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## Muslim Midwives between Traditions and Modernities: Being and Becoming a *Bidan*

### *Kampung* in Satun Province, Southern Thailand

Claudia Merli

#### **Introduction**

This article analyses the transformations and changes facing the indigenous midwives in Southern Thailand where approximately 70 to 80 percent of the local population is Muslim. In Satun province the Muslim population mainly speaks Thai but about 10 percent of the group is bilingual and also uses Malay, the dominant language in the other three southern Muslim provinces of Pattani, Yala and Narathiwat.<sup>1</sup> Malay speakers call indigenous midwives *bidan kampung* (literally village's midwife), whereas the Thai term is *mootamjae* (หม่อมตำบ่อ). The activity and practice of these elderly women have been increasingly affected by the introduction of modern medical healthcare and obstetrical services, especially the availability of village health centres, District Hospitals and Satun General Hospital. Over the last 40 years, the Public Health Office and Satun General Hospital alternately organised training and refresher courses focusing on biomedical obstetrical techniques, sterilization of instruments and hygienic procedures. A simple assessment at the end of the course would qualify indigenous midwives to receive licences and to be registered, a step which has become compulsory if they are to continue practicing. Nowadays the *bidan kampung* are still active

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<sup>1</sup> This article is based on material collected during field research toward my PhD dissertation at Uppsala University, and with funding generously awarded by The Donner Institute of Åbo Akademi (Finland) and the Swedish Society for Anthropology and Geography. This project received the approval of NRCT (National Research Council of Thailand). Returns to the field in 2007 and 2009 were funded by Lars Hierta Memorial Foundation. Several people made critical and encouraging comments. I would like to thank Ing-Britt Trankell, Jan Ovesen, and Anne Guillou. Special thanks also to Thomas Henfrey. I am forever indebted to the women and the traditional midwives who shared the intimacy of their experiences with me. I acknowledge the invaluable collaboration and friendship of my two assistants Mrs. Nitima Bintammangong and Mrs. Anyavalee Srichanapai. However, responsibility for what is stated in this article is exclusively my own.

but their practice has been modified, de-emphasizing their presence during actual birth in favour of a focus on the ritual moments concerning mother and child, both during pregnancy and following birth. The training itself has ambivalent outcomes, since *bidan* are included into the modern medical system but at the same time their activity is controlled and limited, to favour rural women's reliance upon medically-trained obstetric nurses and gynaecologists. The *bidan* can still intervene in case of births that are considered hastened and therefore treated as "emergency". The complexities of these changes are mirrored in the midwives' life stories. For the younger generation, the "mission" of becoming a *bidan* — once embedded in the social and economic life of the village — has become a problematic choice between two worlds.

### **The region**

Satun is one of the four southernmost provinces of Thailand (bordering Malaysia) where the majority of the population is Muslim, in contrast to the predominance of Buddhism at the national level. The three provinces located on the southeast coast, Pattani, Yala and Narathiwat, have been historically characterised by dramatic episodes of violence and insurgency, resisting the progressive assimilation into Siam of the independent Malay kingdom of Patani during the 19<sup>th</sup> century in alternating periods of remission and resurgence. A new escalation of violence not entirely ascribable to separatist militants, and a reaction of military repression, began in 2000 and left on the ground thousands of victims. Political and social analyses of the situation attempt to identify underlying causes and dynamics. After the military coup of September 2006 and ensuing governments, the local situation remains unsettled with recurring news of bomb attacks and killings (for the most recent debate see Chaiwat 2006; McCargo 2006a, 2006b, 2008; Srisompob and Panyasak 2006; Tan-Mullins 2006; Ukrist 2006; Wattana 2006).

Satun (located on the southernmost west coast) has always been presented as a model of integration. "Integration" has two connotations, referring on the one hand to harmony among local people belonging to different ethnic or religious groups (Malay- and Thai-speaking Muslims, Thai

Buddhist, and Chinese Buddhist and Confucian),<sup>2</sup> and on the other hand to that between the Muslims and the government authorities. Of Satun's population (247,900 according to the most recent national census of 2000) around 70 percent are Muslims, who reside predominantly in rural areas (home to 83.9 percent of the population). Most are employed in rice farming, rubber production, or fishing, in most cases as household activities in which men and women cooperate. Commercial activities include fabric and clothes shops, food stalls, and small restaurants.

### ***Health systems***

In a demographic study conducted in Pattani province, Sudaarat Tiiraworn (2002) shows how despite the availability of maternal and child health care (MCH) provided by the government, home births with a *bidan* still represent around 60 percent of cases. Sudaarat associates this figure not with women's level of education but with other variables such as residential area and pattern (nuclear vs. extended family), and nature of economic activity. Women residing in urban areas and with an income source related to commerce would mostly use hospital services, whereas those residing in rural areas and unemployed or employed in agriculture would first resort to other kinds of help and counselling, ranging from family members' advice to traditional practitioners' services. According to Sudaarat, this pattern also affects infant mortality rates.

The Public Health Office<sup>3</sup> (PHO) of Satun annually publishes an information booklet about organisation of health services and resources in the province. In 2009, the General Hospital and the five Community Hospitals have a total capacity of 366 beds. PHO also organises a web of 52 health centres scattered over the territory. The ratio of doctors to population is 1:6,248. National health policy has changed during the last 10 years, passing from the so-called 30 Baht health policy

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<sup>2</sup> The definition of these differences comports many problems, first of all because it includes linguistic, ethnic and religious features which are not equally attributed. The Thai government avoids referring to the Muslims in the South as Malay, as many claim to be, because this would lead to acknowledge a different ethnicity and hence a possible ground to claims of autonomy or independence. The aim of the Thai government has always been to assimilate this group, thus referring to the population as Thai Muslims.

<sup>3</sup> For all the material collected here I would like to thank the Director of Public Health Office of Satun at the time of research, Dr. Somruan Danprachankul who introduced me to his staff of collaborators. They have provided statistics and provincial data.

promoted by the previous Thaksin government to improve access to health services for the economically disadvantaged, to the universal coverage of the present day (see Hughes, Leethongdee & Osiri 2010 for an extended analysis of this policy change). In health centres on Satun territory a public health officer is available daily, and both a medical doctor and a pharmacist one day per week. The health centre is also the place where childbirth is registered, and in rural areas it provides immunisation programmes and monitors mothers' recovery after childbirth. In 2000 Satun also had three midwife clinics, where nurses trained in Western medicine could be summoned to attend labour (PHO 2000: 2). Two of these have since closed down due to low demand. The PHO lists also 763 health volunteers providing counselling and gathering data in villages of the Municipal District, each assigned about 10-15 households to survey.

Referring specifically to care for mothers, the District Hospitals (DH) and General Hospital (GH) in Satun town run ANC (antenatal care) centres: the GH receives expectant mothers twice a week during morning hours. Here women attend counselling sessions and, if they consent, can have their blood tested for sexually transmitted diseases (syphilis, HIV, and hepatitis B). During her first visit the woman has a physical external examination carried out by a gynaecologist. Considering the possible embarrassment of being examined by a male doctor, the hospital has since 2004 employed a female gynaecologist, and expectant mothers can choose the one they prefer. After the first visit to the ANC, subsequent check-ups are scheduled every four weeks, but during the last month of pregnancy (or in case of particular conditions) at intervals of one to two weeks. During pregnancy women can choose also to consult an indigenous midwife for massage. Both Muslim and Buddhist women follow this practice.

### ***Mootamjae and Tok bidan: indigenous midwives***

In the Thai language the traditional midwife is called *mootamjae* (หมอด้านเย) where *moo* (หมอ) is the generic term used to address a doctor or medical practitioner, either “traditional” or “modern”. In

Malay she is called *bidan kampung*, and is addressed with the honorific prefix Tok that, as Chen noted, is never used in Malaysia to refer to obstetric nurses exclusively trained in the biomedical system (Chen 1977). The career of a *bidan* involves the transmission of knowledge within a family, usually following matrilineal descent. Different systems of medical knowledge worldwide use different terms to refer to these (usually aged) women who assist women and childbirth, but health and government organizations use a technical term designating a single category to include all variations, emphasizing the strictly obstetrical practices: traditional birth attendant (and its acronym TBA). The term recurs especially in works detailing the introduction of cosmopolitan obstetrics and training in developing countries where manually skilled women apply their knowledge of childbirth and pregnancy (see Pigg 1995 for a critique of this and other acronyms used to identify local practitioners and healers; Jordan 1993: 170). The term TBA is used to refer to indigenous midwives, whether or not they have received any formal training (see Chen 1977; Stephens 1992). Stephens introduced the term “trained TBA” (abbreviated to TTBA) when referring to indigenous practitioners with some degree of formal training in biomedical techniques (1992: 813). In Malaysia TBA is used in opposition to “government midwife,” a term which refers to obstetric nurses in the biomedical system. However, according to Wazir Jahan Karim (1984) under the global icon TBA we could identify at least four kinds of practitioners, depending on the presence or absence of licensing/registration, usually received after brief formal training. In her study on Kedah, north western Malaysia, Wazir lists the following types of *bidan*: a) registered/active: similar standard of hygiene as the government midwife, with training; b) registered/inactive: due to illness or old age; c) unregistered/active: not informed about registration or opposing it; d) unregistered/inactive: too old to perform (1984: 161-162). Other scholars (Kamal 1998) trace differences in terms of economic gain and social radius of action, starting from the trained/untrained traditional midwife practising for a living, through those practising sporadically, to women helping birth exclusively among kinfolk. In Satun I interviewed licensed indigenous midwives, the majority still active, and a few inactive due to old age. The “inactivity” of the older women refers only to the moment of the

actual birth: many still perform ritual acts for both mothers and children and are well known as skilled masseuses. All the indigenous midwives I met had practised regularly in the past with varying levels of economic compensation (from small tokens of appreciation to standard fees) for the support provided to women. For some this was the primary source of income but more often it was a supplement to other sources.

### ***Between family tradition and government licensing***

The inclusion of indigenous midwives in government health systems presents practical, organisational and political problems. Addressing the organization of medical training in different countries, Neumann and Lauro stated that “the problem is to provide for long term supervision, re-supply of sterile items and refresher training” (1982: 1820). Stephens (1992), considering the transmission of effective knowledge within formal training and the effects of this in India, notes and summarizes previous findings from other contexts by Sogunro (1987) and Jordan (1989), saying:

“[...] there are some indications that the ‘integration’ of TBAs into allopathic health systems involves limited (and sometimes inappropriate) transfer of technical skills and subsequently little back-up, recognition from allopathic counterparts or support - financial or otherwise.” (Stephens 1992: 815)

The ambivalence of the relationship with the health system is particularly evident in relation to the economic outcomes for the midwife. Even if training includes the supply of new equipment, as it also encourages the final referral of cases to the local hospital or the involvement of a biomedically trained nurse for the actual birth the indigenous midwife can suffer a loss of both autonomy and income (see Stephens 1992: 816). Additionally, if, as in some cases, one of the goals of the training programme is to create a low-cost and effective service for the population (Neumann & Lauro 1982: 1817), in the long run any economic benefits for midwives will be undermined by the obstetrical services provided by the government.

Mixed working teams formed by one “TBA” and one government midwife were introduced in Malaysia during the 1970s.

“Where it has been more successful, the *bidan kampung* attends in the capacity of ritual specialist, general helper, and a supporter of breast-feeding and of other useful traditional practices, whilst the trained midwife is the specialist for the actual delivery of the mother, the cutting of the cord and the care of the newborn and mother in terms of physical illness.” (Chen 1975: 178)

The issue of possible collaboration and integration is still discussed in Malaysia (Ali and Howden-Chapman 2007).

In Satun the option of mixed teams has never been practised. *Bidan kampung* have attended courses and received training for at least the past 35 years,<sup>4</sup> they are registered and receive a “license” which they call a “card.” Some of the Buddhist *mootamjae* showed me their card, a light green-blue colour with their picture on it. Most times when I asked Muslim *bidan* I was told that they had lost the card. The event was discussed with great hilarity and considered very amusing. The courses could be organized at Public Health Centres in the villages, also attended by *bidan* from different areas of the province. At the beginning of my research some of the eldest *bidan* stated that no new courses were being organized and so no new *bidan* were allowed to enter the practice. However, as I will describe later, courses are still organized, but sometimes old *bidan* prefer not to go. Another factor influencing attendance at these courses is the involvement of younger *bidan* in other economic activities that do not allow for prolonged absences. The licensing is considered important by the *bidan*, and they contrast their position with that of other women who wanted to become *bidan* but did not receive the “card,” either because “they were too lazy to attend the course” or because they were not accepted by the organizers. One of my informants referred to the women

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<sup>4</sup> One of the oldest *bidan* I met had the first course about 40 years ago.

practising midwifery without government licensing as *moothyan* (หม้อต้ม), literally an unauthorised physician.

### ***New equipment and licensing***

In earlier times, a *bidan* completing formal training was given a full set of equipment contained in a metal or leather box with engraved the name UNICEF (United Nations International Children's Emergency Fund). The box contained sterile bandages, rubber to tighten the umbilical cord, enema bulbs, clamp and forceps, scissors, alcohol, a spring scale, printed instructions for following pregnancy and childbirth, kidney basins and enamel bowls. The *bidan* could go to the nearest Health Centre to replenish supplies of alcohol and disinfectant. At present the situation is less homogeneous: some instruments are provided to younger *bidan* without the metal box, simply wrapped in an envelope or soft bag, and the full set of equipment is retained at the Health Centre in the village, where the *bidan* can go and collect it in case of need. This arrangement can also become a means to control the *bidan*'s activity. In other cases the bag remains with the *bidan* but she must buy those items which need to be replaced. The high symbolic value attached to the equipment affects the perceived status of the practitioner, whether or not she actually uses it. The grandchild of one old *bidan* told me that nowadays Public Health wants to take back the equipment when a *bidan* dies, to avoid it being handed over to a younger female relative to continue the family tradition. Therefore, the *bidan* ending her activity for age reasons is asked to return the box with the equipment to the nearest Public Health Centre. In this sense the equipment cannot be considered an endowment but rather a leasing. Public Health officials can visit the house of the indigenous midwife and inspect the equipment to assess if it is kept according to a good standard of hygiene. One gynaecologist lamented that cockroaches are often found in the bag, which rather than testifying to poor hygiene and storing procedures would prove lack of use. In other contexts it has been recorded that when items could not be refilled or substituted, indigenous midwives resorted to the old methods (cf. Grace 1996: 159 in Indonesia). To the equipment is ascribed a symbolic value

often independent of operational utility. *Bidan* also express preferences for certain pieces of equipment over others; many mentioned the sharp scissors were better than the old bamboo split used to cut the umbilical cord, others considered the spring scale the best instrument since it served to assess the weigh of the newborn baby. One midwife liked the latex gloves and plastic apron best, to protect herself from contact with possibly contaminated blood.

By attending training the *bidan* obtains permission to practise and is registered on the PHO record of practising indigenous midwives. This official endorsement (vested in the “card”) not only gives the *bidan* legal permission to perform, it also enhances her status within the community. Only a registered *bidan* can go to register the newborn baby at the Public Health Centre in the village, often accompanied by the newborn baby’s father.

#### ***Short term and long term effects of training***

Training has both short- and long-term effects on midwives’ activities. In the short term, midwives acquire new knowledge which can be used to heighten their status in the community. This can be associated with a request for higher fees for their services. The immediate sign of this change of status is the performance of hygienic procedures such as washing hands with soap, and in particular the use or display of medical equipment. In the beginning of the training era indigenous midwives received an immediate economic gain in the form of compensation from the government to attend the courses. The course and licensing created a distinction, which they certainly sought to reinforce, between themselves and unlicensed midwives.

The possibility to attend courses where several midwives from different parts of the province gather together provided these women with three distinct and very important opportunities. The first is the exchange of information and knowledge about “traditional” techniques of dealing with difficult labours, retained placentae, twins, breech presentations, entanglement of the umbilical cord around the baby’s neck, and other birth complications.

The second is networking and acquisition of details about other indigenous midwives in the province, a sort of social mapping. The *bidan* could reconstruct their own ancestry and family traditions and this knowledge is still vivid today, so that midwives in Satun remember the names and families of the midwives of Tung Wa (northern part of the province) and vice versa.

The third is the opportunity to define a common strategy. The *bidan* used to discuss the biomedical notions and procedures taught in the course. If these instructions contradicted their own shared “traditional” cosmology and ethnophysiology of birth they could decide to drop the former altogether. One such example concerns the procedure of cutting the umbilical cord. According to local midwifery, the umbilical cord can be severed only once the placenta has also been expelled as the act is part of elaborated cosmological and physiological conceptions considering the newborn and the afterbirth as a sibling set, a notion shared by many other cultures. When medical personnel instructed traditional midwives to cut the umbilical cord immediately after the baby has emerged from her mother’s body the *bidan* were very reluctant to accept this idea, and in discussion among themselves agreed to follow a different course of action.

In the long term these initial positive effects of training are counterbalanced by less favourable ones. The most noticeable in Satun is the decrease in the number of births attended. After all, one of the instructions the *bidan* receive is to refer pregnant women to the hospital. This would lead, apparently, to a steady loss of income. But whereas in the past *bidan* provided a combination of antenatal care, childbirth and postpartum services, nowadays this is limited to postpartum massage, bathing, and ritual services, without a substantial change in the fee. This would demonstrate that *bidan*’s practice is not perceived as restricted to or primarily concerned with birth attendance (as the fashionable acronym TBA implies), since the economic value attributed to her presence is unaffected. The fee is the same, it is the involvement of the *bidan* itself which is negotiated and paid for.

One of the long-term effects is to transform traditional midwives into sentinels of risk in pregnancy, as they have been trained to detect the signals. At the same time they act as an interface

between health authorities and communities in fields such as contraception, immunisation, and public health. As they are respected in their communities their opinion is influential. They exercise control over the practice of midwifery without licensing, defending their own interests and those of public health officers alike.

### ***Being a bidan***

To be a *bidan* a woman should fulfil three main criteria: 1) licensing, 2) family tradition, 3) assistantship to an older *bidan*. Of these elements the second seems to be the most important, at least to the people using the services of the *bidan*. The first proceeds from governmental health authorities. The latter two are conferred by the local social group, a community validation. Roziah, a licensed *bidan*, told me that she was asked to be present at a birth when she had not yet attended training; she refused to help fearing potential consequences if the labour was difficult or ended tragically. People in the village went to ask her because her father's mother was a *bidan* and also because as a young girl she was following the *bidan* of her village of residence, "learning on the job".

A recurring element in midwives' life stories is that often the prospective *bidan* was summoned by people in need of help, who could not find the "official" *bidan* in the village (very often her mother), on the occasion of a sudden onset of labour. In this sense, the villagers almost provided an investiture to the new *bidan* and their responsibility, as a result of descent. Three *bidan* told me that they first reacted with reluctance and bashfulness, making excuses not to attend the births. However, they were inevitably persuaded to help and upon a successful first childbirth gained the general trust and attained the status of recognised *bidan*.

Some *bidan* can claim to be the seventh generation in a lineage: a *bidan ketujuh*<sup>5</sup> who is considered particularly knowledgeable, especially about rituals and use of incantations. Two *bidan* stated they were the thirteenth generation in a family lineage of *bidan*. When a *bidan* states that she

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<sup>5</sup> *Ketujuh* means 'the seventh'.

has learnt from her mother or mother's mother/father's mother she does not claim to have received any sort of instruction, even if only informally. When encouraged to state the kind of training or instruction received within her family one *bidan* answered: “*Bidan* is not for learning, it comes along, it is not like going to school to become a [biomedical] doctor.”

*Bidan* is a gift rather than a practice apprehended. Many *bidan* claim to have received a call in the form of a dream (*mimpi* in Malay). Wazir Jahan Karim conducted her research on traditional midwifery in Northern Kedah (which until the Anglo-Siam Treaty of 1909 included the territory of Satun) where *bidan* take up their role in the community “when they can show that they have dreamt of certain verses and spells used by the *bidan kampung* or have dreamt of actually performing a delivery” (Wazir 1984: 160). Apprenticeship (*menuntut*) is also possible, followed by a dream (*menurun melalui mimpi*) (ibid.). In Satun, the late *bidan* Mak Hitam told her story of following the reverse path: she first received a dream at the age of 15, from her *Nek*<sup>6</sup>, who showed her how to be a *bidan*. When she recalled the dream her narrative flowed, repeating over and over the objects she was presented with and their disposition.

“Nek Nek, Nek [said] ‘come, come!’ . [She] ordered Mak Hitam to rise, to rise and look at what is on the tray... what is on the tray is: three *bujam*<sup>7</sup>, one bar of resin, already made a light [lit a candle], where is the light, resin resin... Resin... Me, the grandchild... one bar... three *bujam*, *bujam*... One candle, three *bujam*, three bars of resin... Three *pinang*... one *pinang* in three *bujam*... three *bujam*, three *pinang*, three *sireh*, three *pinang*, three *sireh* . . . They are all already dead, only Mak Hitam is left... the thirteenth [*bidan*]... Mak ‘Tam was given a dream, after that Mak Hitam could make...”<sup>8</sup>

The *pinang* (the areca nut) and *sirih* (betel leaves) are common in ritual offerings in Asia and Southeast Asia, especially to cement social contracts (engagement, wedding), and are also

<sup>6</sup> Shortened form for *Nenek*, female direct relative in the ascending third generation.

<sup>7</sup> *Bujam* is a bag made of screw pine (*Pandanus*), traditionally used to carry betel-leaves, herbals, etc.

<sup>8</sup> Nek Nek, Nek, ke mari ke mari ke Mak Hitam, suroh bangit Mak Hitam bangit tengoh apa ada apa tadah... apa ada apa tadah *bujam* tiga biji damar sebatang, buat pelita dulu, dulu mana ada pelita, damar damar... Damar... kita cucuh... sebatang... *bujam* tiga biji, *bujam*... Dian satu satu, tiga biji *bujam*, tiga damar... *Pinang* tiga... *pinang* sebiji *bujam* tiga, tiga *bujam*, tiga *pinang*, *sireh* tiga, *pinang* tiga, *sireh* tiga [...] Sudah mati habis tinggal Mak Hitam seorang... tiga belas ... Mak Tam bagi bagi mimpi Mak Hitam boleh buat selalu...

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considered appropriate offerings to the spiritual world. The *bujam* is the usual container to carry these items, along with quicklime, added to make a betel quid to chew. After this dream Mak Hitam followed and helped her sister, who was at the time the “official” *bidan*; upon her sister’s death she started practising. A dream can be strongly connected to the desire to become a *bidan* and represents a sort of validation of this wish. According to a village woman: “If a *bidan*’s daughter or granddaughter ‘wants’ to become *bidan* she buys a dream”.

The knowledge about a *bidan*’s activity and skill spreads easily over the territory and still today the old *bidan* remember the names of famous *bidan* practising when they were young and their family ties with present-day *bidan*. Young *bidan* could remember having resorted to the older *bidan* for knowledge of herbals or how to deal with difficult deliveries. This knowledge extends beyond manual ability.

### ***Bidan as ritual expert***

When it comes to changes in the activities of *bidan*, there are similarities between Malaysia and Thailand. In Malaysia, the role of the traditional midwife progressively shifted towards ritual expertise, which already represented a good part of her practice. The *bidan kampung* attends births as complex *rite de passage*, also enacting measures for emotional support; she performs as both general medical practitioner and exorcist (Chen 1975: 178; Wazir 1984: 160). Also in Thailand, she was in the past involved in activities such as supervising the disposal of the afterbirth and taking care of both mother and child; in this role of guide along the path to motherhood she is a major figure. She can also be called to resolve children’s health problems, especially if she is an elder and a *bidan ketujuh*.

Following the timeline of reproduction, we can distinguish three areas of ritual activity for the *bidan*. First, the prepartum period. On the occasion of a woman’s first pregnancy, during the seventh month Muslim women perform a ceremony called *mandi tian* in Malay or อามน้ำ 7 เดือน (*ap*

*nam chet duean*) in Thai (literally “bath of the seventh month”), in which the *bidan* takes part. Some of the goals of this ceremony are: to guess the sex of the foetus, to ensure it is in the correct position, and to predict if the childbirth will be easy or difficult. It is also a ceremony recognising a woman as a mother-to-be. Apart from this specific event, the *bidan* can perform regular massage on a woman’s abdomen, softly locating the baby in the womb starting from the first months of pregnancy. If a breech presentation of the child is detected during the last few months of pregnancy the *bidan* will gently manipulate the child in order to turn her in the correct position. The technique is known in biomedical terminology as external cephalic version and it was also commonly practised by obstetricians and midwives in the Western world. *Bidan* in Satun are discouraged from performing it during the training and are advised instead to refer the pregnant woman to the hospital to schedule a Caesarean Section.

Second comes care for the woman during the postpartum period. In Satun Muslim women still consistently practise the “lying by the fire”, performed all over Southeast Asia with some differences in the duration and position of the fire, beside or below a bed made of bamboo or wooden planks. In Malay the practice is called either *berdiang* or *salaian*, in Thai *juu fai* (อยู่ไฟ, literally “to be” or “to stay” with the fire) or *juu kam* (อยู่กรรม), a term interpreted differently but which has been connected to *karma* or restrictions (see Phya Anuman Rajadon 1961; Poulsen 1983; Mougne 1978; Muecke 1976; Whittaker 2002). In Satun, the “lying by the fire” is nowadays performed almost exclusively by Muslim women, with an ideal duration of 44 days. The process is associated with restoring the heat lost during childbirth, but it is mainly a ritual cooking of the mother, bringing about her spiritual maturation as a nurturer (see Trankell 1995 and Whittaker 2002 for Northern Thailand). During the first three days after childbirth the *bidan* gives the woman a warm bath with herbals, massages the woman’s body to increase circulation, especially on the legs, to fasten the muscles and rejoin the hipbones. If it is a woman’s first birth the *bidan* (or alternatively another older woman) will also instruct the young mother on the proper use of the iron tool or stone

(called *tungku* in Malay, and ก้อนไฟ *koon saw* in Thai) used to massage the abdomen after being heated on the same fire located nearby the bed.

Third is the postpartum care of the child. The *bidan* arranges and carries out rituals for the newborn, whether a boy or a girl. I refer here exclusively to the Muslim midwives. After the umbilical cord's stump has fallen the *bidan* (or alternatively the Imam) shaves the head of the baby. This ritual is accompanied by what is called *belah mulut* in Malay, or *pid paag* (ปิดปาก) in Thai. Whereas *belah mulut* means “cutting the mouth” or “opening the mouth,” *pid paag* means literally “to close the mouth” but the shared meaning is to guard the baby’s speech and expressions in the future. To this end several things are passed over the baby’s lips, including a ring, honey, sugar, salt, banana, cooked rice and a date. The Muslim *bidan* also performs circumcision on the girls, called *sunat* (Merli 2008b, 2010). This is usually limited to a pricking or nicking of the girl’s clitoris or clitoral hood, to draw some drops of blood as a ritual cleansing, and as a sign of her entrance into the Islamic community. The *sunat* falls into the perinatal practices since it is usually performed shortly after birth or within one to two years. Female circumcision is not publicly acknowledged with a large celebration as male circumcision is (see Merli 2008a, 2010).

### ***New generations of bidan***

In the present situation the passage of knowledge to the new generation of *bidan* is problematic. One of the explicit goals of Public Health authorities is to endorse policies that will finally put an end to the activity of indigenous midwives. This aim is promoted through education concerning women’s safety during delivery: the presumed risks associated with a home birth, in less than satisfactory hygienic conditions, are strongly stressed, and reminders of the difficulties of transportation in case of a sudden emergency are used to encourage women to choose birth in one of the hospitals available.

Other circumstances may further complicate the situation. On the one hand, there is a possible lack of interest in continuing the family tradition in midwifery in the face of multiple social changes, especially concerning education and alternative employment opportunities. On the other hand, if there are women who aspire to becoming *bidan*, they must confront many obstacles, first of all the resistance of the health authorities. Training is limited to refresher courses and new trainees are not accepted. For those motivated to become *bidan* attendance on a course is necessary to receive formal authorisation for their activity. This situation can lead the prospective *bidan* to totally refuse contact with health authorities, perceived as antagonistic, and possibly choosing to practise without official approval, that is to say “illegally.”

Fatimah is a woman in her early thirties who is related to one of the most renowned and old *bidan* in Satun, Tok Cik, who is approximately 87 years old. The old *bidan* has no children and Fatimah is her brother’s granddaughter. At the beginning of my research they lived together in Tok Cik’s house but during the final two years the old *bidan* left following a period of quarrelling. When I last interviewed her, Fatimah was not certain if she will continue the family tradition because it is not something she can plan and decide, “if it happens then it will be.” But, when on the occasion of the training arranged by Satun GH in February 2004, which I attended, Tok Cik was summoned for the refresher course, she did not go and instead sent Fatimah. On this occasion there was another woman, niece of another old *bidan*, who followed the same course of action. They were accepted at the moment of registration and attended the one-day-course, substituting their aged relatives.

As in the past, these courses are a valuable occasion to meet *bidan* from other parts of the district, like those coming from distant Lipeh Island. During pauses the *bidan* congregate to talk; topics usually centre on present activity and troublesome delivery situations, particularly retained placentae. As an occasion to exchange information among experienced *bidan*, for the young or prospective *bidan* it is a golden opportunity to listen to expert women who have faced these very problems and can compare solutions, feelings, and attitudes. In discussion, a range of knowledge

concerning specific problems emerges, from the use of oil for massage to an incantation to help expel a retained placenta.

*Bidan* can hold contrasting views about the exchange of information, and especially incantations (*jampi* in Malay, *khaathaa* คาถา in Thai) or prayers (*doa*), during these meetings. However, a shared opinion is that a “real” *bidan* would never ask another *bidan* about *jampi*, because the request would betray or insinuate that she has no knowledge of her own. However, a *bidan* can decide to share her knowledge spontaneously. Feelings surrounding the sharing of *jampi* can be ambivalent: secrets not to be revealed but at the same time useful knowledge that could help another *bidan* facing troubled births. Guarding jealously one’s own *jampi* could signal a lack of recognition among other practitioners, whereas older *bidan* can feel more comfortable about sharing their knowledge and may be willing to demonstrate their level of ritual mastery. Incantations are the tools of *bidan*’s practice and are received from an elder *bidan* or revealed during a dream. Incantations are often complex and include Malay, Thai and Pali terms, testifying to a high degree of hybridization, not only linguistic but also at the level of cosmology. The late Mak Hitam wanted to talk about her *jampi* and shared one with other *bidan* attending the refresher course in 2004. Since Mak Hitam’s daughter did not want to take up the call she thought her knowledge would die with her. Her daughter Maryam was not interested. Mak Hitam died in 2008. During my returns to the field in 2009 and 2010 Maryam regretted not having learnt the *jampi*, as if she had suddenly realized the loss.

The *jampi* are an essential part of *bidan*’s practice, probably the only “learning” and “studying” they acknowledge as transmitted and not spiritually received. They resemble the function of surgical equipment in the sense of aiding manual skills, which are often described by *bidan* as uncontrollable, guided by a spirit, and in terms of possessing tactile will. What drives the young generation of *bidan* to continue the family tradition is what their predecessors also recognised in their own personal history, a call to help women in trouble, women in labour.

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Abstract (1500 signs max)

This article portrays the life and activity of Muslim indigenous midwives in Satun province, Southern Thailand. Their art is transmitted almost exclusively through the maternal line and their traditional knowledge has been modified, transformed and reinvented but never abandoned, even as new biomedical information and techniques have been imparted during formal training. The indigenous midwives combine new knowledge with their more traditional practices such as use of incantations, ritual expertise, pre- and postpartum massages. They maintain their status in their communities thanks to their capacity to relate to both traditional and biomedical worlds. The reception of new equipment and the burden of bureaucratic control represent new elements in their lives and create a gap with the new generation of midwives.

Key words (between 5-10)

Indigenous midwives, Thailand, family tradition, TBA training, ritual practice

Presentation of yourself (academic background, position, field of studies).

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