnant woman if she is educated, otherwise grandmother, not the mother. She is freer to talk to the grandmother. Usually she can make up own mind if educated; [women educated to a] higher standard understand more. They are taught about pregnancy at school (Sichali 05 07 00).

This experienced professional midwife also commented that women who live in town with their husbands make their own choices with their men. Women living patrilineally could decide for themselves and being away from the matrikin, she suggested made women more independent saying 'one who stays with the mother learns less'.<sup>13</sup>

### **The role of men – husbands, *mwinimbumba* and fathers**

Men featured often in decision-making scenarios, the general consensus between male and female groups being that the role was specifically that of providing support as can be seen from the following comments:

- The husband is the one who pays so has a say in what happens (Sambani women 22 11 99);

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<sup>13</sup> Mai Sichali's own husband was from a patrilineal area.

- The husband is responsible for the pregnancy so is important (Sambani women 22 11 99);
- And for fathers – they are worried about their daughters so like to know what is happening (Malinga women 27 11 99).

The following sections address male responsibilities in childbirth decision-making relating to the roles detailed in chapter 4.

### *Husbands*

The emphasis on men as head of household is widely articulated as being the right and proper way to live, with some responsibility being shared. Yet the evidence indicates that husbands may not be available. When they are present though, how do they take part in decision-making for childbearing?

To determine whether male and female views were substantially different I analysed what four male and four female groups said when directly asked about husbands' responsibilities. The results are illustrated in Table 5.1, again demonstrating the support aspect clearly. 'Women' in this table invariably signifies the flexible grouping of older female kin and friends.

Table 5.1 Male and female group opinions on husbands' roles in decision-making around childbearing

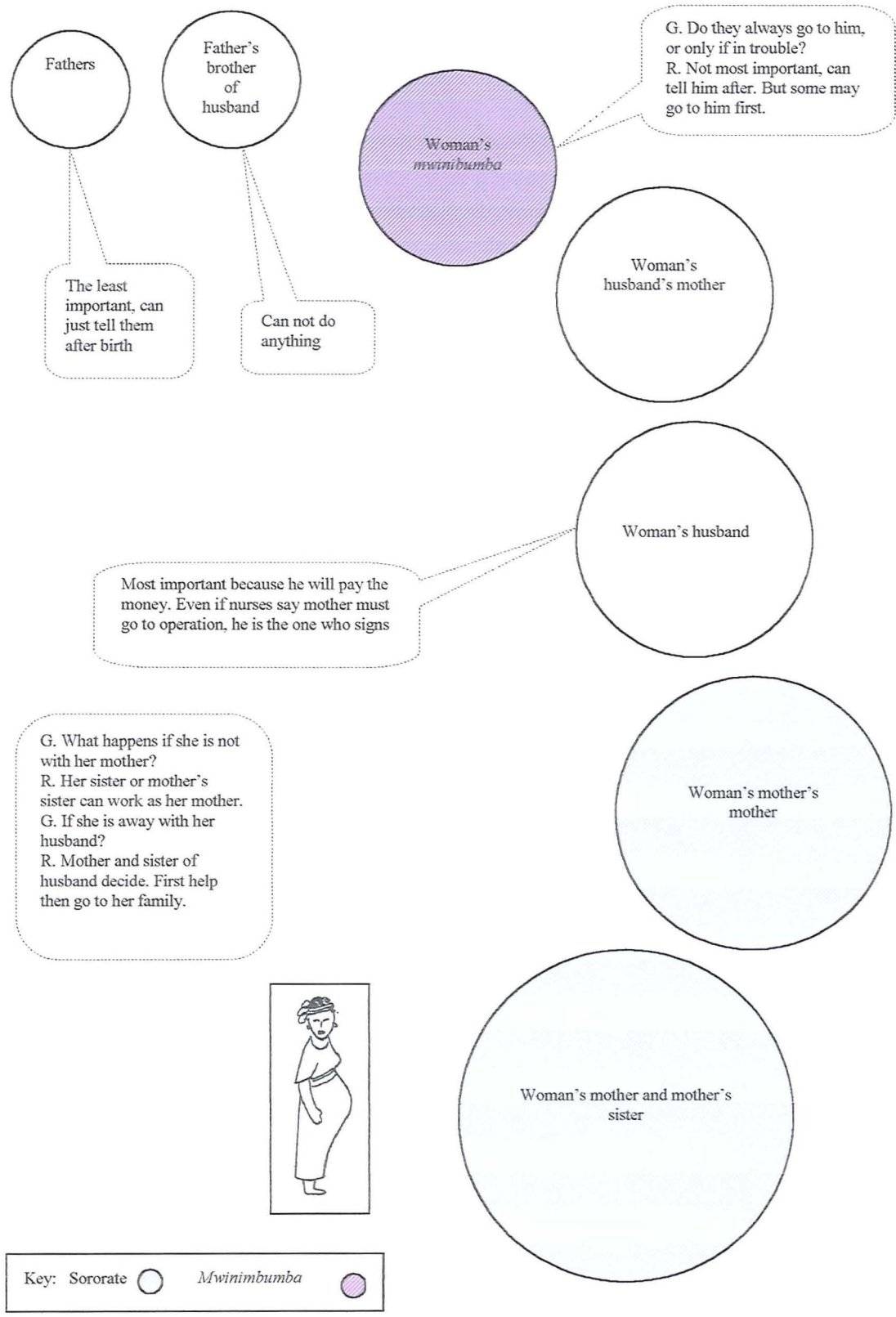
Male opinion		Female opinion	
Malinga men 17 11 99	Husband decides when people sick, specific pregnancy action not noted	Women decide, husband informed when baby born, husband decides only for sick people	Sambani women 22 11 99
Mithawa men 23 11 99	Husband pays, women decide	Husband decides	Malinga women 17 11 99
Malinga men 27 11 99	Mainly women who decide but husband can take wife to hospital without women's agreement	Her mother decides	Sambani women 22 11 99
Malinga men 22 06 00	Husband knows, gets worried, leaves in hands of women	Husband informed early in labour, expected to help. Women decide	Malinga women 27 11 00

Overwhelmingly the husband is seen as the one to provide – money, transport for hospital referral, and agreement when surgery is needed. This is shown clearly in Venn diagrams

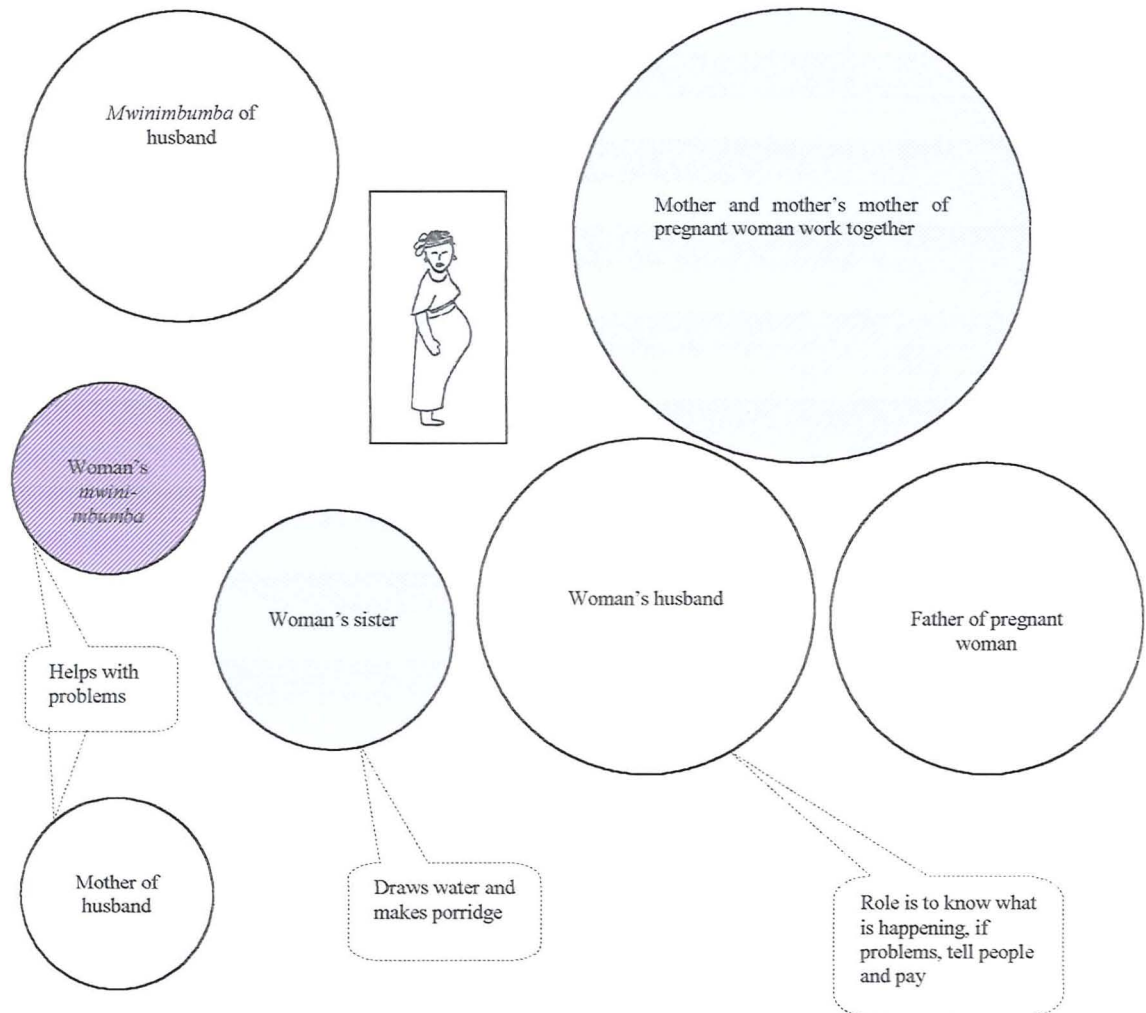
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A and B (figs. 5.6 and 5.7) which indicate responsibility for payment and consent for emergency surgery. More than once I was informed that husbands need to sign the consent for caesarean section but Headman Kalanje was one of few who addressed what happens in their absence, indicating that women make decisions in such circumstances (19 07 00). Majami (case study 5) also mentioned having signed for herself despite being semi-conscious.

**Fig. 5.6 Who makes decisions about where a woman should give birth?**  
**Sambani women 21 11 99 Venn diagram A**



**Fig. 5.7 Who makes decisions about where a woman should give birth?  
Mithawa men 23 11 99 Venn diagram B**



'If the TBA is worried, talk to ladies, must take to hospital if they fail to help. The ladies listen; it's up to them to do what they want.  
 G. Do women just take themselves?  
 R. They go direct to husband, and father next. The two men will discuss how they can pick her [up] – make a push chair [wheelchair] or get transport.  
 G. If they need help or transport, who do they go to and how do they get money?  
 R. *Mwinimbumba*, uncle of husband, woman's husband and father, all go together – use ruling party (village) Chairman – use some men to make wheelchair.  
 G. Does the party Chair act as village leader?  
 R. Chair and Headman work together. If at the point of making wheelchair, he will rule that it must happen.  
 G. Does he have the power to get the men to help?  
 R. Yes'

Key: Sororate ○ *Mwinimbumba* ●

Alongside the emphasis placed upon older women as decision-makers, and women alone when necessary, others indicated how men too could act independently. Regina followed up her statement that women could decide for themselves: 'even the husband can escort his wife to the hospital and report later to her relatives' (16 06 99). Men should stay around in case they are needed (Mithawa men 23 11 99) and should do as bidden by the women and *azamba* if wives need help. As shown in Fig. 5.9 – the husband pays, the women decide, and husbands and fathers may collaborate. The Mithawa men described how a husband cannot refuse the women's request but can conversely insist on her hospital transfer against their advice if he believes it to be necessary. This was confirmed by the Malinga (27 11 99) and Mithawa (23 11 99) women who reinforced the view that women must comply. Indeed a primigravid woman's husband might be powerless in the face of older women's decisions. Nevertheless Midwife A (2003) told me a different story, of men who might respond to a woman's request to take her to the hospital with 'Ah don't go there, I don't have money to pay them. I think it's better to deliver at the *azamba*'.

Overall the impression given is of husbands on stand-by, sometimes actively intervening, sometimes only informed of wives' labours labour after the birth, and generally standing back from actual decisions. Midwife B (2003) reported birth as being seen as a woman's 'disease' so women's business. This is unlike illness in the household where husbands play significant roles in deciding what to do according to Sambani women (15 11 99) and as appears to have happened in case study 5. Stella, who had more contact with labouring women than anyone in her area, presented a dissenting opinion when she asserted that relatives only assist in taking a woman to hospital. The husband would be the one to make decisions on behalf of his wife if he was present.

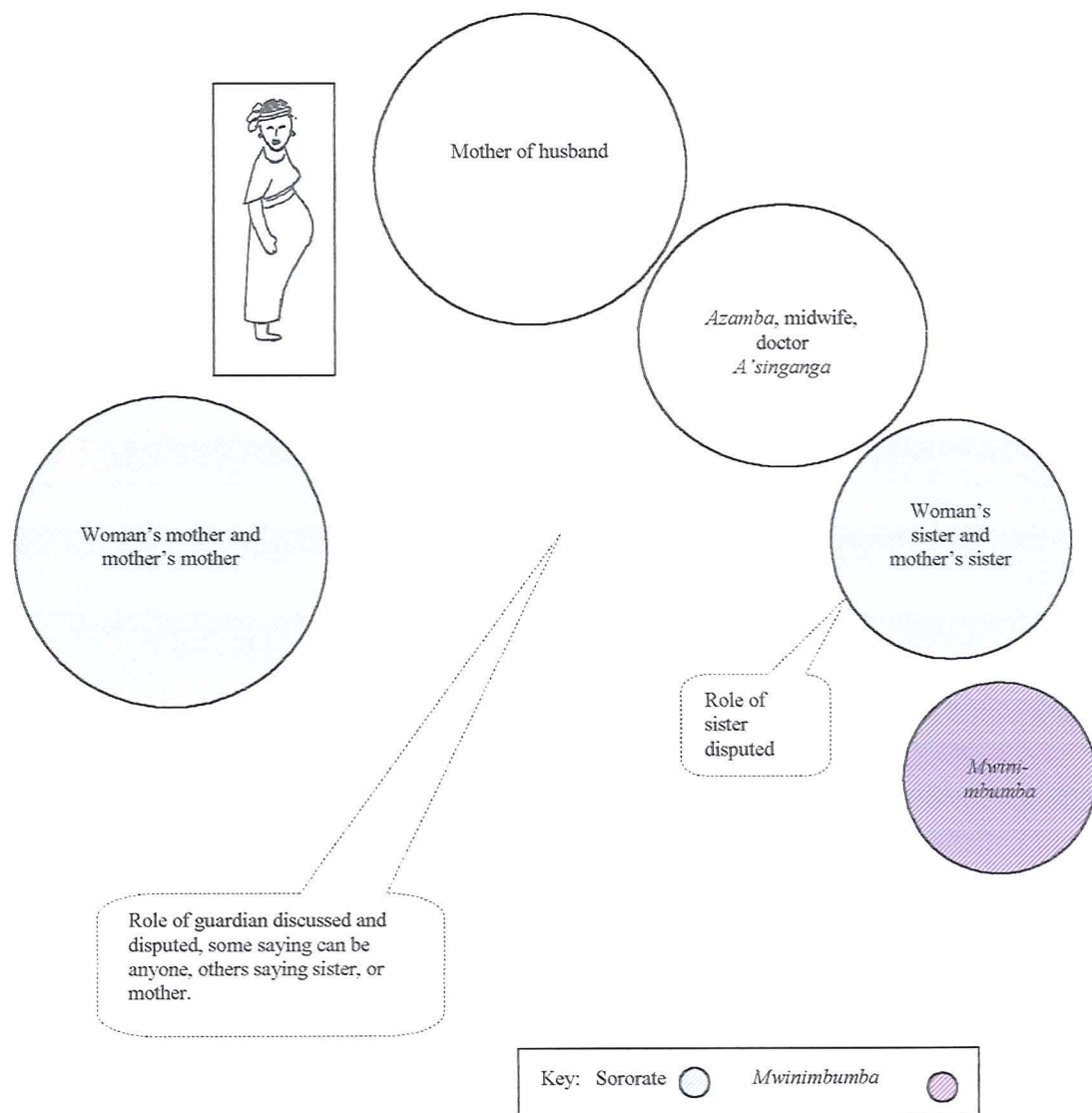
### ***Fathers***

The role of fathers then is one of support, and again being available if needed. As stated previously (Malinga women 27 11 99) fathers want to know what is happening and indeed may pay for hospital and transport if the husband has insufficient money. It is also possible that the kin of both woman and husband may get together to pay. The father of the husband fulfils this role if the couple is resident in his household. Headman Mithawa's role as father (case study 2) is not described but he was visibly active in supporting Valestar after the birth.

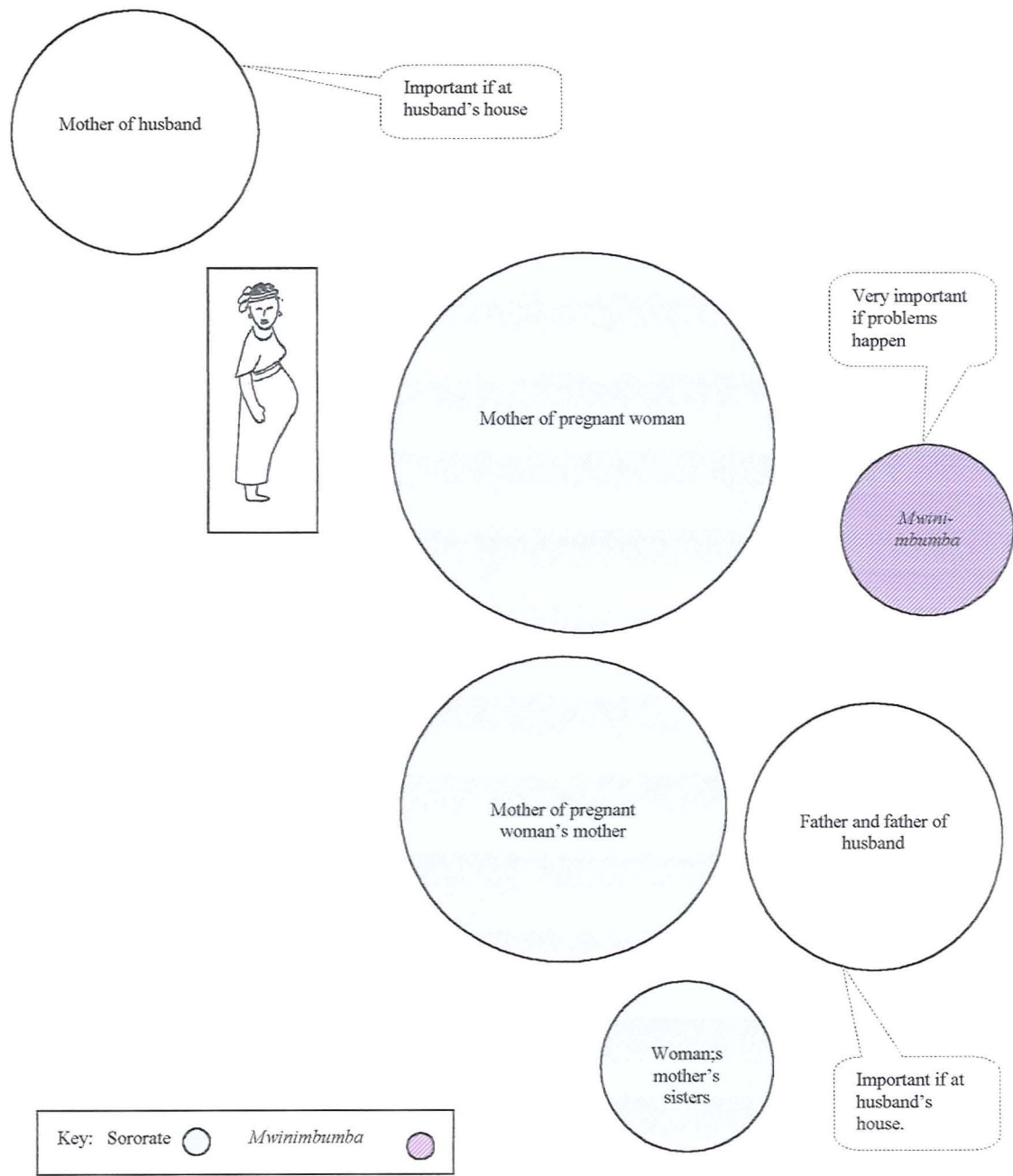


Husbands' and fathers' responsibilities were discussed by most groups when asked to look specifically at decision-making for birth. Although the Venn diagrams produced by these groups often placed them as insignificant actors (Venn diagrams A - D (figs 5.6 - 5.9), collaboration featured strongly. Mithawa men for example cited fathers, husband and *mwinimbumba* working together and perhaps involving local officials to provide support for women in emergencies.

**Fig. 5.8 Who makes decisions about where a woman should give birth?  
Malinga women 27 11 99 Venn diagram C**



**Fig. 5.9 Who makes decisions about where a woman should give birth?  
Malinga men 27 11 99 Venn diagram D**



### *Mwinimbumba*

The *mwinimbumba*'s position as advocate and supporter was particularly significant in Dannis's story (case study 4). I first encountered Dannis's *mwinimbumba* in this role when I noticed him sitting with Stella, asking her to request that I drive Dannis to hospital in my car, the only one available. I had met him previously as a respected older member of the community and a participant in group discussions. It was his own wife who had advised Dannis's mother to ignore Stella's recommendation to take her to hospital when she first became ill. I do not know how early he became involved or whether he was concerned with seeking help from the 'traditional' healer. But at some point he, or his niece, Dannis's mother, had decided she was too sick to delay further and had sought the advice of the Headman who had recommended requesting my help. This support role of the *mwinimbumba* when things go wrong is again reinforced visually in most of the Venn diagrams and decision trails.

As night time travel is considered to pose serious security problems (from bandits and witches) for women and their female supporters needing to go to hospital, the *mwinimbumba* may be asked to provide a male escort. Husbands and fathers may do this or he may accompany the woman himself. He may also be called upon to provide credit if the women are unable to gather enough money for transport and treatment (Sambani women 22 11 99) and his importance increases if the husband is away.

The *mwinimbumba* continues to have responsibilities for women living virilocally, particularly for passing messages to women's matrikin. Collaboration between the groups is common, described positively by Morris (1998) as 'warmth', and emerged strongly when groups were creating the Venn diagrams. Mothers or sisters of husbands might intervene, they 'first help then go to her family' (Sambani women 21 11 99). The duty to report back to the pregnant woman's matrikin remains.

### **The role of senior women**

The largest body of evidence points to the very significant role played by the childbearing woman's female matrikin, or if living virilocally, by her husband's female relatives. Even then the woman may well return to her natal village for the period before the birth, especially as many women living virilocally in this area are very young and technically only 'engaged'.

The woman's mother and her mother are the focal point for support. The Malinga women's group insisted that the grandmother is the first one the woman goes to upon realising that she is in labour (27 11 99) and that her mother is second choice. This reflects the reported reservation between some mothers and daughters and the joking relationship that skips generations (Radcliffe-Brown 1952) and may be important for confidences and friendship as described in chapter 4.<sup>14</sup> An argument developed in this Malinga session about whether female relatives or the husband should be informed first, and about whose role it is to send messages. Nevertheless they agreed that both mothers should be informed, and that generations and kin groups should cooperate. This group painted a vivid picture of a large gathering of female kin at the *azamba*'s house ready to help as necessary. In former times, and currently in some other communities, these women would themselves have been acting as midwives to the labouring woman.

These senior women are backed up as previously described (but at a discreet distance) by the men, possibly from both sides. (Mithawa men 23 11 99). It was recognised that experienced women need less support with making decisions but that they still need to tell someone. 'Even with the second and third or fifth they need help' (Sambani women 3 7 00).

Although the woman's mother and grandmother are shown as the main decision-makers and supporters for birthing women, the role of uterine sisters or 'little mothers' (sisters to women's mothers) cannot be ignored. These women stand by in case of help being needed in the mother or grandmother's absence and may share the load by working in shifts. Several of those I met in the maternity *chitando* were accompanied by sisters or 'aunts' who would escort them there, cook and care for them both there and when in the maternity ward, and escort them and the newborn infant back home. A specific role for the sister is to make porridge for the woman when labouring or newly delivered. Porridge is seen as essential to give her energy and ease the infant's passage into the world and a marker of a good hospital midwife also is to provide porridge.<sup>15</sup> This

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<sup>14</sup> Morris (1998) describes this as being related to the fact that clan membership jumps a generation and so same sex child and grandparent (*ambuye*) are seen as siblings. Young women may have spent a great deal of time with their grandmothers when growing up and the relationship may be firmly established.

<sup>15</sup> Failure by hospital staff to provide porridge (and hot water for bathing) is a common reason for choosing to use the *azamba*.

role is important for hospital birth as such basic services are not provided and purchasing meals from the kitchens is very expensive. Difficulty in identifying someone to act as guardian may be a barrier to hospital birth. Midwife B (2003) reported how her sister had given birth with an *azamba* purely because her mother was sick and her aunt was too busy to stay with her the two or three days in hospital.

Despite the rhetoric and the evident flexibility around who decides, experienced women often appeared to quietly pack their bags and just leave (on foot) when labour commenced, at least in the daytime when men and female kin might be working at some distance in their fields. It is notable that case study 5 is the only one in which the husband appears to feature, and then only mentioned at the end as the final arbitrator.

The data presented to this point has all been obtained from case studies, participant observation and informal and semi-structured individual and group interviews. I turn now to the survey conducted in the early part of the fieldwork which has also yielded useful data.

### Survey confirmation

The survey evidence features a convenience sample of women who had given birth in the previous year and were known to the *azamba* and selected by them so has no reliability or validity in the pure statistical sense. However the survey did appear to include almost the whole population of women filling my criteria. It alerted me to important issues early in my fieldwork, and furthermore showed the following results which back up the overall evidence gained from participant observation and interviews. Seventy-six women with babies under one year of age were interviewed and decision-making agents were reported as follows in Table 5.2.

Table 5.2. Decision-making agents for surveyed women

Woman herself	24
Mother, mother's mother, sisters, mother's sisters	40
Husband	6
Woman herself and husband	1

A variety of people, including the woman herself if experienced, can and does clearly make decisions regarding place and support person for birth. I also note that few addressed the decision to use trained *azamba* as opposed to giving birth alone or with untrained women – this was accepted as the norm alongside hospital birth. It is also clear that no specific and inviolable formula exists for making birthing decisions. This might have great significance when problems arise, a time at which delays may easily occur. This is considered next.

### Delays

Being able to make decisions quickly with and for women if problems arise is a very significant issue considering how significant delays in seeking help are for their safety (see chapter 1). These women do not necessarily need to wait until husbands arrive, nor for mothers or mothers-in-law. Neither are they obliged to await male escorts as the following two exchanges demonstrate:

G: Do they have to wait for someone to say yes they can go to the hospital?

R: They just decide to go to the hospital. It is a family problem; they don't go to other people (Sambani women 03 07 00).

G: If a woman wants to go to hospital or a mother sends her daughter, do they have to ask permission or do they just go?

S: They just go, they don't wait for the father of the girl,<sup>16</sup> that is an urgent matter, he is [just] told it (Malinga women 05 07 00).

Individuals may of course differ in their reaction to the moment and Dannis and Mafewa both waited for matrikin (case studies 3 and 5). Delays in seeking specialist help may occur for reasons as simple as having no-one to care for children or the inability to identify men to escort the woman and her guardian during night hours. It is also inevitable that some women who intend to walk either to the hospital, or to the home of the *azamba* may leave the departure so long whilst awaiting the return of a specific person from afar that they have to change plans because of imminent birth. This may have happened to Dalita (case study 1) although plans frequently go awry after several births because of the

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<sup>16</sup>The significance of the use of 'father of the girl' rather than 'husband' is unknown.

speed of labour. Midwife A (2003) provided another example of a reporting trail (woman → husband → grandmother → husband's *nkhoswe* → woman's *nkhoswe*) that inevitably led to a delay in making a decision about place of birth. Midwife B (2003) explained however how a man might avoid delays by escorting his wife to hospital, leaving her there then returning to find a guardian. Many people find ways around practical problems if determined.

The delays addressed here are mostly specific to the issue of who makes decisions. The delays experienced by Dannis and Majami are also linked to concepts of normality in pregnancy and birth which arise again in chapter 7 alongside the matter of delays experienced because of confessing adultery.

Before synthesising the evidence around decision-making roles and practice I bring together final evidence around women's autonomy (some of it used previously) and how this affects what happens.

### **Female autonomy**

I have shown how women's overall autonomy around areas of life other than reproduction is generally significant in this community, at least in theory. This must inevitably vary between households and marriages, and coercion can alter the balance of power. Even young women have some autonomy once married according to Stella, and to a degree have some freedom beforehand even though they may lose parental support as can be seen in the next two ~~next two~~ exchanges:

G: Right. So when does a daughter start making her own decisions? Is it when she has a husband?

S: When married. When she is at her parents' home she has to follow their rules, like these women that are here are big but they follow my rules. I can tell them to go to the garden and they have to do it.

G: Right. If she is left alone after being married ...?

S: She decides on her own because she has [become used to] doing that with her husband ...

S: ... unless if the daughter is doing something bad the parents can [only] advise her.

G: Right. What happens if she does not?

S: We just leave her ... These days its very difficult because when you are strict on her she can take 'Termic' and die.

I: She is saying that if the daughter does not follow the advice they will just leave her to do what she wants (Kamuntolo 17 06 99).

Stella's views on disposal of property quoted in chapter 4 demonstrate how free women might be to order their own lives which might then extend to childbearing. She argued that women can have access to money saying 'I can sell anything that I want' (17 06 99). Elsewhere Stella explained how women could 'get by' on their own although options did not go much beyond informal sector trading. Even those with a good education could find paid employment very difficult to achieve, as is also the case for men. So married, if not single women, may have considerable control over their own destiny, at least if they own property.

Generally then, childbearing women are not expected to be able to make their own decisions until they are more experienced but then they may have enough autonomy to do so.

### **Discussion: the relationship of the data to secondary sources**

The secondary sources considered previously shed some light on the issue and provide a framework for discussion but have limited similarities to the Malawian situation.

It is apparent that those featuring in this research bring together whoever is immediately available within the matrilineal community to make decisions and act how they see fit at the time. There is no evidence here of a clearly defined therapy group such as described by Janzen (1978) for illness, and Goforth (1988) specifically for childbearing. Even the gathering of kin to identify the cause of prolonged labour and seek confession of extra-marital sexual partners' names, reported by the Safe Motherhood Project Team (Matinga, personal communication, 2000) and relatively common in patrilineal areas, rarely happens in this locality, according to residents. Some similarity perhaps exists with Janzen's descriptions in that complex cases may span a variety of actions and decisions over time.<sup>17</sup> The decision trails (figs. 5.2 - 5.5) provide strong

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<sup>17</sup> Janzen refers to 'excruciating social conflicts' having to be resolved before seeking 'life-saving' medication (1978:227).



evidence that one helper after another may be tried in order to find a solution to women's difficulties.

There is no evidence in my data of one person acting as therapy manager although the woman's mother or mother's mother certainly takes a central role and the *azamba* perhaps come close. Moreover, there is no apparent predetermined process, people request or accept help as they see fit as the process of childbirth unfolds. At this point similarities with the Janzen model emerge as the woman's supporters choose from the options presented to them by those who have been consulted,<sup>18</sup> not necessarily following the advice of those holding the technical expertise and knowledge as with both Mafewa and Dalita (case studies 3 and 4). I consider this further in chapter 7. Moreover Feierman (1985:78) notes that the Bakongo decision-makers studied by Janzen 'worked out a shared view of clinical reality' which might not separate social effects of choices and technical ones with varying consequences for the 'patient'.

The jural and social coercion and constraints identified by Sargent (1987) in Benin on where women could give birth and who might control events are not evident in my data. The planned resistance and strategising to evade unwelcome choices that Sargent found is not apparent in my data either although there is no way for me to know how deliberate some actions may have been. Examples are the actions of Dalita in ignoring or apparently not recognising the onset of labour, and Valestar in seeking help too late for her predictably rapid labour (case studies 1 and 2). Notwithstanding this, perfectly reasonable explanations exist for what happened to both of them. Furthermore, there is none of the coercion used by Benin authorities to persuade women into hospital, local health personnel informally admitting that maternity services would be unable to cope should large numbers of women request hospital birth.

Another significant difference between the women of Sargent's acquaintance and the women in matrilineal Malawi is the Benin view of women as childlike and largely subordinate to husbands except in the reproductive domain. Those women about whom Peters, Spring, Vaughan and Morris spoke, and those whom I encountered wielded considerable power at local level, and not just domestic and reproductive. It is however

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<sup>18</sup> Morris (1996a) asserts that the therapeutic role of the kinship group in Malawi is mainly one of support.

uncertain how much difference access to land and control of produce and property makes when it comes to self-determination around childbirth. Likewise, the ability to choose and reject marital partners using the safety net of matrikin does appear to be reflected in some freedom around childbearing choices. However, it cannot be assumed that economic autonomy necessarily translates into cash that women can use to support their preferred actions, especially in the local context of sharing and demands on couples noted in chapter 4 as sometimes causing them to relocate. Although in a very different patrilineal Madras community, Vera-Sanso found women's income to be seen as serving the interests of the family (1995) rather than their own. A significant difference that nevertheless arises is that women's rights to control of property detailed by my informants gives them advantages at least in principle.

A significant element in the degree of self-determination for women is seniority through age and existing status as mothers. While in other societies such as Benin and Sierra Leone (Sargent 1982, 1989, MacCormack 1994) initiation and status are vital (see chapter 2 and 6), here the importance appeared to be related more specifically to age and experience as a mother. The differential between the power to make choices of a woman who has not yet given birth, and one who is experienced is very significant in the data although Majami (case study 5) appeared to lose this advantage once in labour. If this change in women's autonomy is general once women are in strong labour, then it is similar to the findings of Jeffery et al. (1989) and Jordan (1993).

Despite all the evidence about who controls choices within the matrilineal community, no decision-making path can be completely pre-determined. Matters can take a different turn at any point and women's experience may then represent the outcome of circumstance. Majami (case study 5) reached the point of no return when she could no longer make her own choices and her kin did not at first contest the authority of Grace, Valestar (case study 2) chose to turn aside from her planned journey to the hospital so gave birth in the comparative safety of Stella's house. If Stella had delivered Dannis herself (against official policy) Dannis might have given birth safely in Stella's clean environment instead of by the roadside, and perhaps not become infected. A quick judgement on the normality of Dannis's symptoms, which apparently did not reflect any resistance to biomedicine in her mother's sister, nearly led to her death. These are perhaps unique turns of action, 'contingencies' according to Foucault (Mills 2003) but remind us that purposeful choice grounded in local systems is not alone in affecting people's lives.

## Conclusion

In this chapter I have presented fieldwork evidence to support the development of my argument that women who have previously experienced childbirth have a substantial degree of autonomy around decisions made for birth. For others, it is the older women who make most decisions. The husbands of married women might play significant roles or may alternatively stand back and not intervene. Other female and male kin group members play important supporting roles for these women in whom the continuation of the matrilineage is invested. I have used secondary sources to explore issues around these dynamics.

To a degree this chapter presents a rosy picture of cooperation and benevolence that may not always match the reality for women giving birth. O’Laughlin (1995) provides a reminder that household members have different agendas that may influence their actions and attitudes. In much of my data men appear to support their wives, but other comments relate to men who do not bother, or mothers who send first-time labouring daughters off to hospital unaccompanied. I developed no idea at all of what happens to young women who abandon the community norms and perhaps follow men, only to become pregnant far away, out of reach of the matrikin who may anyway have washed their hands of them. Neither do I know how women fare if they follow work opportunities and do not have even male partners’ kin to support them, or if they are left alone. It is not difficult to see how women could fall through the ‘matrilineal safety net’. Then there is AIDS which is transforming many communities into groups of the young cared for by each other and by the oldest generations, and the safety net itself into one full of holes.

Women can be seen as strategising agents in the evidence, the most obvious example being Majami choosing to go to specific *azamba* to avoid hospital referral. Others undoubtedly strategised similarly and made decisions that suited their specific, possibly non-childbearing needs but did not fall prey to such serious consequences. Provided women know enough to make choices, it is usually possible for them to do so and their kin will cooperate. At the worst they will leave them to their own devices if they really do not approve. Obstructive husbands can be sanctioned or ‘chased away’ and they cannot prevent wives from being referred to hospital. At the same time, older female organisers of support cannot prevent men from taking them. Ultimately (for good or ill)

the hospital birth choice is privileged. The following chapters provide some indication of why this is so.

I have then presented four particular factors that emerge from the data that are, I argue, especially significant for decision-making around birth. The first three areas are the roles that exist within lineage and residence groups, household headship, and the relative autonomy of women dependant upon age. The fourth is dependent upon these three, being the accommodation reached around the potential tension between male roles as head of household, and the power of women who transmit the substance of relatedness.

Having considered who makes decisions in the household in this chapter, in the next I will present address the issue of knowledge and how it is linked to the power to make decisions.

## **Chapter 6: Childbirth 2: Power through knowledge: who defines what matters?**

Each society has its regime of truth ... its types of discourse which it accepts and makes function as true; the mechanisms and instances which enables one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value ... the status of those who are charged with saying what counts as true (Foucault in Rabinow 1984:73).

### **Introduction**

Chapter 5 ended with the proposition that household dynamics in this matrilineal society generally make it possible for mature women, if not younger ones, to make their own birth choices with or without the support of husbands. Older female matrikin are very influential but women who have given birth previously can generally strategise according to their own perceived needs.

In this chapter I address issues that are foundational to decision-making around childbirth related to knowledge as power; in other words, who has the knowledge and consequential power to make decisions? This prepares the ground for considering what the precepts are that underpin this knowledge in chapters 7 and 8 and the techniques and procedures likely to be used according to the quotation from Michel Foucault introducing this chapter.

Women's own ability to strategise is bound by what they know as well as their position in the society. Equally pertinent are the characteristics of the knowledge itself and its perceived credibility and status, and the credibility of those possessing such knowledge. Here I explore the forms of knowledge that govern action and the ways in which the knowledge of childbearing women and those who influence them is developed. This contributes to investigating how knowledge is made use of in terms of legitimacy, authority and power, and to the synthesis of decision-making strategies in chapter 9. Knowledge is intangible but its effects on power relationships may not be, and field data are used to make the exercising of such power visible. I also use data to demonstrate what

this knowledge is and how it links directly to the concepts which will be explored in chapter 7.

This chapter makes use of key literature on biomedical and ethnomedical precepts and knowledge and on the anthropology of childbirth outlined in chapter 2. I first clarify what I mean by knowledge, and how I see this as different from the concepts that underpin it. I find the ideas of Barth helpful in this task. I then consider the knowledge that people use to determine action and how that is developed and controlled by those inside and outside of the community. Legitimacy is integral to people's acceptance of those 'in the know' such as the *azamba* and the formal health system employees, so this will be addressed later in the chapter.

### **The meaning of knowledge**

For Barth knowledge is 'what a person employs to interpret and act on the world' (2002:1). It consists of the attitudes, categories and concepts, information and skills used to structure reality and to provide 'materials for reflection and premises for action'. This is social action and the whole is 'culture'. I maintain that no knowledge set is a bounded entity; it changes according to new learning and experience, and fresh outlooks and insights. Knowledge then cannot be reified without becoming increasingly irrelevant despite the efforts of stakeholders in maintaining the status quo. New knowledge does, however, need to be congruent with currently held ideas to be successfully assimilated as noted in chapter 2.

A final comment from Barth that I find helpful in grasping the meaning of knowledge is that we rely on the judgement of those we trust. To determine this we use personal criteria of validity which themselves are constructed within our own traditions and are congruent with experience and socialisation (2002:2). Such legitimacy is explored later in the chapter.

The knowledge that governs what we do is more than the sum of its parts. Moreover it is the locus of power for those who 'have it' over those who do not, as will be seen when knowledge development, legitimacy and power are explored.

Knowledge discussed in this thesis will be classified as biological and biomedical, and indigenous and ethnomedical. Often called 'traditional' and thought of by some as outdated superstition, ethnomedical knowledge may in reality be no more static

than biomedicine and continue to incorporate new ideas in unproblematic ways. A very real fieldwork challenge arose with efforts to tease out 'reminiscing' from contemporary knowledge and practice. It is knowledge that governs action now that matters but with an eye to its historical foundation.

### **The knowledge that determines action: its development and use in the fieldwork community**

The main actors who feature in this chapter are the pregnant women and their kin and households, and the *azamba*. Other informants were the supervisor of the *azamba* Mai Sichali, hospital-based midwives, Village Heads and the local head teacher. The overall structure will be to consider what the knowledge base of both women and the *azamba* consists of and how it is constructed, developed and represented. Who controls the knowledge and passes it on is considered alongside issues of hegemony and contestation, and how this affects decision-making.

#### **Childbirth knowledge of women and the wider community**

I will first consider the knowledge of the women and community as a whole, what that knowledge is about, how it is constructed and transmitted and who is responsible for its perpetuation. The knowledge that matters encompasses getting pregnant, being pregnant, labouring to give birth, and the months after the birth.

#### ***Pluralistic and layered: knowledge that matters for childbearing***

In order to learn more about the community knowledge than I could by observation alone I met with both older and younger groups of women in discussions focussing on the themes, and also with groups of men. I talked informally with the secondary school headmaster and with Mai Sichali in her role as supervisor of the *azamba*, and finally with professional midwives including Sister Fleur<sup>1</sup> who was British. Separate groups were convened to address knowledge acquisition and transmission. Concepts of health and

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<sup>1</sup> Pseudonym.

childbearing will be addressed in chapter 7 so are generally not considered here other than to consider the nature of the knowledge set.

A key area of the knowledge of women concerns fertility and its regulation. Providing children for the matrilineage is important but the contemporary struggle to survive is resulting in a desire to limit family size. Knowledge about family-spacing<sup>2</sup> is seen as important but inadequate, with biomedical contraception featuring in a partial way alongside older herbal knowledge. Older Kalanje women said to me ‘Traditional child spacing had been there for centuries. They used to give medicine and you tie the medicine round the waist<sup>3</sup> till the time when you want to have another child ... you take the string away when the baby starts walking’ (16 06 00).

Herbal medicine is used too for infertility which is as significant as the ability to limit family size. Biomedically-based knowledge appears to be limited to speaking of ‘some disease’ (probably sexually transmitted infections) as a cause for infertility, and a more inclusive category of barrenness in women and impotence in men. This was the subject of lively discussion with men described as having ‘useless private parts – has just got them as a gift but they’re no use’ (Mithawa women 16 6 00). Some partly biologically congruent knowledge was apparent with talk of ‘watery sperm’ and an obvious appreciation of male as well as female infertility that may result in the man being sent away from the household. Fertility is illustrative of the layered nature of ways of knowing; the local knowledge around fertility encompasses both the use of antibiotics provided by hospital and herbal medications, again often worn by women as waist strings. Both ethnomedical and biomedical therapies are seen as effective although some men held healers to be more helpful than hospital doctors.

Discussion on knowledge about pregnancy and birth caused great excitement amongst the women and provided a wealth of information except regarding conception about which women were shy. Despite the information about fertility and infertility already addressed, and raucous remarks about men from older women, I could glean little information about people’s knowledge about what ‘triggered’ a pregnancy beyond sexual

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<sup>2</sup> Family spacing is the accepted term used for contraception in Malawi where both Roman Catholicism and the pro-family environment precludes the use of other terminology.

<sup>3</sup> Waist string amulets made from plant roots.



intercourse and sperm and blood producing the child. Questioning people about this appeared to provoke mild amusement as reported by Jeffery et al. (1989) although I would hesitate to say biomedical explanations were completely taken for granted by my informants. Articulated knowledge was restricted to external signs of pregnancy and fetal movements, sickness and pica.<sup>4</sup> Such signs are used by older women as confirmation of pregnancy, inspection of young women being the duty of grandmothers or older matrikin rather than mothers because of the 'shyness' and avoidance between mother and daughter previously reported.

Each female group demonstrated some knowledge of nutrition for pregnancy. They also repeatedly explained pregnancy maintenance through sexual intercourse and protection of the child through abstinence in later months. Such prescribed and proscribed sexual activity is a clear element in the knowledge base for pregnancy, the Kalanje women reminding me that both women and men should remain faithful and trust each other. These mostly older women became very excited at this and commenced an initiation dance indicating this as knowledge transmitted through 'old-style' rites. Such knowledge was clearly grounded in the cosmology that features in chapter 7.

Knowledge passed on to young women includes practical aspects such as position for intercourse in pregnancy and foods to be eaten. Recommended foods generally matched biomedical nutritional thinking based upon food groups with some exceptions,<sup>5</sup> the main differences noted being warnings against eating away from home for fear of witchcraft, or eating something prepared by a woman who had attended a funeral. Such warnings are further explored in chapter 8 as they were expressed as dangers.

Labour and birth were discussed with similar enthusiasm, demonstrated by some groups in dancing and singing and often with everyone laughing and talking at once. Younger women who had already given birth talked freely of their knowledge about the commencement of labour, the importance of a good position for the baby, biomedical

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<sup>4</sup> Cravings for unusual foods and normally inedible substances, supplemented here by unpleasant smells.

<sup>5</sup> Queenie provided a list of foods women should eat and those that should be avoided, mostly because of consequences for the unborn baby. The food groups quoted by many as important for pregnant women followed a clear biomedical categorisation equating to proteins, carbohydrates, vegetables and fruit. This reflects an old education campaign.

treatments, some local remedies in current use for difficulties and others now outdated such as ‘doctors’<sup>6</sup> flushing the vagina with medicine (Kalanje women 11 07 00). Herbal remedies featured more consistently in information from the Kalanje group of mostly very elderly women: ‘You give her traditional medicine and the placenta comes out’. Their details of umbilical cord treatment and disposal methods for the placenta matched those described by the *azamba* and addressed later.

Despite the women’s willingness to share what they knew with me, analysis reveals limited information that sheds light on younger women’s knowledge about labour and birth other than that which can be categorised as biological and biomedical. They conveyed expectations to me of birth as a biologically based life process and reliance on the *azamba* and hospital staff as those having the knowledge needed to help them.

Community knowledge around birth has other, non-technical, aspects regarding practical problems of getting to hospital quickly, and popular knowledge of what happens once there. The need to overcome transport constraints to reach emergency care competes with a local rhetoric of poor quality care. Each group talked at length about hospital experiences, the life-saving treatment received and the kindness or neglect and cruelty encountered. So onto a respect for what the hospital had to offer, a superimposed message of adverse aspects of care formed part of the local knowledge set concerning birth. Reading signals from women’s preoccupation with it, I argue that such ‘common’ knowledge may be as important in influencing decisions as the promise of helpful technical intervention when needed. This indeed becomes part of the local notion of risk and is addressed more fully in chapter 8.

I talked to one male group about their knowledge of childbearing. The consensus was that they did not know enough and wished to know more in order to support their wives better. Biological knowledge has clear importance for these men. This extends to family planning where one man explained that strife could occur between husband and wife if he did not understand it. Concern was expressed that there was no one with whom a man is free to discuss his wife’s pregnancy if worried; he can talk only to her. It is evident that men feel excluded from the female arena of birth. Men know when their wives are labouring but leave her in the hands of her parents: ‘When the wife

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<sup>6</sup> ‘Doctor’ here signifies the *Asing’anga*.

is in hospital, the husband gets so worried about the pregnancy. He is waiting and doesn't know what will happen or whether his wife will be alright' (Malinga men 22 06 00).

Having considered what people know, the next area addressed is how women's knowledge develops.

### *Developing their knowledge, how do women learn?*

Knowledge is transmitted purposively to young women and men by local custom and practice which is, however, changing. The first stage of initiation takes place around puberty and, known as 'going to the river', constitutes a separation period at the riverside accompanied by advisers.<sup>7</sup>

According to literary sources, the initiation of young Malawians concerns education for life as well as a symbolic rite of passage. Girls are initiated before puberty by respected advisers (*anankumwi*) who teach them about puberty and how to behave toward their elders.<sup>8</sup> Boys may have their own initiation rites but Morris (2000) reports these as more variable. This is aimed at 'proper formation for ... future roles as husbands and wives in a way which would dissuade them from falling victims of moral laxity' (Chakanza undated). Van Breugel (2001) reports the essence of such teaching as imparting the 'wisdom of the tribe' and of ancestors, moral instruction being handed down through proverbs and stories. Ritual aspects feature largely as expression of such wisdom and entail transformative 'warming' from the coldness of childhood to the warmth of a sexual being (Morris 2000). Morris proposes three basic functions of Malawian initiation: sexuality and gender identity, kinship, and the harnessing of nature's powers for social reproduction. The instruction of young women around puberty then features largely gender-specific knowledge on personhood and sexuality, practical teaching such as cooking, and conveying moral values and norms. In pregnancy couples are taught the obligations of marriage and parenthood, and sexual taboos relating to

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<sup>7</sup> Rivers have ritual importance elsewhere too where the riverside is the place where older Nguni (Zulu) women take primigravid women to 'bleed' the vulva in cold water (Brindley 1985). Morris's account (2000) of female initiation amongst the Yao features mainly 'domestic' village space however with visits to streams at specific junctures.

<sup>8</sup> Seeing a girl in her early teen years curtsey before her grandmother, my interpreter explained this as the mark of proper training from 'going to the river'.

pregnancy (Morris 2000). Alternative instruction may be available for Christians, or they may attend traditional rites selectively.<sup>9</sup>

Today the contemporary local expression of the process is reduced in length and content and partially replaced by individual attention from advisers selected by parents, or by advisers nominated by churches and mosques. There is much regret expressed that the young no longer know how to behave and some comment on the failure of parents to take responsibility for it (see below). Before considering the field work evidence on this however, radio and formal school education will be addressed.

### *Learning about childbearing outside the community and household*

Radio undoubtedly has an important role in transmitting knowledge<sup>10</sup> but many households do not own a radio. Poorer young people have limited or no access to money to buy their own and are unlikely to control what they hear otherwise. Head Kalanje expressed distaste at the content of some programmes saying that such things as pregnancy should not be discussed openly; Sambani women told me a radio might be turned off in such circumstances. One exchange was especially illuminating. I had asked what advice young women were given about how to recognise pregnancy problems and we had begun to talk about postnatal infection.

G: Are there messages about these things on the radio?

Group: It is a secret; on the radio they cannot do this, men would not want women, if there were this thing about smelling on the radio. They would not ask women about marriage [to marry them].

G: Have there been plays on the radio?

Group: They do it as a drama on the radio, but people don't see it as the real thing.

G: Do people not listen?

Group: They listen but still the bad smell is a secret.

G: There was a drama about a man outside the hospital, whose wife has just died. He is talking to another man – the wife died four weeks after the baby was born.

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<sup>9</sup> I have identified no sources detailing instruction given specifically for childbearing, unsurprising since writers are mostly male. Preparation of women by health care providers also appears to be non-existent in Malawian literature other than Safe Motherhood Programme evidence (for example 1999) on teaching communities about childbearing danger signs.

<sup>10</sup> A television service now exists in Malawi but inhabitants of the area studied do not have electricity let alone being able to afford television. Young men visiting bottle (soft drinks and beer) stores may watch televisions powered by car batteries.

Group: They heard that drama but they don't take it seriously, because women keep it a secret, otherwise men would not like women (Mithawa women, group 2, 17 07 00).

These women clearly felt that husband's views of them were more important than any perceived advantage of men's preparedness for birth. This is not however congruent with what the men had told me about their desire to know more. It is evident too that radio may be less effective for transmission of childbearing knowledge in resource-poor areas than programme makers and health educators like to think.<sup>11</sup> I note however that hospital midwives interviewed each felt that women, men and the general public are becoming increasingly well-informed. Midwife C (2003) gave me examples of where people, including strangers, had responded appropriately to women who had collapsed at home or by the roadside and had carried them on stretchers to the hospital. Bleeding, severe headaches and oedema are danger signs that are usually recognised as a result of broadcasts.

Secondary schools have an increasing role in increasing knowledge around reproduction but young women often drop out before reaching the stage when it features and the cost is too high for many households.<sup>12</sup> Biology is compulsory in secondary schools and efforts are made to integrate HIV and AIDS. Sex education is however not a requirement in Catholic schools and depends on individual teachers' commitment and willingness to address it. The local head teacher showed me the written material he used and explained his approach; he believes that young people value honesty and open attitudes. He reported students to be curious and appreciative of sex education classes asking for detailed explanations of pregnancy and childbirth. He declared his main message to be that very young women are not ready for pregnancy while the pelvis remains immature, and that their lives are at risk if they do become pregnant. This teacher reported significant opposition to his teaching from within the community, having received complaints from those who believe that such knowledge causes improper behaviour.

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<sup>11</sup> Radio is being used specifically in the region by the DFID funded Safe Motherhood Project to raise community awareness of danger signs in pregnancy (Ashwood-Smith personal communication, 2000).

<sup>12</sup> The current secondary school fee (about £60) is equivalent to 10 sacks of maize per term.

Pregnancy amongst very young women is nevertheless seen as problematic with many missing out on education because of it. A pregnant student would have to leave and returning is very difficult without significant help. This concern is different from former times when pregnancy as early as twelve years was accepted, but it still happens. Many first-time mothers are too young to have benefited from whatever education is provided. Moreover, the preparation of young people for pregnancy and labour, as opposed to health and social skills education (including avoiding sexually transmitted infection and pregnancy) is probably beyond the remit of schools. Sister Fleur reported to me:

We ask in clinic if they know the signs of labour and tell her to have a chat with someone like [her] sister. They have no idea and are very frightened, may be hysterical and screaming. Often they are not rational but the midwife or student sits down by the bed to have a woman to woman chat (09 07 00).

Antenatal clinic midwives try to tell young women at least what to take to hospital but demonstrated a minimal role in preparation for labour. Observed clinic education sessions were didactic and non-participative relating chiefly to childhood illness. Moreover these 'talks' were directed at perhaps one hundred women sitting with their babies and young children on rows of benches in a church. Numbers at hospital sessions were smaller but the surroundings were intimidating and the style no different. A recent development (2003) has been the introduction of video shows<sup>13</sup> in hospital clinics and the encouragement to discuss hospital birth with husbands.<sup>14</sup>

Antenatal consultations presented significant opportunities for communication but minimal talk occurred within those that I observed. Nevertheless the Mithawa women did attribute some teaching about birth to clinic midwives. My view is dominated by scenes witnessed at clinics where I took a non-participant observer role. Young women generally submit to physical examination and to kindly questioning about their health but with minimum return communication and no opportunity made for discussion or for women to pose questions of their own. Midwives instruct women considered to be at risk of birth problems to go to hospital in labour and to tell their families that they must take

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<sup>13</sup> Videos have been provided by the Safe Motherhood Project. These are aimed at improving awareness of danger signs in pregnancy (Malawi Safe Motherhood Project 2003).

<sup>14</sup> It is planned to develop a programme nationwide to involve husbands in education about pregnancy and birth (MOHP 2003).

them there. This is noted on the record cards the women carry but may not be able to read. The young primigravid women, not being supposed to know anything or to talk of pregnancy, acquiesce, possibly kneeling silently before the midwife as final instructions are given. The real decision-makers are outside of the clinic or back at home – the mothers and grand-mothers and the concerned, if less powerful, husbands. I could see no significant attempt made by clinic staff to harness the good-will of these gate-keepers.

### *Community based learning and teaching*

The *azamba* reported similar experiences to hospital midwives, often finding that young labouring women come to them knowing very little nowadays. Initial teaching has to be provided during labour to reassure and calm them. Older women and the *azamba* were critical of the neglect of the parental duty of arranging for advisers to visit in pregnancy before labour begins. Kalanje group women explained

... some girls have not been advised at home, ... she just cries and says she will not do it. The TBA starts to teach her what she will do. She is told to push and the baby will come out, otherwise she will die. Out of fear she does the work (17 07 00).

The system of advice and initiation into womanhood is customarily staged in Malawi as described in chapter 2: pre-puberty, following the first menstruation, on marriage, in early pregnancy, just prior to labour, and after the birth. Each stage takes place ‘just-in-time’. It is evident that this policy is considered to be inadequate by younger Sambani women, all now mothers, who explained:

We would like to learn about periods; when we did [got] them we thought we had hurt ourselves, why we were having blood? Maybe we had an accident with a knife. Mothers know that it is a period, and mothers explain the cause of it (05 07 00).

These women also commented critically that many learn some aspects at school and from friends, and appear to ‘know everything’.

It appears that initiation after the first menstruation, mostly labelled ‘old-style’, focuses largely on avoiding pregnancy, sexual norms and taboos including behaviour whilst menstruating, and learning to please husbands sexually. The older Kalanje women, who were mainly Yao, were the most forthcoming. With clapping instigated by Regina, and using their upper bodies to dance in a sitting position because of their age, as in fig.

6.1, these women explained that both girls and boys are 'informed about each other' and that Muslim boys are still circumcised during initiation rites. They discussed the need for boys to supply their own razor blade because of the risk of HIV transmission and the importance of discontinuing old Islamic practices involving a single knife. Yao boys, whether Muslims or Christians, are warned that young women can become pregnant aged as young as ten. According to my interpreter Francis there is no real initiation rite for Lomwe boys or girls but they might join Yao friends, some Lomwe (Christian) boys being circumcised alongside Muslims.<sup>15</sup>

Fig. 6.1 Women continue to dance even when aged



Initiation appears to have changed substantially. Earlier rituals continue to some extent but external influence, such as the Christian stance against older rites, has led to new methods of life preparation. I was given a description of a replacement rite, in which Roman Catholic advisers take groups of adolescent girls apart for approximately five days. Good behaviour, including respectful attitudes, is included (as described for the older ways in chapter 2) and some information is provided about what to expect in pregnancy. A new feature considered vital by religious and secular advisers is to address HIV and AIDS from the age of nine years. Jane insisted however that the (Catholic)

<sup>15</sup> Female genital cutting is not practised in Malawi in any form but very young women are taught to elongate the labia minora to increase sexual pleasure for themselves and their husbands.



Church does not, in her experience, teach about sex, only about 'respecting your husband'.

According to the Kalanje women the content of Christian and Muslim teaching of the young is very similar and generally inadequate for their needs. Those not taking part in either 'old style' or religious rites might receive home visits from individual advisers appointed by parents. It was nevertheless clear that some girls miss out completely, the blame for such neglect being laid upon parents. Others insisted that young people may in any case refuse teaching and go their own way.

Once pregnant for the first time, a woman informs her grandmother or another older kinswoman. Advisers are appointed to teach her and her husband together about pregnancy. This includes the duration of sexual intercourse during pregnancy, fidelity and contact with the dead.

Women may receive further visits to teach them about labour. Female informants were more forthcoming here, explaining that ensuring this happens is the mother's responsibility. The Kalanje older women were dramatic in telling about education for labour, showing me how they would demonstrate giving birth and warn a pregnant woman that being scared might cause problems. Sambani women were more sceptical about how much young women listen, asserting that 'you can't tell them anything nowadays', an attitude mirroring any conversation about the generation gap in the UK. The Mithawa women discussed it in this way:

R1: Let me answer briefly. When the young girls are expecting, if the parents don't offer any advice to the child, just leaving her to give birth when the time comes, I think that the doctors are faced with problems on the day because they don't know how to explain certain things to the young mother to be. But once it's known that a young girl is pregnant, she is usually given advice so that she won't be scared when labour starts. She's told that one day if this or that happens, don't be surprised because it means that the baby is on its way and when the doctors tell you to do certain things, you shouldn't be scared. Can someone please add to that?

R2: I blame some parents for this problem – they don't always give advice to their children.

R3: No, I don't agree. There are two sides to consider. Sometimes, a girl meets a boy and they get to know one another and start sleeping together. Inevitably, the girl falls pregnant but does not tell anyone until she's at an advanced stage. So how is the parent supposed to give advice to someone who has not confided in them and told them she's pregnant?

R?: Some of them [girls] react angrily when they are asked questions saying 'What makes you think that I'm not well?' So you don't give her any advice - that's why it sometimes seems that

parents fail to advise their daughters about what to expect during pregnancy and what happens during labour (Mithawa women, group 2, 13 07 00).

These women discussed also the need for women to know to go to their elders when contractions commence, not to damage the baby by crying, or ‘shame all women’ by crying in the hearing of men other than their husbands, and how the baby will be born. The reasons for labour pain, such as the baby turning, and that the baby will emerge from the vagina ‘where you were having sex’ was also listed as important for them to understand as was knowing how to breathe and ‘let the baby out’. Malinga women indicated the importance of knowing that babies ‘don’t just come out on their own’.

The Mithawa women specified that information should not be conveyed by the newly advised to unmarried women, and ended this discussion by celebrating birth in song – provocatively according to the audiotape translator (see fig.6.2).

Fig. 6.2 Celebrating birth



Advisers meet the couple together following the birth to warn against early resumption of intercourse because of the risk of *mdulo* wasting disease in the husband, or sickness in the infant. Yao women reported this as being especially important in the Nguru<sup>16</sup> tradition

<sup>16</sup> *Nguru* is the alternative name for Lomwe people and has derogatory undertones.

(Mithawa 17 07 00).

It is very evident that the ‘just-in-time’ education is intended, if not deliberately, for compliance and ensuring appropriate behaviour rather than for making choices. Aside from their low status, many young women have inadequate knowledge to empower them to make decide for themselves. In summary women are taught over the years to:

- be polite to elders;
- act appropriately when menstruating;
- comply with avoidance rules;
- avoid HIV infection and extra-marital pregnancy;<sup>17</sup>
- satisfy the sexual needs of men and treat husbands with respect;
- act in pregnancy so as to minimise harm;
- know what to expect and how to behave in labour;
- comply with postnatal sexual abstinence to protect the infant and husband.

So the knowledge of women and men around pregnancy and birth consists of a mix of biological and biomedical, ethnomedical and equilibrium concepts (see chapter 7), but with biomedical apparently being more significant for birth than for pregnancy. Having suggested when discussing the meaning of knowledge that no knowledge set is a bounded entity, I have however summarised the knowledge of this community according to the assertion of Barth (2002) that knowledge consists of attitudes, categories and concepts, information and skills. This is illustrated in Table 6.1.

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<sup>17</sup> Despite the evidence that the provision of information about HIV is generally patchy, it was frequently quoted as a necessary part of education for life for both sexes.

Table 6.1. The knowledge of the fieldwork community around pregnancy and birth according to Barth's framework.

Categories	Indigenous and ethnomedical	Biological and biomedical
<b>Concepts</b> (see chapter 7)	Equilibrium of life force maintained through contained sexuality Sex as transformative Harm through imbalance and personalistic influence	The body as a machine that can go wrong, unrelated to social context Mind-body dualism
<b>Attitudes</b>	Knowledge is for: <ul style="list-style-type: none"> <li>• socially acceptable behaviour</li> <li>• compliance</li> </ul>	Knowledge: <ul style="list-style-type: none"> <li>• provides empowering life skills</li> <li>• is for both compliance and transformation</li> <li>• may be seen as subversive</li> </ul>
<b>Information and skills imparted</b>	Socialisation: how to behave respectfully and please men, and how to behave in labour Maintenance of equilibrium through morally acceptable actions (Information provision about what to expect and how to respond is becoming increasingly neglected by some parents)	Socialisation: how to behave acceptably Communication and empowerment What to take to hospital (Information provision about what to expect and how to respond to events is very limited)

Having summarised the local knowledge set in terms of Barth's definition, I turn to the knowledge of the *azamba*.

### **Eclectic practice: the knowledge of the *azamba***

The substance of this section is the knowledge and its development of the *azamba* of my acquaintance, examining the way in which each entered the role and learned her craft. I then consider the formal training programme provided by the health authorities as this is the main way in which biomedical concepts and knowledge are introduced to women who probably had minimal exposure previously. It is evident from my brief contacts with other trained *azamba*, and casual conversations with many people<sup>18</sup> that Regina and Grace have typical backgrounds, only that of Stella being less conventional.

<sup>18</sup> Examples are Mai Sichali, Sister Fleur, Midwives A, B, and C and Technical Advisers (Safe Motherhood Project).

### *Regina*

Regina started to work with her mother's mother in 1949, helping her with births as an apprentice until the latter died after six years when Regina took her place as village *azamba*. Her grandmother taught her many things, and Regina developed an extensive knowledge of techniques and herbal remedies to use when consulted on a variety of disorders, or when visiting women's homes to help them through birth. At this time, when women might have as many as twelve children, they were both very busy; sometimes they would travel as far as 25 kms. and stay away for several days.

In those days, if complications arose they would refer women to the old city hospital. Few women in their area gave birth alone or were attended by older non-specialist women; most came to her and certainly did not give birth alone in the fields, a situation which continues today. Regina reported birth as being easy then:

Regina: In the old generation you just boil water and help the lady to bathe, and then you can help. They would put a bath towel in the bath with warm water and put it on the back, helping her to relieve the pain and give birth more easily, but these days the girls cannot understand that they can do just that - so the hospital is used.

G: What if the woman did not use a TBA or the hospital?

Regina In the past it was not difficult. A woman would cook here and have labour pains, - people would hear the baby was born, complications were very rare. If there was no one to help she could damage herself. Labour was easy in the past ... people followed rituals, rules of the culture and advisers. Now people have stopped following the culture and things are more difficult (06 07 00).

Regina returned often like this to rituals, 'culture' and *chisawawa* (adultery during pregnancy) and to postnatal sexual taboos. Changing moral behaviour was her frequent lament, brought up in answer to my many questions about difficult birth. In this interview Regina provided more detail about what her grandmother had taught her, insisting, as in the quotation above, that birth is a natural thing and that the most important thing she had learned from her was to 'look after people's lives'.

Whenever I spent time with Regina I found the same eclectic mix of notions about health and birth underpinning her knowledge base and her actions that are explored in chapter 7. Two examples indicate the change to her knowledge brought about by the training course and also the mix of forms of knowledge. Regina shared with me what she

knew about the effect on the fetus of the woman's position during labour and birth,<sup>19</sup> claiming that ~~and~~ she had not used squatting in the corner, the birth position which dated from her mother's time, since attending the course. I asked her what she thought of giving birth upright. This was dangerous she said, as the baby's head could not be seen and might do damage, and as for giving birth on hands and knees – the baby would just go back inside.<sup>20</sup> Her eclectic knowledge base is also illustrated with her concern for witches delaying the birth process, her knowledge of herbs to 'untie' the woman, and her confidence in caesarean section as a way out, also explored further in chapter 7.

Regina's knowledge of herbal remedies for slow labour, possibly the same ones as for 'being tied', was clear, so too was her understanding of the boundaries to their use set by the authorities. I am less certain of how constrained her practice is by such rules. Case study 5 (chapter 5) appears to demonstrate disagreement between mother and daughter about the use of herbs and Regina often expressed disapproval of her daughter's actions.

Other evidence clearly demonstrates how her herbal knowledge is situated within the social context of birth. She described to me first the treatment for pregnancy sickness learned from her mother, then how sickness indicates an 'unhappy baby' and home. 'At home, maybe some relatives are not happy' she explained.

I enquired how Regina handled specific biomedically defined birth problems. She had just told me that 'In the TBA course, we were taught that patients had to be handled properly and if the patient is really having problems, send her to hospital – do not proceed'. She listed some of the differences between what her grandmother had taught her and what she has learned 'at school', focussing especially on changing knowledge about how to manage excess bleeding. For this she must refer women to hospital but herbs exist to deal with it. After-pains occurring during breast feeding she described as the uterus 'crying for the baby', but suckling the infant to encourage the expulsion of the placenta or

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<sup>19</sup> Optimal positioning of women for birth is a very contemporary preoccupation in the West amongst women and midwives alike.

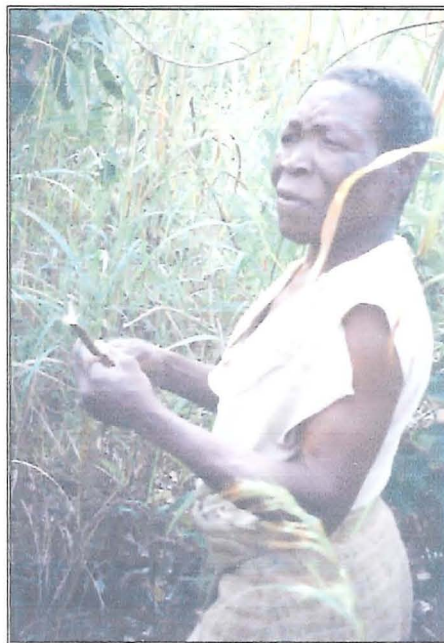
<sup>20</sup> Inability to see the emerging head easily was a common reason given for such resistance when upright positions were re-introduced to UK practice. 'Going back inside' is probably her personal perception of the process.



to stop bleeding, is unknown to her.<sup>21</sup>

A key part of the herbalist and *azamba* knowledge is where to find and identify therapeutic ingredients. Regina often referred to women having 'not enough blood' and the plant substances she was seeking with Jane and me (see chapter 3 and fig. 3.4) were intended to treat this. The tree root she dug up with her hoe<sup>22</sup> was *chigaga*<sup>23</sup>, (see fig. 6.3), the leaves she identified as *mlumbwa*. Boiled up with other leaves she could not find, she would use these ingredients to make a black liquid to be drunk as a treatment for 'not enough blood' (apparently meaning anaemia).<sup>24</sup>

Fig. 6.3 Medicinal roots located



Other remedies were once included in her herbal armoury, such as those for infection, all

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<sup>21</sup> 'After pains' are experienced as the uterus contracts to prevent bleeding and are increased by suckling, so stimulating hormone release and strong, painful contractions. Although unproven as a remedy, suckling may be useful to encourage normal separation and expulsion of the placenta and prevent and treat abnormal bleeding. This practice is used by some UK and North American midwives.

<sup>22</sup> The hoe is an indispensable tool for herbalists according to Morris 1996a.

<sup>23</sup> Of these names, only *Chigaga* is identifiable in Morris's ethno-botanical text (1996a). He specifies the scientific name as *Acalphya villicaulis*, and lists many uses including reproductive ailments, *mdulo* or *tsempho* wasting disease consequential on adultery, and to increase lactation. Blood problems are not included. This is one of many herbs referred to as *mwanwamphepo* and is also a popular charm used to protect infants. Morris lists thirty herbs used for childbirth problems and many more for reproductive ailments.

<sup>24</sup> I note the black colour of Coca-Cola used by local women and others (Safe Motherhood Project 1999) to treat haemorrhage (see chapter 5 for colour symbolism).

of which she claimed have been replaced by hospital referral and treatment.

Regina went on to describe what she does if the placenta fails to come out or is expelled with 'buttons' missing saying 'If everything has come out, everything is alright but if buttons are not unfastened then the TBA ... should send the patient to hospital for a check' (06 07 00).<sup>25</sup> The placenta should not be dealt with carelessly as it may be sought for illicit purposes (witchcraft according to a Safe Motherhood Project report 1999).<sup>26</sup> Regina's information awakened in me a memory of the care with which a British woman I once attended in the UK had organised the safe disposal of her placenta, being suspicious of the intentions of another who was present. Regina said:

The placenta might be thrown into the pit latrine, perhaps in a broken pot. At one time it would just be thrown into the rubbish pit. It is not discarded carelessly however as people want the cord to mix with medicine to help them to become rich (06 07 00).

Regina's knowledge about treating babies' umbilical cord stumps and the avoidance of early pushing has clearly been affected by government training and she was frequently critical of untrained women that she used to encounter. She cuts cords with new razor blades, expecting women to provide these themselves,<sup>27</sup> and applies spirit supplied by her supervisor to the stump instead of using bamboo slivers and ash. She described skills such as resuscitating newborn babies, replacing a prolapsed uterus and dealing with a malpositioned fetus by examining the woman's abdomen, correcting the position, then getting the woman to push once the head was down and 'some water, slippery fluids and blood' appear. For her, membrane rupture and fluid loss is indicative of normal progress. She also advises pregnant and lactating women about nutrition and foods to be avoided. Earlier interview notes demonstrated my growing respect tempered with some remaining negativity:

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<sup>25</sup> The placenta has a lumpy appearance similar to a cauliflower. 'Buttons' describes these lumps (segments), known biomedically as cotyledons. Heavy bleeding or serious infection follows if some fail to detach from the uterus with the placenta. Experienced eyes can detect missing cotyledons on inspecting the placenta.

<sup>26</sup> *Azamba* are encouraged by their supervisors to dig pits dedicated to placenta disposal (see figs. 6.6 and 6.7). Dead body matter is believed to contain the life force of a person and, during initiation, Chewa women are taught to guard their 'monthly cloths' (Van Breugel 2001).

<sup>27</sup> Women did not always supply blades, especially new ones. Knowing this, I question whether a sliver of newly cut bamboo might be less likely to cause infection than a re-used razor.



This includes excellent examples of why a well-trained TBA is better than none; despite having beliefs incongruent with biomedicine she still has safe ideas and practices such as slow pushing. (Field notes 16 06 99).

Regina's expertise could at times bring her into conflict with others and she recounted an incident when untrained women had called her to a difficult birth. She described how she had shouted at them for making the woman push too early, how important it was to push *pang'onopang'ono* (little by little), not too hard or too much. She described how she had predicted accurately when the child would be born, replying that she was 'told at the training' when asked how she knew. The grateful woman giving birth had cried that her baby could have died without her help.

Regina recounted some of her other knowledge to me; she could deal with problems other than reproductive ones. *Mlumbwa* leaves, she said, could be used for diarrhoea, she listed 'multivitamin' remedies, treatments for gonorrhoea, and a mixture of *chigaga* and *sungachuma* leaves she uses for the protection of a newborn baby if carried by someone who has been sexually active. She also treats infertility and her knowledge and skills bring her considerable local renown, indeed I witnessed both men and women arriving for consultations.

### *Grace*

Regina's daughter Grace was as forthcoming as her mother about her knowledge but demonstrated greater inconsistency and more obvious contradictions. An example of this was her declaration that the 'old ladies' had agreed to cease using the herbal oxytocic *mwanamphepo* at the insistence of the health authorities because it was so dangerous, but her own claims that she could use it. She seemed to feel invincible.

Grace had completed a similar hospital course to the one her mother had attended and is still officially apprenticed to her. Her government approved status is that of assistant although some long-standing dispute with her mother to which I was not privy was evident.<sup>28</sup> I learned from several sources that she had caused problems for her mother through her unpredictable activities. Nevertheless, Grace too was very busy and women walked long distances to seek her help. Undoubtedly part of this popularity was her

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<sup>28</sup> Grace still had the status of apprentice at my most recent visit although Regina's increasing sight problems made attending births more difficult and Grace was increasingly acting independently.

reluctance to refer to hospital women who did not fit the strict official criteria for *azamba* care and for her use of *mwanamphepo*, no doubt too for her knowledge of analgesic herbs.

Grace claimed knowledge of pain relievers for labouring women. She believed there was great pain when the baby fights and breaks its way through the placenta. Her supervisor denied knowledge of any such herbal substance<sup>29</sup> but this claim was at the heart of the ethical dilemma described in chapter 3 and appendix 3. The statement also indicates a particular view of body structures as the placenta is only rarely situated between the head of the fetus and its 'way out'.<sup>30</sup>

The use of herbal stimulants was seen as one of the greatest difficulties by the supervisor who suggested regretfully that women do not believe labour can happen unaided. Mai Sichali said that Grace:

is still believing what she was taught [by her mother], goes back to giving [local] medicine,<sup>31</sup> [she] tries medicine first, she believes [in] both [systems]. She has so many patients because of medicine ... mothers still believe medicine will make them deliver quickly (05 07 00).<sup>32</sup>

Responding to my enquiries about specific knowledge learned from Regina, Grace repeated the messages about the dangers of pushing too early and described being taught to assess the adequacy of 'the way'<sup>33</sup> of the mother before birth. She described 'entering' [the vagina] with gloved fingers and freely informed me that they are taught not to do this in the hospital course. For village birth they should only use official criteria such as having previously given birth normally, having a baby in a normal position, and never carry out internal procedures. Figs. 6.4 and 6.5 shows drawings that both Grace and Regina made to illustrate which women they could deliver at home and which must be referred to the hospital. Grace claimed a better understanding than her mother 'because of

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<sup>29</sup> Analgesic herbs for childbirth feature in the listings of Morris (1996) so my scepticism at the time may have been unfounded.

<sup>30</sup> Only when a placenta is situated very low does it obstruct the birth passage, an uncommon but very dangerous condition that leads to heavy bleeding, often death of the baby and perhaps the mother.

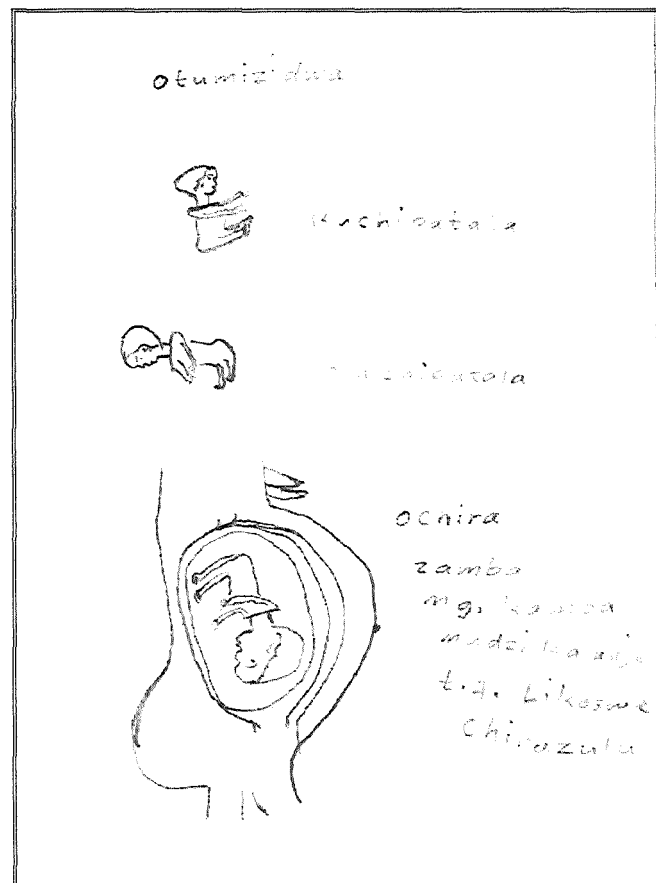
<sup>31</sup> 'Medicine' is used to denote herbal remedies, uterine stimulants being included among those known as *mwanawamphepo*.

<sup>32</sup> Jeffery et al. (1989) noted similar eagerness in women of rural North India to speed up their labours; women might seek out those willing to use remedies such as uterine stimulants for their labours.

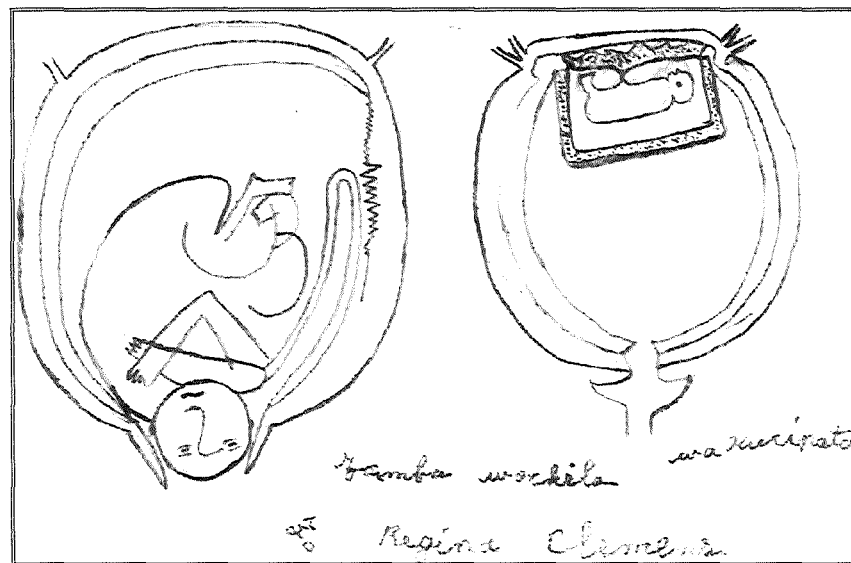
<sup>33</sup> The 'way' was used in translation to denote the vagina and its opening (introitus). The same translation was used by women and *azamba* in Bullough's 1980 research.

some education' and because of being given it by the hospital. I was not convinced. It seemed to me that Regina understood more clearly what was expected of her despite her advanced age, minimal formal education and the many years of practice which had elapsed before she had been officially trained and recognised. The vivid and complex nature of Grace's knowledge appeared to be grounded in ideas at least as pluralistic as her mother's and are further explored in chapter 7. This was expressed in actions that did not always match her words and could appear to be reckless, or at least over-optimistic about the extent of her capabilities and scope of practice.

Fig. 6.4 Fetal position and *azamba* responsibilities: Grace Kamba's drawings<sup>34</sup>



<sup>34</sup> 'Kuchipitala' or 'kuchipito' in these drawings means 'to hospital'.

Fig. 6.5 Fetal position and *azamba* responsibilities: Regina Clement's drawings<sup>35</sup>

Mai Sichali expressed her confidence in supervision, rather than more training, as the answer to helping people like Grace to practice more safely.<sup>36</sup> For her, training is only part of the process of turning a woman who is customarily used as a specialist in assisting birth into one whose knowledge develops in the way the health authorities deem safe. For Grace, shame had been used to reinforce training and supervision. After the incident with Majami a meeting had been called of all local *azamba*. They had been reminded not to keep women beyond six hours and never to use 'medicine'. Their instruments, and thus their recognition, might otherwise be withdrawn. The whole neighbourhood appeared to know of the Majami incident and the District Supervisor (senior to Mai Sichali) had also become involved.

### *Stella*

The third *azamba*, Stella, demonstrated quite different characteristics. The retired professional midwife to whom she apprenticed herself many years ago taught her typical biomedical practices and techniques. She was eventually called for government training

<sup>35</sup> This drawing is a second version, the first having been eaten by Regina's goat

<sup>36</sup> The *azamba* in this area are supervised with monthly visits that include inspection of their equipment, birth houses and record books, and practice discussion. Any reported adverse incident is investigated promptly. This routine is far in advance of the general situation in Malawi (MOHP1995). I note that there is no evidence of supervision including observation of practice.

and there learned the limits to her practice, apparently following these criteria ever since. She also learned to keep records.<sup>37</sup> Stella assisted and then succeeded her mentor on her death. Complying strictly with laid-down criteria has, she believes, led to her being less busy than her nearby colleagues as women wanting to give birth at home go elsewhere if they do not match her criteria with which most are familiar. Stella is however highly respected as an *azamba* and appreciated by the Village Heads, not least for her welfare work. She uses her herbal knowledge within the household but it remained unclear whether she uses her knowledge for the benefit of others.

Stella talked to me about her course; most of the time they were ‘just learning’, which I understood to mean ‘listening’, but they were taken to one woman each in the hospital whom they had to help to give birth under supervision. Teaching and learning appear to have been mainly verbal rather than practical although Stella had the benefit of time spent with a midwife in a community health centre setting. In the course of her training, Stella learned about positions for birth. I was curious to know more because evidence, for example that provided by Regina, indicated that women lay flat for birth and I had been unable to obtain a clear picture of what used to happen. Stella said that during the course the *azamba* learned to instruct women to lie flat but the health centre midwife had advised her to encourage women to assume any position they wished.<sup>38</sup> I later discovered from Regina and from Mai Malinga that women used to be supported squatting in a corner or would sit propped against a pounding pestle that had been padded with cloth (Deputy Headwoman Malinga 15 07 00).<sup>39</sup>

Stella had been taught to correct the fetal position in late pregnancy if necessary but to send women to hospital if a malposition became apparent in labour. She recited a list of circumstances she was not permitted to deal with herself, the list matching that quoted to me by Mai Sichali, but claimed that those she did assist (usually in emergency)

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<sup>37</sup> The *azamba* are each expected to keep a record book of basic details of women’s progress and care, completed in Chichewa and using some symbols. They accomplish this despite varying levels of literacy.

<sup>38</sup> Received wisdom in global thinking is that African women stand or squat for birth, a physiologically more effective position than lying flat as in much of Europe and North America, or even worse being tied into leg-up positions with metal poles and stirrups to hold the legs apart (lithotomy) as in the USA. Such rhetoric about African women takes no account of coloniser and mission influence that introduced such western practices long ago.

<sup>39</sup> Bullough (1980) similarly describes Malawian women squatting and leaning against pounding sticks, companions providing support to the knees and shoulders.

rarely experienced actual difficulties. Damage to the birth canal, malaria and anaemia worried her but she insisted on women attending clinic and checked the baby's heartbeat with her ear on the woman's abdomen. Stella advised on nutrition utilising the 'three food group' system described above.

We often talked casually 'midwife to midwife'. I asked her about perineal damage and episiotomy because 'damaging the way' was a concern frequently expressed by women and *azamba*. I was curious about episiotomy because it was apparent that this, like lying flat for birth, had been introduced by colonisers and had taken hold in the formal maternal care system.<sup>40</sup> Now many practitioners in former colonising countries are changing to more natural 'physiological' practices as a result of research. Stella confirmed that episiotomy is commonly performed in the hospital and is used 'to avoid damage' especially for first babies. She claimed to deliver babies without cutting (not permitted anyway for *azamba*) and without tearing. This exchange followed:

G: You are able to deliver babies without cutting or damaging the way but hospital people cut the way. What do you think?

S: The labour pains come differently and there are some elderly women in the village who cause the way to be damaged but ... damage of the way in the village is lack of patience (17 06 99).

Stella made no comment about hospital practice. Nevertheless this topic arose repeatedly in group sessions with women citing 'cutting the way' as a reason for both using and for avoiding the hospital.

Mai Sichali explained the difference between *azamba* to me. She suggested that local ones perform better than most because of close supervision but this had to be regular and involve the follow-up of any reported problems. Younger *azamba* generally follow guidelines more willingly than do older ones whose ideas are deeply ingrained. Those known additionally as healers follow their own ways more. An intractable problem for Mai Sichali, apart from the use of uterine stimulants, is the insistence of older women on giving water to newborns when exclusive breast-feeding is being encouraged.<sup>41</sup> The

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<sup>40</sup> The situation may be perpetuated by the 'charitable' exporting of outdated textbooks to poorly resourced countries such as Malawi.

<sup>41</sup> This is to avoid infections from unclean water and to reduce the risk of mother-to-child transmission of HIV via breast milk when 'foreign' substances (such as water) have previously damaged the gut. Exclusive breast-feeding is not normal practice in Malawi (Save the Children 2002), as is shown by the figure for 1992  
Continues over

*azamba* are nevertheless essential in Mai Sichali's view, and popular because of their knowledge, the supportive care they give, their warm welcome and reassuring seniority compared with young hospital staff.

### **The Government training programme for TBAs**

*Azamba* chosen by the village women and Heads are assigned to local training programmes once they have gained some experience apprenticed to an already recognised *azamba*. I wanted to find out first-hand what such programmes are like but none were held during my fieldwork period. It proved to be inappropriate for me to observe the one training meeting held as it was an emergency response to Grace's misdemeanour (chapter 3 and appendix 3), the TBAs having been called to remind them of forbidden practices and to interview and assess each one individually. I was able however to talk about training programmes to a variety of people and was provided with a copy of the curriculum.

It is evident from my contact with the local *azamba* that the programme (at that time) concentrated on theory and giving information, with a smaller element of practice-based learning. Each TBA appeared to work with a hospital midwife to care for one woman only although Stella benefited from extra opportunities in a local health centre.<sup>42</sup>

The TBA curriculum (MOHP 1994) covers the full spectrum of normality and problem areas that one might expect from any midwifery programme including identifying problems and dealing with them appropriately, referring where needed for medical care, and caring for the infant.

It is not possible to determine how TBAs are taught now other than from clues afforded by the programme wording – 'lecture/discussion' and 'listens', 'demonstration' and 'observes'. Listening and watching are supplemented by role play and by singing and dancing according to Mai Sichali. The extent to which there is exchange of ideas, experience, and two-way learning is unclear. The curriculum does not indicate how underlying concepts are explained and whether the issue of congruence between the

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of 3% of babies being exclusively fed during the first six months of life although in 2000 this rose to 63% at age four months (NSO 2001).

<sup>42</sup> The TBA programme is ten years old and is currently awaiting revision.

learners' ways of knowing and the biomedical view arises in any way. Literary evidence suggests that the pre-existing knowledge and views of indigenous midwives are rarely taken into account and that if they are acknowledged, ridicule is common and prohibition the prevailing attitude (for example Jordan 1993, Pigg 1997). Furthermore, the curriculum document addresses technical knowledge and skills only so the attitudinal models that learners witness and the principles of care they are taught cannot be determined.

*Azamba* have significant potential for helping communities: in mobilising them to prepare for and recognise emergencies and respond appropriately, to act as advocates for women and act as bridges between the communities and formal health services. None of this appears in the written curriculum but might still feature in programmes, my experience as an educator suggesting that such documents quickly become outdated and ignored, and that confident learners and teachers can easily subvert and transform them. Whether these *azamba* in rural Malawi, many with limited education and literacy skills, have such confidence and benefit from the affirmative support needed from educators to achieve this is unknown.

Whatever the strengths and weaknesses of the TBA training programme may be, the official recognition gained through attendance is important for conferring legitimacy on the *azamba*. Multiple sources indicated that untrained *azamba* are rarely used now by women in this community and that even older women normally advise against using them. Only one source, a professional midwife (Midwife A 30 09 03), suggested that many women are unable to distinguish between trained and untrained *azamba*.

Finally, it can be seen that both biomedicine and ethnomedicine interact in the knowledge and practice of the *azamba* and jointly form the foundations for all that they do. This eclectic approach to childbearing appears to be accepted by women who continue to respect and use them.

**'At the TBAs' they respect you' but hospital can do more: people's views of the *azamba***

I remained alert for community opinions about the *azamba* as these would have significant influence upon their legitimacy and decisions made by others. The high level of respect for their knowledge and skills showed clearly although several people suggested hospital is nevertheless best in case of problems, with the availability of blood



transfusion and surgery being the main advantages cited. Fear of bleeding is apparent and is further explored in chapter 8. Stella's mother described a time to me when there were no trained *azamba* and women used to die attended only by inexperienced older women.

Some evidence exists that care provided by the *azamba* is also chosen for economic reasons even when a woman may prefer hospital care and this was confirmed by hospital midwife informants.<sup>43</sup> A Malinga women's group member explained:

If you are at home it is because you have no money. If you go to the antenatal and they see how the baby is inside, they tell you if you should come to the hospital. At the TBA they cannot know what to do. At hospital they can do operations and help the pregnant woman in other ways (05 07 00).

In this narrative women appeared to foreground biomedical technical knowledge as well as comment on cost as a deterrent. This emphasis is however tempered with appreciation for care the *azamba* offers that might be missing at the hospital:

At the hospital they don't give water [for bathing] but the TBA does this. The TBA can make porridge for you, and the hospital doesn't give you porridge. They will ask your guardian to make porridge ... but the TBA cooks her own porridge. If she [the woman] feels backache the TBA can help with hot water. But not the hospital ... some nurses have *chipongwe*<sup>44</sup> ... nurses when young are just so nasty. At the TBAs' [house] they respect you. ... [while nurses] say 'You are alone here. You were both doing it [sex] but the husband is at home ... it isn't me who made you pregnant ... you should have thought of this when you were enjoying yourself' (Malinga women 05 07 00).

Clearly then, community birth is seen as second best in some ways but the respect of the community lies with the *azamba* rather than at least some of the hospital staff who are found lacking in respectful and caring attitudes, attributes women expect of their carers.<sup>45</sup> Indeed it could be argued that such caring competencies are indeed knowledge as well as attitude, and not separated as they may be by professional midwives (and noted amongst

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<sup>43</sup> Hospital care is expensive in terms of disruption, perhaps having to pay for domestic help and field labour as well as hospital and drug charges; few here used free government services because of distance, limited resources and standards that were criticised locally. *Azamba* might accept payment in kind or instalments, or provide free care. The mission hospital charged for everything but was normally the institution of choice for women of this community despite some reservations about junior staff attitudes.

<sup>44</sup> *Chipongwe* translates as 'bad attitude'.

<sup>45</sup> This lack of respect is so common worldwide that Samuel notes its presence as a theme in almost every chapter of the Rozario and Samuel (2002) edited text.

Harvard medical students by Good and Delveccio Good 1993).

The Village Heads also showed evident respect for the knowledge of the *azamba*. Mai Malinga believed people followed new ways although needed more information to ensure the early identification of problems. 'Women die of ignorance' she said. She suggested women no longer wish to use untrained and elderly helpers for birth and prefer the trained *azamba* or hospital. Headman Kalanje supported this explaining that 'the old ladies understand this'.

Provided with reports from the Safe Motherhood Project, I looked to these for congruence with my findings on people's attitudes toward the knowledge and attitudes of the *azamba*. The key feature of reports from several districts in the region are that kindly attitudes, staying with the woman even at night, the provision of food and hot water for washing, and the acceptance of delayed payments or payments in kind, are universally recognised strengths of TBAs. Hospital staff are commonly considered to be rude, lazy and unkind and apt to leave women unattended or to deliver with the help of a cleaner. However, people believe access to emergency services to be a problem with TBA care and many of them make women push too early (Safe Motherhood Project 1998, 1999).<sup>46</sup>

### **Legitimacy, knowledge and the ownership of technology**

I have demonstrated in chapters 4 and 5 that the matrilineal way of life confers substantial legitimacy on the authority of mothers and grand-mothers of pregnant women. It is nonetheless difficult to distinguish the influence of status from that of the ownership of knowledge.

Grace and Stella evinced concern about their recognition and legitimacy as *azamba*; at no point did I hear this from Regina who had earned it by virtue of long experience and having delivered most of the local babies for half a century. Until recently Grace and Regina were the only ones to have a designated birth house and this was of concern to Stella prior to her own being built.<sup>47</sup> She reported problems with some older

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<sup>46</sup> The most recent report from this project indicates the severity of staff shortages and how hospital cleaners continue to deliver many babies (Malawi Safe Motherhood Project 2003).

<sup>47</sup> I note the comment of Morris (personal communication, 2003) that Yao women gave birth at one time in the fields because they were 'cool' and the villages was 'hot'. No informants provided such information during my fieldwork and, checking back, I learned that this practice arose because fields were free of  
Continues over

women who claimed that having no dedicated space meant there was no difference between her and themselves for birth. Stella used one of her own rooms, or at times a specially cleaned corner of a shed. This lack of symbolic legitimacy was compounded by having no official birth kit; she had assembled her own. The government supply of such kits had been exhausted at the time she attended the training course and had not been replenished. So Stella, despite her practice excellence, had at that time no technology to symbolise and legitimise her status except her birth register, a waterproof apron and rubber gloves. She did nevertheless have both charismatic and authoritative status by virtue of her reputation and acceptance by the community and authorities, eventually reinforced by the construction of her own birth house.

Grace painted the old birth house she and Regina used in different coloured muds, decorated it with health posters, and constructed an ornamental placenta pit (illustrated in figs. 3.6 and 6.6). This striking brick structure around the pit takes the shape of an Ngoni/Zulu head-dress. Such a structure is a substantive symbol of legitimacy and provides a sense of place for village births.

Fig. 6.6 The Kalanje placenta pit's construction was inspired by a Ngoni head-dress and symbolises legitimacy for Grace



sexually active people so 'cool'; guarding the house from 'hot' people is now considered to be adequate (Sichali, personal communication, 2003).

The thatched birth house was mysteriously burned down one night but the new building, previously illustrated in fig. 3.7, rapidly began to be seen as more prestigious with its glazed windows and lockable doors, fired brick walls and galvanised roof, and ultimately curtains and beds.

To Grace, her rubber apron and stainless steel bowls (also seen in fig. 6.6) are clearly legitimising symbols signifying that her position and knowledge are sanctioned by the state. One of her first actions in the early days of fieldwork had been to show me her equipment and register.

Grace also claimed to use scales to assist her in identifying babies' growth. I later discovered that she did not actually own any but helped at the antenatal and child clinic by weighing women and older babies. Grace keenly desired a set of scales for her birth house, in order to turn it into a 'hospital'. The power of the symbolism of scales can be inferred from the local term for the antenatal clinic '*Sicale*'. Scales and weighing were also casually mentioned in a group discussion around pregnancy and safety.<sup>48</sup> I asked what differences the group perceived between the past and today. They replied:

In the past there were no scales and no antenatal [clinic]. Now they use the antenatal [clinic] and things are much better. If there is a problem it is solved easily because of the hospital ... they know problems easily in the antenatal clinic (Sambani women 10 06 00).

Legitimacy as a skilled carer is also enhanced for Grace by her ability to examine women in pregnancy. Neither Stella nor Regina specifically made this claim although both can turn badly positioned fetuses. Stella also mentioned hospital plans to hold a regular antenatal clinic in her birth house when it was built. The possession of skills of examination, and the siting of a clinic in the *azamba*'s own space are equally symbolic. The herbal oxytocics used by Grace, and possibly Regina, also add to their legitimacy and increase their clientele. The use of oxytocin injections features strongly as specialist knowledge in other countries also (Jeffery et al. 1989 and Sargent and Bascope 1997). I suggest that Grace was in effect constructing her knowledge as authoritative by extending her visible capacity as an *azamba* just as Jordan (1993) witnessed obstetricians doing in

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<sup>48</sup> On returning to the field while writing this thesis I found that the *azamba* have each been supplied with either scales to weigh newborn babies or with a foetal stethoscope to listen to the heartbeat in pregnancy and labour. They did not receive both because of equipment shortage.

the USA.

For Grace then, her position is legitimised and made more powerful in some senses by her knowledge which included her access to both ethnomedical and biomedical ideas. Stella concentrated on the biological and the biomedical; Regina appeared to take in both, possibly not distinguishing between them in any specific manner.

### **The evidence analysed: knowledge, power and supporting literature**

In this section I address knowledge and power issues in relation to the secondary sources discussed in chapter 2, first concerning the *azamba* then returning to childbearing women and the wider community.

The knowledge development of these *azamba* was through the apprenticeship mode and formal, state controlled learning of biomedical precepts. Forms of knowledge that were new to them were superimposed on a pre-existing knowledge set handed down from their elders – except in the case of Stella whose entire role preparation had been in the biomedical way of birth. They continue to demonstrate different ways of assimilating and accommodating this knowledge: Stella shows apparent comprehension, compliance and congruent activities while Grace reveals an unpredictable pluralism with some independent innovation. Perhaps Grace is rejecting imposed knowledge in favour of situated knowledge just as did Mayan midwives according to Jordan (1993). Perhaps she just moves more easily across the continuum, or the boundaries between layers of knowledge are particularly permeable for her. Despite the dissonance between the foundational knowledge and the powerful biological and biomedical paradigm I found no other evidence of substantive contesting or resistance except for the incident with Grace and Majami.

Regina actively maintains and utilises the knowledge that has served the women in her care for many years, but generally accepts the biomedical authority of the formal system. I observed no indication however that *azamba* and women comply with recommendations for hospital birth just to be seen as ‘modern’ as Pigg (1997) found in Nepal. Grace was however eager to demonstrate her possession of modern equipment and the claim to use the flat birthing position might have constituted such a claim to ‘being modern’.

The culturally specific knowledge of the *azamba* is largely the same as that of the older women who make decisions for women pregnant for the first time. Their knowledge is specialist, but not unique although the official training adds an edge of legitimacy, no doubt reinforced by the apparently universal assumption of the primacy of biomedicine. No matter that this biomedicine is obviously (to me as observer) layered with ethno-medical knowledge; for many informants (both lay and professional) ethno-medicine is dismissed as *mwanbo*, 'old ways' and 'tradition' and biomedicine given higher status even if only partially comprehended or mediated by local interpretations and experience (Good 1994).

Community knowledge around birth is mediated by a sense of propriety that prevents much discussion and, although young people should receive the formal education normally seen as empowering and enabling women to make birth choices (see Samuel 2002 for Kerala and Sri Lanka), many young women drop out before getting far enough to reap the benefits. Education may anyway be less than emancipatory depending on whether the power dynamics of their situation leave them scope for independent action (Kumar and Vlassof 1997).

To a significant extent, knowledge development at community level comprises preparation for socially acceptable behaviour and conveying core values (La Fontaine 1985) rather than for empowerment. I saw no evidence that community-based life-preparation went as far as knowledge and skills for making choices around childbearing. The contemporary elements that did feature, of avoidance of HIV and inappropriate pregnancy, both fitted customary moral preoccupations addressed in chapter 7 and described by other scholars such as Morris (2000) and Probst (1995).

Women who have previously experienced childbirth generally make their own decisions about place of birth and who should support them. The knowledge they acquire through personal experience and the community 'initiation' processes enables them to make some selection from alternatives on offer. Younger women are generally subject to decisions made by their matrikin who, moreover, largely control what knowledge is imparted to them and may withhold it until immediately prior to the life stage to which it applies. This 'just in time' approach existed long ago in Malawi (Mitchell 1959), and has been reported elsewhere, for example for India regarding sexual relationships (Jeffery 1979) and Mexico for birth (Sargent and Bascope 1993). Such withholding of information

in effect maintains the status of older women as those with the authoritative knowledge, so perpetuating it as Jordan says (1993) and reducing their agency (see chapter 2).

Malawi society is of course changing and the young are seen as no longer compliant. The reaction observed here appears to be to leave them to their own devices; in this case they do not even benefit from the formal life preparation that is sanctioned by the community. There is then hegemony of the powerful knowledge-holders but an easy-going abandonment of responsibility rather than any real contest between generations. Not even the professional midwives appear to develop their potential as channels for the knowledge development of young women or the wider community.

Responding to Jordan's call to examine authoritative childbearing knowledge in different communities (1993), it is apparent that the knowledge that governs action in this community is not a bounded entity. It is made up of divergent and potentially dissonant ways of knowing. One is internationally accepted as a prevailing discourse and based upon scientific discovery. The other is locally constructed and fits people's perceived needs and notions: it informs, upholds and perhaps reproduces the structures within which individuals exist (as Foucault argued in the quotation above). In reality of course there is not so much a division between forms of knowledge as a continuum along which lay and professional alike may move depending on circumstance. So the knowledge that governs action is as pluralistic as the notions of health and well being in Malawian thought that underpin them.

Knowledge also needs to be congruent with local perceptions and match local definitions of birth in order to gain people's attention and govern action as discussed in chapter 2 (Jordan 1993). Barth (2002) talks of notions of validity that are used to determine trustworthiness of judgements and how such notions will be congruent with experience and socialisation. In this environment differing forms of knowledge come together and appear to be accommodated fairly comfortably as Stoner (1986) and Vaughan (1991) found.<sup>49</sup>

In the end, when a woman or her matrikin are planning for birth, or she is already labouring, a decision is made based upon the pre-eminent knowledge in the mind of the most influential person involved. Although matrikin, and sometimes husbands, are

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<sup>49</sup> Vaughan speaks for Central Africa and Stoner reviews work on pluralism from across the world.



significant decision-makers, the *azamba* have earned legitimacy, and possess charismatic authority and the respect of the community so that they are often considered the ones with the knowledge to govern action. Nevertheless they are authorities by virtue of this knowledge, and clearly not 'in' authority except with their own kin. This is illustrated by case studies 3 and 4 (chapter 5) in which Stella's advice was not followed, and in case 5 where Majami was removed from Grace's care despite her protests.

These birth specialists hold no sanctions of their own other than withdrawal of support and each expressed to me that they would use this if necessary. They would not attend women who refuse to comply with advice to go to hospital, and declared themselves to be reluctant to respond if called to women 'in extremis' when untrained attendants or family members found themselves unable to help. The *azamba* told me of their fear of official sanction and sullied reputations that could accompany being associated with disaster. Besides, they are subject to powerful others who they were expected to obey, similar to Sande TBAs in Sierra Leone (MacCormack 1981). Grace described to me an incident that took place four years previously with which her mother had refused to become involved:

Yes, someone died because of that [bleeding] ... Not in my place, but at another place, the [pregnant] woman didn't come to [Regina] the TBA. She was at home and lost too much blood. The old woman [delivering the baby] said it would stop, she didn't have the knowledge. ... She had twins ... at home. The grandmother helped her to give birth. ... The placenta didn't come out and the woman died. The grandmother didn't come herself, but she sent another old woman to tell my mother, who said that it was dangerous to give birth in the village. Some people die if a person has no training from hospital for being a TBA. My mother didn't go because she didn't want to be accused of failure; they came ... too late (Grace Kamba 10 07 00).

Such conflict is however uncommon and authoritative knowledge continues to reside with both the *azamba* and the professional midwives staffing hospitals. Local support for biomedically structured hospital birth is substantial. Professional help is unavailable in the home in Malawi, and doctors are seen as having very powerful means of dealing with problems at their disposal – even problems defined by indigenous concepts. So hospital birth has many advantages for women. Forcing such a choice between professionally attended hospital birth and lay help at home could be seen as a coercive exercise of power. No one knowledge paradigm, or one authority or organisation is fully ascendant



however and other considerations such as poor quality care (as Samuel 2002 suggests for South-East Asia) and practicality were influential in choice (as Sindiga 1995 describes for Africa).

A general understanding of mutual need and a degree of respect from both ends of the carer continuum generally prevails with some exasperation shown by hospital midwives about *azamba* ways. The existence of a universalising project of those in power in promoting their knowledge as dominant (Vitebsky 1993) nevertheless holds true in this environment. In many ways, these health service personnel are custodians of biomedical knowledge. They may chastise publicly (as with Grace) and hold the ultimate sanction of removing official recognition and equipment, the symbols of their craft, from their lay colleagues. The *azamba* are always being watched, at least from afar, as with Foucault's notion of surveillance (1997).

Indigenous and ethnomedical knowledge is undoubtedly demoted to 'beliefs' as Vitebsky (1993) suggests. Such 'beliefs' include specialist knowledge of rites considered to be important by the community. The older women in the fieldwork community controlled initiation rites in times past, to an extent they still do as church and community or family appointed advisers even where 'going to the river' has ceased or become attenuated. As with the Mayan midwives of Cosminsky's acquaintance in Guatemala (1994), and the *dai* in North India studied by Chawla (2002) the *azamba* would once have been counted as ritual specialists. Specific rites of birth are not evident now and little was said about the past. However, like the Mayans, *azamba* would once have been responsible for maintenance of 'hot' and 'cold' equilibrium (see chapter 7) to some extent, if only by guarding the vulnerable woman and baby from inappropriate contacts. Furthermore hot bathing is important to Malawian women and is a key element missing from hospital care which was frequently articulated as a good enough reason for choosing the *azamba* for birth. The emphasis placed upon bathing raises questions about its meaning. However I saw no evidence of this or any other practice having a specific heating role as it does in Guatemala and elsewhere so its purpose may be merely to comfort. Despite not being ritual specialists, the *azamba* advisory role continues; Regina and Grace provide significant services to the communities as did Stella as Church appointed adviser to young people.

I have argued that biomedicine is powerful in the eyes of the community and is differentiated from indigenous medicine as the authoritative knowledge that is officially

legitimised and largely governs action. However people have not abandoned indigenous forms of knowledge for making choices around childbirth; this, I suggest, indicates that power is not invested in biomedicine alone as an explanatory theory. This may be because biomedicine tends to ignore the social context of childbearing (Jeffery and Jeffery 1993) and illness (Lock 1988, Kleinman 1995) and is limited in its congruence with indigenous ideas of the body, health and well-being.<sup>50</sup>

For Barth (2001) concepts and categories are elemental to knowledge and action. The eclectic nature of these foundational concepts of health, well-being and childbearing, and the evident accommodation between potentially dissonant paradigms that I encountered, are the theme of the next chapter.

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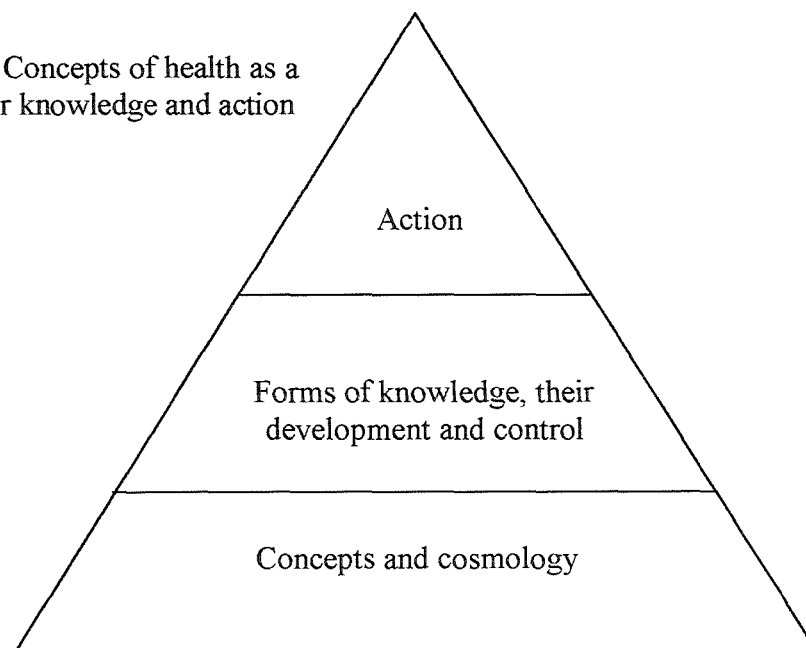
<sup>50</sup> I do not address here other issues of accessibility and acceptability.

## Chapter 7: Childbirth 3: 'Hot' sex, 'cool' people; a discourse of balance and transformation

### Introduction

Having considered marriage and residence patterns and how these affect decision-making around childbirth in chapters 4 and 5, and then considered the power to make decisions that knowledge brings to people in chapter 6, I start here to look at the ideas of health and childbearing that underpin that knowledge. My understanding of the foundational nature of concepts of health as a basis for knowledge and action is illustrated as a pyramid in fig. 7.1.

Fig. 7.1 Concepts of health as a basis for knowledge and action



In this chapter I consider what people believe about health and the body, and explain the importance for health and wellbeing of an equilibrium between 'hot' and 'cold', especially for safe transformation to new states such as motherhood. This prepares the ground for looking in the next chapter at risk talk – prevailing views of threats to childbearing women whether biomedically described or dangers from outside. Although notions of risk and danger for childbearing women feature specifically in chapter 8, I note

here that it was often through such expression that people conveyed basic concepts to me. This means that 'risk' language features in this chapter too.

In this chapter I address the dominant idiom of sexual activity as an essential part of maintaining the life-force and the protective and energising equilibrium between 'hot' and 'cold' states of being. I consider ideas of morality and immoral behaviour, witchcraft and sorcery (briefly) as activities that are considered to influence both health and behaviour. Later in the chapter I address potential tensions between indigenous/ethnomedical and biological/biomedical discourses of well-being and ill-health that my evidence reveals, using local and global literature as support. Secondary sources, mostly local to Malawi and neighbouring areas, are used to assist in developing understanding of these complex issues. This supports the development of my understanding of the complex ideas that informants take for granted. The case studies recorded in chapters 1 and 5 are used to explore the concepts that influence decisions made. These locate the data and discussion within the context of rural birth and illustrate the plurality of ideas that prevail.

The key finding is that the prevailing contemporary discourse is a pragmatic acceptance of older explanations and ethnomedical ideas, and more recently introduced biological and biomedical ones. Little inconsistency is seen by people in the community in making use of both such potentially contradictory paradigms. More specifically, the underlying narrative is an enduring one of sexual propriety, health and illness couched in terms of physical, supernatural and moral explanations. These often incorporate some biomedical knowledge, if partial and integrated with older ways. Such a pluralistic view supports a comfortable accommodation of theories and liberal choice of therapy when difficulties occur.

### **Local narratives and concepts discussed**

The next three sections consider the dominant Malawian themes of sexual activity and its importance for well-being, the equilibrium between 'hot' and cold states, and moral and immoral behaviour. This last section includes material on adultery because of its close relationship to maternal health, and on witchcraft and sorcery, themes that will be

developed further in chapter 8 as external forces threatening the woman and her child. These concepts are closely interlinked and involve all areas of life but their impact upon childbearing women and their babies provides the overall focus. Addressing first the areas of 'hot/cold' equilibrium, then morality and immorality, I find that sexual activity and its relationship to the life force and wellbeing, known as *moyo*, is fundamental. It is however less easy to understand through the primary data alone so will be explored further afterwards as an explanatory concept.

### **Hot and cold equilibrium for health and its relationship to childbearing women**

Francis, my first interpreter and a local man, explained how women are considered to be 'cold' when pregnant or newly delivered and 'hot' when menstruating. Husbands/partners, he explained, are also believed to be 'cool' and vulnerable and, like pregnant women, should not eat (ritually) 'hot' food prepared by menstruating women. If they did so, the 'cold' pregnant women might miscarry or have malformed babies – particularly with their faces still unformed, and men may fall ill. With this explanation Francis introduced me to a view of pregnant women as 'cool' and vulnerable while I received from him and from elsewhere seemingly oppositional assertions of women being 'hot' and therefore dangerous. Such was the confusing manner of my introduction to key concepts in local cosmology.

I later realised that ideas about ritual 'hot' or 'cold' status pervade much of Malawian literature about health, illness and reproduction, and link with a variety of practices and taboos especially regarding sexual activity. It is evident that this 'hot' and 'cold' balance is the dominant idiom underlying the way health and life processes are conceptualised. This is indicated both in my own data which I describe first, as well as in the secondary sources I used to help me understand what I was observing and hearing. An obvious relationship with behavioural norms also emerged but the range of information was often confusing until access to literature opened up the system's internal logic. I also began to understand the differences and connections, and the importance of the *mdulo* complex of diseases described below (the consequence of imbalance) as the way in which

the community's expectation of individuals is articulated as a set of loosely bounded social norms and, at least in principle, governs people's lives and the way they control their behaviour.

### *The consequences of imbalance*

The constant theme around vulnerability mainly concerns a disease in men and babies (labelled variously as *tsempho*, *mdulo* and *kaliondeonde*) and believed to have the potential to kill them, and labour problems and death for women (explored below and picked up again in chapter 8). 'Cutting' (defined as pain, mainly abdominal), cough, wasting, and often diarrhoea are symptoms quoted. Several informants commented that *mdulo* and *kaliondeonde* are like AIDS although predating this by many years; Morris (1985) reports a link with pulmonary tuberculosis as do Kabwazi et al. (2001). These authors reported a common belief that AIDS (*edzi*) is the new name for *kaliondeonde*, which was always in the past thought to be caused by not observing sexual taboos.<sup>1</sup>

### *Death and funerals*

Death and funerals are occasions when equilibrium may be overturned for those involved, with consequences for pregnant woman and others as the following dialogue demonstrates:

[A woman] is sometimes feared, for instance when there's a funeral a pregnant woman mustn't touch any medicine – we always prepare traditional medicines at funerals. ... We don't allow her to help with the cooking ... a pregnant woman mustn't sleep at a funeral and she mustn't eat any food prepared there otherwise she might have a miscarriage (Mithawa women 21 06 00).

The use of 'feared' suggests that pregnant women are not welcome at funerals as well as being themselves vulnerable.<sup>2</sup> The vulnerability of pregnant women extends to a wide scenario of death-related events including second-hand contact via others who have been involved with a death such as seen in case study 2, chapter 5, or husbands who have dug graves or helped to wash or bury bodies (Kalanje women 17 07 00). All graveyards are in

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<sup>1</sup> *Mdulo* (cutting), *tsempho* (wasting), and *kaliondeonde* (AIDS type symptoms) are used in confusing ways and real clarity has eluded even significant authors such as Chakanza (undated), Morris (1985, 2000) and Probst (1995).

<sup>2</sup> The Yao do not permit women to enter a graveyard (Morris 2000).

woodland, which is seen as sacred and 'cool', as are the elderly and corpses also 'cool'. Contact with death is 'heating' so 'coolness' is a prerequisite those dealing with it. Sexual intercourse, a 'heating' activity, is proscribed throughout the community when someone has died.

***Menstruation: 'hot' blood***

The taboo against sexual intercourse during menstruation was a proscription that was constantly raised in discussions. Women would formerly leave a sign, such as a string of red beads over the bedroom door, to warn their 'cold' husbands that they were not available for intercourse. Two Village Headwomen, both now living alone, explained their own practices of leaving a bead on a window ledge, one using red and the other white.<sup>3</sup> One explained that she was taught that 'You should not walk behind your husband's back during a period ... the husband would have backache'. Asked whether they would sleep separately when she was menstruating she replied 'Yes ... I would be scared that my husband would want sex, and [if he did] he would have a disease, stomach ache, on the navel' (Headwoman Sambani 14 06 00). She signalled her menstruation by removing the waist beads she normally wore, thought to stimulate men sexually, then replacing them as a sign that menstruation had ceased 'so that he could visit me'.

It is important too that a menstruating woman should not put salt in food as it acts as a transmitter of 'heat'.<sup>4</sup> A man might suspect adultery if his wife served him unsalted food when he knew she was not menstruating. This taboo was often quoted to me, although with the comment on one occasion that no educated person is going to be convinced by such a thing.

Cooking is an activity often quoted as problematic for childbearing women as food might be a transmitting agent for 'heat' if the cook should be menstruating. This may of course relate to salt inclusion rather than the actual act of cooking.

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<sup>3</sup> I am unaware of any significance in their choice of bead colour but note the fact that they specified them.

<sup>4</sup> Confirmed by Morris (1998) and Probst (1995) among others.

*Prenatal sex*

Sexual intercourse in pregnancy is important but celibacy is expected from around eight months of gestation until several months after the birth (see below). Late pregnancy abstinence protects the husband as well as the fetus from ill effects. A more common explanation concerned preventing stillbirth or babies being born with a hole in the head if the parents continue intercourse through to the labour (for example Mithawa women 21 06 00). The woman would also feel shame, as a baby born 'slippery' indicates to the midwife continuing parental sexual activity, this being seen as 'dirty' (Malinga women 16 06 00). Regina and Grace however reported that sex may be continued right through pregnancy if a medicine is given to protect the fetus.

Until the recommended time for ceasing such activity, the couple is expected to have frequent sexual intercourse to 'feed' the unborn child, a 'good' birth weight confirming they have done so. Semen is seen as essential to nourish the child and its provision is part of a man's duty of care to his wife and baby. Semen and female blood are said to combine to provide white bones and hair, and red flesh and blood<sup>5</sup> respectively for the foetus (Chakanza 1998b, Morris 2000). Eating porridge or okra provides alternative means of feeding the fetus if the woman is alone and also of assisting birth: 'The woman makes watery porridge or okra and drinks it frequently – this is slimy just like the husband's semen and it helps the birth passages to expand' (Malinga women 16 06 00). The Sambani women (10 06 00) commented that such use of porridge is no different from its provision in labour by hospital midwives but sex clearly has a dual purpose: nourishing the fetus and preparing the birth canal for labour.<sup>6</sup>

The idea that substances reach the fetus and the birth canal directly from the mother's stomach became evident. Grace illustrated her own perception of the uterus as being open at the top ready to receive food directly for the baby by means of a sketch in

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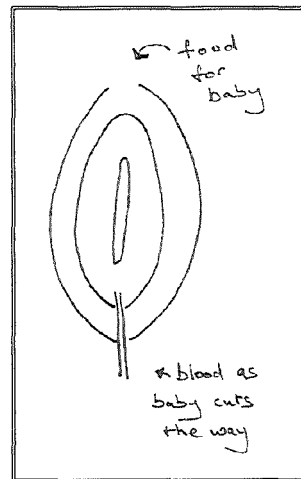
<sup>5</sup> Blood is seen by Malawians as the most essential of body fluids or humours that are linked with vitality and so with well-being, blood in particular being linked with the matrikin (Morris 2000). He describes the process of formation of the foetus as analogous with cooking.

<sup>6</sup> It is understood now in biomedicine that substances known as prostaglandins that are present in semen play a role in preparing the cervix of a woman for labour.



the sand (copied into fig. 7.2). Her drawing shown already in fig. 6.4 includes the same element although smaller.<sup>7</sup>

Fig. 7.2 Sand drawing of the uterus



### *Childbearing: 'cool' women, 'hot' labour*

Returning to the apparent paradoxical nature of views of childbearing women as both dangerous and vulnerable, women's vulnerability is demonstrated by the common insistence that those in contact with women in labour should not be sexually active. Conversely, their dangerousness is demonstrated by the reported refusal of some men to carry a labouring woman to hospital on a stretcher fearing wasting sickness or testicular hydrocele (Ashwood-Smith, personal communication, 1999). I enquired specifically about this practice, as it would surely have direct bearing on decisions made, the timeliness of referrals to hospital for problems and ultimately on women's safety. Deputy Headwoman Malinga insisted that this refusal to carry a woman was rarely a problem locally now although she believed it still occurred in Sena areas further south. Grace supported this, saying men knew their actions would be life-saving so were not frightened to assist.<sup>8</sup> Curious as to how such danger from touching a labouring woman might be

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<sup>7</sup> I noted that other drawings seen (Safe Motherhood Project 1999) do not display such an opening so this idea may have been unique to Grace – a probability since confirmed (Sichali, personal communication, 2003).

<sup>8</sup> Nguludi hospital midwives confirmed this with their stories of strangers picking up and carrying women to hospital on stretchers described in chapter 6.

interpreted outside of the immediate community, I asked how this applied to male medical doctors. I was assured that they are at no risk because of their rubber gloves, and also because their medicine is more powerful than indigenous therapies.

Childbearing women's vulnerability demands great care by family members, known as 'looking after the pregnancy'. Parents of the pregnant woman and her husband are expected to remain celibate around the time of the births of their daughters or daughters-in-law or, otherwise to avoid them. As the Mithawa women said:

When the baby is born the grandmother of the baby, on the mother's side, should wait for the baby, and not go and make love with the husband until the baby's cord has fallen down. Then they can resume sex. The baby dies if the grandparents make love secretly (06 07 00).

This quotation demonstrates a focus on protecting newborn infants. According to the Malinga women (16 06 00) women's mothers should not cook for their own daughters if recently sexually active and would be afraid even to visit them in hospital. This is less important, it was reported, than for those women remaining at home and protective 'medicine' could anyway be used instead.

If recently sexually active women should not hold newborn babies or attend labours, did this then mean a midwife could not deliver a baby if she had been sexually active in the last few hours? Not so, I was told, since the hospital medicine is more powerful anyway and rubber gloves protect the woman and baby from contact with carers who have recently had intercourse, just as doctors are protected from 'hot' women (Sambani women 03 07 00).

Stella assured me that this prohibition no longer mattered; she took no notice and none of her patients had come to any harm. Chakanza (1998b), among others, however points out that women may not trust hospital midwives to remain 'cool' and may therefore seek indigenous medicine to protect the newborn.

By far the most attention was paid by my informants to the problems caused to labouring women by infidelity in pregnancy, either perpetrated by their husbands or themselves. I turn to this next and return to the theme in chapter 8 to analyse it in relation to risk and decision-making.

Men and women are considered to have the same blood after some years together; a new partner introduces new blood and potential disturbance or impurities that can be passed to the wife (Matinga<sup>9</sup>, personal communication, 2000). Matinga suggested that there is clear evidence of specific concern over sexually transmitted infections to add to worries over 'disturbance' of equilibrium.<sup>10</sup> The consequences can be serious – delays in labour, obstruction, stillbirth and death of the woman.

Probst (1995) specifically explains that adulterous sex is 'hotter' than that between marriage partners, so making adulterous men who have had sex with menstruating women the most dangerous of all to their pregnant wives. Men, it was reported by my informants, know that women may die – enough indeed for them to control their behaviour. In the words of the Malinga and Mithawa groups:

Some men even like other women a lot but they do not go with them when [the wife] is pregnant. They know the woman can die with the pregnancy (Malinga women 16 06 00).

Men are taught 'If your wife is pregnant don't sleep with a girlfriend. If you then come and sleep with your wife, that will cause a miscarriage. Maybe the other woman has just had a period' (Mithawa women 17 07 00).

The main danger appears to be articulated here as the continuing sexual relationship with the wife after the adultery, rather than the infidelity itself causing her danger. This suggests that the consequences of her husband's adultery for her safety are greater than are those of missing out on the feeding of the fetus with semen addressed previously. It was even suggested that concealed infidelity was less problematic than when it was revealed. However the real problem was the promiscuous husband who would be less likely to take his responsibilities for his wife's safety seriously and protect her by abstaining from intercourse with her on his return.

Male infidelity is considered to be sufficiently common that warnings form part of the advice given to the couple when the woman first declares her pregnancy to her matrikin (or his kin if they are living patrilocally). Talking to women in Kalanje I heard of similar instructions to those specified by the Mithawa group as follows:

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<sup>9</sup> Priscilla Matinga is a local anthropologist who worked at that time for the Safe Motherhood Project.

<sup>10</sup> Chakanza (1998b) describes the same concern for mixing blood.

When a woman is pregnant the older people realise and call the man – they advise him not to go with other ladies... In the past, if a man does these things, women were dying during birth, but now they can do operations. Most of the ladies in the past were dying. The way for the baby was not opening (16 06 00).

The Mithawa women's views were in clear agreement with this, explaining how promiscuity during pregnancy may bring a difficult labour and caesarean section upon women (21 06 00). The problem was however easy to solve now because of the hospital, recommending the same remedial action as did Regina. They clearly indicated through these statements that uncontained sexuality forms part of their language of risk for pregnant and labouring women just as it did for Tanzanian women in Allen's study (2002).

The pregnant woman too is expected to remain faithful to her husband throughout the pregnancy with the same consequences for harm threatened although the risk is specific to pregnancy and labour, a comment never made in relation to men. The Sambani group explained:

When she is pregnant she shouldn't do *chiwerewere* [adultery]. She should have sex only with her husband. ... If she is not pregnant she can do what she wants. ... She can be in problems by going with different men [in pregnancy]; she will have difficulties in labour. There are many powers in her body (10 06 00).

It is notable that harm brought by male infidelity during pregnancy is so much more frequently cited than is the harm from female extra-marital affairs. There is no suggestion in the data that male activities are inherently more dangerous than if the woman is herself adulterous; indeed the fear of husbands having had sex with menstruating extra-marital partners might apply as well to a woman's new partner having had sex with another menstruating woman such as his own wife. There is, rather, the overall assumption of it being men who 'do *chiwerewere*'. The evidence may of course have been differently weighted if more male individuals and groups had taken part in interviews.<sup>11</sup> My findings are however supported by Morris (2000) who puts the same emphasis on male infidelity causing harm to pregnant women and their children. This focus on male behaviour and

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<sup>11</sup> I noted in chapter 3 that men eventually began to demand payment for interviews.

sidelining of female may relate to the emphasis on matriliney, it not being of very great consequence for the lineage if the progenitor, or the one to 'feed' the fetus with semen, is someone other than the husband. Other sources notably ignore male infidelity and concentrate on female (for example Demographic Unit, University of Malawi 1986, Safe Motherhood Project 1999).<sup>12</sup>

### *Postnatal sexual abstinence*

I was repeatedly informed of the need for couples to avoid sex for several months following the birth in order to protect the infant from the heat of sexual activity, and the husband from blood. The man may suffer from *mdulo* as might the baby if the parents have sex too early.<sup>13</sup> The ideal period of postnatal abstinence was variously described to me as nine, eight and six months, or 'until the baby sits' but with the frequent comment, 'the young now don't follow our ways'.

Until the baby sits and starts laughing [sex is precluded], then people start sleeping together. All the bad things inside the woman have gone. They go to the hospital and clear inside,<sup>14</sup> give medicine and then they sleep together (Kalanje women 11 07 00).

The Kalanje women spoke about postnatal intercourse being possible earlier following D and C and the provision of medicine by the hospital. Hospital medicine would, I suggest be antibiotics and a synthetic oxytocin but local remedies might also be given, both being known as *mankhwala*. Their concern, accompanied by great hilarity and joking, was stated as being for 'other things ... going to the penis of the husband' and causing disease. This concern for male contact with 'bad blood' was reinforced by the Sambani women (02 07 00).

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<sup>12</sup> Attribution to female infidelity and lack of acknowledgement of male is notable also with sources external to Malawi such as The Prevention of Maternal Mortality Network (1992) and Asowa-Omorodion (1997).

<sup>13</sup> Child spacing has been proposed as more functional explanation for abstinence (Demographic Unit, University of Malawi 1986) and again wasting (*tsempho*) as the consequence of parental sex for infants.

<sup>14</sup> 'Clear inside' refers to dilatation and curettage operations (D and C) that might be performed to remove retained products of conception in the case of abnormal bleeding after the birth, and to prevent infection.

*Transformational sex and vulnerability*

Hot/cold ritual status then is intrinsically linked with sexual activity, which causes a person to be 'hot', as well as to other 'reproductive' activities – menstruation, labour and the time after birth, all times when blood discharges are apparent and women are passing from one state to another.<sup>15</sup> Infancy is also a time of transformation. The newborn infant is seen as 'cool' (*wozizira*) and in need not just of protection but also 'warming' achieved as part of the rituals accepting it into the community, so becoming a new cultural entity (Davis-Roberts (1992). Although the topic arose commonly I gleaned little indication that postnatal sexual rituals and infant warming and incorporation practices (still used extensively by the Sena) continue today in this Lomwe, Ngoni and Yao area. Such rites involve sexual intercourse, specifically coitus interruptus, being performed by parents or substitutes with the baby between them once the period of postnatal abstinence is over. This is the point, according to Chakanza (1998b), at which the infant becomes fully human and entitled to a normal burial, whereas if it dies earlier it must be buried in a shallow grave to prevent infertility in the mother of whom it is still considered to be a part. Without such care the 'cool' child may develop *tsempho*, a wasting illness with limb and abdominal swelling and dry hair, the description of which bears a distinct resemblance to Kwashiorkor, a form of malnutrition,<sup>16</sup> and may lead to death. Prior to the ritual sex the 'cool' baby is protected by amulets from accidental contact with those who are 'hot'.

Transition pervades other customary activities in Malawi and sex may be used to 'cleanse' after miscarriage or widowhood<sup>17</sup> although as previously discussed, this is to return women to a state of normal 'warmth' rather than to deal with pollution (Morris 2000). Similarly the female initiate may be 'warmed up' through the sexual activity of the

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<sup>15</sup> Chakanza (undated) confirms how heat is directly concerned with reproduction, with menstruating, labouring and newly delivered women being considered 'hot'. Morris (2000) explains the vulnerability of women as the loss of heat because of bleeding that makes childbearing women cool and vulnerable. It is the excess heat of the red blood rather than the person that is seen as powerful and potentially harmful to such as men and newborn babies.

<sup>16</sup> This similarity to child malnutrition is supported by Morris (1985). I note also that resumption of sexual activity is likely to lead to pregnancy once breastfeeding diminishes, and a child succeeded quickly by another is more likely to be malnourished.

<sup>17</sup> The husband and another related male fulfil the cleansing role for miscarriage and bereavement respectively. It is unclear how important this is now; the topic is absent from data collected in this fieldwork.

*mfisi* or 'hyena', an unidentified male appointed to perform sexual intercourse at night with girls as young as nine years as part of initiation.<sup>18</sup> Morris here uses the term 'transformative' for the way sex is used. Davis-Roberts (1992) points to the creation of new cultural identities<sup>19</sup> and Ngubane (1977) describes a Zulu magical marginality between life and death that demands boundary setting through sex.

Both Chakanza (undated)<sup>20</sup> and Morris (1996) suggest that women are in a state of transition during pregnancy, birth and menstruation. Morris indicates that it is productive, creative activities, not just reproductive ones, that are 'hot' (hunting, smelting, beer brewing, as well as pregnancy, menstruation, sexual activity) so the person undertaking these must start off 'cool'. This indicates that a menstruating or pregnant woman is herself not dangerous to a man; it is the production of blood or the sexual activity, or the transformation to motherhood itself that is heating. Morris (1998) confirms this regarding blood and sex, although not specifically regarding transitions to motherhood. He describes the states of pregnancy and menstruation as actually being 'cold' because they are losing 'hot' blood, and so women need to protect themselves, for example from the heating activity of cooking. They also must protect others such as husbands from contact with their heating bodily processes through the effects of eating the food they have prepared (2000), or indeed through sex.

Although I knew Malawian theories to be humoral in basis and the states of being 'hot' (blood, redness, fire, anger) and 'cold' (represented by water, semen, whiteness) to be important, I was able to elicit little primary evidence about what lay behind the ideas. Practice often reflected the issue but rarely did anyone talk about the concepts, only the resulting actions as one might expect for an aspect of everyday life. I finally consulted Priscilla Matinga as well as local literature<sup>21</sup> to help me to make sense

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<sup>18</sup> Such initiation is now condemned as an abuse of children's rights and immensely dangerous in this time of AIDS. It is however still prevalent in some areas and may take place several times, initiands sometimes having to raise funds themselves to pay for several visits. Though officially condemned, even educated men joke about the practice (Ashwood-Smith, personal communication, 2000). I also witnessed the making of such jokes at an academic conference.

<sup>19</sup> Davis-Roberts (1992) uses 'framing' for coitus performed under specific conditions for specific purposes.

<sup>20</sup> The author is assumed by deduction to be Chakanza.

<sup>21</sup> I found the reports emanating from the Safe Motherhood Project particularly useful alongside Morris (1998 and 2000) and Chakanza (undated, 1998a and b).

of my data. Matinga emphasised the potential weakening of the body if excess 'heat' or 'cold' is encountered and the importance of equilibrium with practices directed at achieving a beneficial harmony or warmth necessary for health and maintenance of the life force (explored later in this chapter). Although unclear from primary and secondary data, it could be deduced that the 'heat' of childbearing is itself related to transformation to motherhood.

Morris (1996) indicates blood and fire as being 'hot'; he emphasises elsewhere (2000) that it is the activity, not the person, which is 'hot' or 'cold' and that there is no element of clean/unclean or gendered pollution. My data could be read otherwise as the following quotation demonstrates, with a specific reference to 'bad' and 'things inside' reaching the husband. The Kalanje women (11 07 00) quoted above used similar phrases and spoke of actively clearing such 'bad things':

She becomes dangerous to the husband, and to any man. They mustn't sleep together. The man can become very ill if he sleeps with the woman who has just given birth. She is still having bad blood ... [after] seven months then it is clear (Sambani women 02 07 00).

The language used by Grace was also suggestive of a state of uncleanness when reporting how a man might deal with such enforced abstinence to avoid consequences which she incidentally likened to HIV:

G: What happens if she doesn't [wait]?

Grace: The man can contract a disease. If he wants to sleep with his wife earlier he has to take her to the hospital where she is cleaned at the [operating] theatre<sup>14</sup> but if [they don't do this] he will lose weight, his hair becomes loose. He feels cold, he wants some meat, sometimes his feet might swell and eventually he might die (04 06 99).

Such language does not preclude the relevance of Morris's assertion if the view is taken that 'bad' is synonymous with the 'heat' and transformational power that causes imbalance. The alternative explanation to pollution, supported by Morris (2000), is that surgery removes the 'hot' blood condition from the woman to which the husband is vulnerable when exposed during sexual intercourse.

Drawing on fieldwork evidence and secondary material has illustrated a complex set of relationships between sexual activity, transitional states, particularly



reproductive ones, achieving a healthy equilibrium and successful childbearing. Table 7.1 summarises the results of 'hot' and 'cold' imbalance in relation to childbearing women.

Table 7.1 The results of imbalance when a 'hot' person is in contact with a 'cool' person

'Hot' person in contact	with vulnerable 'Cool' person leads to →	Specific consequences of 'hot'/'cold' imbalance
Sexually active person (touching) Sexual activity of couple's parents	Pregnant or labouring woman	Birth problems
Menstruating woman	Pregnant or labouring woman	Birth problems
Person (including the husband, his extramarital partner or the pregnant woman herself) attending a funeral, grave digging or handling the dead	Pregnant or labouring woman	Birth problems
Adulterous husband, or pregnant woman's extramarital sexual partner (see chapter 8).	Pregnant or labouring woman	Delay or obstruction in labour, 'bloods' have been mixed
Menstruating woman who prepares food / adds salt	Pregnant or labouring woman	Miscarriage or malformed infant
Sexually active woman	Newborn or young infant	Wasting and death of infant
Women with blood discharge following birth, miscarriage or planned abortion	Husband/sexual partner	Wasting disease or death
Couple having intercourse during postnatal months	Infant and husband/sexual partner	Wasting disease or death
Menstruating woman who adds salt to food	Male partner	Wasting disease or hydrocele

'Cooling' states are pregnancy, infancy, celibacy, pre-pubertal childhood, post-menopause.

'Heating' states are sexual activity, contact with death, menstruation and postnatal bleeding.

This summary is confirmed by Probst:

The basic rule now is that people with a different ritual temperature should not come into contact with each other via touch or the mediums of salt, blood or sexual fluids lest one of them fall sick and even die. Thus *mdulo* diseases are caused by a clash between different (ritual) temperatures.

Probst asserts moreover that the 'hot' and 'cold' balance idiom relates entirely to the presence or absence of sexual activity and 'encompasses the whole life cycle of a person'

(1995:8). Sex then is hedged around and about by a plethora of prohibitions and instructions because of the potential for harm as well as good and the need to maintain balance; this is reflected in the dominant narrative about infidelity and pregnancy that is explored next.

### ***Moyo* and sex: maintaining the life force**

*Moyo* is both a physical and social status, necessary for the attainment of peaceful relationships. 'Hot' and 'cold' equilibrium and morality, sex as powerful and transformative during times of changing status, are all integral to *moyo*. This is discussed next, again using secondary material to support the development of understanding as it was rarely articulated to me.

The need for social harmony described by Morris (2000) connects with overall concerns with avoiding discord, an issue arising in this chapter as the link between health and morality and in Malawi generally as a studied avoidance of disagreement. Whereas views of healthy living deriving from the biomedical paradigm tend to focus on the physical and to some degree on the mind, *moyo* (the life-force) is an all-embracing concept. Sexual activity is an essential element of maintaining this; Chakanza (undated: 1) again says:

Because of the high esteem people have for life in the mystical sense, sex and sexuality are crucial to the origin, growth, preservation and continuity of life here on earth and beyond.

Sex, then, is used in some senses as medicine but has a far deeper rationale beyond the use of sex for ritual cleansing and as a transitional marker or instrument, for example for absolution after illegal abortion, or re-thatching a burned roof (Ashwood-Smith and Bokosi 2003). No-one talks about it (apparently, except to interviewers), yet almost everyone does it. It is seen as great fun – hence the delight and raucous laughter often encountered when I interviewed older and the very old women, but promiscuity is universally condemned despite the apparent looseness of many marriage ties.<sup>22</sup> Sex is demonstrated vividly in women's public dance and constantly alluded to in the

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<sup>22</sup> This highlights the difference between casual sex and serial monogamy.

accompanying songs, children could see and hear these but were always chased away when groups discussed it with me. I quickly learned not to start an interview session until all young children had been dismissed, not to talk about sex in the presence of young unmarried women or about childbearing to those who had not yet given birth, or to expect much information on the topic from a mixed sex group.

It is clear that an all-pervading emphasis exists on right behaviour, on what is moral and what is not, as part of *moyo*. Moral behaviour chiefly involves issues around fidelity and the consequences of not remaining faithful to a marriage partner. It also encompasses witchcraft and provides a clear rhetoric of risk and danger especially to childbearing women and their babies that influences decision-making. For this reason these two topics are addressed in more depth in chapter 8.

### **Biomedicine and ethnomedicine: ways of thinking about ill-health, childbearing and therapy**

Leaving aside sex as transformation and therapy, and wellbeing as social as well as physical, evidence arose frequently about further ways of dealing with health problems. The *azamba* have extensive knowledge of herbal remedies or *mankhwala* (medicine); as part of their power base this was addressed in chapter 6. However there are lessons to be learned from their narratives and from case studies and other data regarding local notions of what works, and what does not.

It is clear that people's ideas and actions regarding health and illness are influenced by ethnomedical and biomedical concepts and people move freely between forms of therapy and their specialist practitioners.<sup>23</sup> Herbal therapies are also known and used by many women for minor household ills. Ethnomedicine uses herbal and animal substances, and divining for the 'why' and 'how' of ill health may or may not be integrated with treatment. Regina claimed to have medicine to deal with bewitching of pregnant women, and for pregnancy sickness – the result, she told me, of an unhappy

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<sup>23</sup> Seeing D and C as a way of making postnatal sex safe for the male partner (see above) is just such a pluralistic approach.

fetus and unhappy home thus providing a significant social context for a physical problem.

*The azamba: childbirth specialists in whom ways of thinking meet*

The 'hot' and 'cold' equilibrium theories of wellness often underlie actions in parallel with biomedical concepts. Regina provided the supreme example of this mix of paradigms believing that caesarean section was a useful means of dealing with infidelity and its consequences. Figure 7.2 which indicated the results of imbalance can be taken further to encompass what Regina told me about the combination of old and newer ideas for preventing and dealing with problems. She clearly defined these as biological in effect – obstructed labour and illness in the infant – but moral in causation. This can be seen in Table 7.2 As Matinga explained when explaining personalistic causation 'The doctor can treat [obstructed labour] but it is still seen as a witchcraft problem' (personal communication, 2000).

Table 7.2 Regina's remedy combinations for obstructed labour and illness in the baby.

Problem	Cause	Prevention of harm	Curative remedy
Long or obstructed labour	Infidelity in pregnancy	Herbal remedies Naming partners	Herbal oxytocic or intravenous oxytocic infusion Caesarean section
Illness in newborn baby	Parental sexual activity breaks postnatal taboos	Herbal medicine	Herbal medicine Medication from hospital

Most of this evidence concerns how the body works. It is easy to presuppose an understanding of the body's structure that matches the biological view; such an assumption could be misleading but was difficult to explore. Discussing birth practices casually one day provided one opportunity when Grace told me that attempting to push a baby out before it is ready could cause a woman to block her uterus, but her meaning was unclear.<sup>24</sup>

<sup>24</sup> This was the occasion when Grace made the sand drawing shown in fig.7.1.

Having considered the concepts that underpin the practice of the *azamba* I now consider briefly other healers generically known as *asing'anga*.

***The asing'anga: specialist in physical and supernatural therapeutics***

The *asing'anga* is a practitioner who uses herbs, animal parts and possibly divination to help the sick. The label *sing'anga* or 'African Doctor' is seen everywhere on painted signs by the roadside, often accompanied by a red cross and 'Hospital' or *Chipatala*<sup>25</sup>, indicating the help available in the often ramshackle building nearby.

Chakanza (1999) defines the various therapeutic roles, all of which may be incorporated in the practice of one person according to the circumstances:

- herbalist, dispensing roots and herbs only (Morris 1998 includes animal products but specifies the pre-eminence of herbs);
- diviner who consults oracles or ancestors on illness causation (usually personalistic) and cures;<sup>26</sup>
- spirit medium or doctor who is possessed by an ancestral spirit in order to seek cause and remedy<sup>27</sup> and may be used when witchcraft or sorcery is suspected.

The term herbal is usually used in the Malawian context to denote medication dispensed by the *asing'anga* and includes substances of animal origin. Morris (1998) emphasises the 'natural' products employed and criticises those such as Janzen who appear to ignore the physical elements of medicines, concentrating mainly on symbols, magic and ritual. Chakanza (1999) claims that herbalists may not wish to be considered as magicians or sorcerers.

Divination is commonly used to identify the cause or agent responsible for an unexpected event or illness and is probably a classic feature of established help-seeking behaviour. It may be used alongside other therapies, perhaps by the same practitioner.

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<sup>25</sup> English words are often transformed into a Chewa version as with *chipatala*.

<sup>26</sup> Diviners may particularly be consulted if the search for relief has been unsuccessful (Morris 1996) and, he stresses, themselves use herbs to treat those who seek their help. Morris indicates that these claim to be the true *asing'anga*.

<sup>27</sup> Spirit mediums and ritual specialists (*namkungwi*) are usually female (Morris 1996).

Morris (1985) asserts that divination relates specifically to the articulation of social conflict and often is practiced by a different person than is herbalism. It is perhaps a quest to know 'why me' and 'why now'. Medicine may be sought too for protection against misfortune such as bewitching and theft. It is likely that some recourse to a diviner occurs in this community but this does not feature in my data. Moreover I saw no sign of therapeutic rituals and drumming such as Janzen describes (2000) so I will not address the issue further although understanding that passing over such a huge area does not alter local reality.

This difficulty in defining terms and whether they are specific to one paradigm and therapy cannot however ignore the real differences. As Morris (1998) point out, the animal and vegetable substances sold by the herbalist have intrinsic power and curing properties for the Malawian as well as symbolic or allegorical meaning. Substances, of which Morris has counted over 500 in plant species alone, may be intended to protect against further harm as well as to cure. The herbalist is expected to know how to manipulate the intrinsic powers for the good (or evil) of the client. Morris explains how these powers are attributed specifically to certain plants and animal substances, and that the generic term, *mankhwala*,<sup>28</sup> used for them refers more to the powers than to the physical properties.

Having addressed the concepts that prevail as influences on action the final section of this chapter addresses these same areas as paradoxes.

### **Paradoxes and tensions in ways of thinking**

In this section I explore some of the apparent paradoxes and tensions in health beliefs and practices using secondary literature which considers how people hold ideas that can appear contradictory to western observers, and simultaneously take pragmatic approaches to decision making.

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<sup>28</sup> Fertilisers and insecticides are also included in the classification as are substances used to protect objects, for example from theft.

It became evident that biomedical and ethnomedical paradigms together informed actions, often interchangeably. Natural and personalistic therapies might be seen as little different from biomedical by local people; not so by formal health service providers as is demonstrated by attitudes to herbal substances such as that given to Majami (case study 5, chapter 5 and Appendix 3). Both biomedical practitioners and indigenous ones use uterine stimulants on occasions in labour. The herbal uterine stimulant used is significantly different from the oxytocin used by obstetricians and midwives mainly in terms of its toxicity and the uncontrollability of its dose level and action. One, in my experience, is dismissed by western practitioners as dangerous traditional medicine that may cause the uterus to rupture; the other is part of the everyday armoury of the obstetrician and midwife trained in the biomedical tradition despite occasional uterine rupture even when used 'properly'.<sup>29</sup>

### **Inclusive and flexible attitudes to practice**

Expressed ideas and practices evident in this rural setting indicate a complex, fluid and inclusive approach to life that mostly unproblematically embraces both the 'old ways'<sup>30</sup> and those deriving from biomedicine as interpreted by colonisers and those who followed them. The importance of ancestors and the problem of witches, faiths introduced by western and African missionaries, herbal and animal medicine, 'western' drugs and surgery, sorcery, divination and prayer all underpin the actions of the community members I encountered. This is reflected in the eclectic and varying ethnomedical practice too.

Such eclecticism appears to form a comfortable foundation for decisions made by most people except for evangelical and some Roman Catholic Christians who feel even the use of herbal medicine has to be discouraged because of the difficulty of

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<sup>29</sup> Mahomed (1987) provides evidence of this for Zimbabwe and notes that 43% of uterine ruptures occurred during hospital care. The overall literature on the topic (and personal experience) shows little attention to iatrogenic problems and only occasional attribution in print to lay practice (such as Nkata 1996). This demonstrates how little attention has been paid to this within medical research, or perhaps illustrates the difficult nature of such research.

<sup>30</sup> 'Old ways' was a phrase commonly used by informants when talking to me, according to interpreters and translators. It is accepted that 'old ways' must themselves have incorporated change and adaptation over centuries especially in relation to population movement.

separating it out from witchcraft and sorcery. Chakanza (2000:21) uses the phrase 'irretrievably pagan' to describe the general Christian church view of the origins and practice of indigenous medicine.<sup>31</sup> Strathern and Stewart (1999) suggest that 'modern' biomedicine is similarly unable to tolerate a mix between the naturalistic (to do with the body itself or physical causes) and personalistic (attributable to the intervention of some being). Meanwhile many informants, pregnant or not, moved freely between herbalist, spirit healer, formal health services and probably the diviner.<sup>32</sup> Fieldwork evidence suggests this layering of ideas is not just applicable to rural people, and that highly educated and professionally employed people may also think and act at concurrent levels of conceptual imagining and belief. This is confirmed by Forster (1998) who demonstrates the pluralistic nature of Malawian ideas about the aetiology of AIDS. These are closely related to Morris's taxonomy of illness causation theories pertinent to Malawian healing practice (1985:17, 18):

- Natural or 'Acts of God' (the most common)
- Moral or ritual misdemeanour
- Witchcraft or sorcery
- Spirits.<sup>33</sup>

Chakanza (2000) takes this further, suggesting a division of labour depending on the perceived cause of problems. He claims that herbalists are used for natural problems, diviners for sorcery and witchcraft, and spirit healers and mediums for ills caused by dead spirits. Morris finds reality to be more complex than this as 'even market herbalists may talk of witchcraft, *mdulo* and spirits' (Morris personal communication 2003). Indeed Morris (1996) demonstrates that individual Malawian practitioners may embrace multiple roles and refer clients between colleagues and to formal health services, and may use

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<sup>31</sup> The Nation newspaper published an article recommending the disentanglement of herbalism and witchcraft to enhance its contemporary acceptability (Nyirenda 1999).

<sup>32</sup> Ngubane (1992) shows how moving between practitioners is unproblematic within African ethnomedical systems and referral to biomedical care is common. Biomedical practitioners, she suggests, rarely hold such liberal attitudes.

<sup>33</sup> Spirit-caused illness, witchcraft or sorcery may be related to revenge or jealousy.



formal health services themselves. The suggestion of Strathern and Stewart (1999) that modern therapies are usually chosen for modern diseases is limited in its application within Malawi. As Janzen found in Zaire (1978) therapies of different forms are complementary rather than competitive. Particularly helpful are Mogenson's findings that the Tonga of southern Zambia comfortably define and redefine as they speak, often contradicting themselves as they reflect on a researcher's questions and revise their answers (1997). Their own categories are complex and cannot be pinned down easily.

Grace demonstrated such fluidity when discussing her use of herbs with me. We were talking, I thought about the uterine stimulant, soon after she had been censured for her actions in caring for Majami and blamed for her ruptured uterus (see chapters 3, 5 and appendix 3). As noted in chapter 3 and 6, she now appeared to be claiming another use for it:

G: You mention pain medicine today; another day you mentioned medicine for making the baby come faster. What do you mean?

Grace: The baby has not come but the medicine is to stop the pains. There is no medicine to make the baby come faster.

G: Does the medicine make the uterus work harder?

Grace: It has nothing to do with the uterus — the medicine is to release the pain only.

(10 07 00).

Returning to my notes to find her previous statements I realised Grace had spoken about her use of such medication only informally rather than in recorded interviews. I could not finally determine whether pain relieving and labour stimulating medications were separate items, represented different uses for one substance or indeed whether the analgesia explanation had been invented. Reading Morris (1996) clarified what I was observing, that in his experience too, individual remedies may be used for more than one purpose, and, moreover, the cause of a problem might be differently attributed depending on the context.

### **Dynamic, contradictory and complementary: practice without dilemmas**

My data generally appears to confirm what Chakanza (1999) says about Malawi, and Strathern and Stewart (1999) suggest more generally, namely that traditional practice will

change and adjust, incorporating new ideas in a dynamic way to suit local conditions. People hold contradictory ideas and do not see this as problematic; for many there is no conflict. I was seeking explanatory paradigms and exploring concepts I understood poorly, and often experienced difficulty in framing queries. I sought a direct cause and effect explanation along the lines of the biological/biomedical model, enquiring from informants unused either to such probing around taken for granted idioms, or to categorising. Informants, including my interpreter Jane, consequently found it hard sometimes to understand what I wanted to know or why it mattered. As Gordon says when she discusses biomedicine (1988:23) 'one participates *through* background assumptions, one does not consciously *see* them'. This applied equally to researcher and informant.

An important example of the easy accommodation of different paradigms is the apparent ease with which Regina and Grace mixed cause and effect at will – such as the earlier example of Regina illustrated in fig. 7.2. Biomedicine classifies obstructed labour as a mechanical problem with the solution also a mechanical one aided by stimulants, whereas Malawians might rather see it as a moral one with the alternative solutions of confessing infidelities (moral) or caesarean section (mechanical), and their own version of stimulants. The aetiology of, and therapy for, delay and obstructed labour is a supreme example of how the naturalistic and personalistic articulate. There is evident understanding of unborn babies being too big or badly positioned, of pelves being too small or labour contractions weak. Yet it is also asserted that women or husbands may have committed adultery during pregnancy or have been 'tied' by jealous witches. Several solutions address these problems none of which are exclusive to one theory of causation. Confession of extramarital sexual partners' names is one method, apparently less common now in the community studied. The use of herbal medicine is a second, medicine to counteract the effect of the bewitching a third, and of course caesarean section can be performed in hospital.

Previous dialogues demonstrate the mixture of biomedical elements and ritual imbalance theories relating to pregnancy problems. This is also indicated in the following passage. I had asked whether young pregnant women should be warned of problems to look out for and received this answer:

Yes it's a good idea. If she's told the do's and don'ts of behaviour while pregnant, she'll be aware, for example, of what to eat and what not to eat, whom to avoid contact with and how to look after herself (Mithawa women 13 07 00).

These women had just told me that it was important for a young woman to permit her attendants to examine her in labour, so were affirming the biomedical, but in providing more detail about eating, emphasised her ritual status saying:

She's supposed to be careful not to eat 'hot food' [prepared by menstruating women] ... she will miscarry or end up giving birth to a malformed baby ... sometimes with the face still unformed.

The subject of eating was thus complex, as enquiries about what pregnant women should eat or avoid might as well bring talk of food prepared by menstruating women, as be a listing of nutritious foods straight from a health education session, or be foods to be avoided because it was believed that they might harm a foetus.<sup>34</sup>

The case studies in chapter 5 also illustrate very clearly the mix of ideas, demonstrating the parallel influences on people's ideas and actions:

- For Dannis's kin, hospital medicine is powerful but local therapy might as well be tried first.<sup>35</sup>
- Valestar and her mother respected the hospital as the place to give birth when the risk of bleeding had been increased by several past births. At the same time, her mother did not touch the baby because she had been in contact with the body of her dead grand-child so might risk the welfare of this new one.
- The *azamba* who used the uterine stimulant were renowned publicly for their knowledge but conversely reported the ban on its use. They may have used it commonly in small amounts and indeed had told me so, but when Majami's labour was slow Grace was tempted to try a little more and a little more –

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<sup>34</sup> A quoted example of food potentially harmful to unborn babies was banana, believed to make them have excess lung secretions once born.

<sup>35</sup> The socio-economic considerations of locally available and often cheaper traditional medicine may also be important as suggested by Strathern and Stewart (1999).

apparently to five doses. With a badly positioned baby, disaster was inevitable as Grace tried to over-ride a circumstance explainable biomedically as the body's own protective 'slow-down'.

When discussing the simultaneous vulnerability and dangerousness of pregnant women I quoted the fact that hospital doctors were excluded from the rules as their medicine was powerful and they wore rubber gloves. As well as indicating the efficacy of a barrier to pollution, the gloves, this indicates how people did not necessarily see biomedicine as different in kind from the 'old ways', but as more powerful. At the same time, both may be seen as having powers that are lacking in the other as the following quotation illustrates:

If inside - there is damage, at the hospital they fail: but traditional medicine is stronger for this. Tablets from the hospital do not work. But some medicine from the hospital works well. – [However] when a patient has a bad smell, they give the patient traditional medicine – this is better than at the hospital (Mithawa women 12.7.00).

Accommodating potential dissonance is evident around religion too with the assumption in everyday life of Christian and Islamic beliefs although mingled with the influence of witches, spirits and ancestors over personal well being. This is illustrated by an early conversation I had with my first interpreter, a devout Catholic and previously a seminary student. Francis explained how his mother's friend, also Catholic, was dying because the ancestors wished her to become a 'medicine woman' and she was refusing because of her faith. 'The ancestors are therefore getting their revenge' he told me. I recorded that I could not determine what he himself thought of this and that I did not feel ready to ask. Another conversation raised the same questions in my mind when he explained how snakes could be created magically in order to take vicarious revenge or to steal money on behalf of a thief. Asked if it made a difference if the victim was a Christian, he explained that only visiting a healer would help. A reading of the explanations of Morris (2000)

suggests that this healer would probably have been providing 'medicine', remedies to placate the ancestors, and that the snake might be viewed as an ancestor in animal form.<sup>36</sup>

### **Good sex, bad sex: reflections of a life view**

Stewart and Strathern (2001) suggest that humoral systems as organizing paradigms indicate essential ideas about life and the body. Here in the Malawi data and secondary material, the supreme element has to be the one of the life force or *moyo* being related to sexual activity but I do not suggest the body is the only focus. Community, perhaps the clan or matrilineal line, may be indicated as a vital focus when moral behaviour and transgressions are such a major preoccupation. Frequent comments were made to me about 'girls with bad attitudes' or who 'went with boys' (meaning young unattached women who had sex with several partners), and infidelity caused concern when men with newly delivered wives had intercourse with other women. Sex might be viewed as essential to well-being, but when men risk the lives of wives and babies by not waiting the nine months of postpartum abstinence (added to two months of antenatal abstinence) they are seen as risking the family, and the wife is considered to be within her rights to send him away. So it appears that the wellbeing of the matrilineal community is as important as that of an individual.

Chakanza (undated) discusses the moral responsibility of people to handle the balance of negative and positive aspects of sexuality, upsetting the 'hot/cold' balance and being seen as a moral transgression which can lead to illness and death. The Malawian ethnomedical system is thus rooted in cultural presuppositions (Hahn 1995:135) which indicate what is valued, particularly propriety and marital fidelity, and how people should behave. In this community disease is often attributed to transgression of social norms and, as Morris (2000:86) says, traditions can 'bolster secular authority'. A general acceptance was noted in the community and among other informants that rules (or taboos as people called them), as well as being an expression of local ideals, encourage acceptable

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<sup>36</sup> One day I witnessed a determined but unsuccessful hunt for a black mamba which had been seen near the homestead and which the men wished to kill. This suggests that not all snakes are seen as ancestors; according to Morris (2000) snakes are considered to be non-aggressive and are not killed, however poisonous, if thought to be transformed ancestors.

behaviour. Even the threat of witchcraft appeared to have the effect (if unintentional), of creating conformity through shame, secrecy and fear of being different.

### **Cosmology: explanatory systems and social control**

Questions can be posed about whether the social norms relate to social control or to cosmology and explanatory mechanisms, or both. The cosmology itself may act as a controlling influence. If the physical and social aspects of *moyo* are both important, with sexual activity as a vital aspect of keeping the life force going, then control aspects are perhaps essential to the balance of such a powerful force.

The framework of transformation and containment, and hot and cold balance can be an explanation for experience. It coincides with what the community requires of its members, including the link between the fear of witchcraft and disruption to social harmony. This is further explored in chapter 8. So a framework is perhaps constructed that enables people to understand what is happening, or alternatively to ensure the desired outcomes are achieved (Pearce 1993). Such a framework assists in handling the vulnerable times of transformation, both providing explanations linked to behaviour and indicating the actions that conform to societal philosophy and norms. Such frameworks provide views of normality which are distinctively moral and related to the social order (Prins 1992) as well as being rooted in the physical.

This can be seen also in relationship to the wasting and 'cutting' diseases that are considered to result from transgressing 'taboos'. Effectively these old diseases provided room for what Nichter (1992) called moral commentary. Such a language of morality is also clearly developing within Malawi around the newer problems of HIV and AIDS which are now is considered by many Malawians to be the judgement of God for bad behaviour (Forster 1998). Similarly Mogensen (1997) found the Tonga of Zambia linked AIDS to a wasting disease recognised traditionally as being related to transgressing sexual mores and sounding the same as *mdulo* – there seen as pollution from having intercourse with a woman who had miscarried and had not carried out sexual cleansing rituals.

### **Acceptance, nostalgia and ambivalence**

There is undoubted acceptance of newer ways and the facilities offered by hospital maternity care, as demonstrated by the case of Valestar amongst others. Adverse comments that I heard were limited to criticisms of staff attitudes. There is however nostalgia for the past with some believing labour and birth are now taking longer, young people are now more promiscuous, and new parents less willing to wait out the prescribed period of postnatal celibacy. Regina lamented the days when birth had been easier and when rituals, rules and advisers were followed, not least because the lack of knowledge demonstrated by young women when giving birth leaves her now with a more difficult task of coaching them through labour.

I detected ambivalence about hospital referral also. Although hospital is frequently articulated as the optimum birthplace, many do not make it, and for all sorts of practical reasons few lodge at the maternity *chitando* to avoid journeys in labour. Physical problems are recognised but sometimes attributed to witchcraft, potentially causing delay. 'We see physical problems, they see bewitching' said the Sister Fleur; yet in reality I suggest 'they' see both and, moreover, consult indigenous healers and hospital staff without necessarily discriminating about category or cause.

### **Conclusion**

In this chapter I have explored the philosophies underlying the local view of health, illness and childbearing. I have used data and some secondary sources to support the laying out of local expressions of common regional ideas. I have moreover considered some of the contradictions and complexities that might affect decisions made.

The evidence gathered during fieldwork demonstrates that informants place great emphasis on the maintenance of equilibrium between 'hot' and 'cold' ritual states and blame imbalance and excess for a variety of sickness and misfortune, both in relationship to childbearing and outside of it. A clear moral element is indicated, with what is adjudged to be 'bad' behaviour being held responsible for serious consequences. Such behaviour relates specifically to sex but also to bewitching as an explanation for

misfortune – and in fact for good but unexpected consequences too, such as the acquisition of money or property. Those most vulnerable to harmful consequences are those considered to be in marginal states: infants, pre-pubertal children, the pregnant and the elderly. It is uncontrolled or uncontained activity that gives concern (Davis-Roberts 1992), especially the sexual, with blood and salt becoming transmitting agents. Sex is however powerful and transformative. Thus health beliefs can provide an important indication of what is valued in a society and for my informants this is specific. At the heart of the health concepts lies the idea of *moyo* and sex as empowering and transformative as well as ideas of morality that link to the Malawian sense of harmony and community.

The whole data set relating to health, childbearing and the maintenance of equilibrium between 'hot' and 'cold' by appropriate moral behaviour, is a form of narrative and narrative is a means of explaining experience and making sense of it in the context of what others do (Mogenson 1997). People explain what is happening to women who are pregnant and giving birth and to new mothers and their babies (and husbands) in terms of a narrative of sexual propriety as well as in terms of often partially understood biological and biomedical knowledge. Such ideas are layered and dynamic but articulated with decreasing clarity the deeper they lie. People distinguish between what they call the old and new, yet in their actions and often their speech integrate them unproblematically. Articulation and action are often out of step one with the other as people apparently accept a variety of views and accommodate potentially dissonant ideas and pluralistic views of prevention and therapy in essentially pragmatic ways. This will be considered further when decision-making is explored in more depth in the final chapter.

Much of the discourse around the concepts that affect the pragmatic choices and decisions made is one of vulnerability and protection of the balance needed for health. Indeed the language that informants used in talking to me and even the language of many of their actions in making decisions was effectively one of risk. This was particularly so when involving immorality, taking life-giving sex outside of the household, and also the external dangers of personalistic ill-will. These prevailing concepts of risk and danger significantly affected decisions made around pregnancy and birth so are considered next in chapter 8.



## **Chapter 8: 'Someone might tie something on you'; body risk talk, from biology to bewitching to morality and back.**

### **Introduction**

The purpose of this chapter is to examine notions of risk and danger, focussing particularly on the issues which are thought to be of such importance that they influence decision-making, where necessary viewing this alongside global perspectives. It adds further information about influences to those explored in previous chapters.

Before reviewing and analysing the fieldwork data I will clarify concepts and the language of risk and danger. I then present fieldwork evidence and end with discussion of this in the light of secondary material including major theorists and those writing in a local context, most of which has been reviewed in chapter 2.

The emerging scenario of risk for childbearing women is clearly linked with the social and moral expectations and boundaries explored in chapter 7, with special attention being paid to liminal states. Although the key features of the local construction of risk indeed emerge as taboo and pollution, they are perhaps better described as related to morality and fears of malevolence actuated through witchcraft. At the same time, the fear of biologically defined complications and practical concerns around banditry make for a significant counterbalance between risk factors in making choices about where to seek help for pregnancy-related needs.

The risks addressed in this chapter specifically concern the woman's safety, although inevitably touching on the child's. Other morality and balance issues described in chapter 7 are substantially to do with male and infant welfare or fetal survival and have less to do with decisions and actions concerning women's own childbearing needs. The evidence and the analysis of the notions of risk and danger will finally feed into the concluding synthesis on decision-making found in chapter 9.

### **The language of risk and danger**

Risk and its management is a recurring theme in technical literature as noted in chapter 1, focussing on the principle of birth being normal only in retrospect. Perceptions of risk and consequent actions may differ however when mediated by alternative views of health and childbearing to those biomedical themes that determine prevailing international views. Fieldwork data demonstrate a clear articulation of a language of risk and danger by informants, a language that is embodied in the actions that result from it. The concepts of risk that emerge – biomedical, biological, moral and a fear of malevolence – link firmly to ideas of health and reproduction, to community and matrilineal kin dynamics, to knowledge and authority. They are distinctive as 'local' but, as is demonstrated in fig. 7.5, problem, cause and effect integrate directly and unproblematically with the biomedical in local idiom.

Articulated often as fears or dangers in the evidence, such ideas govern what people consider might happen as the consequence or neglect of specific actions, thus contributing to a risk analysis process and to risk management local style. Through analysis of the significance of the perceived hazard, substantial weighting of alternative scenarios occurs – walking at night versus giving birth at home, adultery now versus obstructed labour in the future. Concern for future consequences addresses potential loss and harm that is not just biomedical but personal and essentially local in nature; concerns are not necessarily expressed in the language of epidemiology.<sup>1</sup>

### **The risk approach to childbearing and its relevance to making decisions**

Firstly the risk approach to maternal health care is considered briefly and three research reports are discussed because their relevance to childbearing or to Malawi clarifies why it is important for me to consider risk and danger. I then proceed to fieldwork evidence.

The risk prediction approach to birth was promoted extensively in the 1980s (Backett et al. 1984) and into the 1990s, the expectation being that women could be

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<sup>1</sup> Such risk talk must have been common worldwide and through history, as suggested by the plethora of protective Indian female deities, women being perceived as vulnerable to spirit attack (Samuel 2002). An example is Hariti, the ancient Buddhist goddess of childbirth featured in the title of the Rozario and Samuel's text (2002) 'Daughters of Hariti', her 'daughters' being midwives.

selected for special attention according to anticipated risk and predicted need in order to reduce morbidity and mortality. The focus on prediction, positive discrimination and risk as a proxy for need was a particularly influential project within maternal health care. This continues in Malawi where women are advised to give birth in hospital in specific circumstances.<sup>2</sup> Such an approach suffers from inadequacies, since it relies on sending to hospital women most of whom then give birth normally (thus discouraging others from following advice); meanwhile others who receive a low risk prediction may experience difficulties birthing at home. The approach is largely discredited by the new emphasis on the risk faced by every woman outlined in chapter 1. Leaving aside the technical argument, this contemporary universalist approach takes account neither of facility overload in resource-poor countries, nor of people's realities, perceptions and preoccupations. Some of these are indicated in the following sample of risk-focussed research projects:

- Ager et al. (1996) studied perceptions of health risks in Malawi focussing on malaria and schistosomiasis. Biomedical beliefs emerged as influential but not the only determinants of decisions, with beliefs having communal rather than individual origins. Preference for biomedical treatment was overwhelming in cases of malaria and schistosomiasis. Traditional systems, fear of kinship jealousy and evil spirit action emerged as being more significant for other problems such as epilepsy and mental illness. Respondents in this small study were relatively pragmatic and not 'locked in' to one form of risk perception and treatment choice.
- Risk-benefit analysis amongst pregnant women in San Francisco (McClain 1983) demonstrated that women magnified the benefits and minimised the risks of chosen strategies. Conversely they focussed upon the risks and minimised the benefits of rejected options, thus reassuring themselves about their choices.
- Atkinson and Farias (1995) explored the construction of an explanatory model of childbirth decisions amongst women in urban north-east Brazil. They found socio-cultural contexts to be as important as local health system practices and structures.

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<sup>2</sup> Those who are likely to be advised to give birth in hospital are those women with first and twin pregnancies, high blood pressure and abnormal positioning of the baby. Others include adolescents and much older women, or those who have given birth many times or encountered previous difficulties

- These three examples demonstrate how risk enters into thinking but concerns other than those of health care professionals are often prioritised. In these studies, choices derived from local concepts and contexts were socially congruent and pragmatic, choices being served by risk analysis rather than risk determining action. This supports my view that the complex area of risk and danger that appeared in the narrative of my informants contributes to bringing together an argument about how decisions are made in the study context.

Take out bullet.

### Concepts of risk in the community

The influences on the way people perceive risk and danger are considered here, first addressing risk themes that derive from indigenous notions of well-being and harm first considered in chapter 7, then biomedical concepts of danger that people use.

#### *Mdulo, mfiti*<sup>3</sup> and *mankhwala*; local risk concepts as explanations for childbearing going wrong

In this section I present evidence that indicates the way in which women and those making decisions for them consider risk. These risk aspects relate specifically to childbearing itself rather than to practical ones such as those of night-time travel – such as banditry as noted in chapter 3 and vaguely articulated fears of spirits and witches abroad after dark.

Risk talk in the community focussed around transgressing moral boundaries and 'hot/cold' imbalance, bewitching, and biomedical problems. This section is organised around these categories.<sup>4</sup>

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<sup>3</sup> Witches.

<sup>4</sup> I had anticipated addressing the notion of proscribed and prescribed foods also but, as Allen found in Tanzania (2002) this featured hardly at all in my data apart from the nutrition ideas noted in chapter 6 and one brief 'list' from Regina of potentially harmful foods so I take it no further. The Safe Motherhood Project (1999) documents are more explicit about forbidden foods in other areas of southern Malawi.

*Mdulo and labour troubles; uncontained heat and sexual activity's outcome*

Becoming confused about the relationships between what I was seeing I asked Regina, one of my most consistent informants, outright about the risks pregnant women face that might affect how women and their kin might act and the choices they might make. Before discussing any biomedical categories she returned immediately to the themes of direct or vicarious contact with death, menstruation and infidelity that emerge in chapter 7, predicting that the woman would need to 'deliver through operation' if infidelity had occurred in pregnancy. In one statement Regina brought them all together, so demonstrating her view of what she had previously evaluated as lack of care of one partner for the other (see 17 05 99):

They mixed the bloods from the other woman and the pregnant one will have problems ... sometimes the other woman will be in her period ... and that can be even more dangerous [than contact with death] (06 07 00).

The specification of adultery as a cause of delay is so absolute for Regina that she is able, she informed me, to identify its occurrence in retrospect by the progress of labour. Stella appeared not to share such views; indeed she expressed her opinion to me that delay and obstruction are due only to a small pelvis or 'just the way labour goes'. In chapter 7, other activities are also reported as causing problems for childbearing women, such as the sexual activity of parents. These appeared to focus on the welfare of newborn babies rather than on women's safety when analysed and were, moreover, articulated in more vague ways.

The potential importance of the adultery as risk theme in local thought cannot be underestimated because of its significance for how decisions are made around pregnancy and birth. The difficulties women might encounter were not generally specified other than citing delayed labour and obstruction.<sup>5</sup> Although such views were strongly and frequently expressed the most effective solution remained biomedical, that is caesarean section. Prior to referring women however, many *azamba*, such as Grace and probably Regina, might endeavour to forestall or relieve the problem with the other solutions seen in table 7.2:

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<sup>5</sup> These are among the commonest causes of morbidity and death for women and babies living in poverty; especially when childhood malnutrition has caused pelvic deformities.

protective medicine and the herbal uterine stimulant. Thus the potential for delayed referral, or for choices of carer to be made because of access to medicines, remains despite the importance given to surgical delivery, as is shown in Majami's story (case study 5, chapter 5 and Appendix 3).

The remedy selected must, I argue, provide some indication of how a problem is perceived. The herbal oxytocic was expected to prevent and treat, the protective medicines worked not just against the consequence of adultery but also to prevent and treat the effects of witchcraft, since bewitching or being 'tied' could also constitute a prolonging factor in labour (see below). So effectively there are:

- three causes of delay or obstruction: adultery, bewitching and tying, and physical abnormality;
- one potential serious outcome: delay and a 'stuck' baby, possibly both mother and baby being injured or dying;
- four available remedies: protective and curative medicine, uterine stimulants, caesarean section, and the confession of extramarital sexual partners' names (see below).

There is a clear understanding that a slow labour may occur because the baby is too large or is badly positioned, the pelvis too small or the labour contractions too weak. The supernatural attribution perhaps indicates the need for explanations as with the Malawian question about why one man was bitten by a typhus-bearing tick when his brother was not (Wilson 1982, Van Breugel 2001). This of course directly parallels Evans-Pritchard's examples from the Azande (1976, see chapter 2).

The complex aetiology of problems and multi-faceted solutions can themselves be seen then as risk-factors. Not only might local medicines be used but emergency obstetric care might not be sought until the names of (male or female) sexual partners have been declared, a continuing practice in other areas of southern Malawi. Most specifically in patrilineal areas, relatives of husbands may insist on home birth so that they can witness the normality or otherwise of the labour that signifies that the woman has

remained faithful (so indicating that the fetus is of the male lineage).<sup>6</sup> If delay is noted, the woman may be forced to swallow castor beans, one for each illicit sexual partner.<sup>7</sup> Although this ritual and insisting on confessions to 'release'<sup>8</sup> the labour may lead to potentially dangerous delays from the biomedical viewpoint, local people (confirmed by Mai Sichali) reported this practice to be less common in this environment than elsewhere in Malawi.<sup>9</sup>

These aspects of risk relate to a substantial degree to the 'other' – the other woman, the other man – and what such misplaced sex might do. They are mainly external risks (as are banditry and night witches) that, significantly, appear to loom larger in people's risk scenarios than internal ones described in chapter 7.

Such risk talk emerged often and unexpectedly but did not appear to include postnatal dangers other than those connected with sex and the *mdulo* complex (see chapter 7). Whereas many people, including Malawians (Morris 2000), might show concern over other aspects of women's vulnerability to physical risks from everyday activities (and pollution risks to others) and put women into seclusion until the umbilical cord falls off, this appears no longer to be the case in this group of communities. I had seen women carrying water from the well after three days, and had interviewed many sitting in their compounds surrounded by kin. Eventually I asked Grace what activities a newly delivered woman could do (04 06 99) and she talked of household tasks that were safe for her to carry out. She could draw and carry water, chop wood, pound maize, work in the fields, and carry head loads from about five days after the birth especially as she,

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<sup>6</sup> Douglas (1966:132) shows how pollution roles serve to indicate transgression of moral boundaries by outcome. Marwick (1965) remarks that blame for a difficult labour is attributed to the male and that only if confession yields no result is infidelity attributed to the woman, the Chewa believing the baby will be born when the 'real' progenitor is named.

<sup>7</sup> The choice of castor beans is curious, castor oil being an old British remedy for initiating labour. The beans however contain highly toxic ricin so may be less innocuous than the oil; taking them in quantity may account for some of the toxic effect of herbal remedies reported by professional health carers.

<sup>8</sup> Van Breugel (2001) provides explanations for mechanisms of harm that match my own biomedically predicated speculation regarding the psychosomatic effect of guilt – that it may affect hormone balance and so weaken contractions. The Chewa believe that fear will make a guilty woman tense and lead to a difficult birth, while confession and medicines help her to relax. So local and biomedical logics here coincide.

<sup>9</sup> To comment from a Foucauldian perspective, the choices reflected in this desire to observe a daughter-in-law's labour are between two notions of risk – infidelity and doubtful paternity (so the well-being of the lineage), and the physical safety of the woman and her baby. Likewise there are contested domains of power, in-laws or health service personnel, and the choice for women between two types of surveillance of their bodies.

Grace, had protective medicine for backache and iron medicine to make the woman strong.

A clear picture emerged of women, their husbands and kin living within tightly prescribed and proscribed behavioural boundaries to reduce the risk to childbearing woman, and more generally to maintain marital and community solidarity. Pollution is a key feature, sperm and blood in the wrong place, the transmission of danger via body fluids, death and new life being incompatible. The community clearly desires a couple to 'grow a good baby' for the continuation of the lineage but one that is not damaged by 'excess' nor by uncontained heat transmitted by extramarital intercourse. However Mai Sichali commented that women were no longer as tightly hedged around by taboo as they once were; then 'they could not move' she said. This suggests that, like the Zulu women studied by Ngubane (1977), women held the main responsibility for constraining the polluting power of their own reproduction. An opinion matching that of Winnie Sichali came from another (unnamed) key informant who explained that taboos hold much less power now and, to an extent some are maintained just to keep older women happy. Such is the power of compliance. Maybe then, if this community is typical of others, people's ways are changing. Although herbal remedies are seen as 'worth trying', no longer here is the fear of the effect of adultery on a pregnant and labouring woman, and the need for confession by the woman or her husband, as likely to lead to delays in seeking help as once was the case, and appears still to hold sway in some other places.

### *Mfiti: pregnancy and bewitching*

I began to gain an impression of the perceived personalistic influences over the lives of my informants early in my fieldwork because of the conversation with my interpreter (chapter 7) about his mother's friend which raised the topics of ancestors, vicarious revenge, and witches taking animal forms.<sup>10</sup> Fieldwork data gradually began to indicate more ways in which malevolence is explained, but without the dimension of ancestors. Despite the early explanations provided by Francis I saw no evidence at any time of concern with ancestral anger at pregnant women and such lack of emphasis was confirmed by others (Kamuntolo, Sichali, personal communications, 2003).

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<sup>10</sup> Morris (2000) explains that medicine is needed to produce such a transformation.



Gradually I built up a perceptual model of local concern for what witches could do to pregnant women and of the potential for accusation but this remained sparse and difficult to comprehend without the support of literature and talking to people such as Priscilla Matinga. In retrospect I realise that my informants were often vague, maybe unwilling to speak out or unable to articulate their thinking. No doubt the truth lies somewhere in the middle, and that what people said (and what I was permitted to see) was influenced by what they knew of my own background and of course by their own religious affiliations.

Sister Fleur's statement 'We see physical explanations, they see bewitching' (chapter 7) may have fallen short of acknowledging the dual nature of local beliefs about aetiology of illness and pregnancy problems. It did however provide insight into what I was observing and how supernatural explanations for the 'why' and 'how' questions exist alongside a biologically congruent understanding of physical problems and remedies.

Fear of being bewitched is very real within the community and is clearly linked to human agency and to jealousy. It provides an 'idiom of misfortune' (Evans-Pritchard 1976) and appears to be part of everyday discourse. Women feel very vulnerable in pregnancy. Grace has no children, all having been stillborn; a hospital midwife eventually advised her to stop trying. This was her explanation for her babies' deaths which was embedded in a narrative of two marriages that failed because of infertility caused by the evil influence of her first mother-in-law:

I was bewitched. I had my first boyfriend [and] we agreed to marry but we were discouraged by the parents [because] we were related. At that time I was already pregnant. When labour started my mother sent my husband's mother to fetch traditional medicine. It was believed that the problem was due to this medicine. ... The first child was the first to be killed by the medicine ... I got married again and the other babies died as well ... in labour ... the child died inside and I was told it was due to witchcraft (04 06 99).

I learned how important concealment of labour from potentially jealous others is considered to be through the birth house building project. I became frustrated by increasing demands for special features and refused to pay for an extra back door which would have enabled labouring women to avoid being seen when going to the pit latrine. It was only when Regina and Grace forfeited a window to fund the extra door that I understood its importance and relationship to the fear of being bewitched.

This need for maintaining secrecy around labour to avoid the risk of bewitching arose several times and was confirmed by Midwife B (2003) who described seeing women walk unaccompanied to hospital. According to the Deputy Headwoman of Malinga, some women hide rather than inform anyone of their labours preferring to give birth quietly and alone, or pack some clothes and leave on foot for the *azamba* or hospital. Speaking for some of the time as though she were a labouring woman Mai Malinga said:

[Other people decide] they are going to bewitch you [so that you will] have problems giving birth; so you don't tell everyone [that you are in labour. You will then] have a quick birth ... [In other cases] people will use 'medicine' to cause problems. The baby can end up with an operation and it can even lead to death – this is why they [women] keep it a secret. ... They [who do this] are bad people, with a bad heart. Sometimes a woman is going to have twins and they ... die. Sometimes there is jealousy because things are nice ... some are not happy if you are successful and they punish you in childbirth so that you will die (15 07 00).

Such reluctance to seek help has clear potential consequences for women's safety when problems arise, and the supervisor confirmed that delays may occur in getting to the hospital through this desire for secrecy. A group of young Malinga women also raised the importance of concealment, although here emphasising risk to the infant rather than themselves, saying

When in labour you try to hide. They [others] should just know when the baby is born. Sometimes people can bewitch the baby. The baby can be born dead when many talk (15 07 00).

Bewitching was frequently quoted as underlying the desire for secrecy regarding pregnancy and labour. It may have been the reason for Dalita's delay in declaring the commencement of her labour (case study 1, chapter 5). It may also be a factor in the common late acceptance of antenatal care seen as a problem in Malawi.<sup>11</sup> Bicycle ambulances as described by Lungu et al. (2001) were infrequently used in their pilot study because of the visibility they enforced and the fear of subsequent witchcraft. Women in the study villages protested similarly that using the bicycle ambulance broadcast their

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<sup>11</sup> Attendance in fairly early pregnancy is considered desirable because of the contemporary emphasis on improving women's general health status, dealing with anaemia, and giving tetanus and malaria prophylaxis. The average first visit is at six months although almost all women attend eventually (NSO 2001).

labouring state to all and sundry and a jealous person might 'tie' them. If they walked, people would merely assume they were going to their gardens.<sup>12</sup>

Peoples' views about the risk of movement at night were difficult to reconcile with each other and presented a confused picture. A classic and self-contradictory story was presented by Midwife B (2003):

Women do come at night; they come with the husband or relatives. I remember someone coming in at 5a.m. ... she was fully dilated with the head just delivering. I asked why the delay [and was told] it was during the night and everyone was refusing to walk.

Midwife B went on to attribute the fear of night walking to the darkness and robbery, not to witches. Midwife C (2003) believed that a greater willingness to walk at night, at least in groups, became noticeable once the recent incidents of ritual murder had ceased.<sup>13</sup> When enquiring cautiously how, apart from using 'medicine', people might bewitch a pregnant woman I was simply informed 'they tie people' or 'they tie something on them'. Such tying relates closely to similar ideas about binding and obstruction encountered in other parts of the world where pregnant women must, for example, unbraid their hair or untie knots in clothing during labour, open padlocks, avoid sitting in doorways, at crossroads, or crossing the legs. Husbands likewise may be required to remove neckties and belts when the woman is labouring (Laderman 1983, Jeffery et al. 1989, Ashwood-Smith, personal communication and 1996, Bates and Turner 2003).

This theme of 'tying' arose several times. Kalanje women asserted that magic could be used to tie a woman so that she could not give birth, and that this was very dangerous; a woman could die (11 07 00). Regina claimed to be able to deal with such pregnancies using 'medicine' in such a way that tying need not be a problem (16 06 99). She suggested that heavy postnatal bleeding also could be caused by bewitching and lead to death. Matinga likewise mentioned bleeding being attributed to witchcraft with

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<sup>12</sup> A bicycle is supplied having a stretcher which fixes on as a trailer. The bicycle ambulance programme continues despite some negative views. These villages had no bicycle ambulances during my fieldwork but on my recent return I found two had been supplied and put into the custody of the *azamba*.

<sup>13</sup> I note that my main fieldwork visits took place around that time so the killings undoubtedly influenced the views of those interviewed. Nevertheless they appeared to have a more substantial impact than might be expected for events that were acknowledged to be very unusual, almost as though they typified universal fears despite their rarity.

'something being tied' and, in her examples, not recognised as a biophysical problem (20 07 00). 'Medicine' was needed that could be obtained from specialist practitioners and sellers both for causing harm and for relieving its effects.

Matinga described two body maps that women had drawn as part of the Safe Motherhood project research on which the presence of 'medicine' inside the uterus was indicated. Because of this belief, Matinga said, delays often occur in referring a bleeding woman to hospital while traditional healers are consulted. Local medicine as part of witchcraft needed local remedies. If such healers fail the woman may be taken to hospital where the doctor's powerful medicine is seen as being able to overcome witchcraft. This might inevitably lead to delays in seeking emergency obstetric support but I gleaned no evidence of recent local problems with regard to bleeding. Matinga went on to talk of 'cutting the womb', caesarean section, being seen as the only option because of being 'tied so much with witchcraft'. The prevailing ideas in the wider region then matched closely the information Regina had provided that is illustrated in fig. 7.5. I asked Regina whether women could influence or change what happens to them in labour and what might cause suspicion of witchcraft:

Regina: When the woman is in labour ... it is done naturally, they do not give any medicine. Birth is a natural thing. But when they know the girl has problems from the witch doctors, then they give her medicine to help her. The witch can tie something on her [so] there are problems of giving birth. TBAs know what to do; they give the patient medicine to drink.

G: How do they know that witchcraft has happened?

Regina: She can be in labour, but no contractions, and no liquids coming out. ... They know that the lady is all right when the waters have broken.

G: Why might someone do witchcraft, is it because they do not like the person?

Regina: Witchcraft is done because they think there is a disagreement in the village. If someone is bewitched there can be problems. The witch can tie a pregnant woman, so that the baby will not come out (06 07 00).

Although Regina had talked again of tying here it remains unclear just what that means. She did, however, provide evidence of conflict within the community being thought to be behind bewitching.

Stella was more sceptical as usual. Before my final departure I talked to her at length to clear up outstanding questions and attempt to sort out some of my confusion. I asked her if people were still frightened of being tied with witchcraft. She acknowledged

that people used to think this way but she herself does not think like that now. If something is wrong or clinic staff members warn a woman, she should go to hospital. She believes prolonged pregnancy to be the result of mistaken 'dates' rather than tying.<sup>14</sup> This did not really clarify what Stella believed others thought however; rather it indicated her personal conclusions.

Although Stella's exclusive emphasis on biomedical causes of problems is fairly unusual, many respondents demonstrated some understanding of biomedical ideas and risk, even if thoroughly mixed with older local thinking. A selection of this evidence will be considered now in relation to the effect on making decisions.

### **'Is she alright or is she going to die?' Biomedicine and risk in community language**

Just as people demonstrated mixed notions of biomedical principles they also demonstrated complex ideas of biomedically formulated childbearing 'risk', and moreover, ambivalence toward forms of care and choice of carer.

Women noted that they did not know what might happen during labour, and this could be reason enough to choose hospital birth. I asked the Sambani women's group whether women feared birth. They replied 'Everyone becomes worried about the pregnant woman, is she alright or is she going to die? Everyone is pleased when the baby is born ... It can be dangerous giving birth' (03 07 00). Death is however seen as rare now because the hospital can act whereas many women used to die when the hospital was not much used (Malinga women 05 07 00). They also strongly attributed the increased safety to their *azamba*.

Husbands evidently worry about their wives as shown above. One of the male groups confided to me how much they would like to be more involved in the pregnancy and keeping their wives safe. They often felt pushed aside and ignored.

A significant conversation took place with the wife of the *mwinimbumba* to Dannis and her mother, Mai Bamuli (case study 4, chapter 1 and 5). Mai Bamuli's advice had probably led to delays in seeking medical treatment for Dannis's postnatal infection. I

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<sup>14</sup> This comment incidentally indicated that tying could signify prolonged pregnancy, not just cause prolonged labour as I had initially assumed.

was therefore anxious to interview her regarding her involvement in the events but feared causing offence. Much later I seized an opportunity to talk to her, embedding potentially sensitive questions in a life history format, thus avoiding direct enquiry about the 'near-miss' incident. We talked about her children who were born in the 1940s and 50s:

G: Were the births at home?

Mai Bamuli: I didn't have them in hospital. I was scared, I had them at home. Only the boy was born in Zimbabwe, in hospital. [Yet] here at home I was afraid ... I used to sit down and cry... It was nice to have a child in hospital. The nurses looked after me.

G: People are frightened of hospitals – what of?

Mai Bamuli: People are scared of Malawian hospitals, [in those days] we didn't know much about hospitals and there were many misunderstandings, nasty stories made people frightened.

G: Is the hospital a good place to have babies, or is home better?

Mai Bamuli: It is good to have children in hospital, if it is complicated then it is easier – doctors can solve things. TBAs are all right but not if there are problems (05 07 00).

So Mai Bamuli demonstrated having been scared of birth herself but also of the prospect of hospital birth until she had experienced it. Despite having given birth mainly at home, she nevertheless indicated that complications could not be dealt with adequately there, causing her to recommend hospital birth. This was not what I had anticipated in view of the advice given to Dannis and her mother.

A wide range of views and ideas about specific risks became apparent. Bleeding and problems with the placenta were mentioned several times and are evidently feared as something for which there is no real remedy in the community. This finding is confirmed by the evidence from hospital midwives discussed in chapter 6 and matches the findings of the Safe Motherhood Project (1999). Also listed as problems to be feared were breech birth, large babies and the need for caesarean section, delay in labour, and even stress damaging the baby,<sup>15</sup> and crying (by the woman) damaging the uterus. Hospital birth is considered to be good for preventing and treating bleeding as it can be stopped there and blood transfusion be given.<sup>16</sup>

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<sup>15</sup> Allen received this same explanation for the discouragement of crying by the labouring woman in Tanzania, where crying was believed to hamper pushing and so harm the child (2002).

<sup>16</sup> The DFID funded Safe Motherhood Project carried out comprehensive assessments of community knowledge of biomedical risk factors within the region following a radio information campaign (Safe Motherhood Project 1999).

The topic of blood transfusion and risk arose frequently, most often as a positive aspect of the care hospital staff can provide. This was the most usual way in which transfusion was represented. I enquired further into the ways this group of Mithawa woman viewed the procedure. The reply given was:

If the woman needs blood, they call relatives to donate [it] and check [that] the relative has no diseases. They give blood from the bank immediately then wait for your relative to replace the blood they give you (12 07 00).<sup>17</sup>

Two young women in Malinga mentioned the risk of contracting HIV from infected blood as a risk of hospital care, at the same time indicating the importance of having access to transfusion. They replied to my question about it in this way:

R1: Blood transfusion is good, otherwise you will die. That is, if the blood is alright.

G: What do you mean, if the blood is alright?

R1: Sometimes it is infected.

G: Do they not test for HIV?

R2: Yes they test.

R1: Some say it isn't good to have a transfusion ... because some can give you AIDS (15 07 00).

Although most informants gave no indication of the risk of becoming infected with HIV from transfusion making them wary of attending the hospital, it might nevertheless be a significant factor in their choice of place to give birth.

Women conveyed other mixed messages about hospital birth expressing fear of injections and pain, but suggesting that these injections are good for speeding birth (Mithawa 12 07 00). The 'pain' mentioned appears to be that of accelerated labour, achieved biomedically with intravenous oxytocin infusions.<sup>18</sup>

Episiotomy emerged as a key concern amongst women and difference between professional and lay care with both positive and negative remarks being made about it.

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<sup>17</sup> The mission hospital screens all donated blood for HIV. Although most informants know this, the fear of HIV transmission remains. Sometimes the blood supply runs out and the person in need has to wait for the arrival of members of the kin group to supply blood directly to her, provided the group matches and this person tests as HIV negative.

<sup>18</sup> This is the pharmaceutical equivalent of the *mwanamphepo* herbal oxytocin uterine stimulant. It could more controversially be attempted by single injections although no evidence of this arose.

These same Mithawa and Malinga women spoke favourably of 'widening the way' and helping the baby out, the former group saying:

The TBA has no instruments and training for [episiotomy]. At the TBA when the baby is big, you just keep pushing and the baby tears the vagina – they treat you with salt but it doesn't help and you have pain all the time – but at the hospital you have quick healing and they take out the stitches (Mithawa women 12 07 00).

The overall impression gained was that women viewed such surgical intervention sufficiently positively for it not to prevent them seeking hospital care. My attempts to find out what women thought about having their bodies cut brought confusion rather than information. Resisting the temptation to tell them what I thought of it on a technical level and with the benefit of contemporary research, I merely made a comment about negative personal experience which caused gales of laughter.

As already mentioned women were generally much more critical of the attitudes encountered in the hospital than of the facilities and technical skills (as again is noted in Safe Motherhood Project documents).<sup>19</sup> The local *azamba* are seen as always kind, supportive and accommodating, providing all that women need for their comfort, but hospital staff do not meet the same standards, even in the well-respected mission hospital. A simple question from me about the kindness of nurses and midwives brought a vehement response:

Some are shouting at you. Some are standing [by] and don't care ... sometimes they do their own knitting when the patient is crying, they say, 'did I get you pregnant?' ... they are snobbish ... they say they don't want to hear your voice ... if it is at night it is worse ... they have a sarcastic attitude, and they do not respect patients (Mithawa women 12 07 00).

One woman continued to describe how her daughter-in-law was left unattended for three days and gave birth alone. Others commented on the tiredness of midwives so alluding to

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<sup>19</sup> Poor staff attitude was noted in the situational analysis on compliance carried out in Mwanza District Hospital and was specified there as a major reason for 'high-risk' women refusing to use the hospital. Women with limited education perceived themselves to be treated worse than others who were better educated, with adolescents and primigravid women in particular being targeted (Safe Motherhood Project 1999). Other reports from the same project (Simpson 1998) similarly emphasise this and highlight staff dissatisfaction with the care they provided. This theme runs through maternal health literature worldwide.



their morale and the demands made on them.<sup>20</sup> Some made more positive comments, describing midwives putting pillows 'at women's backs' to relieve pain, and knowing just when to return to see them and when they would give birth, then helping them to 'push well'. Generally they see risks, at least some adverse aspects, in hospital birth but these are more of neglect and negative attitudes rather than of specified adverse physical outcomes.

Although negative staff attitudes do not constitute direct physical danger to women, I argue that they and poor quality care are indeed risk factors for two reasons. Not only does fear of encountering poor attitudes and inadequate care discourage women from seeking professional help when they need it, it is generally accepted that substandard treatment and delays in providing essential emergency care (the third delay in the Thaddeus and Maine (1994) model) are responsible for most maternal deaths.

Two final pieces of evidence about local perceptions of specific dangers come from talking to Headman Kalanje and Deputy Head Malinga. Mai Malinga shared with me her concerns about transport difficulties people experience if a woman needs referral for a childbearing emergency. She reported:

Transport is very difficult; sometimes a person can die before reaching the hospital if there is no car. They make a stretcher-bed to do that work, but it takes a long time with nails and wood (15 07 00).

Mai Malinga showed great respect for Stella, specifying her understanding and use of 'modern' practices instead of old ones, such as giving birth against a pestle and rolling the abdomen with it to speed the birth, such practices mostly now being past history. Nevertheless she expressed the concern that Stella can provide only so much help and also that the village people need more education, some dying of ignorance.

Headman Kalanje expressed another view of risk – concern for lack of family planning and women whose husbands would not countenance the control of family size.

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<sup>20</sup> This fieldwork took place at a time when proposed national salary rises were delayed, and when payments were made irregularly, at least within state institutions. Health service morale was low nationally and, even in CHAM hospitals, difficulties would have been experienced as staff salaries were covered by central government funds. I note that another proposed pay rise, planned to counteract serious loss of staff through migration, has recently been cancelled on the recommendation of donors (Boseley 2004).

He showed concern also about the cost of hospital birth to households living in poverty (see chapter 1), praising the good service and flexibility of the *azamba* who are prepared to accept deferred payment or payment in kind. I remembered at this point having learned from women and the hospital administration that women could not leave the hospital until they had paid the bill, often leading to extra nights to be paid for while kin sought to raise enough money.<sup>21</sup> Almost all women use either hospital or *azamba*, he explained, and older untrained women no longer undertake deliveries, understanding both the danger of this and the fact that the *azamba*, unlike themselves, have received some training (19 07 00).

So from this evidence comes a clear message of the perceptions of biomedical risks prevalent in the community. Most showed respect for the abilities and attitudes of the *azamba* but are very aware of their limitations. Demonstrating their considerable respect for the local hospital (despite the concerns about attitudes expressed above) women often reported to me the life-saving role that it plays. One group had this to say:

It is good at the hospital, the doctor knows quickly if the baby has diseases and can treat them right away ... sometimes a baby can be born with eyes closed<sup>22</sup> but a doctor can give quick treatment ... they can increase water in the body if you have lost it, and blood can be given ... if the baby is big, the midwife has metals<sup>23</sup> to put inside ... with the TBA you would have died (Mithawa women 12 07 00).

Alongside the fears there is a strong thread running through the data of birth as normal and of women choosing to use the *azamba* when they anticipate normal birth, in addition to appreciating their caring attitudes.

Women evidently view choosing hospital care as a risk reduction strategy. They do however see limits to what the hospital staff can do, some women believing traditional healers' medicines to be more effective for some problems such as internal trauma, even for infection. Safety also comes at a price; as indicated earlier, that of having perhaps to

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<sup>21</sup> This is generally considered to be a better situation however than some facilities where prepayment is demanded.

<sup>22</sup> This phrase 'with eyes closed' probably indicates a newborn in poor physical condition and in need of resuscitation.

<sup>23</sup> Obstetric forceps, used to assist the delivery of a baby at a difficult birth.

run the gauntlet of rude and uncaring staff members, especially younger ones, and pay for the privilege.

Throughout the group sessions specifically designed to enquire into ideas about place of birth the women gave fairly clear and biomedically congruent accounts of the physical difficulties that can arise for childbearing women. Neither substantial lack of understanding of what might endanger their safety and that of babies, nor significant attitudes that might prevent women receiving appropriate care, were demonstrated to me particularly by the group of mature younger women in Mithawa. This is, however, different from the findings reported by the Safe Motherhood Project researchers (such as 1999) who, as well as finding a fairly well-developed physiological understanding of body changes in pregnancy and knowledge of hospital interventions, found little awareness of danger signs and how to react appropriately. Bleeding is generally recognised and feared everywhere but responses may be idiosyncratic and inappropriate, these researchers finding, for example, significant faith in the use of Coca Cola for bleeding as did I from a few people (chapter 6).

Fieldwork data produced evidence of ideas about potential harm that accords with much of the ideas from secondary sources explored in chapter 2. I deal further with the manner in which such approaches to risk affect childbearing women and the decisions made next.

### **Pregnant women at the 'crossroads of life and death': Analysing the risk discourse**

It is easy to identify how risk is politicised at local level in Malawi and how individual choices are grounded in the specific environment. Without denying the strength of influence of contemporary biomedicine in this particular community and its ultimate use for 'rescue', local discourse, I suggest, gives substantial attention to 'older ways'. A key difference between this world and my familiar western one is the apparent absence of the coercion towards compliance with powerful professional others that is often evident in UK. The pragmatic world of household concerns and locally constructed risk discourse may well take pre-eminence.

Concerns for poor carer attitudes, and to a lesser degree iatrogenic concerns, form part of women's risk analysis emerging from my data. These women however have more to contend with such as their difficulty of accessing emergency care and the added perceptions previously described, of having to run the gauntlet of witches and thieves at night, the fear of the strange hospital environment and often-unwelcoming midwives. The 'risk' of giving birth at home, or at least within the village environment, with a familiar face must seem not so bad after all. A local herbal remedy, confession of past misdemeanours (on the apparently rare occasions when it is expected) or a visit to the diviner to determine what or who caused a problem may seem an easy way out of a childbearing dilemma.

One can expect to find that marriage is central to a complex system of alliances for production and reproduction and that this would be reflected in the prevailing view of risk and the behaviour people expect of themselves and others. Malawian matrilineal society is clearly less dependent on the long-term maintenance of its marriage relationships; women in this community are less firmly constrained than they might be in patriliney and men as well as women are subject to expectations and taboos around relationships. The patrilineal kin groups in Malawi who desire to supervise the labours of daughters-in-law to check paternity will have bought the rights to their reproductive powers and children by paying *lobola*, customarily in cattle. No such practice appears to exist in the local expression of matriliney;<sup>24</sup> this may be the reason why no assumption of specifically female infidelity is made in these villages. If any judgement is made here, it tends to be of male infringement of moral codes, perhaps of male reproductive powers being 'out of place' when given to other than the wife. These men who are free to go unhindered but with limited rights, and are liable to expulsion for unacceptable behaviour, exist on the boundaries of the community and household. These are the men who are considered to endanger their wives and children by 'going with girls' or 'wandering around' and giving to others, also on the boundaries, what belongs to their wives. Such boundary transgression described by Lupton (1999a and b) produces risk for the woman too – physical risk in childbirth, the taboo representing the societal view of satisfactory relationships and the consequences of transgressing it.

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<sup>24</sup> I found no evidence of men paying for rights over children as did Morris (1998) in some matrilineal communities.

The rhetoric of risk to the woman and child specifically concerns such adultery occurring during pregnancy and the postnatal period, some informants telling me it was less important at other times. From the view of Douglas's model, pollution ideas clarify uncertainty over moral principles, demonstrate their infringement and provide incentives and punishments. Such rules she sees as a form of social control which perhaps serves to punish the guilty when open chastisement is inappropriate. The potentially protective matrilineal context and relative lack of concern with paternity, along with the preference for peaceful relationships, could be just such an environment.

The risk talk recorded in this chapter then is congruent with Douglas, Lupton and also Van Breugel's work on pollution and taboo. Childbearing women, their older matrikin and the *azamba* alike articulate risk as vulnerability of the woman and her child to the effects of out of place or unbalanced 'heat' resulting largely from unrestrained transformative sexual activity, and equally transforming death. This vulnerability extends from pregnancy through to the period of lactation, although focussing in on labour, and is both direct and vicarious.

The views expressed about 'heat' transfer could all be aligned to pollution, the mixing of blood with extramarital sexual intercourse, infection with gonorrhoea and HIV, transmission by touch and cooking as well as sexual activity, salt and blood as mediums. Touch-related transmission could be interrupted by the barrier of protective gloves worn by health care professionals and *azamba* alike (see chapter 7). No-one mentioned the obvious – condom use to prevent such risk. As Krinsky states (1992) such risks could have been selected for attention because they maintain (or, I would add, articulate) the way of life.

Local expectations are clearly expressed in taboos and transgressions. I return to the women of Kalanje (16 06 00) whose narrative expresses the continuance of old dangers alongside new solutions. They said 'In the past, if a man does [adultery], women were dying during birth, but now they can do [an] operation ... [formerly] the way for the baby was not opening'. Their language of risk expressed congruence between local cosmology and new biomedical opportunities. They articulated cause, effect and solution, unselfconsciously using a mixture of paradigms along the way.

Explanations for the unexpected in terms of spirit attack or malevolent bewitching by envious others can provide not only the reason why but also the 'who', so

providing scapegoats too. This has two effects that may make substantial difference to women's safety in an emergency, reluctance to declare pregnancy or the commencement of labour, and to walk at night. Malevolence from insiders is explained as jealousy such as for successfully achieving pregnancy or motherhood, blame being attributed to someone who wishes to 'eat' the baby or 'tie' the woman so she is unable to give birth or expel the placenta. These can perhaps be explained too, like other instances of witchcraft, as reversals of the norm (Mayer 1982).

There is a clear and substantial congruence between the ideas of witchcraft and pollution that the informants describe, and the literature of other scholars. This material highlights the role of these devices as strategies for expressing and symbolising expectations, managing harmonious communities and maintaining the matrilineal group intact. Taking note of informants' views, pollution ideas and the fear of witchcraft possibly do help to ensure compliance with the norms of the group.

How then does the local rhetoric of risk and danger translate into action and the decisions made?

### **Decision-making and the language of risk**

If some people have power by virtue of their status and knowledge within the community, then to some extent the language of risk that matters is that of these people, at least for younger women. This is born out in the case studies presented in chapters 1 and 5 which illustrate a range of notions of risk and responses by (often older) decision-makers. A changing balance of ways of articulating risk could be detected however in the words of both young and old, a mixture of biomedically described risk, malevolence and infringement of moral codes. Despite some references to normality, biomedically oriented risk language clearly appears in the evidence as uncertainty about what might happen to a woman and her child, made most visible by the phrase 'women at the crossroads of life and death'.

Despite the language of risk and fear, this does not constitute a total pre-occupation for pregnant women and those responsible for them. Certainly they are not ruled by the logic of safety that proposes institutional care at all costs and, least of all by interventionist approaches such as those prevailing in many areas of the world for caesarean section (see for example Donner 2004 for Calcutta). The reasons for this are not

difficult to work out. One is immediate – that most women experience problem-free childbearing. Secondly, life for women is still situated in the (usually natal) community; the protective cocoon is the kin or marriage group, the self is subordinate or at least acts with reference to that group. The frame of reference is local rather than global; many rarely or never visit the nearest town only 17 km. distant. The other is more profound: though hardly a context of modernity and globalisation, Malawi cannot escape the consequences of it. The population's main concern is with the security of food supplies, inflation and worsening poverty, the behaviour of the young, and AIDS-related illnesses. Local people cannot escape change as they gather less cash from selling surplus crops, pay more for fertiliser and seed, worry about the rains failing, and pay more for drugs and hospital care. They see health services deteriorate and school class sizes soar as health workers and teachers become AIDS patients – and the problems are attributed to 'democracy'. Against these, maternal health rather fades into the background.

Other generalising principles can be seen at work in the data. Bodily risk, iatrogenic risk, loss of individual control, and the exclusion of factors like emotional satisfaction are part of the whole spectrum of risk in childbirth (Lane 1995). Lane suggests that risk language, the language of obstetricians, has colonised childbirth. Biomedical discourse is significant in Malawi and women suffer from it in similar ways to women in the 'modern' world – loss of control, some unnecessary interventions, and neglect of non-physical needs. Such difficulties may of course be apparent in indigenous care systems too. As ever these women may be disadvantaged; they are subject to change, such as universal hospitalisation and intervention, just as that change may be rejected elsewhere. Medical hegemony in the UK has been challenged by government and consumers, and pre-occupation with the body challenged by women. Malawian service providers could be said to be too busy trying to keep women alive with severely limited resources to worry about such things, a claim that has a worrying legitimacy as its effects can serve to keep women away from professional care.

In the end, women and those who influence what happens to them take all these factors into account and make their own risk judgements that may not match establishment ones. As well as relating to quality, they may encompass the moral order and ill-will already discussed as much as the biomedical. Some of the most significant physical risks for women are attributed with apparently equal strength in this way.

## **Conclusion**

I have argued in this chapter that there are three specific areas of risk that are expressed by women, their kin and community members such as *azamba* and officials that are likely to affect the decisions they make. These are biomedical ideas of risk and danger, bewitching through envy and jealousy, and problems with the pregnancy and birth that are related to pollution concepts, societal taboos and moral expectations. The way in which the discourse of risk articulates with other themes considered to determine what happens to childbearing women is considered in the final chapter.



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## Chapter 9: Conclusion

### Introduction

This thesis emerged from an early questioning of how older women had become so ignored by health care providers like me when they evidently had so much influence, even in the so-called nuclear family of the UK as well as in Africa. This developed into an interest in women's agency and the influences over the choices they themselves make, and those made for them around pregnancy and birth. From working with mainly British families as a community-based midwife in UK, and having worked in Senegal many years previously I had begun to take note of the context-free nature of much of the evidence used to make policy around childbearing. I thus became interested in how the theory and practice of anthropology could be used to show up the less visible elements in women's lives. I hoped that such findings could sensitise others to those things that matter to women, and provide a deeper view of issues that need to be taken into account beyond the focus on risk and the 'otherness' of the global agenda of saving lives. I knew that there must be more beyond the assumptions that women do not make use of maternal health services because of poor understanding, because of 'cultural practices', and because husbands and mothers-in-law controlled what women do. Moreover I became wary of the exclusivity of biomedical construction of 'other' systems of practice as incongruent with safe childbearing.

Through my fieldwork experience in southern Malawi and the writing of this thesis I have constructed a view of decision-making around childbearing that puts women, particularly older women already experienced in birth matters, in prime place. This assertion is relevant specifically to the community studied which displays an enduring and conscious emphasis on matriliney and matrilocality. Men, when present, as heads of household or supporters of their female matrikin, tend to maintain a secondary role as facilitators in childbirth.

Childbearing women are situated within a variety of contexts of power and knowledge specific to the dynamics of matriliney and matrilocality, including those local expressions of health, well-being and harmony, and the biomedical imperative to save

lives and its attendant risk discourse. They are also caught up in the pragmatic realities of fulfilling their expected female roles in this subsistence agricultural society. Some women make their own choices about birth place and attendant; others have these made for them, usually by older female matrikin. Such decisions are, however, made in a relatively benevolent manner although younger and inexperienced women are usually kept in ignorance of the information needed to decide for themselves. These influential older matrikin operate within pluralistic ways of viewing childbearing, influenced by both indigenous concepts of health, and expressions of values such as morality and balance, and also by biomedical ways of approaching and dealing with childbearing. In this context concepts of risk and safety, assumed by biomedicine to be undisputed, incorporate indigenous ideas such as fear of personalistic malevolence expressed as bewitching, as well as assumptions founded in biology and biomedicine.

## **Matrilineal decision-making analysed: a summary of the thesis**

### **Setting the context: chapters 1 - 3**

The setting for the research was described in chapter 1 and the local and the global environments discussed. These contexts provide a major focus for effort to improve women's physical health during childbearing. I reviewed current emphases in global policy and related biomedical and social science literature, bringing out how risk emerges as a constant theme with an underlying assumption of the primacy of biomedicine and its outcome, professionally provided and controlled maternal health care. Other issues that arose were the contemporary rights-based emphasis on skilled attendance at birth and the effect on indigenous systems.

I then continued to examine the anthropology literature in chapter 2, focussing on specific issues such as the way in which birth provides an entry-point to understanding culture and values, and relationships of power and agency. I also identified a newer strand in the anthropology of birth which focuses on modernity and development, agency and adaptation to global imperatives. Issues within the literature of knowledge and gendered power were explored and consideration given to the development of knowledge and

legitimacy. Notions of risk and danger were examined particularly as ways of explaining the values of a society and of attributing blame for adversity.

My desire to unravel some of the less well-understood areas of the childbearing experience of women is grounded in an awareness of the limitations of the medical paradigm that has dominated my professional life. Given that such a background had the potential to blind me to what I might see, I therefore focussed in some detail in chapter 3 on the ways in which I approached and carried out fieldwork. I was very aware of the dilemmas I might encounter as someone with more technical and biomedical knowledge than most anthropologists would have, and one bound by the ethical imperatives of the health care professional as well as those of the anthropological researcher. I knew that this background might affect my relationships in the field and make it difficult for me to be alert to what women and those around them could tell me. Consequently I explored these issues at some length to ground the work in credible methodology and practice of research that could also overcome the time constraints that I was experiencing. I made no attempt to conceal or discount my background, rather I used it knowingly in the way I conducted myself and my enquiries, and analysed my data. People cooperated beyond my wildest dreams, and welcomed my interpreter and me each time I returned to the community from periods working back in UK.

#### **Relationships and decision-making dynamics: chapters 4 - 5**

Through the data I collected I have constructed a view of decision-making around childbirth that, at its most elemental, demonstrates how power resides most significantly with women, particularly with older women who act utilising layered concepts that embrace both indigenous and biomedical ways. Their power derives from their control over their own knowledge and from the distinct relationships that prevail within this strongly matrilineal and matrilocal setting. The practice of matriliney and matrilocal residence in this community makes, I argue, for a relatively supportive environment for pregnant women through whom the substance of relatedness passes. They are both needed and irreplaceable. Kin groups use a variety of strategies to ensure women's welfare, including scrutiny of husbands' behaviour and by the appointment of the *mwinimbumba* to act for the welfare of women in the sororate. Such oversight continues in principle both during betrothal, when the couple may be resident with his kin, and when eventually resident as a married couple with her matrikin. It continues despite the acceptance of men

as heads of households. Even the couple living away for work purposes are, at least in theory, observed in this way. Support from matrikin may extend to help with funds if emergency care is needed for a labouring woman, and even husbands' kin may step in with financial support. Women who bear children when single normally remain with their kin provided they are not in dispute with them. Their behaviour toward their kin is the determining factor and those perceived as having 'bad attitudes' may ultimately be abandoned by their matrikin whether married or not.

Women here have some control over their resources because of their control of land and their customary right to reject abusive or adulterous males. Female headed households may experience hardship but have some protection when living with kin. This picture may of course change in households and communities that are disrupted by AIDS deaths.

A key element of health professional rhetoric concerning Africa relates to delays encountered in seeking care because kin wish to supervise women's labours to detect potential female infidelity, and to seek confession when labour is prolonged. This is not a common problem in this matrilineal community, probably because female infidelity does not affect the matrilineage.

Notwithstanding these findings, young women who have not given birth are most often totally subordinate to older women in the household so may not be free agents. Although these older women are the organisers of birth support they do not constitute a formalised therapy group; the woman's mother's mother often being the key person. The experienced woman however may make her own decisions, with the support of her husband, *mwinimbumba* and older female kin. The situation may be different too for those who achieve more education and have access to paid work.

The power dynamics of this situation are thus embedded in systems of matriliney, matrilocality and apparent female agency. These are perhaps better described as notions of relatedness that are expressed in matrilineal relationships and matrilocal residence patterns. Relatedness is transmitted through the female line; kin groups have an interest in maintaining the wellbeing of their own women and do so through matrilocality. Women are generally stable household members and, while honouring men as heads of household when present, in effect constitute the central supporting pillar of the institution.

**Knowledge and its relationship to power: chapter 6**

As I became involved with the community I began to identify how broadly I needed to look at their reality, including the pluralistic nature of the concepts underpinning actions in pregnancy and birth, and the power involved. Instead of being so many theories, these ideas came to life. I had previously been interested in the concept of authoritative knowledge and the way control is exercised by those who 'have' it. I now observed that this form of authority is shifting and dependent upon circumstance, and that it is by no means the only influence on what women do. This is borne out especially clearly in the case studies in chapter 5.

The knowledge about childbirth that is used to determine action is mainly invested in the older more experienced women of the community, including the *azamba*, like Stella, Regina and Grace who are both government trained and accredited. The older women control how younger women are educated and prepared for birth, a staged process wherein information is customarily given 'just in time'. This process, like puberty and marriage preparation, is breaking down, according to some older respondents who bewail the failure of parents to ensure their daughters are properly 'advised' while today younger women (and some husbands) also complain that they want to know more about birth and that adequate information is currently not available to them.

Health care workers outside of the community have a key role in providing information to enable sensible choices to be made. However the interactions I observed were minimal and didactic when I was present, and confined instructions regarding primigravid women (usually to give birth in hospital) to the women themselves. Influential older kin, waiting outside the examination room, were excluded from such conversations. This constituted a serious loss of opportunity to enlist the support of a group who are in principle largely prepared to support midwives' advice and have the authority to follow it through.

It is clear then that, where childbearing is concerned, power is essentially female and further that it is not invested solely in biomedicine. Legitimacy of knowledge and how it translates into authority and action is closely related to local respect for elders, particularly those in the matrilineage. Such elders may include not only women themselves but also men who have proved themselves by long association with the community. Such legitimacy is also invested in the *azamba* who have years of experience,

were apprenticed to respected predecessors and have received government training and certification. Moreover these women hold birth record books, equipment and specialist buildings for births – all forms of ‘technology’. Even the regular supervisory visits they receive are effectively part of their legitimacy. Most people respect them for their knowledge, skills and caring attitudes while being aware of their limitations. Many women select birth with the *azamba* or just end up there, sometimes for practical or financial reasons, sometimes for fear of witches or night-time bandits, occasionally because the mother or grandmother is absent. However most women could, and some do, find a way of making use of the maternity waiting hostel despite the hardships this often entails. The greater legitimacy of the hospital and its biomedical knowledge is evident especially for emergencies and despite reservations regarding poor attitudes and quality of care.

Knowledge is closely controlled in this community. Customary systems of passing it on are largely breaking down and are currently being inadequately replaced. *Azamba* and professional midwives alike complain that primigravid women know nothing, not even the ‘just-in-time’ knowledge they customarily acquired through initiation and marriage and birth preparation. Yet these older women remain in control in real terms however much they complain about the attitudes of the young. Paradoxically the local secondary school head tries to teach young people who are eager to learn but is opposed by community members. With professional midwives making limited use of opportunities available to them, the resultant situation is one in which young and inexperienced women have limited access to the knowledge they need to make their own decisions and thus remain largely dependent upon their elders for making choices of birth place and carer on their behalf.

### **Concepts of health and well-being, risk and danger: chapters 7 - 8**

Notions of healthy and problematic childbearing are grounded in the local cosmology but heavily influenced by biomedicine. There is no real consistency evident in how these views link to choice of place of birth and carer. Prevailing notions are thus pluralistic, often with cause of difficulties and appropriate remedies selected interchangeably from the potentially dissonant biomedical and indigenous paradigms.

The underlying philosophies of health are undoubtedly related to concepts of morality and well-being. *Moyo*, life-force, is intrinsic to well-being and closely linked to transforming and empowering sexuality. Sexuality is however bounded by moral expectations emerging as notions of taboo and pollution. Sex is transformative, but dangerous when out of place, this danger being expressed as lack of equilibrium between heat and cold. So a narrative of sexual propriety underlies ideas of what is safe for childbearing women and what must be avoided.

In the end, though, such a narrative says nothing about how women are likely to respond to the choices on offer between place of birth and carers. Neat devices explain away potential dilemmas, such as that hospital midwives and doctors may be potentially dangerous to a woman because of recent sexual activity but the wearing of rubber gloves is protective of the vulnerable woman and her infant. Thus it can be argued that people accommodate to potentially dissonant ideas and take an essentially pragmatic and pluralistic view. It may be the case that this is an adaptation to changing views on health and well-being. Certainly some younger women reported to me that their views had changed but they kept this quiet to avoid upsetting the 'old ones'.

Gradually over the months of fieldwork I began to pick up information on the fear that also affects the decisions made. Jealousy within the household, the kin group and wider community is clearly expressed by some as a fear of either being bewitched, or being accused of being a witch. A language of risk and danger is articulated that contains both elements of intentional and personalistic harm, and also that of biomedical risk as expressed by health service personnel and radio health education campaigns. The local idiom then is of risk concepts that encompass biomedically described consequences, moral misdemeanour and a fear of ill will.

Decisions are however often pragmatic. The intention to give birth in hospital may be expressed, women's willingness to do so being indicated by prior hospital birth histories. Yet failure to 'make it' in time is nevertheless common, notwithstanding the practical difficulties this may indicate possible ambivalence. Evidence abounds in the data of a respect for both indigenous and hospital care and an articulation of the strengths and weaknesses of both.

## Synthesising the arguments: decision-making around childbearing

This thesis is about how decisions are made around childbearing, the dynamics of power and conceptual influences on these processes. I make the following propositions:

- Women experienced in childbearing have a substantial degree of agency to make their own choices, in principle having access to resources through the control of land from the matrilineage (although poverty will limit this).
- Younger inexperienced women may have similar access to resources but are expected not to have enough knowledge about birth to make such choices. For them, their mothers, mothers' mothers and older female kin are key decision-makers.
- Some women make decisions with their husbands. Some men decide for their wives, others feel pushed aside. However, the male role is largely one of supporting the women and providing necessary resources, for example for hospital care. As resident husbands their role is that of head of household but they are incomers to the household and may be also to the community. Therefore they are somewhat vulnerable to criticism and sanctions from wives' matrikin. Male matrikin have an important role as *mwinimbumba* in ensuring the welfare of all women of the sorority and their support may be enlisted even when they or the women themselves are living away.
- This environment provides a relatively supportive one for childbearing women. This raises the question about whether this is related to the importance of female reproductive powers to the matrilineage, or conversely the enduring close relationship arising from long-term residence in the natal community.
- Knowledge is controlled to some extent by older matrikin although customary systems for knowledge transmission are reported to be breaking down and are considered to be inadequately replaced. Such replacements may be individuals appointed by kin, or advisers appointed by a church or mosque. Formal education has an increasingly important role although this is often opposed by community members when it includes teaching about sexual activity. It is unlikely to be an



adequate preparation for childbearing. Opportunities for preparation are taken up to a very limited extent by the formal maternity service personnel.

- Technical knowledge and expertise is at the heart of the legitimacy of the *azamba* and equally of the professional maternity service. Respect for both is evident within the community. Although reputedly working from different principles, *azamba* and professional attendants alike may have complex interwoven views.
- Forms of knowledge that govern action and the underpinning cosmologies are utilised in a pluralistic way. Both biomedicine and indigenous concepts of well-being provide the foundation for decisions made, often simultaneously. Local cosmology focuses on equilibrium theory, with hot/cold balance constituting the expression of the importance of sexual activity for health and maintenance of the life force, but contained within morally expressed boundaries.
- Some notions of risk and danger are different from those grounded in biology and biomedicine, although biomedical problems are recognised to some extent. Discordant relationships emerge as influential in the way that fear of bewitching can influence women's willingness to disclose their pregnancies or labours and occasionally lead to delay in seeking help.
- If either form of knowledge is privileged in decision-making I argue it is now biomedicine that is in the ascendant, at least for emergencies, but is decidedly not hegemonic. While biomedical services are seen as the way to rescue a difficult situation they are not necessarily the everyday choice for birth.

These propositions have implications for the way maternity services are provided, thus contributing both to debates around appropriate service provision, and debates in anthropology. Each of these is now considered in turn.

### **Contributions to contemporary international maternal health debates and local and international implications**

The implications around maternal health concern chiefly the lost opportunities for involving older women of the community in supporting young women to make

appropriate choices for pregnancy care and for birth. Professional carers do, of course appreciate the local context far better than I could ever do. However, for whatever reason, overwork and lack of resources for example, midwives tend not to make good use of these women. The person who receives professional advice about what to do when labour commences is generally the pregnant woman alone, often a young woman who understands almost nothing of what the midwife is talking about and who may have little say in what happens to her. I have enduring memories of very young women kneeling respectfully in front of the kindly midwives of the community outreach team who were providing their antenatal care, and agreeing to give birth in hospital. Meanwhile their older matrikin sat waiting outside the door and their men were nowhere to be seen.

My argument should not be taken as support for universal hospital birth, bearing in mind the evidence from Koblinsky et al. (1999) which proposes community birth with a professional midwife and good emergency back-up as a safe and effective solution to women's needs. Rather, I argue for the principle of involving these powerful women if professional midwives want pregnant women, especially the young and inexperienced, to make appropriate choices and plans. Moreover, these older women are very keen to safeguard the welfare of their kin and not at all averse to biomedical precepts although a degree of ambivalence is obvious. Rather I maintain that enlisting them in supporting planning for safer childbearing has the potential for substantial change in childbearing prospects for women.<sup>1</sup>

I make a similar argument for increasing the role of men in supporting their wives. From the analysis of my data I am confident that men want this, wish to increase their knowledge and that some feel side-lined. How easy this will be to reconcile with the gendered power relationships and reach comfortable accommodations is unknown.<sup>2</sup>

Although not included in the original focus of this research, there is a another debate to which this work contributes which concerns the role of indigenous midwives in

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<sup>1</sup> A contemporary approach is birth (or emergency) preparedness in which communities plan ahead for the communication and transport needs of women alongside developing an awareness of danger signs to watch for in pregnancy and labour. This is supported by future Malawian policy (MOHP 2002).

<sup>2</sup> There is some evidence, gathered on the most recent visit to the field that health care professionals are beginning to involve men more, at least in antenatal care (Midwives A and C, 2003 and MOHP 2002). I tentatively offered the idea of involving older women more, asking whether these midwives thought it might be useful and received a very positive response. It is not currently a feature other than seeking the guardian's support in hospital if a woman is uncooperative in labour.

future maternity care and whether they should be abandoned or their positive contributions incorporated. I accept that some practice unsafely, fail to respond appropriately to childbearing difficulties, intervene dangerously and may cause infection (all aspects which apply to some professional 'skilled' attendants). I acknowledge too that supporting them further can be seen as a distraction (personal communication, AbouZahr 2002) when trying to achieve global targets for improving the health and survival of women and babies, and that all women have the right to the best possible care. Without engaging too deeply in this complex and heated debate I can however make one very specific contribution, namely that the cadre of indigenous midwives and the supervisory support they receive are extremely varied, a factor that is not usually taken into account in international literature and policy. 'Lowest common denominator' descriptions are applied to these women, labelled 'unskilled' by the international community; moreover, an assumption prevails that 'the best' incorporates only those labelled 'skilled' by virtue of their training (for example WHO 2003).

Women expressed a clear message about the positive contributions that their *azamba* make to meeting their needs, while complaining that such attributes are often missing from professional hospital-based care. This study reinforces the need for this to be taken into account in future developments as acknowledged by such authorities as Thaddeus and Maine (1994), UNFPA (1997) and researchers such as Asowa-Omorodian (1997). Apart from their current role as midwives, these women have great potential for community mobilisation and enabling birth preparedness. In the Malawian context they are also powerful women whose alienation could be counter-productive.

This research also adds to the body of knowledge reviewed in chapter 2 about how women and communities respond to childbearing and the decisions that need to be made. It demonstrates the plurality of concepts that underpin choices and actions, and their often apparently contradictory nature, yet with an internal logic consistent with the cosmology. It demonstrates how women's agency works in a specific environment, and it speaks against uncontextualised assumptions of patriarchy and control by males and mothers-in-law. It shows how vulnerable are uneducated young women and those kept in ignorance of what to expect in childbearing. The challenge that emerges is inevitably how such evidence can be used to make a difference, to inform policy and be incorporated into the ongoing development of services that meet women's needs and so will be used more effectively. Such a challenge is made harder by the tendency, implicitly criticised at the

beginning of the thesis, to rationalise and use research merely to improve compliance and preserve biomedical hegemony.

### **Contributions to anthropological debates and knowledge**

It is clear from the evidence and analysis presented that focussing on childbirth enabled me to develop a broader view of my topic and engage with more theoretical areas than I had anticipated. I needed to draw on wider debates and theoretical perspectives to begin to understand the complex and often confusing messages that I was receiving through living in the community. I was however beginning to see alternative perspectives to what I was reading and practical examples to bring it alive, thus enabling me to contribute to these debates. These include firstly notions of 'relatedness', secondly residence patterns and gendered power in a contemporary matrilineal society, thirdly how moral norms are linked to women's reproductive capacity and fourthly, how societal values are expressed in everyday life. Finally it provides an example of alternative perceptions of risk around one topic – childbearing.

### **Matriliny and relatedness**

The enduring nature of matriliney in this community that emerges from the evidence is notable in view of the past predictions of its demise in the face of modernity and economic change analysed in chapter 4 (see for example Schneider 1961, Brantley 1997 and Morris 2000 for differing views). Acknowledging the fact that this community is still deeply economically disadvantaged, and that increasing wealth, if it comes, or increasing distress from AIDS related household fragmentation may change the situation, most people (including men) currently express a clear view that this is their preferred way of living. Such specific inheritance, lineage and residence patterns have clear connections with female welfare and security and this finding adds to the understanding of both.

The data presented in chapter 4 strengthens the evidence that the meaning of matriliney is more than inheritance and property, it is relatedness and community, the sharing of 'one breast' (descent via females) and living together as matrikin even if this is symbolic and from afar. Its children (of both sexes) matter for the continuation of the

lineage as is demonstrated in a number of ways. One is by the support systems for women and their potential effect on childbearing women's welfare. Another is the acceptance (if with disapproval) of young single mothers. A third is the apparent assumption that infidelity which occurs in pregnancy is usually male and that, whoever is the perpetrator, it is harmful to the mother and baby. The outsider's contribution is important as progenitor, to impregnate and support the mother, nourish the fetus and continue to support them following the birth. Yet even being provider of 'flesh and bone' to his offspring through transformative sex appears to be secondary, with women indicating the availability of food substitutes to ensure adequate growth of the fetus in the absence of husbands. Husbands' own lineage continuity is ensured by their uterine sisters (who have shared the same breast) and their role in securing this operates through the position of *mwinimbumba*. This contributes to debates about relatedness and how it works in local practice.

### **Gender and power**

I provide an illustration of gendered power in this thesis and how it works in one particular community. Here the authority and influence of mature women emerges strongly from the data not only in the reproductive domain but also in relation to control of land and the produce grown, albeit in collaboration with their husbands when they are present and have satisfactory relationships. This analysis reaches similar conclusions to those of Peters (1997a, 1997b) but contrasts with the findings of researchers working in other societies where power may largely be held by males and women need to devise techniques actively to circumvent their limited agency (Lock and Kaufert 1998). Nevertheless, women may not have much more control over their own fertility than reported elsewhere in Malawi (for example Opportunities and Choices 2002a), even if for lack of resources as much as lack of power.

In a matrilineal context, there is an obvious potential gender tension which might appear to leave the status of men unresolved and transitory as suggested by scholars such as Holy (1996) reviewed in chapter 4, since power, at least in the domestic domain, is largely female. However the rhetoric expressed and maintained by women in this environment attributes to men the dignity and status of men as heads of households as well as the vital role noted above as guardians of their own matrikin which transcends the

potentially unstable marital relationship and any change of location. In addition, this perhaps provides some indication of the continuing acceptability of matrilineality to men.

Generally, then, there is an expectation of comfortable accommodation between men and women and mutually respectful behaviour that is not commonly reported in literature. Nonetheless, both men and women articulate the need for men to fulfil their obligations of support, sobriety and fathering children in exchange for the honour, care and companionship provided by a woman and access to her body and fields. Women can survive without resident marital partners and many do, at least for a time, although life becomes lonelier and often harder. Unlike many African women described for example by Schoepf (1998) and including Malawians from patrilineal groups, those who feature in this study can, at least in principle, send away husbands who prove to be inadequate, irresponsible or violent.

### **Morality and values**

It is clear that community members see local practice as both indicative of their values and related to harmony and order. Clear relationships emerge between expressions of values and morality, and ideas of pollution and taboo. This applies to the well-being of pregnant women and babies already noted and to wider everyday activities. Sex is so valued for maintaining *moyo*, and seen as so powerful, that it is subject to checks and balances that extend to everyday activities as well as intercourse. Out of place sexual activity harms, moral misdemeanours endangering everyone's health. This study then puts flesh on the bones of the equilibrium theory expounded by authors such as Van Breugel (2001), Probst (1995) and Morris (1996, 2000) by providing fieldwork evidence of how maintenance of 'hot/cold' balance, both ensuring and containing transformative sex, works in one locality.

The values of the society and the need to maintain cohesion are to a degree expressed in the bodies of the women of the matrilineage. The reproductive capacities of women are powerful in the same way as sexuality, and these also need to be contained to maintain balance. Conversely, the way childbearing is viewed demonstrates how women are viewed as I noted above with regard to relatedness and residence; they need to be protected from the effects of immorality. It also leads to the proposition that women's reproductive powers are so important to the matrikin, as Meillassoux (1981) maintained,

that values and practices focus on their vulnerability and that of their infants through the full cycle of puberty, menstruation, conception, pregnancy, birth and lactation. My evidence does not, however, allow me to distinguish between women's value as bearers of children for the lineage, and being valued in their own right.

The importance of group harmony is likewise expressed through childbearing women. The ill-will and envy of others are articulated here as fear of bewitching resulting in failed pregnancy or problem labour. This is in accordance with the findings of, for example, Kielmann (1998) and Allen (2002) and adds weight to the observation of relative benevolence toward women and to their degree of agency. The local expression of community values and witchcraft indicates the importance of the symbolic nature of reproduction just as much as do the concerns of global policy advisers for physical safety explored in chapter 1.

### **Notions of risk**

In many societies, and certainly in the global policy literature reviewed in chapter 1 such as Thaddeus and Maine (1994), risk language around childbirth tends to concentrate on biomedically defined danger to the body of women and babies. The people in this community take a wider view than that, incorporating ideas of moral risk, pollution, taboo and personalistic malevolence through witchcraft. Together these produce a multi-layered risk scenario that underpins decisions made around place of birth and choice of carer and adds to the growing knowledge of alternative approaches to risk and childbearing. These ideas of risk are situated at the interface between modernity, in the form of biomedicine, and local paradigms which are more personal and immediate than the propositions of theorists such as Beck and Giddens.

### **Limitations, strengths and methodological issues**

I carried out this research as a middle-aged, British midwife and anthropologist and made no attempt to conceal my background. I did not want to mislead, and could never have maintained such a deception anyway. I entered the field troubled and uncertain about how I might handle childbearing eventualities in which I would normally intervene.

Entering people's lives, they opened up to me enabling me to learn things I never expected to be revealed. Inevitably I sometimes missed much and misunderstood on many occasions, but often further opportunities would arise that helped me to clear up such confusion. Always an honoured guest rather than part of the fabric of the society, I was heavily dependent upon my interpreters and English speakers in the community to back up my limited language ability. The choice of childbearing as the focus for the research was mine and I largely set the agenda in more specific enquiries.

I soon recognised however, that I was well prepared by my working background for getting to know people and talking informally to women and men who appeared never to have been asked for their views before and whose way of life was very different from my own. I quickly learned to identify instances when my interpreters and I did not understand each other fully, or when they went astray or mistranslated, and to my relief had this confirmed by all three of my Malawian audio-tape translators. Nonetheless I remained frustrated by missing much of the chatter and asides that did not get onto tape, and especially by picking up little of the meaning of the songs they sang for me and the dances they performed.

A more specific limitation is that opportunities were restricted for observing health service staff at work with community residents, or for talking with those from the local hospital let alone observing them at work in the hospital setting. Interviewing was confined to senior personnel and a few hospital-based midwives about their views of the women in their care, the communities from which those women came, and about decision-making processes in those communities. With more time, observation and discussion could have illuminated for me their own notions of childbearing after years of biomedical influence which would provide insight into their actions and attitudes toward their clients and the *azamba*. I gained tantalising glimpses of underlying concepts that are often pluralistic like those of their lay counterparts but was unable to take this further. Nevertheless, this was not the real purpose of my research and, given the time constraints, I believe the choices I made were the right ones and that such investigation provides opportunities for future study.

Another limitation is that I prioritised talking to people and being around in the community rather than attending births. Undoubtedly this constituted a shying away from the potential dilemmas I might encounter to some extent, but my main reasons still stand. My purpose for being in the field was not to find out how women and the *azamba* (or



hospital staff) 'did birth' or how decisions were made about actual birth practices. Rather, I was investigating community dynamics and conceptual systems, knowledge and power around the childbearing experience as a whole. Attending more births would have enhanced my data on such themes I am sure, given adequate time. However, interviews and group sessions provided a wealth of information and once I had made an agreement to meet people I could not abandon them or cancel the session at the last minute to attend a labour and birth. I knew from experience that they would be less likely to leave their fields and domestic tasks to meet with me on the next occasion. I had another motive too in not seeking out labouring women purposefully. Inevitably people may 'perform' when watched unless being observed is common-place. I was fairly certain that one of my main respondents would have done just that, perhaps to the detriment of those in her care. Given this set of circumstances I would do the same again.

Aware of the potential for developing misleading ideas I learned to remain alert for evidence to support or refute my findings and I would often deliberately bring conversations around to a topic which I wanted to cross-check with different informants. Undoubtedly, my past experience meant that I had the necessary skills to do this naturally. I observed daily life and took part as much as possible; I met and talked to women of all age groups and to (mostly older) men in group settings and as individuals. Key informants agreed to meet me and I had repeated access to Village Heads, school teachers, health care professionals, public health advisers, local academics and a Malawian anthropologist. I also had access to a wealth of local knowledge in the form of literature on Malawi both at Chancellor College, University of Malawi and at home in the UK.

Although potentially very disruptive, my returns to Britain enabled me to seek out prior knowledge on specific topics and make progress in understanding them. Consequently, regrets about lost opportunities and missing data are relatively few. Being able to visit the area briefly to plan the research then return, again briefly, in the late stages of writing to check my findings have made it much easier to make the best use of fieldwork periods and be confident in what I have to say.

My background and personal circumstances brought a special perspective to the study. I was able to build relationships quickly with people from very different backgrounds to myself and to each other, and to incorporate the knowledge, personal skills and attitudes of anthropologist, midwife, and mother into my research. I was also

stimulated by a wealth of unanswered questions and curiosity, most of which still lies ahead.

### **Suggestions for future research**

There are a variety of areas related to the issues raised in this thesis that could be illuminated by anthropological method and theory, or that could contribute to anthropological knowledge. The following comments focus on some of the specific questions emerging from the findings presented.

The most obvious technical issue for further exploration concerns the way professional midwives do, or do not involve and mobilise community members for the benefit of childbearing women. Here the question relates specifically to the (I argue) neglected influence of older matrikin and their willingness to incorporate biomedical ideas within the conceptual basis for their action. It would also be worthwhile to investigate the development of male involvement in such largely matrilineal contexts and their expressed desire to be more informed about childbearing. Such research would necessarily be linked to a programme of action.

Related to this as potential areas for policy-related anthropological research are the future involvement of indigenous midwives in maternal health services and ways in which they can best contribute from their currently strong position in Malawi to provide the kind of care women desire. Two related areas could contribute to such a proposal or stand alone. One idea is to investigate networks of power relations between the different groups that care for pregnant women (midwives in the broadest sense of the word), the other is to examine the 'shared space' of the hospital labour room from the points of view of both childbearing women and midwives.

The ways in which young women are currently prepared for childbearing and earlier stages in their reproductive life is unclear. This would make an interesting study spanning customary and contemporary systems and contributing to anthropological knowledge and women's health issues. Inevitably, a Malawian female anthropologist would gain more insight than would I; having said that women might be more concerned with being ridiculed by fellow Malawians and the ethical issues around making secret knowledge public would be as difficult for them as for me.

Comparative work on how different patterns of relatedness and residence affect childbearing women would provide a clearer indication of the factors that influence what happens to them. I have concluded that the matrilineal community I studied appears to provide an environment that is relatively benevolent to childbearing women. Such a focussed enquiry could find out in what ways this occurs and feature patrilineal as well as matrilineal communities.

Similarly pertinent would be to explore stories in greater number and depth than I have here:

- The stories of generations of childbearing women: a historical element is touched upon in this thesis but knowing more about what happened in the past would clarify further what people do now and the concepts behind their actions;
- The stories of contemporary childbearing women – how choices are made and why, what happens to them as a result of these choices – contextualised with regard to their life circumstances;
- The stories of men living as *chikamwhini*, the incoming stranger.

Two more (and I believe novel) areas of questioning have arisen for me. One concerns the sustainability of the matrilineal way of life as AIDS-related deaths disrupt households. The other is a very theoretical puzzle: are the moral values indicated in the equilibrium concepts and described in this thesis the same in Malawian patrilineal groups or are they different, or differently expressed? To what extent is there a connection between these and the need to protect reproduction within the lineage? This assumes a link between protecting the lineages and the values that are expressed; is this assumption accurate?

## **Finally**

The knowledge base that informs action in this community derives from a set of concepts about the body, health and childbearing that embraces both biological and biomedical views, and local concepts and ethnomedicine in a pragmatic and layered way. These complex local concepts, of sexual activity as a powerful force essential for well-being, of

the need to balance these forces expressed as cold and vulnerable, and hot and dangerous are expressed within the community in a variety of ways. The need to contain such forces emerges as a set of expectations and taboos that are taught to young people and particularly focus on sexuality and death. Community cohesion is important too: the young are taught respect from their earliest days and the importance of avoiding envy and jealousy is expressed as a fear of being bewitched or of being accused of witchcraft.

Specialist knowledge of childbirth is concentrated now amongst the local indigenous midwives and in health service personnel, both kinds of specialist being respected in this community for their particular strengths. Hospital staff are seen as life-savers, the *azamba* are credited with a form of practice that provides both a degree of safety and kindly support often missing from the practice of the professionals. The *azamba* epitomise the eclectic nature of ideas about pregnancy and birth, some moving easily and unselfconsciously between explanatory paradigms. Some hospital staff also demonstrate such pluralism but this needs further investigation.

The matrilineal and matrilocal context remains very significant and offers childbearing women a relatively benevolent arena for making their own choices when experienced, or at least having decisions made by older female kin who generally have their welfare at heart, and men who carry a community-imposed expectation of taking a strongly supportive role.

## References

- AbouZahr, C. (2001) 'Cautious champions: international agency efforts to get Safe Motherhood onto the agenda', in De Brouwere, V. and Van Lerberghe, W. eds. *Safe Motherhood Strategies: a Review of the Evidence*, Antwerp: ITG Press.
- Agar, M.H. (1996) *The Professional Stranger: An Informal Introduction to Ethnography*, 2<sup>nd</sup> edition, San Diego: Academic Press.
- Ager, A., Carr, S., Maclachan, M. and Kaneka-Chilongo, B. (1996) 'Perceptions of tropical health risks in Mponda, Malawi: attributions of cause, suggested means of risk reduction and preferred treatment', *Psychology and Health*, 12: 23-31.
- Allen, D.R. (2002) *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania*, Ann Arbor: The University of Michigan Press.
- American Anthropological Association, (1998) 'Code of Ethics of the American Anthropological Association', available at <<http://www.aaanet.org/committees/ethics/ethcode.htm>> accessed 2 February 2001.
- Ashforth, A. (2001) 'On living in a world with witches: everyday epistemology and spiritual insecurity in a modern African city (Soweto)', in Moore, H.L. and Sanders T. eds. *Magical Interpretations and Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*, London and New York: Routledge.
- Ashwood-Smith, H. (1996) *Indigenous Childbirth: Unbinding Bundles the Mangyan Way*, Liverpool School of Tropical Medicine, MSc. unpublished dissertation.
- Ashwood-Smith, H. and Bokosi, M. (2003) 'A study of sexual beliefs and practices in Malawi: implications for HIV/AIDS control strategies', available at <<http://www.virtual-teams.org/HSaMH/>> accessed 14 March 2000.
- Association of Social Anthropologists of the UK and the Commonwealth (1997) *Ethical Guidelines for Good Research Practice*, available at <<http://www.les1net.man.ac.uk/sa/ASA/ethics.htm>> accessed 2 February 2001, now <[www.theasa.org/ethics.htm](http://www.theasa.org/ethics.htm)>.
- Asowa-Omorodion, F.I. (1997) 'Women's perceptions of the complications of pregnancy and childbirth in two Esan communities, Edo State, Nigeria', *Social Science and Medicine*, 44.12: 1817-1824.
- Atkinson, S.J. and Farias, M.F. (1995) 'Perceptions of risk during pregnancy amongst urban women in northeast Brazil', *Social Science and Medicine*, 41.11: 1577-1586.
- Backett, E.M., Davies, A.M. and Barvazion, P. (1984) *The Risk Approach in Health Care with Special Reference to Maternal and Child Health, Including Family Planning*, Public Health Papers no. 76, Geneva: World Health Organization.
- Barber, G.D. (2003) 'To tell or not to tell? ethics and secrecy in anthropology and childbearing in rural Malawi', in Caplan, P. ed. *The Ethics of Anthropology: Debates and Dilemmas*, London: Routledge.
- Barnard, A. (1994) 'Rules and prohibitions: the form and context of human kinship', in Ingold, T. ed. *Companion Encyclopaedia of Anthropology, Humanity, Culture and social Life*, London: Routledge.
- Barth, F. (2002) 'An anthropology of knowledge', *Current Anthropology* 43.1: 1-17.
- Bates, B. and Newman-Turner, A. (2003) 'Images and symbolism in the birth practices of traditional cultures', in Dundes, L. ed. *The Manner Born: Birth Rites in Cross-Cultural Perspective*, Walnut Creek, California and London: Altamira Press.
- Beck, U. (1992) *Risk Society: Towards a New Modernity*, London, Thousand Oaks California and New Delhi: Sage Publications.
- Bergstrom, S. and Goodburn, E. (2001) 'The role of traditional birth attendants in the reduction of maternal mortality', in De Brouwere, V. and Van Lerberghe, W. eds. *Safe Motherhood Strategies: a Review of the Evidence*,. Antwerp: ITG Press.

- Bernard, H.R. (1995) *Research Methods in Anthropology: Qualitative and Quantitative Approaches*, 2<sup>nd</sup> edition, Walnut Creek, London and New Delhi: Altamira Press.
- Boseley, S. (2004) 'One small miracle brings hope to thousands threatened by AIDS', *The Guardian*, 16 Feb., available at <[www.guardian.co.uk/print/](http://www.guardian.co.uk/print/)>
- Brantley, C. (1997) 'Through Ngoni eyes: Margaret Read's interpretations from Nyasaland' *Critique of Anthropology*, 17.2: 147-169.
- Briggs, P. (1996) *Guide to Malawi*, Chalfont St.Peter, Bucks: Bradt Publications.
- Brindley, M. (1985) 'Old women and Zulu culture: the old women and childbirth', *South African Journal of Ethnology*, 8.3: 98-108.
- Browner, C.H. and Sargent, C.F. (1996) 'Anthropology and studies of human reproduction', in Sargent, C.F. and Johnson, T.M. eds. *Medical Anthropology: Contemporary Theory and Method*, Westport, Connecticut: Praeger.
- Browner, C.H. and Press, N. (1997) 'The production of authoritative knowledge in American prenatal care' in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Bruwer, J. (1948) 'Kinship terminology among the Cewa of the Eastern province of Northern Rhodesia', *African Studies*, vii.4. Dec: 185-87.
- Bujra, J. (2000) 'Risk and trust: unsafe sex, gender and AIDS in Tanzania', in Caplan, P. ed. *Risk Revisited*, London and Sterling, Virginia: Pluto Press.
- Bullough, C.H.W. (1980) *Traditional Birth Attendants in Malawi: the Development of a Training Programme*, University of Glasgow, MD thesis.
- Bullough, C. (2000) 'An assessment of the effectiveness of traditional birth attendants in improving the outcome of pregnancy and delivery', unpublished report undertaken by John Snow International (UK) on behalf of Department for International Development (UK), Ref. dfRC/in0101.
- Callaway, H. (1992) 'Ethnography and experience: gender implications in fieldwork texts', in Okely, J. and Callaway, H, eds. *Anthropology and Autobiography*, Association of Social Anthropologists Monograph 29, London and New York: Routledge.
- Callister, L.C. (2001) 'Culturally competent care of women and newborns: knowledge, attitude, and skills', *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 30.2: 209-215.
- Campbell, O.M.R. (2001) 'What are maternal health policies in developing countries and who drives them? A review of the last half-century', in De Brouwere, V. and Van Lerberghe, W. eds. *Safe Motherhood Strategies: a Review of the Evidence*, Antwerp: ITG Press.
- Camey, X.C., Barrios, C.G., Guerrero, X.R., Nuñez-Urquiza, R.M., Hernandez, D.G. and Glass, A.L. (1996) 'Traditional birth attendants in Mexico: advantages and inadequacies of care for normal deliveries', *Social Science and Medicine*, 43.2: 199-207.
- Caplan, P. (1995) "'Children are our wealth and we want them': a difficult pregnancy on Northern Mafia Island, Tanzania", in Bryceson, D.F. ed. *Women Wielding the Hoe: Lessons from Rural Africa for Feminist Theory and Development Practice*, Oxford and Herndon, Virginia: Berg Publishers.
- Caplan, P. (2000) 'Introduction: risk revisited', in Caplan, P. ed. *Risk Revisited*, London and Sterling, Virginia: Pluto Press.
- Carsten, J. (2000) 'Introduction: cultures of relatedness', in Carsten, J. ed. *Cultures of Relatedness: New Approaches to the Study of Kinship*. Cambridge, New York and Melbourne: Cambridge University Press.
- Chakanza, J.C. (1998a) 'The mbumba (lineage) set up today in Malawi', *The Lamp*, iv Jan-March: 26-28.
- Chakanza, J.C. (undated) 'Sex and sexuality: cultural perspective', *The Lamp*, no.11: available at <<http://www.montfortmedia.com/thelamp/>> accessed 28 December 2001.
- Chakanza, J.C. (1998b) 'Traditional birth rituals in Malawi', *The Lamp*, 14: 27-29.
- Chakanza, J.C. (1999) 'Traditional healers in Malawi', *The Lamp*, 20: 20-21.

- Chakanza, J.C. (2000) 'Traditional Healers in Malawi: part II', *The Lamp*, 21: 20-21.
- Chalmers, B. (1990) *African Birth: Childbirth in Cultural Transition*, River Club, South Africa: Berev Publications.
- Chambers, R. (1995) 'Paradigm shifts and the practice of participatory research and development', in Nelson, N. and Wright, S. *Power and Participatory Development: Theory and Practice*, London: Intermediate Technology Publications.
- Chapman, R. (2003) 'Endangering safe motherhood in Mozambique: prenatal care as pregnancy risk', *Social Science and Medicine*, 57.2: 355-374.
- Chawla, J. (2002) 'Hawla, gola and the mother-in-law's big toe: on understanding dais' imagery of the female body', in Rozario, S. and Samuel, G. eds. (2002) *Daughters of Harūi: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Coffey, A. (1999) *The Ethnographic Self: Fieldwork and the Representation of Reality*, London, Thousand Oaks and New Delhi: Sage Publications.
- Collier, J.F. and Rosaldo, M.Z. (1981) 'Politics and gender in simple societies' in Ortner, S. and Whitehead, H. eds. *Sexual Meanings: the Cultural Construction of Gender and Sexuality*, Cambridge: Cambridge University Press.
- Cosminsky, S. (1994) 'Childbirth and change: a Guatemalan study', in MacCormack, C.P. ed. (1994) *Ethnography of Fertility and Birth*, 2<sup>nd</sup> edition, Prospect Heights, Illinois: Waveland Press.
- Davis-Floyd, R.E. (1992) *Birth as an American Rite of Passage*, Berkeley, Los Angeles and London: University of California Press.
- Davis-Floyd, R.E. (2000) 'Mutual accommodation or biomedical hegemony? Anthropological perspectives on global issues in Midwifery', *Midwifery Today*, 53, Spring, 12-16 and 68-69.
- Davis-Floyd, R.E. (2001) 'La partera professional: articulating identity and cultural space for a new kind of midwife in Mexico', *Medical Anthropology*, 20:2, 185-243, Special issue on midwifery, Part 1.
- Davis-Floyd, R.E. and Davis, E. (1997) 'Intuition as authoritative knowledge in midwifery and home birth', in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Davis-Floyd, R.E., Pigg, S.L. and Cosminsky, S. (2001) 'Introduction: daughters of time: shifting identities of contemporary midwives', *Medical Anthropology*, 20:2, 105-139, Special issue on midwifery, Part 1.
- Davis-Floyd, R.E. and Sargent, C.F. (1997) 'Introduction: the anthropology of birth', in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Davison, J. (1995) 'Must women work together? Development agency assumptions versus changing relations of production in Southern Malawi households', in Bryceson, D.F. ed. *Women Wielding the Hoe: Lessons from Rural Africa for Feminist Theory and Development Practice*, Oxford and Herndon, Virginia: Berg Publishers.
- Davison, J. (1997) *Gender Lineage, and Ethnicity in Southern Africa*, Boulder, Colorado and Oxford: Westview Press.
- Davis-Roberts, C. (1992) 'Kutambuwa ugonjuwa: concepts of illness and transformation among the Tabwa of Zaire', in Feierman, S. and Janzen, J.M. eds. *The Social Basis of Health and Healing in Africa*, Berkeley, Los Angeles and Oxford: University of California Press.
- Daviss, B. (1997) 'Heeding warnings from the canary, the whale, and the Inuit: A framework for analysing competing types of knowledge' in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Demographic Unit University of Malawi, (1986) 'Report of Workshop on the Value of Children and Family Spacing Practices in Malawi', held in Zomba, October and Lilongwe December.
- Dermann, B. and Ferguson, A. (1995) 'Human rights, environment, and development: the dispossession of fishing communities on Lake Malawi', *Human Ecology*, 23.2: 125-142.

- Donner, H. (2004) 'The place of birth: childbearing and kinship in Calcutta middle-class families', *Medical Anthropology*, 22:4, 303-341.
- Douglas, M. (1966) *Purity and Danger: an Analysis of the Concepts of Pollution and Taboo*, London and New York: Routledge 1995 edition.
- Douglas, M. (1969) 'Is matriliney doomed in Africa?' in Douglas, M. and Karberry, P. (eds.) *Man in Africa*, London: Tavistock Publications.
- Douglas, M. (1992) *Risk and Blame: Essays in Cultural Theory*, London and New York: Routledge.
- Douglas, M. (1994) *Risk and Blame: Essays in Cultural Theory*, 2<sup>nd</sup>. edition, London and New York: Routledge.
- Douglas, M. and Wildavsky, A. (1982) *Risk and Culture: an Essay on the Selection of Technological and Environmental Dangers*, Berkeley: University of California Press.
- Ebin, V. (1994) 'Interpretations of infertility: the Aowin people of southwest Ghana', in MacCormack, C.P. ed. *Ethnography of Fertility and Birth*, 2<sup>nd</sup>. edition, Prospect Heights, Illinois: Waveland Press.
- Ellen, R.F. ed. (1984) *Ethnographic Research: A Guide to General Conduct*, London: Academic Press.
- Engender Health, 2002 Country by Country: Malawi, available online at: <[www.engenderhealth.org/ia/cbc/Malawi.html](http://www.engenderhealth.org/ia/cbc/Malawi.html)> accessed 21 05 03.
- Evans-Pritchard, E.E. (1976) *Witchcraft Oracles and Magic among the Azande*, Oxford: Oxford University Press.
- Feierman, S. (1985) 'Struggles for control: the social roots of health and healing in modern Africa', *African Studies Review*, 28: 73-147.
- Feldman-Savelsberg, P. (1999) *Plundered Kitchens, Empty Wombs: Threatened Reproduction in the Cameroon Grasslands*, Ann Arbor: University of Michigan Press.
- Fisiy, C.F. and Geschiere, P. (2001) 'Witchcraft, development and paranoia in Cameroon: interactions between popular, academic and state discourse', in Moore, H.L. and Sanders T. eds. *Magical Interpretations and Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*, London and New York: Routledge.
- Fiedler, D.C. (1997) 'Authoritative knowledge and birth territories in contemporary Japan' in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Forster, P.G. (1994) 'Culture, nationalism, and the invention of tradition in Malawi', *The Journal of Modern African Studies*, 32.3: 477-497.
- Forster, P. (1998) 'Religion, magic, witchcraft, and AIDS in Malawi', *Anthropos*, 93: 537-545.
- Foucault, M. (1977) *Discipline and Punish: the Birth of the Prison*, translated from the French by Alan Sheridan, London: Penguin Books.
- Gabe, J. ed. (1995) *Medicine, Health and Risk: Sociological Approaches*, Oxford: Blackwell.
- Gardner, D. (1991) *The Children who Sleep by the River*, London: Allison and Busby.
- Gardner, K. (1991) *Songs at the River's Edge. Stories from a Bangladeshi Village*, London, Chicago: Pluto Press.
- Gardner, K. (1999) 'Location and relocation: home, 'the field' and anthropological ethics (Sylhet, Bangladesh)', in Watson, C.W. *Being There: Fieldwork in Anthropology*, London and Sterling, Virginia: Pluto Press.
- Gay, J., Hardee, K., Judice, N., Agarwal, K., Fleming, K., Hairston, A., Walker, B. and Wood, M. (2003) 'What Works: a Policy and Programme Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions: Module 1, Safe Motherhood,' Policy Project, available at <[www.policyproject.com/](http://www.policyproject.com/)>, accessed 23 April 2003.
- Georges, E. (1997) 'Fetal ultrasound imaging and the production of authoritative knowledge in Greece', in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.



- Geschiere, P. (1997) *The Modernity of Witchcraft: Politics and the Occult in Post-modern Colonial Africa*, Charlottesville: University Press of Virginia.
- Guerts, K. (2001) 'Childbirth and pragmatic midwifery in rural Ghana', *Medical Anthropology*, 20.4: 379-408.
- Giddens, A. (1991) *Modernity and Self-Identity: Self and Society in the Late Modern Age*, Cambridge: Polity Press in association with Blackwell Publishers.
- Ginsburg, F. and Rapp, R. (1991) 'The politics of reproduction', *Annual Review of Anthropology* 20: 311-343.
- Goffman, E. (1959) *The Presentation of Self in Everyday Life*, London: Penguin Books, 1990 paperback edition.
- Goforth, L. (1988) *Household Structure and Birth Attendant Choice in a Yucatec Maya Community*, Los Angeles: University of California, PhD Dissertation.
- Good, B.J. (1994) *Medicine, Rationality and Experience: an Anthropological Perspective*, Cambridge, New York and Melbourne: Cambridge University Press.
- Good, B.J. and Delveccio Good, M. (1993) "'Learning medicine": the constructing of medical knowledge at Harvard Medical School' in Lindenbaum, S. and Lock, S. eds. (1993) *Knowledge, Power and Practice: the Anthropology of Medicine and Everyday Life*, Berkeley, Los Angeles and London: University of California Press.
- Goodburn, E. and Campbell, O. (2001) 'Reducing maternal mortality in the developing world: sector-wide approaches must be the key', *British Medical Journal*, 322. 14 April: 917-920.
- Gordon, D. R. (1988) 'Tenacious assumptions in western medicine', in *Biomedicine Examined*, Lock, M. and Gordon, D.R. eds. Dordrecht: Kluwer Publishers.
- Gough, K. (1961a) 'Descent groups of settled and mobile cultivators', in Schneider, D.M. and Gough, K. (eds.) *Matrilineal Kinship*, Berkeley: University of California Press.
- Gough, K. (1961b) The modern disintegration of matrilineal descent groups. in Schneider, D.M. and Gough, K. (eds.) *Matrilineal Kinship*, Berkeley: University of California Press.
- Graham, W.J., Filippi, V.G.A. and Ronsmans, C. (1996) 'Demonstrating programme impact on maternal mortality', *Health Policy and Planning*, 11.1: 16-20.
- Graham, W.J., Bell, J.S., and Bullough, C.H.W. (2001) 'Can skilled attendance at delivery reduce maternal mortality in developing countries?' in De Brouwere, V. and Van Lerberghe, W. eds. *Safe Motherhood Strategies: a Review of the Evidence*. Antwerp: ITG Press.
- Graham, W.J. (2002) 'Now or never: the case for measuring maternal mortality', *The Lancet*, 359. February 23: 701-704.
- Gray, B.M. (1994) 'Enga birth, maturation and survival: physiological characteristics of the life cycle in the New Guinea Highlands', in MacCormack, C.P. ed. *Ethnography of Fertility and Birth*, 2<sup>nd</sup>. edition, Prospect Heights, Illinois: Waveland Press.
- Greene, P. (1995) 'Discussion: TBA training program', *International Journal of Gynecology and Obstetrics*, 50. supplement 2: S141-S143.
- Hahn, R.H. (1995) *Sickness and Healing: an Anthropological Perspective*, New Haven and London: Yale University Press.
- Hall, J.M. and Stevens, P.E. (1991) 'Rigor in feminist research', *Advances in Nursing Research*, 3.3: 16-29.
- Harris, A. (2002) 'Beranak and bekindu': discourses of risk and strength in childbirth and postpartum practice among Iban communities of Pakan', in Rozario, S. and Samuel, G. eds. *Daughters of Hariti: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Hodgson, D.L. (2001) 'Introduction', in Hodgson, D.L.ed. *Gendered Modernities: Ethnographic perspectives*, New York and Basingstoke: Palgrave.
- Holloway, I. (1997) *Basic Concepts in Qualitative Research*, Oxford: Blackwell.

- Holy, L. (1986) *Strategies and Norms in a Changing Matrilineal Society: Descent, Succession and Inheritance among the Tonga of Zambia*, Cambridge: Cambridge University Press.
- Holy, L. (1996) *Anthropological Perspectives on Kinship*. London and Sterling, Virginia: Pluto Press.
- Homans, R. (1991) *The Ethics of Social Research*, Harlow Essex and New York: Longman.
- Homans, H. (1994) 'Pregnancy and birth as rites of passage for two groups of women in Britain', in MacCormack, C.P. ed. (1994) *Ethnography of Fertility and Birth*, 2<sup>nd</sup>. edition, Prospect Heights, Illinois: Waveland Press.
- Hunt, N.R. (1999) *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo*, Durham and London: Duke University Press.
- Hunter, C.L. (2002) 'Embracing modernity: transformations in Sasak confinement practices', in Rozario, S. and Samuel, G. eds. *Daughters of Harīti: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- International Confederation of Midwives (2000) *International Code of Ethics for Midwives*, available from <<http://www.rcm.org.uk/files/info/documents/230401124908-43-1.doc>> accessed 11 Feb 2001
- Jambai, A. and McCormack, C. (1997) 'Maternal health, war, and religious tradition: authoritative knowledge in Pujehun District, Sierra Leone', in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Janzen, J.M. (1978) *The Quest for Therapy: Medical Pluralism in Lower Zaire*, Berkeley, Los Angeles and London: University of California Press.
- Janzen, J.M. (2000) 'Afterword', in van Dijk, R., Reis, R. and Spierenburg, M. eds. *The Quest for Fruition through Ngoma: the Political Aspects of Healing in Southern Africa*, Oxford: James Currey.
- Jeffery, P.J. (1979) *Frogs in a Well: Indian women in Purdah*, London and New Jersey: Zed Books.
- Jeffery, R. and Jeffery, P. (1993) 'Traditional birth attendants in rural North India' in Lindenbaum, S. and Lock, S. eds. (1993) *Knowledge, Power and Practice: the Anthropology of Medicine and Everyday Life*, Berkeley, Los Angeles and London: University of California Press.
- Jeffery, P., Jeffery, R. and Lyon, A. (1989) *Labour Pains and Labour Power: Women and Childbearing in India*, London and New Jersey: Zed Books, and New Delhi: Manohar.
- Jeffery, P., Jeffery, R. and Lyon, A., (2002) 'Contaminating states: midwifery, childbearing and the state in rural North India', in Rozario and Samuel eds. *Daughters of Harīti: Childbirth and Female Healers in South and Southeast Asia*, London: Routledge.
- Jolly, M. (2002) 'Introduction. Birthing beyond the confinements of tradition and modernity?', in Lukere, V. and Jolly, M. eds. *Birthing in the Pacific: Beyond Tradition and Modernity?*, Honolulu: University of Hawai'i Press.
- Jordan, B. (1977) 'The self-diagnosis of early pregnancy: an investigation of lay competence', *Medical Anthropology*, 1.2:1-38.
- Jordan, B. (1993) *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*, 4<sup>th</sup>. edition, revised and expanded by Davis-Floyd, R.E, Prospect Heights, Illinois: Waveland Press.
- Kabwazi N., Kapululu P., Luhanga T., Nhlema B. and Kemp J. (2001) 'Community perceptions of tuberculosis in three communities in urban Lilongwe, Malawi', slide presentation available at <<http://www.liv.ac.uk/1stm/hsr-JKpp1/>> accessed 8 December 2001.
- Kaluwa, B. ed. (1992) *The Structural Adjustment Programme in Malawi: a Case of Successful Adjustment?* Harare: SAPES Books.
- Kamwendo, L. (1996) 'Birth Rituals: the Malawian Perspective', Presentation made at the International Confederation of Midwives 24th. Triennial Congress, 26-31 May, Oslo, Conference Proceedings 135-138.
- Kay, M. (1982) *Anthropology of Human Birth*, Philadelphia: F.A. Davis Company.

- Kaufert, P.A. and O'Neill, J. (1993) 'Analysis of a dialogue of risks in childbirth: clinicians, epidemiologists, and Inuit women', in Lindenbaum, S. and Lock, S. eds. *Knowledge, Power and Practice: the Anthropology of Medicine and Everyday Life*, Berkeley, Los Angeles and London: University of California Press.
- Kellehear, A. (1989) 'Ethics and social research', in Perry J (ed.) *Doing Fieldwork: Eight Personal Accounts of Social Research*, Geelong, Victoria Australia: Deakin University Press.
- Kielmann, K. (1998) 'Barren ground: contesting identities of infertile women in Pemba, Tanzania', in Lock, M. and Kaufert, P.A. eds. *Pragmatic Women and Body Politics*, Cambridge: Cambridge University Press.
- Kitzinger, S. (1994) 'The social context of birth: some comparisons between childbirth in Jamaica and Britain', in MacCormack, C.P. ed. (1994) *Ethnography of Fertility and Birth*, 2<sup>nd</sup> edition, Prospect Heights, Illinois: Waveland Press.
- Kleinman, A. (1986) 'Concepts and a model for the comparison of medical systems as cultural systems' in Currer, C. and Stacey, M. eds. *Concepts of Health, Illness and Disease: a comparative perspective*, Providence USA and Oxford: Berg Publishers.
- Kleinman, A. (1995) *Writing at the Margin: Discourse Between Anthropology and Medicine*, Berkeley, Los Angeles and London: University of California Press.
- Koblinsky, M., Campbell, O. and Heichelheim, J. (1999) 'Organizing delivery care: what works for safe motherhood?', *Bulletin of the World Health Organization*, 77.5: 399-406.
- Krimsky, S. (1992) 'The role of theory in risk studies' in Krimsky, S. and Golding, D. eds. *Social Theories of Risk*, Westport, Connecticut and London: Praeger.
- Kumar A. and Vlassoff. C. (1997) 'Gender relations and the education of girls in two Indian communities: implications for decisions about childbearing', *Reproductive Health Matters*, no.10, Nov: 139-50.
- Laderman, C. (1983) *Wives and Midwives: Childbirth and Nutrition in Rural Malaysia*, Berkeley, Los Angeles and London: University of California Press.
- Laderman, C. (1987) 'Destructive heat and cooling prayer: Malay humoralism in pregnancy, childbirth and the puerperium', *Social Science and Medicine*, 25.4: 357-365.
- La Fontaine, J.S. (1985) *Initiation*, Manchester and Dover NH: Manchester University Press.
- Laguerre, M. (1987) *Afro-Caribbean Folk Medicine*, South Hadley, Massachusetts: Bergin and Harvey.
- Lancaster, C.S. (1981) *The Goba of the Zambezi: Sex Roles, Economics and Change*, Norman: University of Oklahoma Press.
- Lane, K. (1995) 'The medical model of the body as a site of risk: a case study of childbirth', in Gabe, J. ed. *Medicine, Health and Risk: Sociological Approaches*, Oxford, and Cambridge Mass.: Blackwell.
- Last, M. (1981) 'The importance of knowing about not knowing', *Social Science and Medicine*, 15B: 387-392.
- Last, M. and Chavanduka, G. eds. (1986) *The Professionalization of African Medicine*, Manchester: Manchester University Press.
- Last, M. (1996) 'The professionalization of African healers', in Sargent, C.F. and Johnson, T.M. eds. *Medical Anthropology: Contemporary Theory and Method*, Westport, Connecticut: Praeger.
- Lawson, A. (1949) 'An outline of the relationship system of the Nyanja and Yao Tribes in South Nyasaland', *African Studies*, 8: 180-190.
- Lewin, E. (1998) 'Wives, mothers, and lesbians: rethinking resistance in the US', in Lock, M. and Kaufert, P.A. eds. *Pragmatic Women and Body Politics*, Cambridge: Cambridge University Press.
- Lewis, G. (1975) *Knowledge of Illness in a Sepik Society: a Study of the Gnau, New Guinea*, London: Athlone Press, University of London, and New Jersey: Humanities Press.
- Lewis, G. (1993) 'Double standards of treatment evaluation', in Lindenbaum, S. and Lock, S. eds. (1993) *Knowledge, Power and Practice: the Anthropology of Medicine and Everyday Life*, Berkeley, Los Angeles and London: University of California Press.

- Lewis, G. (2000) *A Failure of Treatment*, Oxford and New York: Oxford University Press.
- Lewis, G. (2003) 'Beyond the numbers: reviewing maternal deaths and complications to make pregnancy safer', *British Medical Bulletin*, 67: 27-37.
- Lindenbaum, S. and Lock, S. 'Introduction (to Part Three): contested knowledge and modes of understanding', in Lindenbaum, S. and Lock, S. eds. (1993) *Knowledge, Power and Practice: the Anthropology of Medicine and Everyday Life*, Berkeley, Los Angeles and London: University of California Press.
- Lock, M. (1988) 'Introduction', in Lock, M. and Gordon, D. eds. *Biomedicine Examined*, Dordrecht: Kluwer Academic Publishers.
- Lock M. and Kaufert P.A. 1998 'Introduction', in Lock, M. and Kaufert, P.A. eds. *Pragmatic Women and Body Politics*, Cambridge: Cambridge University Press.
- Loudon, I. (1992) *Death in Childbirth: an International Study of Maternal Care and Maternal Mortality 1800-1950*, Oxford: Clarendon Press.
- Lukere, V. (2002) 'Conclusion. Wider reflections and a survey of the literature', in Lukere, V. and Jolly, M. eds. *Birthing in the Pacific: Beyond Tradition and Modernity?*, Honolulu: University of Hawai'i Press.
- Lukere, V. and Jolly, M. eds. (2002) *Birthing in the Pacific: Beyond Tradition and Modernity?*, Honolulu: University of Hawai'i Press.
- Lungu, K., Kamfosa, V., Hussein, J. and Ashwood-Smith, H. (2001) 'Are bicycle ambulances and community transport plans effective in strengthening obstetric referral systems in Southern Malawi?', *Malawi Medical Journal*, 12.2: 16-18.
- Lupton, D. (1999a) *Risk*, London and New York: Routledge.
- Lupton, D. (1999b) 'Risk and the ontology of pregnant embodiment', in Lupton, D. ed. *Risk and Sociocultural Theory: New Directions and Perspectives*, Cambridge, New York and Melbourne: Cambridge University Press.
- Lwanda, J.L.C. (1996) *Promises, Power, Politics and Poverty: Democratic Transition in Malawi (1961-1999)*, Glasgow: Dudu Nsomba Publications.
- MacCormack, C.P. (1981) 'Health care and the concept of legitimacy', *Social Science and Medicine*, 15B: 423-428.
- MacCormack, C.P. ed. (1994) *Ethnography of Fertility and Birth*, 2<sup>nd</sup>. edition, Prospect Heights, Illinois: Waveland Press.
- MacDonald, M. (2001) 'Postmodern negotiations with medical technology: the role of midwifery clients in the new midwifery in Canada', *Medical Anthropology*, 20:2, 245-276, Special issue on midwifery, Part 1.
- Mahomed, K. (1997) 'A 5 year review of rupture of the pregnant uterus in Harare, Zimbabwe', *Journal of Obstetrics and Gynaecology*, 7.3: 192-196.
- Mair, L. P. (1952) 'Marriage and family in the Dedza District of Nyasaland' *Journal of the Royal Anthropological Institute*, 81: 103-119.
- Malawi Safe Motherhood Project Management Unit. (2003) 'Six Monthly Report for July-Dec 2002', unpublished document.
- Malawi Government. (undated) 'Malawi National Land Policy', available at <<http://www.malawi.gov.mw/lands/polglos.htm>> accessed 16 October 2003.
- Martin, E. (1987) *The Woman in the Body: a Cultural Analysis of Reproduction*, Milton Keynes: Open University Press.
- Marwick, M.G. (1965) *Sorcery in its Social Setting: a Study of the Northern Rhodesian Chewa*, Manchester: University of Manchester Press.
- Marwick, M.G. (1982) 'Witchcraft as a social strain gauge', in Marwick, M. ed. *Witchcraft and Sorcery, Selected Readings*, 2<sup>nd</sup>. edition, London: Penguin Books, adapted from *Australian Journal of Science*, (1964) 26: 263-268.

- Matsuoka, E. (2001) 'Postmodern midwives in Japan: the offspring of modern hospital birth', *Medical Anthropology*, 20:2, 141-184, Special issue on midwifery, Part 1.
- Mayer, P. (1982) 'Witches', in Marwick, M. ed. *Witchcraft and Sorcery, Selected Readings*, 2<sup>nd</sup> edition, London: Penguin Books, (formerly presented 1954 as Inaugural Lecture, Rhodes University, Grahamstown, South Africa).
- McClain, C.S. (1983) 'Perceived risk and choice of childbirth service', *Social Science and Medicine*, 17:23:1857-1865.
- McGilvray, D.B. (1994) Sexual power and fertility in Sri Lanka: Batticaloa Tamils and Moors', in MacCormack, C.P. ed. (1994) *Ethnography of Fertility and Birth*, 2<sup>nd</sup> edition, Prospect Heights, Illinois: Waveland Press.
- Mead, M. and Newton, N. (1967) 'Cultural patterning of perinatal behaviour', in Richardson, S.A. and Guttmacher, A.F. eds. *Childbearing - its Social and Psychological Aspects*, Baltimore: Williams and Wilkins.
- Meillassoux, C. (1981) *Maidens, Meal and Money: Capitalism and the Domestic Community*. Cambridge, New York and Melbourne: Cambridge University Press.
- Mhone, G.C.Z. (1992) 'The political economy of Malawi - an overview', in Mhone, G.C.Z. ed. *Malawi at the Crossroads: The Post-Colonial Political Economy*, Harare: SAPES Books.
- Middleton, K. (2000) 'How Karembole men become mothers', Carsten, J. ed. *Cultures of Relatedness: New Approaches to the Study of Kinship*. Cambridge, New York and Melbourne: Cambridge University Press.
- Mills, S. (2003) *Michel Foucault*, London and New York: Routledge.
- Ministry of Health and Population, Government of Malawi (1994) 'Revised TBA Curriculum', unpublished document.
- Ministry of Health and Population, Government of Malawi (1995) 'Malawi National Safe Motherhood Programme strategic Plan', unpublished document.
- Ministry of Health and Population, Government of Malawi (2003) National Safe Motherhood Operational Framework, 2002-2007, final draft.
- Mitchell J.C. (1956) *The Yao Village: A Study in the Social Structure of a Malawian People*, Manchester: Manchester University Press
- Mogenson, H.O. (1997) 'The narrative of AIDS among the Tonga of Zambia', *Social Science and Medicine*, 44.4: 431-439.
- Moore, H.L. and Sanders T. (2001) 'Magical interpretations and material realities: an introduction', in Moore, H.L. and Sanders T. eds. *Magical Interpretations and Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa*, London and New York: Routledge.
- Morris, B. (1985) 'Chewa conceptions of disease - symptoms and ideologies', *Society of Malawi Journal*, 38: 14-43.
- Morris, B. (1996) *Chewa Medical Botany: a Study of Herbalism in Southern Malawi*, Hamburg: Lit. Verlag and International African Institute.
- Morris, B. (1996) 'Hunting and the gnostic vision', *Journal of Human and Environmental Sciences*, 1.2: 13-39.
- Morris, B. (1998) *The Power of Animals: an Ethnography*, Oxford and New York: Berg.
- Morris, B. (2000) *Animals and Ancestors: an Ethnography*, Oxford and New York: Berg.
- Morton, H. (2002) 'From Mā'uli to motivator: transformations in reproductive care in Tonga' in Lukere, V. and Jolly, M. eds., *Birthing in the Pacific: Beyond Tradition and Modernity?*, Honolulu: University of Hawai'i Press.
- National Statistical Office, Malawi. (1998) 'District Specific Survey for Chiradzulu', available at <[www.nso.malawi.net/data\\_on\\_line/social/chiradzulu\\_dss.pdf](http://www.nso.malawi.net/data_on_line/social/chiradzulu_dss.pdf)> accessed 27 August 2003.

- National Statistical Office, Malawi and ORC Macro. (2001) *Malawi Demographic and Health Survey 2000*, Zomba, Malawi and Calverton, Maryland, USA: National Statistical Office, Malawi and ORC Macro, available at <www.nso.malawi.net/> accessed 22 May 2003.
- National Statistical Office, Malawi. (2002) 'Malawi: an Atlas of Social Statistics', available at <www.nso.malawi.net/data\_on\_line/general/Atlas/Atlas\_ht.ht> accessed 27 August 2003.
- National Statistical Office, Malawi. (2004) 'Summary of Projected Population Growth', available at <www.nso.malawi.net/> accessed 18 March 2004.
- Newland, L. (2002) 'Beranak and bekindu': discourses of risk and strength in childbirth and postpartum practice among Iban communities of Pakan', in Rozario, S. and Samuel, G. eds. (2002) *Daughters of Hariti: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Ngubane, H. (1977) *Body and Mind in Zulu Medicine: an Ethnography of Health and Disease in Nyuswa – Zulu Thought and Practice*, London: Academic Press.
- Ngubane, H. (1992) 'Clinical practice and organization of healers in South Africa', in Feierman, S. and Janzen, J.M. eds. *The Social Basis of Health and Healing in Africa*, Berkeley, Los Angeles and London: University of California Press.
- Nichter, M. (1998) 'The mission within the madness: self-initiated medicalisation as expression of agency', in Lock, M. and Kaufert, P.A. eds. *Pragmatic Women and Body Politics*, Cambridge: Cambridge University Press.
- Nkata, M. (1997) 'Maternal mortality due to obstructed labour', *International Journal of Gynecology and Obstetrics*, 57.1: 65-66.
- Nyirenda, K.K. (1999) 'In defence of traditional medicine', *The [Malawi] Nation*, 13 Oct.
- Oakley, A. (1981) 'Interviewing women: a contradiction in terms', in Roberts, H. ed. *Doing Feminist Research*, London: Routledge.
- Obermeyer, C.M. (1999) 'The cultural context of reproductive health: implications for monitoring the Cairo Agenda', *International Family Planning Perspectives*, 25. suppl. S50-S55.
- Offiong, D.A. (1991) *Witchcraft, Sorcery, Magic and Social Order among the Ibibio of Nigeria*, Enugu, Nigeria: fourth dimension Publishing Company.
- Okely, J. (1983) *The Traveller-Gypsies*, Cambridge: Cambridge University Press.
- Okely, J. (1992) 'Anthropology and autobiography: a participatory experience in embodied knowledge', in Okely, J. and Callaway, H. eds. *Anthropology and Autobiography*, Association of Social Anthropologists Monograph 29, London and New York: Routledge.
- O'Laughlin, B. (1995) 'Myth of the African family in the world of development', in Bryceson, D.F. ed. *Women Wielding the Hoe: Lessons from Rural Africa for Feminist theory and Development Practice*, Oxford and Herndon, Virginia: Berg Publishers.
- O'Neill, J. and Kaufert, P.A. (1990) 'Politics of obstetric care: the Inuit experience', in Handwerker WP ed. *Births and Power: Social Change and the Politics of Reproduction*, Boulder Colorado: Westview.
- Opportunities and Choices. (2002a) 'Barriers to use of family planning services in Malawi: findings from focus group discussions', Fact sheet 14, Opportunities and Choices, University of Southampton.
- Opportunities and Choices. (2002b) 'Who is using modern methods of contraception in Malawi? Evidence from the Malawi Demographic and Health Survey 2000', Fact sheet 15, Opportunities and Choices, University of Southampton.
- Pearce, T.O. (1993) 'Lay medical knowledge in an African context', in Lindenbaum, S. and Lock, S. eds. *Knowledge, Power and Practice: the Anthropology of Medicine and Everyday Life*, Berkeley, Los Angeles and London: University of California Press.
- Peters, P.E. (1995) 'Uses and abuses of the concept of 'female-headed households' in research on agrarian transformation and policy', in Bryceson, D.F. ed. *Women Wielding the Hoe: Lessons from Rural Africa for Feminist Theory and Development Practice*. Oxford, Berg.

- Peters, P.E. (1997a) 'Against the Odds: matriliney, land and gender in the Shire Highlands of Malawi', *Critique of Anthropology*, 17.2: 189-210.
- Peters, P.E. (1997b) 'Revisiting the puzzle of matriliney in South Central Africa: introduction', *Critique of Anthropology*, 17.2: 125-146.
- Phiri, K.M. (1983) *The Matrilineal Family System among the Chewa of Malawi since the Nineteenth Century: Continuity and Change*. History Seminar paper 19 pp1-25 University of Malawi, Chancellor College.
- Phiri, K.M. and Ross, K.R. (1998) 'From totalitarianism to democracy in Malawi', in Phiri, K.M. and Ross, K.R. eds. *Democratization in Malawi: a Stocktaking*, Blantyre: Christian Literature Association in Malawi, Kachere Books.
- Pigg, S.L. (1997) 'Authority in translation: finding, knowing, naming, and training "Traditional birth attendants" in Nepal', in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Plummer, K. (1983) *Documents of Life; an Introduction to the Problems and Literature of a Humanistic Method*, London: Unwin Hyman.
- Poewe, K.O. (1980) 'Matrilineal ideology: the economic activities of women in Luapula, Zambia' in Cordell, L.S. and Beckerman, S. eds. *The Versatility of Kinship*, New York: Academic Press.
- Poewe KO (1981) *Matrilineal Ideology: Male-Female Dynamics in Luapula, Zambia*, London and New York, Academic Press.
- Policy Project. (2003) 'Maternal and Neonatal Program Effort Index', available at <[http://www.policyproject.com/pubs/MNPI/Malawi\\_MNPI.pdf](http://www.policyproject.com/pubs/MNPI/Malawi_MNPI.pdf)> accessed 27 August 2003.
- Poole, R. (1994) *Dialogue and the Interpretation of Illness: Conversations in a Cameroon Village*, Oxford and Providence, USA: Berg.
- Power J. (1995) "'Eating the property": gender rules and economic change in urban Malawi, Blantyre-Limbe 1907-1953', *Canadian Journal of African Studies*. 29.1: 79-107.
- Prevention of Maternal Mortality Network. (1992) 'Barriers to treatment of obstetric emergencies in rural communities of West Africa', *Studies in Family Planning*, 23.5: 279-291.
- Prins, G. (1992) 'A modern history of Lozi therapeutics', in Feierman, S. and Janzen, J.M. eds. *The Social Basis of Health and Healing in Africa*, Berkeley, Los Angeles and London: University of California Press.
- Probst, P. (1995) 'Dancing AIDS, moral discourses and ritual authority in Central Malawi', Berlin: Institut für Ethnologie Arbeitspapiere No.66.
- Rabinow, P. ed. (1984) *The Foucault Reader: An Introduction to Foucault's Thought*, London: Penguin Books.
- Radcliffe-Brown, A.R. (1950) Introduction, in Radcliffe-Brown, A.R. and Forde, D. eds. *African Systems of Kinship and Marriage*, London and New York: Kegan Paul International in association with The International African Institute (1987 edition).
- Ram, K. (1998) 'Maternal experience and feminist body politics: Asian and Pacific perspectives', in Ram, K. and Jolly, M. eds. *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*, Cambridge, New York and Melbourne: Cambridge University Press.
- Rayner, S. (1992) 'Cultural theory and risk analysis' in Krinsky, S. and Golding, D. eds. *Social Theories of Risk*, Westport, Connecticut and London: Praeger.
- Rhodes L.A. (1996) 'Studying biomedicine as a cultural system', in Sargent, C.F. and Johnson, T.M. eds. *Medical Anthropology, Contemporary Theory and Method*, revised edition, Westport, Connecticut: Praeger.
- Richards, A.I. (1950) 'Some types of family structure amongst the Central Bantu', in Radcliffe-Brown, A.R. and Forde, D. eds. *African Systems of Kinship and Marriage*, London and New York: Kegan Paul International in association with The International African Institute (1987 edition).

- Rice, P.L. and Manderson, L. (1996) 'Introduction' in Rice, P.L. and Manderson, L. eds. *Maternity and Reproductive Health in Asian Societies*, Amsterdam: Harwood Academic Publishers.
- Roberts, S. (1964) 'A comparison of family law and custom of two matrilineal systems in Nyasaland', *The Nyasaland Journal*, 17.1: 24-41.
- Rosaldo, M.Z. (1974) 'Women, culture and society: a theoretical overview', in Rosaldo, M.Z. and Lamphere, L. eds. *Women, Culture and Society*, Stanford, California: Stanford University Press.
- Royal College of Nursing (1993) *Ethics Related to Nursing Research*, London: Scutari Press for the RCN.
- Rozario, S. (2002) 'The healer on the margins: the *dai* in rural Bangladesh', in Rozario, S. and Samuel, G. eds. *Daughters of Harīī: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Rozario, S. and Samuel, G. eds. (2002) *Daughters of Harīī: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Safe Motherhood Initiative. (2002) 'Every pregnancy faces risks', Safe Motherhood Fact Sheet, available at <[www.safemotherhood.org/facts\\_and\\_figures/every\\_pregnancy](http://www.safemotherhood.org/facts_and_figures/every_pregnancy)> accessed 22 March 2004.
- Safe Motherhood Project, Malawi. (1998) 'Participatory Needs Assessment Results: Blanytre District', (unpublished), Southern Regional Office, Safe Motherhood Project.
- Safe Motherhood Project, Malawi. (1999) 'Qualitative Needs Assessment Report: Zomba, Phalombe and Chiradzulu' (unpublished), Southern Regional Office, Safe Motherhood Project.
- Salomon, C. (2000) *Savoir et Pouvoir Thérapeutiques Kanaks*, Paris: Presses Universitaires de France.
- Salomon, C. (2002) 'Obligatory maternity and diminished reproductive autonomy in A'jië and Paicī Kanak societies', in Lukere, V. and Jolly, M. eds., *Birthing in the Pacific: Beyond Tradition and Modernity?*, Honolulu: University of Hawai'i Press.
- Samuel, G. (2002) 'Introduction: the daughters of Harīī today', in Rozario, S. and Samuel, G. eds. *Daughters of Harīī: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Sargent, C.F. (1982) *The Cultural Context of Therapeutic Choice: Obstetrical Care Decisions Among the Bariba of Benin*, Dordrecht, Boston and London: D. Reidel Publishing Company.
- Sargent, C.F. (1989) *Maternity, Medicine and Power: Reproductive Decisions in Urban Benin*, Berkeley and Los Angeles: University of California Press.
- Sargent, C.F. and Bascope, G. (1997) 'Ways of knowing about birth in three cultures' in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Save the Children. (2002) 'State of the World's Newborns: Malawi', Lilongwe, Malawi: Saving Newborn Lives.
- Scheper-Hughes, N. (1992) *Death Without Weeping: the Violence of Everyday Life in Brazil*, Berkeley, Los Angeles and London: University of California Press.
- Schneider, D.M. and Gough, K. (eds.) (1961) *Matrilineal Kinship*, Berkeley: University of California Press.
- Sen, A. (1990) 'Gender and cooperative conflicts', in Tinker, I. ed. *Persistent Inequalities*, Oxford: Oxford University Press.
- Shaw, A. (2000) 'Conflicting models of risk': clinical genetics and British Pakistanis', in Caplan, P. ed. *Risk Revisited*, London and Sterling, Virginia: Pluto Press.
- Schoffeleers, J.M. (1968) 'Evil spirits and problems of human reproduction in the Lower Shire Valley of Malawi', *Malawi Medical Bulletin*, 2.1: 12-17.
- Shore, C. (1999) 'Fictions of fieldwork: depicting the 'self' in ethnographic writing (Italy)', in Watson, C.W. ed. *Being There: Fieldwork in Anthropology*, London and Sterling, Virginia: Pluto Press.
- Sibley, L.M. and Sipe, T.A. (2002) 'Traditional birth attendant training effectiveness: a meta-analysis', Academy for Educational Development SARA Project, March.



- Sindiga, I., Nyaigotti-Chacha, C. and Kanunah, M.P. eds. (1995) *Traditional Medicine in Africa*, Nairobi: East African Educational Publishers.
- Skinner, J. (2000) 'The eruption of Chances Peak, Montserrat, and the narrative containment of risk', in Caplan, P. ed. *Risk Revisited*, London and Sterling, Virginia: Pluto Press.
- Simpson, H. (1998) 'Quality of Care Study, Safe Motherhood Project', unpublished report, Southern Regional Office, Malawi: Safe Motherhood Project.
- Smart, B. (1985) *Michel Foucault*, London and New York: Routledge.
- Spring, A. (1995) *Agricultural Development and Gender Issues in Malawi*, Lanham, Maryland and London: University Press of America.
- Steinberg, S. (1996) 'Childbearing research: a transcultural view', *Social Science and Medicine*, 43.12:1765-1784.
- Stoner, B.P. (1986) 'Understanding medical systems: traditional, modern and syncretic health care alternatives in medically pluralistic societies', *Medical Anthropology Quarterly*, 17.2:44-48.
- Strathern, M. (2000) 'Accountability and ethnography', in Strathern, M. ed. *Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy*, London: Routledge.
- Strathern, A. and Stewart P. J. (1999), *Curing and Healing: Medical Anthropology in Global Perspective*, Durham, North Carolina: Carolina Academic Press.
- Stewart, P.-J. and Strathern, A. (2001) *Humors and Substances*, Westport, Connecticut: Bergin and Garvey.
- Szurek, J. (1997) 'Resistance to technology-enhanced childbirth in Tuscany: the political economy of Italian birth', in Davis-Floyd, R.E. and Sargent, C.F. eds. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, Berkeley, Los Angeles and London, University of California Press.
- Taylor, D. (1991) *The Children Who Sleep by the River*, London: Allison and Busby.
- Thaddeus, S. and Maine, D. (1994) 'Too far to walk: maternal mortality in context', *Social Science and Medicine*, 38.8: 1091-1110.
- Thomas, K. (1982) 'The meaning of the term 'witchcraft'', in Marwick, M. ed. *Witchcraft and Sorcery*, London: Penguin Books.
- Treichler, P. (1990) 'Feminism, medicine and the meaning of childbirth', in Jacobus, M., Keller, E.F. and Shuttleworth, S. eds. *Body/Politics: Women and the Discourses of Science*, New York and London: Routledge.
- Turner, V.W. (1968) *The Drums of Affliction: a Study of Religious Processes among the Ndembo of Zambia*, Oxford: Clarendon Press and The International African Institute.
- UNAIDS. (2002) 'Report of the Global HIV/AIDS Epidemic 2002', available at <[www.unaids.org/epidemic\\_update/report\\_july02/](http://www.unaids.org/epidemic_update/report_july02/)> accessed 21 May 2003.
- United Kingdom Central Council for Nurses, Midwives and Health Visitors (1992) *Code of Professional Conduct*, UKCC.
- United Kingdom Central Council for Nurses, Midwives and Health Visitors (1998) *Midwives Rules and Code of Practice*, UKCC.
- Unnithan-Kumar, M. (2002) 'Midwives amongst others: knowledges of healing and the politics of emotions in Rajasthan, Northwest India', in Rozario, S. and Samuel, G. eds. *Daughters of Harīī: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Van Breugel, J.W.M. (2001) *Chewa Traditional Religion*, edited and introduced by Martin Ott, Kachere Monograph no.13, Blantyre, Malawi: Christian Literature Association in Malawi.
- Van den Broek, N.R. and Letsky, E.A. (2000) 'Etiology of anaemia in pregnancy in south Malawi', *The American Journal of Clinical Nutrition, Supplement*, 72.1(S): 247S-256S.
- Van Hollen, C. (1998), *Birthing on the Threshold: Childbirth and Modernity among Lower Class Women in Tamil Nadu, South India*, Berkeley: University of California, PhD thesis. Published as Van Hollen, C. (2003) *Birth on the Threshold: Childbirth and Modernity in South India*, Berkeley, Los Angeles and London: University of California Press.

- Vaughan, M. (1983) 'Which family?: problems in the Reconstruction of the history of the family in Africa', *Journal of African History*, 24: 275-283.
- Vaughan, M. (1991) *Curing their Ills: Colonial Power and African Illness*, Stanford, California: Stanford University Press.
- Veale, D.J.H., Havlik, I., Katsoulis, L.C., Kaido, T., Arangies, N.S., Olive, D.W., Dekker, T., Brookes, K.B. and Doudoukina, O.V. (1998) 'The pharmacological assessment of herbal oxytocics used in South African traditional medicine', *Biomarkers and Environment*, 2.2,3 available at <[www.lfp.cuni.cz/journals/bioenv/1998/3-2/216-en.html](http://www.lfp.cuni.cz/journals/bioenv/1998/3-2/216-en.html)>
- Vera-Sanso, P. (1995) 'Community, seclusion and female labour force participation in Madras', in Chant S. ed. *Third World Planning Review*, Special Issue on Gender and Development, 17.2: 155-167.
- Vincent Priya, J. (1992) *Birth Traditions and Modern Pregnancy Care*, Shaftesbury, Dorset and Rockport, Massachusetts: Element Books.
- Vitebsky, P. (1993) 'Is death the same everywhere? Contexts of knowing and doubting', in Hobart M. ed. *An Anthropological Critique of Development: the Growth of Ignorance*, London: Routledge.
- Vuyk, T. (1991) *Children of One Womb: Descent, Marriage and Gender in central African Societies*, Leiden - Centrum voor Niet-westers: Studies Rijksuniversiteit.
- White, L. (1987) *Magomero: Portrait of an African Village*, Cambridge, New York and Melbourne: Cambridge University Press
- Whittaker, A. (2002) 'The demise of birth attendants in Northeast Thailand: embodying traditions in modern times', in Rozario, S. and Samuel, G. eds. *Daughters of Harīfī: Childbirth and Female Healers in South and South-East Asia*, London and New York: Routledge.
- Wills, A.J. (1985) *An Introduction to the History of Central Africa. Zambia, Malawi and Zimbabwe*, 4<sup>th</sup> edition, Oxford: Oxford University Press.
- Wilson, M. (1982) 'Witch beliefs and social structure', in Marwick, M. ed. *Witchcraft and Sorcery, Selected Readings*, 2<sup>nd</sup> edition, London: Penguin Books, (formerly published 1951 American Journal of Sociology, 56: 307-313).
- World Health Organization. (1999) 'Reduction of Maternal Mortality: a joint WHO/UNFPA/UNICEF world Bank Statement, Geneva: WHO. Available from <<http://www.reproline.jhu.edu/>> accessed 13 June 2002.
- World Health Organization. (2003) 'Global Action for Skilled Attendants for Pregnant Women', Geneva, WHO Department of Reproductive Health.
- Wynne, B. (1992) 'Risk and social learning: reification to engagement', in Krimsky, S. and Golding, D. eds. *Social Theories of Risk*, Westport, Connecticut and London: Praeger.
- Yanagisako, S.J. (1979) 'Family and household: the analysis of domestic groups', *American Review of Anthropology*, 8: 161-205.
- Zulu, E.M. (2001) 'Ethnic variations in observance and rationale for postpartum sexual abstinence in Malawi', *Demography*, 38.4: 467-479.

## **UKCC Code of Professional Conduct (for Nurses, Midwives and Health Visitors) 1992**

Each registered nurse, midwife and health visitor shall act, at all times, in such a manner as to:

- safeguard and promote the interests of individual patients and clients;
- serve the interests of society;
- justify public trust and confidence and
- uphold and enhance the good standing and reputation of the professions.

As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must:

1. act always in such a manner as to promote and safeguard the interests and well-being of patients and clients;
2. ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients;
3. maintain and improve your professional knowledge and competence;
4. acknowledge any limitations in your knowledge and competence and decline any duties or responsibilities unless able to perform them in safe and skilled manner;
5. work in an open and co-operative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care;
6. work in a collaborative and co-operative manner with health care professionals and others involved in providing care, and recognise and respect their particular contributions within the care team;

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7. recognise and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor;
  8. report to an appropriate person or authority, at least the earliest possible time, any conscientious objection which may be relevant to your professional practice;
  9. avoid any abuse of your privileged relationships with patients and clients and of the privileged access allowed to their person, property, residence or workplace;
  10. protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by the order of a court or where you can justify disclosure in the wider public interest;
  11. report to an appropriate person or authority, having regard to the physical, psychological and social effects on patients and clients, any circumstances in the environment of care which could jeopardise standards of practice;
  12. report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided;
  13. report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice are care;
  14. assist professional colleagues, in the context of your own knowledge, experience and sphere of responsibility, to develop their professional competence and assist others in the care team, including informal carers, to contribute safely and to a degree appropriate to their roles;

15. refuse any gift, favour or hospitality from patients or clients currently in your care which might be interpreted as seeking to exert influence to obtain preferential consideration and

16. ensure that your registration status is not used in the promotion of commercial products or services, declare any financial or other interests in relevant organisations providing such goods or services and ensure that your professional judgement is not influenced by any commercial considerations.

### **Notice to all Registered Nurses Midwives and Health Visitors**

The Code of Professional Conduct for the Nurse, Midwife and Health Visitor is issued to all registered nurses, midwives and health visitors by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The Council is the regulatory body responsible for the standards of these professions and it requires members of the professions to practise and conduct themselves within the standards and framework provided by the Code.

The Council's Code is kept under review and any recommendations for change and improvement would be welcomed and should be addressed to the:

Chief Executive/Registrar

United Kingdom Central Council

for Nursing, Midwifery and Health Visiting

23 Portland Place

London

W1N 4JT

United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

(Original text document June 1992)

[ukcc.org.uk/cms/content/publications/code](http://ukcc.org.uk/cms/content/publications/code) accessed 11.02 01

## Code of Ethics

### INTRODUCTION

In an effort to increase understanding and, hence, use of the International Code of Ethics for Midwives (1999), the ICM Board of Management commissioned the publication of this booklet. The booklet contains the Code, the glossary of terms used in the Code, the ethical analysis of the Code, a brief history of the development of the Code, and suggestions on how the midwife can use this Code in practice, education or research.

International Code of Ethics for Midwives (1999)

### PREAMBLE

The aim of the International Confederation of Midwives (ICM) is to improve the standard of care provided to women, babies and families throughout the world through the development, education, and appropriate utilization of the professional midwife. In keeping with its aim of women's health and focus on the midwife, the ICM sets forth the following code to guide the education, practice and research of the midwife. This code acknowledges women as persons with human rights, seeks justice for all people and equity in access to health care, and is based on mutual relationships of respect, trust, and the dignity of all members of society.

### THE CODE

#### I. Midwifery Relationships

- a. Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcomes of her choices.
- b. Midwives work with women, supporting their right to participate actively in decisions about their care, and empowering women to speak for themselves on issues affecting the health of women and their families in their culture/society.
- c. Midwives, together with women, work with policy and funding agencies to define women's needs for health services and to ensure that resources are fairly allocated considering priorities and availability.
- d. Midwives support and sustain each other in their professional roles, and actively nurture their own and others' sense of self-worth.
- e. Midwives work with other health professionals, consulting and referring as necessary when the woman's need for care exceeds the competencies of the midwife.
- f. Midwives recognize the human interdependence within their field of practice and actively seek to resolve inherent conflicts.
- g. The midwife has responsibilities to her or himself as a person of moral worth, including duties of moral self-respect and the preservation of integrity.

#### II. Practice of Midwifery

- a. Midwives provide care for women and childbearing families with respect for cultural diversity while also working to eliminate harmful practices within those same cultures.
- b. Midwives encourage realistic expectations of childbirth by women within their own society, with the minimum expectation that no women should be harmed by conception or



childbearing.

- c. Midwives use their professional knowledge to ensure safe birthing practices in all environments and cultures.
- d. Midwives respond to the psychological, physical, emotional and spiritual needs of women seeking health care, whatever their circumstances.
- e. Midwives act as effective role models in health promotion for women throughout their life cycle, for families and for other health professionals.
- f. Midwives actively seek personal, intellectual and professional growth throughout their midwifery career, integrating this growth into their practice.

### III. The Professional Responsibilities of Midwives

- a. Midwives hold in confidence client information in order to protect the right to privacy, and use judgement in sharing this information.
- b. Midwives are responsible for their decisions and actions, and are accountable for the related outcomes in their care of women.
- c. Midwives may refuse to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services.
- d. Midwives understand the adverse consequences that ethical and human rights violations have on the health of women and infants, and will work to eliminate these violations.
- e. Midwives participate in the development and implementation of health policies that promote the health of all women and childbearing families. Revised May 1999.

### IV. Advancement of Midwifery Knowledge and Practice

- a. Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women as persons.
- b. Midwives develop and share midwifery knowledge through a variety of processes, such as peer review and research.
- c. Midwives participate in the formal education of midwifery students and midwives.

6 May 1993

### Glossary of Terms used in ICM Code of Ethics

It is the goal of the ICM that this Code of Ethics be used and tested for its relevance to the practice of midwifery and for midwives. One element of understanding relates to the use of language across cultures and societies. Therefore, the following terms are defined as used in the ICM Code of Ethics.

equity in access to health care (preamble): this implies fairness in the allocation of limited resources according to need; for example, vulnerable populations/groups could receive more attention to their health needs and access to services than those who can purchase such services anywhere.

informed right of choice (I.A.): 'informed' implies that complete information is given to and understood by the woman regarding the risks, benefits and probable outcomes of each choice available to her.

human interdependence (I.F.): since midwives work in relationship with women and others and may not always agree about what is right or should be done in a given situation, it is important that midwives seek to understand the reasons for the disagreements with clients or colleagues. Midwives do not stop with understanding, however. They also work to resolve those conflicts that need to be resolved in order for ethical care to continue.

individual conscience (III.B.): defined as thoughtful reflection on, analysis, and ownership of deeply held moral positions; in this context, the midwife can refuse to provide care only if someone else is available to provide the needed care.

professional (Preamble): this term is used to recognize the concept that to be ethical is to be professional, to be unethical is to be unprofessional.

professional knowledge (II.C.): this implies midwifery knowledge gained from both formal and informal educational opportunities that lead to competence in practice.

professional responsibilities (III.): this refers to the broad ethical duties/obligations of the midwife that are not practice, education or research specific.

related outcomes (III.C): midwives are responsible for the results of their own decisions and actions; they cannot be held responsible for outcomes over which they have no control (e.g. genetics). There may be situations in which the midwife is ordered by someone in power to practice in an unethical manner. We appreciate the difficulty of this situation, but the action remains unethical if the midwife chooses to follow such an order. The midwife must be aware of the risks in choosing not to follow such an order, however.

rights of women as persons (IV.A.): human rights related to any research involvement include privacy, respect, truth-telling, doing good and not harming autonomy and informed consent.

throughout the life cycle (II.E.): midwifery care is more than care related to childbearing; midwives care for women of all ages, many of whom never conceive or bear children; use of this phrase is an attempt to cover both the reproductive and gynaecological health care for women.

women as persons (preamble); women will be treated with respect for human dignity (not as objects). Principles of truth-telling, privacy, autonomy and informed consent, doing good and not harming will direct any interaction between women and midwives.

## **ETHICAL ANALYSIS OF THE CODE OF ETHICS**

### **INTRODUCTION**

Ethics codes are often a mix of universal ethical principles and strongly held values specific to the 'professional group'. Below is a brief analysis of the major ethical principles



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and concepts that form the basis for each of the statements of the ICM International Code of Ethics for Midwives.

#### I. Midwifery Relationships

- a. Autonomy and accountability of women
- b. Autonomy and 'human equalities' of women
- c. Justice/fairness in the allocation of resources
- d. Respect for human dignity
- e. Competence. Interdependence of health professionals, safety
- f. Respect for one another

#### II. Practice of Midwifery

- a. Respect for others, do good, do not harm
- b. Client accountability for decisions, do not harm, safety
- c. Safety
- d. Respect for human dignity, treat women as whole persons
- e. Health promotion: attain/maintain autonomy, good/no harm, allocation of resources
- f. Competence in practice

#### III. Professional Responsibilities of Midwives

- a. Confidentiality
- b. Midwife accountability
- c. Midwife conscience clause: autonomy and respect of human qualities of the midwife
- d. Health policy development: justice, do good

#### IV. Advancement of Midwifery Knowledge and Practice

- a. Protect rights of women as persons
- b. Midwife accountability, safety, competence
- c. Professional responsibility: enhance competence of all professionals to do good, do not harm

#### The Process of Development of the ICM Code

The charge to develop a code of ethics that defined the moral context of midwifery in meeting the needs of women came from the ICM Board of Management. A brief history of the process of development of the ICM code of ethics may help the reader to understand more fully how specific principles and concepts were included and why others were not. The Code was drafted in a series of workshops, beginning in May 1986 in Vancouver, and continuing in 1987 in the Hague and in 1991 in Spain.

The final draft, the consensus document of the Executive Committee in Madrid, was presented to the ICM Council in Vancouver, British Columbia, and adopted on 6 May 1993.

Code development began with a review of systems of ethics, an understanding of how

individuals develop morally, and a brief review of the history of code development in medicine and nursing. This was followed by an analysis of the values inherent in the ICM Constitution's statements on the aim and objectives of the Confederation, the ICM/WHO/FIGO definition of a midwife, and accepted ICM position statements as of 1992.

In order to provide a world-wide (global) focus to the ICM code, the group aimed at statements that were often broader in their meaning than individual association codes so that cultural/societal or ethnic variations could be respected. Seven midwifery association codes of ethics received at ICM headquarters during 1991 were analysed, revealing the following ethical concerns:

Safety, competence, accountability, confidentiality, appropriate consultation and referral, respect for human dignity, client involvement in decisions, participation in knowledge development in midwifery and de design of maternal-child health policies, respectful interaction with other team members, health promotion, justice/fairness, non-discrimination, and the education of future midwives.

At all times, the concern for understandability, culturally sensitive wording, and the global nature of the ICM code were kept in mind. Two other important features were agreed: first, that whenever possible, the ICM code would promote a global (universal) level of ethical principles, with reasonable consideration for personal and/or consciously to exclude reference to the law or legal entities within the code. While ethics and law are related, the law varies from country to country. Normally, ethics or ethical systems respect the law, but at times ethics may go beyond the law.

As noted during the introduction to this booklet, the Code of Ethics for Midwives is intended to be a 'living' document, and the ICM welcomes comments and suggestions for enhancing the understanding and usefulness of this document over the years.

## **SOME QUESTIONS ABOUT A CODE OF ETHICS**

### **1) What is a Code of Ethics?**

A code of ethics is a public declaration of the beliefs and values of a profession and the members of that profession. This code makes public the goals, values and morals of those who call themselves 'midwives' - a statement to the public about what the profession of midwifery defines as moral behaviour for its practitioners.

### **2) Why have a code?**

A code of ethics acts as a specific, identifying feature for a particular professional group, both for the professionals themselves and for the general public. In addition, the need for an explicit code has become more urgent in recent years, as an accelerated pace of social and technological change has produced situations that demand an ethical response. Finally, the increased speed and frequency of global communications have made the development of a formal statement of shared beliefs and values vital as an agreed point of departure or common language for the profession worldwide.

### **3) What can't a code do?**

A code of ethics cannot assure ethical practice or 'good' decisions in midwifery care; it cannot 'tell' one how to make ethical decisions or what to do in every situation; it cannot



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prevent its misuse; and the code cannot offer specific issues for discussion or resolution. Finally, a code cannot remove from midwives the responsibility and pain of living and acting, at times, in situations of ambiguity or 'not knowing', of having no in-built guarantees about what, in a given case, constitutes 'right action'.

#### Suggestions on how to use the Code of Ethics

The value of a statement of one's professional code of ethics lies in its usefulness in all spheres of professional practice. For the midwife, these spheres of practice may include direct care-giving, teaching others, administration and research. The following are suggestions of how the International Code of Ethics for Midwives may be used:

In daily practice, the Code can be an important tool or reference point (yardstick) when facing decisions on what one 'should' do in caring for women and childbearing families. While the statements of the Code may not give absolute direction to your decision making, they can (or the ethical principles they are based upon can) offer a framework for action; eg. selecting and option that promotes good or prevents harm to women.

Practitioners could use criteria within the code when negotiating with others in an effort to obtain the best outcomes for women and their families. The code can be shared with the public by the posting of printed copies.

In education, the midwife teacher has an obligation to help students understand what it means to be a moral agent, to practice ethically, and to identify, understand and accept the dominant values of the profession of midwifery. Teaching methods include a value analysis of each statement of the Code, using the Code in the ethical analysis of critical incidents from midwifery practice, and comparing the basic tenets of the Code for Midwives with those of codes from other professional groups. Critical incident analysis can be a powerful teaching instrument at any level, illuminating practice decisions with the code's principles as well as with personally identified values.

In administration, midwives can use the Code to establish a working environment for ethical practice. Administrators can use the tenets of the Code to define expectations of how midwives will relate to clients, as a framework for ethics rounds and for establishing an ethical environment in which employees can function.

In research, the Code explicitly defines the ethical approach of the midwives in Statement III.A and Statement IV. in its entirety. Researchers, whether midwives or others, should adhere to these basic principles.

ICM 5/1999

Caplan, P. ed. (2003) *The Ethics of Anthropology: debates and dilemmas*,  
London: Routledge. Reproduced by agreement. 7

## 'TO TELL OR NOT TO TELL?'

Ethics and secrecy in anthropology and  
childbearing in rural Malawi

Gill Barber

### Introduction

The chapter is about ethics and secrecy, confidentiality and disclosure, the issues that arose in my fieldwork in rural Malawi, and how they were handled. I experienced the issues discussed here as dilemmas and they provide the opportunity for an exploration of the ethics of anthropological research, specifically concentrating on secret and concealed knowledge. There appears to be limited evidence in the literature indicating anthropologists' approaches to these tensions, and little specific guidance even in codes of practice. Furthermore, in this fieldwork two very different professions came together and I take the opportunity to reflect on my position as both midwife and anthropologist, the potential disparity between the two and whether their differing ethical stances can be reconciled.

Before discussing the wider issues of disclosure and anthropology, I describe my pre-fieldwork concerns and fears and how I set about addressing them, and look at the background that constructed fieldwork as potentially problematic for me. As Corey *et al.* (1988) suggest, consideration of personal values and why they are held is vital for ethical decision-making. I next consider the dichotomies between the two systems of medicine encountered and the two codes of practice. The traditional village midwives are then introduced, with analysis of what happened and my response.

The concept of secrecy, and more specifically confidentiality, anonymity and the question about whether to tell or not to tell links three areas of exploration for this chapter. One is a reflexive personal account of experience, the second considers my evidence and what it revealed, and the third describes how the anthropologist's dilemma is lived and resolved. Ultimately it is about the politics of whistle-blowing.

The community in which fieldwork was conducted is very poor, with most people undertaking subsistence agriculture on land that is becoming

GILL BARBER

increasingly deforested and overused. The threat of hunger is never far away. The people are of Lomwe, Yao or Ngoni origin and are predominantly Roman Catholic, Seventh-Day Adventist or Muslim. The community is strongly matrilineal with inheritance through the female line and matrilocality. Many households are female-headed. The area is located some 20 kilometres from a southern urban area of Malawi and served by a well-respected mission hospital and several schools.

My main fieldwork was carried out with three traditional midwives known as 'traditional birth attendants' (TBAs) in international terminology, *azamba* in the chiChewa translation. Often dismissed in scientific literature as illiterate and unlikely to practise safely and hygienically, many women continue to use the services of these midwives in the context of inadequate access to acceptable 'skilled' biomedical care. Unlike 'professional' midwives who have studied on statutory national training programmes to enable them to take legal responsibility for the full care of healthy mothers and babies, traditional midwives generally have been prepared by an apprenticeship (often to their mothers) and some, in recent times, have received a programme of short government training. Their effectiveness in caring safely for women is partly ensured by regular professional supervision and updating. Women themselves almost always select such midwives and an additional aspect of their legitimacy is that they have themselves given birth.

A final introductory note concerns the current maternal health context: women die in vastly greater numbers in poorer countries, a 'natural' disaster commonly equated to the loss every four hours of a loaded jumbo jet. In Malawi as many as one woman in 20 currently dies through childbearing despite extensive efforts, and the situation, both there and globally, shows no improvement, almost certainly because of increasing deprivation and HIV and AIDS. The global focus is now on skilled care and emergency support, including transport and the quality of service provision, but this policy pays minimal attention to the context in which women live and in which choices are made. The fieldwork that is the subject of this chapter was therefore designed to explore the concepts, knowledge and notions of risk that influence decision-making around childbearing.

### Anticipation and reality: The fieldwork – reconciling differences

Before leaving for the field I experienced many qualms about how I would act if a childbirth situation arose that disturbed me. I also anticipated conflicts in people's expectations of me.

What was I to do if I did not like what I saw happening to birthing women? This question is, of course, loaded with assumptions but relates to my attempt to integrate two potentially dissonant personae, the midwife and

the anthropologist. How far would I take my awareness that western concepts of medicine did not have all the answers for birthing women and were inadequate as explanatory paradigms for human experience? I expected local birthing practices to be different from those in the UK yet knew that evidence for making judgements was limited. I must 'think on my feet'.

I planned to spend much of my time with *azamba* and in more anxious pre-fieldwork moments thought about how I might act. Would I ever need to intervene in a birth? Worst-case scenarios were witnessing internal manipulations and pulling on the unborn baby, or the application of substances such as cow-dung and pummelling on the woman's abdomen to speed up the birth, all known practices that I had encountered elsewhere. Less anticipated was being privy to secret knowledge but I anticipated needing to be circumspect towards the local authorities. I needed their cooperation and views but was wary of causing doors to close on me if informants suspected I was reporting back.

This perhaps indicates more concern over the consequences of a loss of trust than with the ethics of confidentiality. In fact I found local people to have rather optimistic expectations of my relationships with health service staff – advocacy was expected of me even to government level. Nevertheless confidences and privileged information could be problematic and it was eventually this that caused me more worry than any need to intervene. I had also to take responsibility for the ethical conduct of my interpreters. News travels fast in a small community and I knew attempts at manipulation were possible.

Plummer (1983) believes exploitation and betrayal of subjects to be a crucial ethical issue. I was aware of the potential for harm to my informants and took account of Homans' warning that social researchers could be held accountable for harm 'only at their peril – proceeding without reckoning the likely consequences and implications of their work' (1991: 176).

### The issue of secrecy

The theme of secrecy emerged unexpectedly. Many people in Malawi live in fear of being bewitched, often by a jealous neighbour or relative, and may therefore go to great lengths to conceal their property. Improving one's house or harvesting a high-yield crop may lead either to being bewitched or to an accusation of having profited by witchcraft. I was acutely aware of my own potential for precipitating jealousy and learned to be discreet, particularly when providing material assistance. Furthermore, fear of witchcraft makes some women reluctant to divulge their labours or to seek help if problems arise. Another important area of secrecy that emerged in this context concerned the influence of marital infidelity during pregnancy on the progress of labour. The concept that infidelity by the woman or her husband can lead to obstructed labour – a highly dangerous situation when the infant

cannot be born – is well known in southern and central Africa. The secrecy element lies in the use of 'telling' the names of sexual partners in order to free up the birth. Waiting for such confession may lead to serious delays in seeking help, compounded in some mainly patrilineal areas by the desire of older kin to monitor the length of labour at home as an indicator of faithfulness. Problems in childbearing may also be seen as the result of bewitching, as happened to Gladys whom I introduce later.

Secrecy has several elements; significant among these is the secret knowledge of women. I gleaned some information by asking how women learned about childbirth now, and saw many tantalising glimpses of the past in people's narratives of 'going to the river' and the 'old ways' of preparing pre-pubertal girls for womanhood and young women for marriage, especially when women danced. (See Plate 7.1.) The overall view was that such ways have now gone for most people, or are practised only in an attenuated form. Wavering on the edge of the ethical issues around anthropological curiosity and the need to know, I finally did not take up an offer to be told the secrets of the old-style initiation of girls which appeared to be largely a discourse on sexuality.

People do not talk publicly about initiation, and their reticence is indicated by the use of the 'going to the river' euphemism. If I had pressed for more information, or taken up the offer made on one occasion, I would then have had to decide what to do with the knowledge. Those who offered to tell me were a group of older women who hugely enjoyed our interview sessions. Would others be as happy for me to know? Would they themselves like to see it written down and perhaps published? What end other than



Plate 7.1 Village *azamba* dancing with other women

curiosity, amounting almost to intellectual voyeurism and ambition to publish, would justify making secret knowledge public?

The secret information that concerned me most had regard to the activities of the *azamba* which I explore in detail later. Should I divulge these or not? The issue was 'to tell or not to tell' both the local supervisor and a wider audience, the latter through the written word. I eventually understood that their activities were not only universally recognised in the neighbourhood, but were instrumental in attracting some of their clients. Matters of confidentiality and anonymity nevertheless still arose about who should know and what should be known. In the end my decision-making was heavily influenced by my initial motivation, which was to explore lesser-known areas of women's lives that influenced what happened to them in childbirth. As a midwife this aim could not be formulated only for curiosity or to add to the global knowledge bank, but indeed for some fairly vague notion of sensitising policy-makers in the hope that women's lives could be ameliorated and the risks they face lessened. The matter of the *azamba*'s herbal armoury was intrinsic to my exploration of the knowledge that governs action in the community, hence I decided that guarding the anonymity of the *azamba* was adequate and that I could publish what I had discovered about their activities.

Before considering what really happened, I need to locate myself in the encounter between two worlds, my familiar world of midwifery and 'the other' as an anthropologist in the field.

#### Two systems of medicine: Western and local

I trained when home birth was still a common option but hospital birth and medical control was on the ascendant though still comparatively 'low-tech'. I much preferred the relative freedom and rewarding relationships of community practice. Working subsequently in Senegal I failed dismally to get to know local people. My knowledge of local healers and midwives was minimal and my attitudes probably as dismissive as those of my Senegalese colleagues.

I returned eventually to the UK to fit back in with difficulty. Becoming pregnant myself concentrated my mind and I realised I did not want the increasingly medicalised birth that many of my clients were experiencing. I covertly attended natural childbirth classes and picked my own midwife carefully. Mentored by a colleague and influenced by the then leading thinkers on the subject such as Leboyer, Odent and Kitzinger, I soon became a 'radical' midwife, a natural childbirth teacher and eventually a lecturer in midwifery.

So I was already poised uncomfortably between two ways of knowing, raised in the confident atmosphere of the western biomedical paradigm, but aware that alternatives were possible, perhaps even preferable. British

midwifery was moving towards peaceful births, in the presence of trusted companions, the avoidance of interference and learning from other cultures. But where should the line be drawn about learning from other ways? Few would doubt the danger of rolling a pounding stick on a labouring woman's abdomen to speed the birth. But the effectiveness of herbal remedies and everyday substances such as Coca-Cola (a Malawian remedy for anaemia) is rarely evaluated. The need for fast action if a woman bleeds heavily is probably undisputed anywhere, but what if a local herb is more effective in stopping heavy bleeding than a long journey to hospital on bad roads, maybe on the back of a bike? It was possible that intervention on my part could itself jeopardise women's safety in some circumstances. How would I determine the wisest action when conducting anthropological research in this unfamiliar environment?

Biomedical accounts of birth are woefully inadequate on their own as explanation for what women experience. Who knows what influence it may have if a woman stands at a crossroads or in a doorway, braids her hair tightly, is 'tied' by a witch or knows her husband has been 'going around with girls' (a not uncommon scenario in Malawi with the celibacy expected of a couple in later pregnancy). Such ideas and their remedies of unbinding and confession are linked in Malawi and further afield with prolonged labour. Influences on the well-being of mother, baby and husband are constant themes in Malawian discourse. Particular emphasis is laid on danger and vulnerability, resulting from imbalances of ritual hot and cold status with their links to moral behaviour and social control. It is plausible that such beliefs, with the attendant fear and its resolution, could influence hormone levels and be self-fulfilling. Yet such a supposition inevitably demonstrates the strength of my biomedical roots as I seek physiological explanations for phenomena, something I found myself doing constantly in the field.

On arrival in Malawi I found a well-developed western-model health service with the informal integration of local forms of therapy. Malawians of all educational levels may turn to traditional healers (*sing'anga*) alongside formal health care. According to Morris (1998) healers' emphasis lies in using animal and plant material although diviners and sorcerers may also be consulted. Forster's work on religion, magic, witchcraft and AIDS demonstrates the attribution of many diseases to spirits, and shows that the relationship between spirits, witchcraft, sorcery and biological disease is a complex one.

The multi-layered and intermingled nature of local therapeutic systems goes deeper than the mere choice of western-trained medical or 'African' doctors in that *sing'anga* and *azamba*, both of whom may act as healers and midwives, themselves use old and new systems simultaneously. Indeed the heavy use of plant remedies which have pharmacological properties suggests a strong biomedical element to the herbalist's knowledge as well as the

intrinsic powers described by Morris and the close link between animal substances and the spirit world (1998).

If Malawians could reconcile such differences and move freely between acologies and therapies, would I be able to reconcile the forms of care I might observe and, more pertinently, the different professional ethical demands?

Both anthropology and midwifery have codes of practice and guidelines. Would they help me to decide how to act?

### Two codes of practice: Anthropology and midwifery

As a UK-registered midwife I am accountable for my practice in whatever environment I find myself. In all circumstances, the safety and welfare of the mother and baby are of primary importance' states the Midwives Rules and Code of Practice (UKCC, 1998). I would not be entitled to practice in Malawi and in any case I was not there for that purpose, but people might not see it that way and thus I could still be held accountable. The UK code was familiar to midwives in Malawi (Msowoya, personal communication) and the International Code of Ethics for Midwives expects the same of midwives anywhere (International Confederation of Midwives, 2000). This encourages respect for cultural diversity while 'working to eliminate harmful practices'. There is no doubt that the interests of mothers and babies, or even the dignity and privacy of individuals such as traditional midwives could never be subordinated to research interests. But what would be in the best interests of mothers and babies and what were harmful practices? This was not as easy to answer.

Still concerned about these issues, I talked them through with the supervisor designated for me by the University of Malawi on behalf of the Ministry of Health. He advised me that the Ministry Ethics Committee approval safeguarded me for either acting in an emergency or choosing to hold back; such dilemmas were well understood.

Yet I considered that even these midwifery codes and the promise of support for my decisions could not determine the appropriate action for me. Could the anthropology codes help?

The latest *Ethical Guidelines* of the Association of Social Anthropologists (1999) articulates the primacy of the interests of research subjects and the need to reconsider the project if this could not be ensured. Confidentiality and anonymity were addressed, the honouring of trust and protection of research subjects. Like the codes for midwives, these guidelines were inevitably general; they were not intended as sets of rules to determine behaviour, but rather as support for decision-making that respects the individuals concerned. They recognise that the researcher's own judgement is necessary, and that this should include regard to the potential outcome, which is situational ethics. As Lewis (2000), an anthropologist with a medical

background, found, the point of intervention cannot be determined before the watershed is reached. I knew I would be sensitive to potential for harm and disturbance, and for me the problem was more about identifying that watershed.

I was able to identify differences and similarities in the codes. Common themes are not surprising when codes are based on the same theories of utilitarianism and duty, and the principles of beneficence, autonomy, and avoidance of harm and exploitation. Themes of exploitation are perhaps most evident in the anthropology guidance, perhaps with good reason when the potential is so great for using people with no reciprocal benefit accruing. Research will often serve the interests of the researcher or sponsors more than that of the researched. This applies too within health care but there the client or patient relationship should provide a degree of protection for the latter, notwithstanding the potential power differential between health professionals and their patients. In addition, the health care researcher is perhaps less likely to be isolated from the gaze of peers than is the anthropologist. In the midwifery and nursing codes, there is such a strong emphasis on the duty of care that exploitation hardly features except regarding avoidance of the abuse of privileged relationships with clients and exploitation for commercial gain (UKCC, 1992). Inevitably, the strongest emphasis is on doing good. The potential for exploitation in research is addressed more specifically by the Royal College of Nursing (RCN) guidelines, which discuss implications for patients (1993), although these do not have the weight of statutory authority behind them as do the codes of the United Kingdom Central Council (for Nurses, Midwives and Health Visitors) (UKCC).

In both professions autonomy is a common thread. In the anthropological literature (ASA 1999 and AAA 1998) autonomy mainly concerns informed consent to taking part in research and disclosure of information and identity. The midwifery codes address the autonomy of women in making informed choices about care, a prevailing theme in Britain for some years. The RCN code acknowledges the ambiguities and dissonance between research and caring roles while emphasising the importance of knowledge generation. It recommends that intervention by researchers be confined to protection or rescue unless the researcher is employed as carer. Nothing is said about reporting malpractice, the problem that was to emerge for me, but the emphasis on anonymity and the confidentiality of privileged information is strong. The UKCC (1998) ambiguously advises disclosure as sometimes justifiable 'in the wider public interest' and supports the reporting of circumstances that 'jeopardise standards of practice'. The RCN (1993) recognises the potential of research for revealing 'deviations' from normal practice, recommending remedial rather than punitive action and condemning management efforts to uncover concealed identities.

Autonomy of decision-making should mitigate against exploitation when foreseeable and potential risks of taking part in research are articulated and full information is provided. Rational agents can then make appropriate

choices although special protection is needed for those who are more vulnerable such as children, the handicapped or mentally ill (Singleton and McLaren 1995). However, no code of practice or ethical guideline can go so far as to determine what to do when individuals are competent but may have limited insight into their potential for harm. Such a concern arose in my relationships with the *azamba* whose experience was largely confined to subsistence farming.

So the codes of practice provided guidance, as did the ethical principles upon which they were based. As Strathern (2000) indicates, they relate individual conduct to a view of good practice. Internalised through years as a midwife, the principles applied as pertinently to my anthropology practice and the codes addressed the same themes. The disparity between them lay largely in the power of sanctions, since, at least in the UK, the midwifery code could be used to support disciplinary action of statutory significance. The world of anthropology could only offer professional disgrace and dismissal from employment. The safety net surely would be 'openness, honesty and integrity' which 'breed trust and respect', and remembering that 'the privilege of research is earned through scrupulous behaviour and carries with it both ethical and moral obligations' (Hicks 1996: 256).

### Fieldwork in practice

First I will introduce the traditional and professional midwives who feature in my work, Sissie, Queenie, Gladys, and their supervisor (all pseudonyms). Sissie was my hostess, a literate woman of my own age with many responsibilities within the community. She was my 'fixer' with all the mixed benefits of support, access and loss of autonomy that this entails. Perhaps the most significant difference between us was the opportunity gap – she had eight children, I had two, which inevitably affected our paths in life. Queenie was in her late seventies, and had long been a traditional midwife – in recent years accredited since she had attended the government course. Gladys was her daughter and assistant and it was she who took centre stage in most of my dilemmas. Each highly respected in the locality; they were answerable to a supervisor, again a woman of my age and a registered midwife.

I became acquainted with several *azamba* through visiting their villages with the clinic team, and then approached the chiefs about eventual residence near Queenie, Sissie and Gladys from whom I received an especially warm welcome. For practical and security reasons I eventually lived in Sissie's household. My interpreters and I spent many hours with these *azamba*. I was amazed at their willingness to talk and help; indeed the success of our research was totally dependent on them.

I quickly began to learn from these *azamba* and give here an example of their openness. Walking along a narrow track together, Sissie spotted a particular tree and gleefully tied a few seeds in the corner of her *chitenge* or

skirt cloth. I longed to ask what she used them for but it was early days and she was laughingly secretive. Could this be the medicine that was used to speed up women's labours and was apparently responsible for many maternal deaths? Would Sissie fear I might report her? This was my first test. I decided to contain my curiosity and wait, and no more was said.

Much later I did indeed discover what these seeds were. Queenie was talking in her hut about her knowledge and her grandmother's teachings and described the way in which young women used the same seeds to make their bodies more sexually attractive. Returning home, my interpreter Jane amused the women of the household by telling the story (completely forgetting confidentiality, of course) and, amidst great hilarity, Sissie asked me if I wanted some. I knew then that I was gaining access to the privileged knowledge of women and later Queenie showed us how to prepare these seeds.

Despite my concerns I witnessed no dangerous practice. Indeed Sissie's midwifery style was very conventional, not surprising since a retired professional midwife had taught her. Sissie often spoke critically of unnamed others she considered 'dirty'. Discussing ways of helping she thanked God for her success and said: 'The labour pains come differently and there are some elderly women in the village who cause the way [the birth passage] to be damaged ... [through] lack of patience – they ask the person to start pushing even when the baby can damage the way.'

Early on Sissie asked me to look at a woman whom she believed to be seriously anaemic and near to her birth. I did not want to be seen as an adviser but Sissie was not going to let me refuse, so we went to see her. I agreed with Sissie and asked her what she thought should happen to her. 'I think she should go to hospital', she replied, and suggested my car could take her. Relieved that we agreed about the risk of bleeding for anaemic women and that no ethical problems arose here for me, I agreed to this.

I found that the combination of cooperation with requests for help, along with judicious questions about what the *azamba* wanted to happen, was a useful strategy. I never interfered, but neither did I refuse help. Their judgements were sound in all cases – a woman in slow labour, another with an open breast abscess, one with a breech baby for whom transport was requested. I agreed to take the last of these to hospital, asking one of the traditional midwives to accompany me as the woman was labouring strongly. We arrived in time with the woman across the back seat, female relative squeezed in beside her and Gladys in front. Gladys escorted her into the maternity unit and returned triumphantly saying the doctor had congratulated her on doing well to bring her in. I will never know whether she requested my assistance because I arrived just then, or whether the long walk would have been unwise in the circumstances.

The midwives may have been selective in choosing those I was permitted to see, or those for whom they wanted transport, but I would have heard of



serious problems eventually. Later in my stay they would just call me saying transport was needed. It was in this regard that I had perhaps my greatest disappointment. Near the end of my fieldwork I began to note how rarely there appeared to be women arriving at night. I realised that Sissie had not been rousing me, considering it to be 'disrespectful' to call me at night. This came to light when Gladys arrived at dawn one day to ask for transport. The woman had been in trouble for some hours but they expected me to refuse to drive at night. Few went out then because of the threat of bandits and of evil spirits, and Sissie certainly did not want me out even in my car. Even the local missionary fathers now refused to carry women to hospital at night because of armed hijacking. Neither did Sissie want me to sleep in Queenie and Gladys' village. Not relishing sleeping on a mat on the mud floor anyway, and somewhat scared by recent local events (six rare ritual murders of women and an armed robbery in the birth hut while I was back in the UK), I obeyed. Inevitably then I diminished my opportunities of observing practice as I visited only during the day when births were fewer and anyway could alter only with difficulty our tight schedule of arranged interviews. So issues of intervention hardly arose – until Gladys had 'her accident'.

Gladys was about 45 and taught by Queenie just as the latter had been by her grandmother. They were both very busy; they lived on the route to the hospital from distant villages and women often got no further than their birth house. Undoubtedly they had a reputation for safe and kindly care. Later I recognised that their willingness to help women considered unsuitable by Sissie (such as first-time mothers) was a factor. Gladys was supposed to work under her mother's supervision although conflict was common and Queenie complained she could no longer teach her. Gladys lived life on the run, was active in the church and political party and helped at the baby clinic. Proud and enthusiastic about her work, she was very keen to help me. She had an ambition to have her own 'hospital'. Unsure what this meant, I soon became aware that she and Queenie were healers as well as midwives. I frequently witnessed Gladys advising women with sick children or dressing wounds, then saw Queenie with two young men who came shamefacedly to see her, a teenage girl giggling in the distance. Laughing and wagging her finger at them she disappeared into her hut and emerged with a package: Queenie was the appointed supplier of free condoms. She also told me of the herbs she used to help women who had miscarried but could not afford hospital treatment. Illegal abortion was, they told me, rare as children were so desired. At 75 Queenie was a woman of many parts.

Gladys had a magnificent thatched birth house with decorated walls, two rooms, store, latrine, washhouse and ornate brick-walled placenta disposal pit designed to resemble a Zulu headdress. (See Plate 7.2.) They were Ngoni, a Zulu group who had fled the Mozambican Portuguese a century ago. Given land by the local Yao and Lomwe community, to me they were now indistinguishable from the Chewa but for language, some still speaking

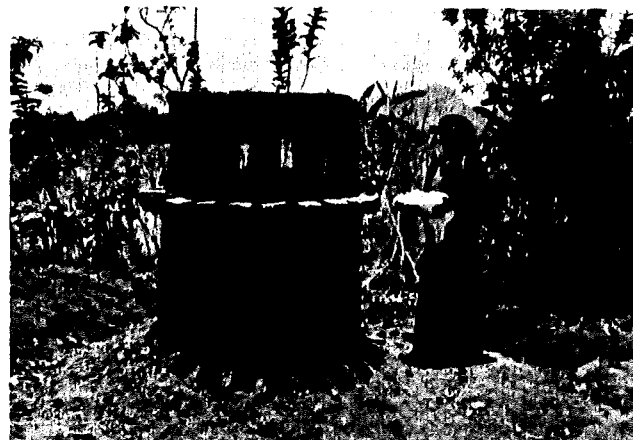


Plate 7.2 Practical and symbolic art: a Zulu head-dress influenced the design of a village azamba's placenta disposal pit

Ngoni. They had even abandoned their customary patriliney and adopted local inheritance through women and matrilineal marriage patterns.

I gradually realised that Gladys' enthusiasm was mixed with unpredictability and a tendency to complicate our work. Queenie would apologise for her as we could wait for hours only to find she was cooking for us or had gone to buy drinks at great expense. Her welcome was always disarming so we often felt beholden and this made it more difficult later. Gladys could nevertheless show great sense and dignity such as when her mother greeted us happily drunk on *chikasu*, her sought-after maize brew, and had to be gently restrained so we could get away.

Gladys had married three times but had no living children. She explained:

I was bewitched. I had my first boyfriend and we agreed to marry but we were discouraged by the parents – I was already pregnant. When labour started my mother sent my husband's mother to fetch *mankwala* (traditional medicine). It was believed that the problem was due to this medicine – so that the baby must die – the other babies died as well – I was told it was due to witchcraft.

The term *mankwala* was used for many substances, as treatment for problems of health and well-being, and as protection of property. Queenie marched off one day, barefoot, hoe over her shoulder, Jane and I trying to

keep up behind. We climbed up through high grass in search of the medicine to 'strengthen the blood' with me watching every step for snakes. I wrote:

Three types of medicine are mixed to produce 'iron' (one of them produces a red liquid when boiled, think she said one produced black liquid – is there an element of colour symbolism there?) for women who have bled in childbirth.

We then searched her deceased mother's garden – completely overgrown around a tumbledown house – in order to find the other roots she needed which she dug from the ground. (See Plate 7.3.) I was amazed at being given this information when she hardly knew me. I was highly curious about this medicine, wondering if it was knowledge of plant materials which strengthen the blood of anaemic women similar to the one that Bullough (1980) had



Plate 7.3 Digging with a hoe in the long grass, Queenie demonstrates her knowledge of plant materials which strengthen the blood of anaemic women

found to be a very powerful oxytocic, a drug to make the uterus contract. This natural remedy is notorious because it works powerfully, but in a highly unpredictable manner unlike the synthetic one used by doctors throughout the world (although this is also dangerous if used inappropriately). The danger in such drugs lies in forcing the uterus to work very hard when the baby is badly positioned, or too large to pass through the mother's pelvis, which may be small or deformed. In such circumstances the uterus eventually tears and both woman and baby die unless they receive blood transfusion and antibiotics. Such obstructed labour is the commonest cause of maternal death in Malawi, being responsible for about 20 per cent (Malawi National Safe Motherhood Programme 1995). In Zambia 85 per cent of women who died had taken such medicine (Nkata 1996).

I soon realised that this labour-stimulating medicine was also part of the skills for which Gladys was known but the supervisor also clearly knew of her activities and said, 'It is a very strong belief that labour has got to have such medicine.' She told me that relatives would even conceal the medicine in porridge for women in hospital causing them to suddenly commence violent labour. However, she preferred supervision to censure, saying that education and understanding were the key to change. This supervisor was convinced of the importance of these TBAs who understood their community and were respected more than were the younger hospital midwives who often had not given birth themselves.

Undoubtedly Gladys had learned her skills from her mother but it was less obvious that the latter used dangerous herbs after undertaking the training course in which the danger of this is explained. Queenie may just have been more wary of me but I learned later that Gladys hid some activities from her mother. In many ways Gladys seemed naïve and told me things despite knowing I could cause trouble. She said:

We give them medicine when sick – when she has backache we give her painkillers but when she is healthy we advise her to eat balanced meals. When she is experiencing oedema we give her medicine to stop it and if she is anaemic we also give her the traditional medicine to bring back the blood to her body.

Gladys also reported giving medicine to relieve pain in labour. I thought this referred to a natural analgesic, perhaps the one used for backache in the statement above. Later I learned more. But for the time being I was happy, assured there had been no maternal deaths in this area in living memory and that they were quick to transfer women to hospital when needed. Gladys, maybe Queenie too, was indeed using the herbal oxytocin to 'help' some labouring women and was proud of her ability. However, her supervisor knew about this so there was no need for me to face a decision about breaking confidentiality or risk my relationship. I returned to the UK for a time,

blissfully ignorant of the fact that my illusions were to be shattered on my return.

### Gladys and her 'accident'

Gladys had been responsible for an 'accident'. I learned of this from the supervisor while driving past her baby clinic. Gladys had kept a labouring woman too long in the village and had given her several doses of oxytocic medicine. When the woman was unconscious and bleeding heavily, her brother-in-law finally took her to hospital in a friend's car. The baby was dead and so, nearly, had been the woman. With a badly torn uterus, a hysterectomy plus blood transfusions from relatives had been needed to save her. Gladys was summoned and threatened with withdrawal of her 'instruments', a punishment of great symbolic meaning. (The importance of these badges of office can be deduced from her photograph taken in front of the ornamented placenta pit.) A meeting of all *azambas* was called to remind them of the rules; everyone in the locality had found out – except me. For days Gladys avoided me. I was dying of curiosity; this was a magnificent opportunity to explore her knowledge and concepts of risk – an important focus of my research. I was told women like Gladys believed what they learned both from training courses and from their elders. (I was reluctant to ask so held back and tried to continue as normal, relying on Jane to be discreet and help me be alert for opportunities.) I wrote in my notes:

I have to find a way of investigating the thinking behind Gladys's actions – she knows very well what the rules are. Why did she not follow them this time? Or has she been sailing close to the wind – and got away with it until now? However she has not told me about the incident herself yet and I don't think it's appropriate to ask her questions outright. I also would like to talk to the woman and her family and I need her help to gain access. At the same time Gladys often surprises me and maybe will just tell me if I'm open. Whatever, it is an ideal opportunity to investigate the dissonance between bio-medical and indigenous ideas about birth and what governs action.

For me it was a gift that I was unsure how to unwrap. I tried on several occasions to provide opportunities for Gladys to bring the topic up. Maybe each of us was trying to outwit the other, and my notes start one day with the triumphant phrase 'hook, line and sinker, I caught her at last'. The opportunity came in the car with no tape recorder running or notebook to hand. Perhaps she allowed herself to be cornered; she had not needed to escort us. We started discussing women who feared being 'cut' at the hospital. Did women she was very worried about ever refuse to go? Yes she had one who

had been first to another midwife. She, Gladys, had been very worried but the woman refused to go to hospital until she started bleeding heavily and could not walk; her husband then took the woman to hospital by car. The baby was born dead by operation and they had to take away the uterus. She was fine now.

After dropping Gladys off to walk home (she seemed in rather a hurry to get away from me), I learned unexpectedly that the woman concerned was related to my interpreter's friend and it could be arranged for me to talk with her. Such are the opportunities of fieldwork.

This all relates to access to hidden knowledge only, but the dilemma 'to tell or not to tell' soon arose.

Gladys had told me she could relieve the pain of women in labour by using herbs. Earlier I had not been alert to the potential significance of this information. Was this the same medicine as the one used to stimulate labour contractions, I asked later, or was it a different one? 'Oh it's the same, it just helps pain rather than altering contractions, then women have less problems because they are not in so much pain', was the reply. 'That is how it helps.' I could believe the principle about pain relief, but selective action of a potent natural chemical depending on what the user wanted of it – that was too much to believe. Mulling over the day's events by the light of my hurricane lamp, that night I wrote:

At first I thought that as long as the supervisor knows it is being given it doesn't matter too much and I would need to say nothing. However it has occurred to me that Gladys may start to give it more often if she really has got it into her head that the stuff relieves pain – so my dilemma is that from a midwifery viewpoint I ought to speak to her supervisor. Yet from a research ethics viewpoint I have privileged information that I should not disclose and it may well ruin my relationship with Gladys, as she will probably find out. On the other hand – she may assume I will tell her. I suppose in the end the safety of mothers has to be paramount and I'm quite sure I am justified in putting 'scientific' knowledge before traditional here.

It was becoming apparent that I would need to 'tell' even if it spoiled the field for me, and I resolved to find a way of doing so when next I saw the supervisor. But I did not see her again. My last meeting was cancelled because of illness and she could not attend my farewell party. Writing a letter was too formal. It has never happened.

There is a postscript to this. I received the detailed transcription of my interview from the translator some time after my final return to the UK. This clearly indicates the contradictory nature of Gladys's statements. It reads:

Me: You mention pain medicine today; another day you mentioned medicine for making the baby come faster. What do you mean?

Gladys: -The medicine stops the pain. There is no medicine to make the baby come faster.

Me: Does the medicine make the uterus work harder?

Gladys: It has nothing to do with the uterus - the medicine is to release the pain only.

Unable to work out what Gladys really believed, what was merely said on the spur of the moment, and which medicine she was really describing, I dropped the subject. I had to be content with the knowledge that many like Gladys accept explanations from both worlds, and they work with parallel and intertwined, though different paradigms of childbearing, or perhaps more correctly, do not differentiate and categorise in the manner in which I do.

#### The anthropologist's dilemma: The politics and ethics of whistle-blowing

Anthropologists live their research. It must be the supreme example of embodied knowledge, and dilemmas cannot be switched off at the end of the day. For me a dilemma existed because of competing paradigms of practice, not so much between anthropology and midwifery as I expected, but more because I believed that no one form of childbirth knowledge had all the answers. The obvious choice from a medical professional's viewpoint was to report what had happened. But my position in the community revealed to me wider consequences of such an action, both for women in the locality and for the midwives who were my main informants and collaborators.

It was important to get it right but codes of practice are designed to guide and alert the reader to the issues at stake; they are ethical principles that express the articulated norms for specific groups. Codes express expectation rather than direction. As Fryer (1995), Whyte (1984) and many others comment, they facilitate ethical reasoning rather than providing moral judgements or definitive answers to dilemmas. Decisions have to be made in the light of the unfolding situation and with hindsight one may wish to have handled a dilemma differently. In the end, attitude is all-important: 'ethical conduct derives from a way of seeing and interpreting relationships' (Kellehear 1989: 71). Codes can do little but indicate a profession's view of desirable attributes, especially when, as in anthropology, there is no universal sanction available except perhaps withdrawal of sponsorship, dismissal and public disgrace. This is a major difference from midwifery in the UK and many other places where practitioners may be called to account under threat of withdrawal of registration, which makes continuing to practice illegal.

Even in such professions where the issue of accountability may be finely honed, codes of practice have no statutory authority, acting as a normative guide backed up in the case of British midwifery by a more powerful set of rules.

There is a long history of the anthropologist as advocate and it may inevitably be a very political activity, although seen as an option rather than a requirement (AAA 1998). Promoting the role of the traditional midwife is a form of advocacy. In effect their status as focal points for my fieldwork was a form of advocacy too within the wider community, my presence as a researcher inevitably acting as a legitimising factor for them. Advocacy is a form of intervention. Nevertheless the more active intervention that I might have undertaken, perhaps to try to deal with Gladys myself and tell her what I thought of her actions, was, I felt at that time, outside my authority and presumptive of my relationship with her. Teaching comes naturally to me but I tried deliberately to leave the teacher part of my self at the airport and adopt the reciprocal stance to my enquiries commended by Oakley (1981) and Anderson (1991). Furthermore, I deliberately cultivated an element of exchange and only shared my practice as they shared theirs and asked about mine. It had taken some effort to convince the community that I was not there to teach; I was reluctant to change direction. Clearly then, there was an element of protecting my position in my decision not to criticise Gladys, both to preserve my access and to retain trust.

There were more altruistic motivations to which I make claim. The big issue was to tell or not to tell. The consequences of not telling the supervisor might be continuing dangerous practice, while the consequences of doing so could lead to a complete lack of experienced care for women. The more probable scenario of excess publicity was that Gladys might be removed from recognition and continue to practice unsupervised and unchecked, and her supervisor shared this understanding. No means existed of enforcing a cessation of her practice. It was my belief that in other ways her care was far preferable to that of the completely untrained women of the village, and that the usually inaudible voices of women could be heard confirming this in my interviews. Women were indeed continuing to seek Gladys's help despite the widespread local knowledge of the incident.

Leaving aside such consequential reckoning, the matter of confidentiality and anonymity remains. I was given information in a private setting, but with the tape recorder running, pen in hand and with no promise for them of anonymity. For villagers interviewed I had promised anonymity, and had guaranteed that it would not be possible to identify what individuals had said in anything I wrote. I had made no such promise to the *azambha*, knowing how much more identifiable they were. Indeed the expectation was that Gladys, Queenie and Sissie would feature clearly in the written word; it was hardly a confidential setting and at the time they did not expect the locality to remain unidentified. They gave me information for a specific purpose, however, and

that did not include reporting on them for disciplinary reasons. Gladys' activities had nevertheless entered the public domain without my intervention, and most importantly, the authorities were conversant with her activities even before she went too far. I nevertheless would continue with the intention to limit their identification to the best of my ability.

It can be seen then that ethical decision-making in anthropology is a dynamic process that has to be taken forward in the context of guidance from those who have been before, but with one eye on the consequences for a variety of actors in the specific scenario. To some extent researchers have to act as agents for these actors and perhaps make decisions themselves that can affect others' lives. It is not as simple as the 'do good and do no harm' of the health care professional, if that can indeed be called straightforward. Certainly it complicates matters when the anthropologist carries another label such as 'midwife' with all the self-imposed and public expectations of doing good, not harm, that go with it. For the anthropologist, however, an added responsibility exists of considering consequences not anticipated by informants.

The issue of secret knowledge and confidentiality is more complicated, then, when informants have limited insight into the potential for trouble inherent in their openness. I moved in from another world, experienced in both one-to-one and group encounters, made friends, and with the help of a local interpreter succeeded in getting people talking in ways they would never normally do. At times I wanted to warn Gladys, 'You shouldn't be telling me this', but I never did. Did she realise how much trouble I could cause for her? With Sissie things were different and she gave me no cause for concern. Sissie appeared to be highly conscious of women's safety and to be conforming to what the authorities wanted of her even to the detriment of her own income. She may, of course, have had more insight into my potential. At the same time am I guilty of paternalism in thinking Gladys may not have known what she was doing? Did she in fact relish the element of confession mixed with showmanship in the way she shared her practice with me? Such a dilemma is indeed anticipated in the *Ethical Guidelines* (ASA 1999), which acknowledge this imbalance in awareness of consequences.

There is another item too on my personal agenda regarding disclosure of information. I believe firmly in the importance of 'traditional' midwives in the context of limited resources and the unreality of expecting rapid change to universal provision of professional skilled attendants for birth. I remain unconvinced by the sceptics' views of problems in educating and supervising them adequately. I also believe that these women will continue to provide a valuable service alongside professional midwives even once the system is fully staffed with such 'skilled' carers, a far-distant situation in environments such as Malawi. Could my revelations about Gladys, a well-supervised 'trained TBA', just serve to reinforce negative attitudes among policy-makers and deprive women of these trusted companions? The international maternal

health community, however, knows already of their limitations and my continued access permitted additional insights into the beliefs and knowledge that underlie the actions of traditional midwives. I can thus bear witness to the care these women provided in circumstances of great deprivation to women who would otherwise give birth alone or with attendants of significantly more uncertain skills. As the *Statements on Ethics* of the American Anthropological Association (AAA 1986) suggested, I have a responsibility to speak out what I know and believe from the vantage point of my professional expertise.

#### In conclusion

Planning my fieldwork led me to expect dilemmas around access to secret information. I sidestepped the issue of the 'secret' knowledge of women – I deliberately did not pursue it further than a minimum on the basis of 'not needing to know'. Such an expedient decision would have to be reviewed if another purpose and more opportunities arose, and women's views on the revelation of their knowledge would have to be sought, understood and accommodated.

I glimpsed the herbal knowledge of the *azamba*, substances commonly used and hardly secret knowledge. I now regret having curbed my curiosity when information was there for the asking. Some information learned was, however, too personal to be revealed and no one knows what this is. Such is confidentiality. Anonymity has, nevertheless, to be actively pursued and demands constant safeguarding.

I finally return to whistle-blowing. I have analysed the background to why I was uncertain how to act, considered the guidance available and described what happened in the field. The codes and literature do not feature specific guidance about the ethics of intervention or about secret knowledge. Case studies (AAA 1998) and examples from the past, enjoinders to consider the public good (UKCC 1992) and the overall emphasis on confidentiality, provide clear principles for the practitioner, whether of anthropology or of midwifery. In the end Gladys was really doing nothing very different from her usual activities and her supervisor was aware of the need to watch and educate her, which got me off the hook. Gladys herself broadcast her skills and knowledge with no fear of retribution until the incident when she went too far; her knowledge was hardly secret. It would have been a different story if I had learned of activities that were not known about already, or witnessed practices of immediate danger to a woman; then my decision-making would have inevitably reached a different conclusion.

As a final assessment, the ethics of anthropology and midwifery turned out to be not so different after all, concentrating as they do on preserving the rights and the good of those who are involved. The dilemmas I encountered

were, moreover, less serious than in my imaginings, and within my capacity to manage from my dual stance as anthropologist and midwife.

**Bibliography**

- American Anthropological Association (1986) (amended) *Statements on Ethics*, Online. Available HTTP: <<http://www.aaanet.org/committees/ethics.htm>> (accessed 13 January 1998 and 22 January 2002).
- American Anthropological Association (1998) *Code of Ethics of the American Anthropological Association*, Online. Available HTTP: <<http://www.aaanet.org/committees/ethics/ethcode.html>> (accessed 2 February 2001).
- Anderson, J.M. (1991) 'Reflexivity in fieldwork: toward a feminist methodology', *IMAGE Journal of Nursing Scholarship*, 23.2 Summer: 115-18.
- Association of Social Anthropologists of the UK and the Commonwealth (1999) *Ethical Guidelines for Good Research Practice*, Online. Available HTTP: <<http://les1net.man.ac.uk/sa/ASA/ethics.htm>> (accessed 2 February 2001).
- Bullough, C.H.W. (1980) 'Traditional birth attendants in Malawi', unpublished thesis, University of Glasgow.
- Cassell, J. and Jacobs, S. (1987) *Handbook on Ethical Issues in Anthropology*, American Anthropological Association, Online. Available HTTP: <<http://www.aaanet.org/committees/ethics/toc.htm>> (accessed 2 February 2001).
- Corey, G., Schneider Corey, M. and Callanan, P. (1988) *Issues and Ethics in the Helping Professions*, 3rd edn, Pacific Grove, CA: Brooks/Cole Publishing Company.
- Forster, P.G. (1998) 'Religion, magic, witchcraft, and AIDS in Malawi', *Antropos*, 93: 537-45.
- Fryer, N. (1995) 'How useful is a knowledge of ethics?' *British Journal of Midwifery*, June, 3.6: 341-6.
- Gennaro, S., Kamwendo, L.A., Mhweza, E. and Kershbaumer, R. (1998) 'Childbearing in Malawi, Africa', *Journal of Obstetrical and Gynaecological Nursing*, March/April: 191-6.
- Hicks, C. (1996) 'Ethics in midwifery research', in L. Frith (ed.) *Ethics and Midwifery: Issues in contemporary practice*, Hale: Books for Midwives Press.
- Homans, R. (1991) *The Ethics of Social Research*, London: Longman.
- International Confederation of Midwives (2000) *International Code of Ethics for Midwives*, Online. Available HTTP: <<http://www.icm.org.uk/files/info/documents/230401124908-43-1.doc>> (accessed 11 Feb 2001).
- Kamwendo, L. (1996) 'Birth rituals: the Malawian perspective', paper presented at International Confederation of Midwives, 24th Triennial Congress Proceedings, Oslo, 26-31 May.
- Kellehear, A. (1989) 'Ethics and social research', in J. Perry (ed.) *Doing Fieldwork. Eight personal accounts of social research*, Geelong, Victoria, Australia: Deakin University Press.
- Lewis, G. (2000) *A Failure of Therapy*, Oxford: Oxford University Press.
- Morris, B. (1998) *The Power of Animals: an ethnography*, Oxford: Berg.
- Ministry of Health and Population, Malawi (1995) *The Malawi National Safe Motherhood Programme: Malawi National Strategic Plan for Safe Motherhood*, Lilongwe: MOHP.
- Nkata, M. (1996) 'Rupture of the uterus: a review of 32 cases in a general hospital in Zambia', *British Medical Journal*, 312, 11 May: 1204-5.
- Oakley, A. (1981) 'Interviewing women: a contradiction in terms', in H. Roberts (ed.) *Doing Feminist Research*, London: Routledge.
- Plummer, K. (1983) *Documents of Life: an introduction to the problems and literature of a humanistic method*, London: Unwin Hyman.
- Royal College of Nursing (1993) *Ethics Related to Nursing Research*, London: Scutari Press for the RCN.
- Singleton, J. and McLaren, S. (eds) (1995) *Ethical Foundations of Health Care. Responsibilities in decision making*, London: Mosby.
- Strathern, M. (2000) 'Accountability and ethnography' in M. Strathern (ed.) *Audit Cultures: anthropological studies in accountability, ethics and the academy*, London: Routledge.
- United Kingdom Central Council for Nurses, Midwives and Health Visitors (1992) *Code of Professional Conduct*, London: UKCC.
- United Kingdom Central Council for Nurses, Midwives and Health Visitors (1998) *Midwives Rules and Code of Practice*, London: UKCC.
- Whyte, W.F. (1984) *Learning from the Field. A guide from experience*, Newbury Park: Sage.