Introduction

Birthing Beyond the Confinements of Tradition and Modernity?

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Birthing has rather belatedly received the attention it deserves—as a fundamental process of all human life, as a subject for academic research, and as a central concern of health policy deliberation and action. Inspired both by a global feminist revaluation of birthing and motherhood and a concern for continuing high levels of maternal and infant mortality in many developing countries (see Royston and Armstrong 1989), international interest burgeoned as can be seen not just in growing literatures in anthropology, history, sociology, development, and health studies (see Schemberg 1995 and 2001) but in a proliferation of programs funded by governments and international agencies.

The first is obvious in that huge and growing global literature exploring the historical transformations of birthing in Europe and North America, the contemporary patterns of birthing in many developed countries, and the complexities of historical and contemporary transformations in many developing countries—in Africa, Asia, and South America as well as the Pacific.¹ Much of this research and writing is suffused with a feminist sensibility that bemoans the increasing male power apparent in the medicalization of birth and discerns how the changing practices of birthing signify broader transformations in relations between women and men and profound shifts in the relations between nature, culture, and “technology” (e.g., Jordanova 1989; Davis-Floyd et al. 1998).

Differences between earlier and later practices of birthing are often described in the contrastive language of “traditional” and “modern.” In places such as America and Australia these differences are conveyed
through a contrast between a greater emphasis on natural or “organic” models and interventionist or “technocratic” models (Davis-Floyd 1994). But in those countries where “modern” methods of birthing have been promoted as part of earlier programs of colonization and later projects of development, such differences of “before” and “after” are entangled with differences between the indigenous and the foreign. This deep but problematic association between the traditional and the indigenous, the modern and the Western is an endemic problem for scholars analyzing transformations in birthing in comparative, cross-cultural contexts (see Davis-Floyd and Sargent 1997; Hunt 1999; Ram and Jolly 1998).

It is also a problem daily confronted by the many programs that address the practical questions of infant and maternal survival in developing countries. These programs often have deep roots in the colonial period—in the work not just of colonial governments and missions but organizations like the Rockefeller Foundation (see Hunt 1999; Lukere 1997).2 Since World War II, international efforts have been consolidated through the work of the international agencies—the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) most notably—and the huge and growing number of nongovernment organizations that give a high priority to programs of maternal and child health. In 1987, such efforts were given a global focus when the United Nations launched the Decade of Safe Motherhood with the aim of halving maternal mortality by the millennium’s end.

This simultaneous burgeoning of both a scholarly and policy concern with birthing is true of the Pacific, as elsewhere. But simultaneous, parallel concern does not imply dialogue. In her conclusion Vicki Lukere (this volume) offers a distillation of some important writing about birthing in the Pacific. The several authors in this volume attest to the important initiatives undertaken by national governments, aid donors such as AUSTRALIAN AID (Australian Agency for International Development), international agencies such as UNICEF, and regional organizations such as the South Pacific Commission (previously the South Pacific Commission [SPC]). But in all this effort, we might discern not only a separation between the several literatures of anthropology, prehistory, history, demography, development, and health studies but also a gap between academic description and analysis and the practical, political issues confronted by mothers and midwives, health practitioners and policy makers. Through this collection, we hope to nar-
row this gap. A deeper understanding of the negotiations between indigenous and introduced practices, and even efforts to move beyond the perduring divisions of “traditional” and “modern” modes of birthing might inform health programs and enhance not just the safety and survival of mothers and babies but their cultural comfort and personal well-being (see also Byford 1999). We hope this book proves of interest to health policy makers and health practitioners—doctors, nurses, midwives, mothers—as well as those scholars concerned about the well-being of women and children through those momentous moments that regenerate human life.

But, of course, not all birthing is blessed in its outcome. Mothers and babies can die during pregnancy and birthing. And in many regions of the world mothers and babies still do die in large numbers (see Royston and Armstrong 1989). The Pacific, and particularly the southwest Pacific, is one such region. In this book, we focus on the southwest Pacific, where in comparison with developed countries, high rates of both infant and maternal mortality persist. Yet, equally important, within this region there are significant differences between countries. We compare birthing in several countries—Fiji, New Caledonia, Papua New Guinea, Tonga, and Vanuatu (figure 1). Such a restricted focus has a good rationale. It raises questions, not all of which can be answered here, about how far different rates of infant and maternal survival derive from differential poverty or development and how far from differences in the cultural politics of birthing. Our examples include richer independent states (Tonga and Fiji), poorer but independent states (Papua New Guinea), and finally Vanuatu and New Caledonia, the latter still, despite the Matignon and Nouméa Accords, an overseas territory of France, heavily dependent on French budgetary support. We might ponder how patterns of corporeal survival and safety are related to what has been called in Aotearoa New Zealand “cultural safety” (Ramsden 1994) or more loosely the zone of mutual respect and comfort that can be negotiated between, or even beyond, “traditional” and “modern,” indigenous and introduced birthing practices.

Survival, Safety, and Well-being

In this region, and especially in Papua New Guinea, high rates of infant and maternal mortality persist. Estimates vary and are always debatable, especially since the highest rates are usually found in places
where the logistics of data collection are hardest and the results most contested. Most recent statistics suggest significant and continuing reductions in infant mortality across the region, with the striking exceptions of Papua New Guinea and Tuvalu, where there was a slight reversal of this trend in the early 1990s (table 1). For Papua New Guinea, infant mortality rates (IMR) were estimated at 82/1000 in 1991 (PNG Department of Health 1991, 7), although later estimates suggested a significant decline to 67/1000 (Brouwer et al. 1998) and even 63/1000 (UN 1997). In neighboring countries, such as Vanuatu and the Solomons, which are in many respects poorer and less developed than Papua New Guinea, infant mortality is, in the most recent estimates, much lower at 44/1000 (down from 91/1000) and 41/1000 (down from 52/1000), respectively (see table 1). Clearly, there is no simple relation between increased wealth or development and a decline in infant mortality. Still, these are tragically high figures, especially in comparison with the rates in Fiji (18/1000, down from 30/1000), New Caledonia (10/1000, down from 19/1000), and Tonga (9/1000, down from 30/100) (see table 1). That the small, independent state of Tonga has a lower rate and a more precipitous decline in infant mortality than New Caledonia, with its large French subsidies, again suggests that the availability of modern, biomedical facilities is
not all that matters. Similar conclusions pertain to maternal mortality rates (MMR), where again Papua New Guinea has by far the highest figures.

Biddulph noted that when fertility rates are taken into consideration, “a PNG woman has 350 times higher risk of maternal death than an Australian woman has” (Biddulph 1991, 440; cf. MacCormack 1994, 1–2).7 In 1991, the PNG Department of Health estimated a range from 2/1000 maternal mortality in urban areas to 5/1000 in rural areas, with very high levels of 12/1000 observed in remote villages without access to health services. The most recent, though controversial, figures from Papua New Guinea suggest continuing high levels of maternal mortality; a WHO/UNICEF study revised estimates of maternal mortality in 1990 with a figure of 930/100,000 live births (see WHO 1996 cited in Byford 1999, 242; but see Jorari and Marckwardt

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**Table 1**

Infant mortality rate: Melanesia, Micronesia, and Polynesia

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*Source: spc 1998, 11, fig. 4*

*Note: The 1998 report is a revision of the report first published in 1994, and the previous levels in this diagram refer to those cited in the original edition.*
This is a shocking statistic, even in comparison with near Pacific neighbors such as Vanuatu and Fiji, which, at latest report, have a maternal mortality rate of 280/100,000 live births and 90/100,000 live births respectively (see WHO 1996 cited in Byford 1999, 242). Tonga was estimated to have a maternal mortality rate between 70 and 80 in 1996. Byford doubts that the differences between urban and rural regions and between different regions of Papua New Guinea can be simply explained as the result of the greater safety of biomedical sites. The same argument probably holds for comparisons between countries.

Apart from the logistical and political problems in the collection, computation, and publication of IMR and MMR statistics, there are questions about how such figures are used—as global indices of the relative “status of women” as in the wall charts of the World Health Organization, UNICEF, or the South Pacific Community and how women are thereby imagined as numbers and persons. Byford (1999) has made the telling point that in the tallies of maternal mortality statistics, “dead women do count,” in a way it seems that live women often do not. She points to poor nutrition, overwork, and a range of other women’s health issues as important causes of continuing high levels of maternal mortality in Papua New Guinea. She avers, “Far from putting the M back in Maternal and Child Health, the selective focus on maternal mortality might be paradoxically legitimating a biomedical control of fertility” (Byford 1999, 255).

So although it is a matter of critical urgency to reduce these levels of infant and maternal mortality, it is equally crucial to address the broader problems of birthing experienced by those who live as well as those who die. Similarly, Underhill-Sem (2000) though keen to deploy the best possible statistics in her feminist demography of Papua New Guinea, notes how the fixation with counting individual bodies relies on universalist, biological notions of “mothers” and occludes the cultural contexts and contests around the processes of reproduction. In strikingly similar ways, the recent work of both Byford (1999) writing on Misima in the Massim, Papua New Guinea, and Underhill-Sem (2000) on Wanigela in Oro Province, Papua New Guinea, relates the ethnographic intimacies of birthing experiences in rural locales to national and global epidemiologies. They critically consider not only the statistics of infant and maternal deaths but the fraught processes of giving life in Papua New Guinea. In their superb analyses, as in the
several chapters that follow, they wrestle with the difficulties of how best to negotiate the continuing tensions between traditional and modern, indigenous and introduced ways of birthing in ways that promote well-being and not just survival (cf. MacCormack 1994, 2; and Lepowsky 1993, 81ff.).

Tradition and Modernity

The chapters in this book—by four anthropologists, a community health worker, and a historian—not only witness the powerful corporeal and cultural processes of the “confinements” of birth; they also attest to the confinements of our languages of description and analysis, too often still cramped by the terms “tradition” and “modernity.” There has been a broader unsettling of this seemingly eternal couple in the social sciences and humanities, as monological models of modernization or development have been displaced by observations of diverse development trajectories and culturally specific modes of “modernities” (e.g., Gomes 1994; Stivens 1998). The very constructs of “tradition” and “modernity” have been continually revealed as reifications that hide the fluidity of past–present and present–future relations (Jolly 1992c; Jolly and Thomas 1992; White 1992). Moreover, in research and practice around birthing, the need to blur, to integrate or mix “traditional” and “modern” has been espoused at least as long as the WHO declaration at Alma-Ata in 1978 (WHO 1978). Moreover, as Lukere (this volume, chapter 4) argues, there is a far deeper colonial history of efforts at translation and integration, as in the negotiation of the relation of the traditional midwife and the Native obstetric nurse in Fiji.

And yet, the use of binaries persists. This not only negates the flexible poise of embodied practice but situates the body of the birthing mother in a posture that amplifies the difficulty, the discomfort, the pain of birthing itself. Moreover, the binaries of tradition and modernity are often buttressed by moralisms, deploying the tropes of darkness and light and of women as victims and women as agents. Strenuous moral adjudications and invidious distinctions are used by advocates on both sides. Those zealously committed to biomedical birthing and modern mothering—missionaries in the past, many governments and international agencies today—typically justify their projects as in the interests of maternal and infant survival, as assuring safe motherhood and securing the “human resources” of the nation.
and globe. They see access to biomedical sites, attendants, and practices as urgent and view the persistence of many “traditional” aspects of birthing as dangerous at least and life threatening at most. For them, local practices typically render women “victims” of nature and culture (see Jolly this volume, chapter 6).

Advocates of “natural” or “traditional” childbirth tend to conflate nature and culture too, but in a way that sees women as agents, not victims, therein. They oppose medicalized birthing as the imperial expansion of the masculinist and technocratic values encoded in modern science. They are unpersuaded by many claims to greater survival and safety in clinics or hospitals and see medicalized birth as depriving women of their organic knowledge and power, of the integration of mind, body, and spirit, and of the female, familial support that traditional birthing allegedly affords (Davis-Floyd 1992; Goer 1995; Wagner 1994). Such celebration of traditional models is sometimes related to a valorization of both the ecological and spiritual foundations of women’s power as grounded in nature.

Morton criticizes the tendency in some feminist anthropological literature to “assume an association between ‘traditional’ practices and women’s empowerment and between ‘Western’ practices and women’s subordination” (this volume, 32). Although Morton herself discerns some ways in which biomedicine disempowers Tongan women, she also perceives some empowering aspects and conversely, some disempowering aspects of “traditional” practice. Like Morton and Mallett (this volume) I want to subvert these moralized binaries. In what follows I explore the difficulties from both sides—how the “traditional” and the “modern” are continuously reinscribed in relation to birthing postures and practices, the site of birth, and birth attendants. I then consider questions about the past and present involvement of men in childbirth specifically and reproduction more generally. Finally, I return to how the interests of Pacific mothers and their children are often identified and explore the tension in the Pacific context between what Scheper-Hughes (1987) has called the poetics and pragmatics of motherhood.

Postures and Practices
The posture of the birthing mother is often used in a graphic way to image agency. Distinctions are regularly made in the literature between “passive” and “active” positions or, as is attested in Ruta Fiti-
Sinclair’s paper on Papua New Guinea (this volume), between the supine position as the preferred, even prescribed, posture of the hospital and the range of positions available in village births—squatting, kneeling forward, gripping a pole behind or a rope or post above (see figure 5). The supine position (coupled with stirrups, shaved pubes, and enemas) has been seen as the safest and most convenient posture for obstetric surveillance and intervention. The way in which the maternal body is thus exposed and available to the gaze of doctors and nurses has of course been criticized since the very earliest days of

Figure 2. Frontispiece to a diatribe of 1793 titled Man-midwifery dissected (cited in Donnison 1988 [1977]).
“man-midwives” in the British birthing chamber—for example, Thicknesse (1765) and Sterne (1760) (figure 2). Many such critics saw the dorsal recumbent position, prone and exposed, as inviting salacious voyeurism (see Rich 1986 [1976]; cf. Jordanova 1989), while some contemporary feminists perceive both a sexualized objectification and a denial of agency to the birthing mother, especially if her passivity is reinforced by anesthesia and forceps delivery. Thus the supine position is a sign of mothers being denied the variety of postures in which they can more directly and energetically deliver and, indeed, a sign of the delivery having been usurped by biomedical attendants. Their critiques of biomedical birthing in Australia and America insist on women’s rights to other postures—moving around, squatting, sitting up, being supported from behind.

But what may seem to be the inherent associations of the supine position with passivity or victimhood and active positions with agency can be seen differently by advocates of biomedicine. Thus Dr. McMillan writing of the southern islands of Vanuatu in 1883 described the position of tugging on a rope or being supported from behind the armpits as “hanging positions,” imaging the mothers as victims, as against what he saw as the natural and comfortable position of “lying down” (1883; see Jolly this volume, chapter 6). Some contemporary proponents of medicalized birth celebrate a woman’s right to choose a painless birth through epidural anesthesia, or even general anesthesia, and cesarean section. Many of the American women studied by Davis-Floyd who were, in her words, committed to a “technocratic” mode of birthing, insisted on epidurals or even cesareans to avoid protracted labor and pain and vaunted their right to choose and, indeed, control (1996, 138).

The binary of activity and passivity is also used to depict other aspects of birthing practice—from pregnancy, through the phases of labor and birth, to how the cord is cut and the placenta evacuated. Again, the differences between “traditional” and “modern”?“Western” practices are usually constructed as noninterventionist versus interventionist (e.g., see Fiti-Sinclair this volume, table 2). There is no doubt that before, during, and after birth biomedicine often favors untoward intervention, using sophisticated technologies to inspect, secure, and schedule the processes. The massive investment in such technologies is patent from the novel processes of fertilization and conception, through ultrasounds, amniocentesis, fetal heart monitoring, anesthesia, induction, episiotomies, forceps deliveries, and ce-
sarean sections. In the United States, at present, fetal monitoring is almost universal, the rate for episiotomies is 90 percent (for first births), for epidural anesthesia 80 percent, and for cesareans 24 percent, overall (Davis-Floyd 1996, 127). All of these are the symptoms of the highly technologized and technocratic practice of Western birthing and have rightly incurred the wrath and the reform of feminist critics (see Davis-Floyd 1994 and 1996).

But this is not typically the “Western” medicine practiced in the small and poor hospitals of the Pacific—not in Port Moresby, Port Vila, Nuku'alofa, Suva, or even Nouméa—and certainly not in the remote clinics or aid posts of those several countries. Thus, although corporeal habits and bodily inspections may mimic technocratic practices in some hospitals in Melbourne or New York (the supine position and stirrups, for example), these are not usually backed up by the machines, the drugs, or the specialist expertise available in such affluent and developed settings. Poverty often ensures less intervention. Fiti-Sinclair (this volume) reports the “very basic facilities” in Port Moresby General Hospital. Morton (this volume) notes that most Tongan women in the hospital had no pain relief apart from pethidine, since anesthesia was rarely available. Thus, Tongan “Western” medicine is not the same as “Western” medicine in Australia or North America, both because it is underresourced and also because technocratic values are not so hegemonic or so supported by advanced biomedical technologies.

Might we, too, gently interrogate the other side of this orthodoxy that “traditional” birthing practices are always “natural” or noninterventionist? It is true that they listened much more to the rhythm of the body and used “hands of flesh” rather than “hands of iron” (Rich 1986 [1976]). But we must be careful not to confuse the “traditional” with the “natural.” Before, during, and after birth the bodies of Pacific mothers were and are subject to indigenous interventions—albeit organic forms that relied on food, plants, and the hands of others to mold the maternal body. We have to see the pervasive stress on food and behavioral taboos for pregnant, parturient, and lactating women as cultural controls, denying women forms of nutritious food that were thought to harm the baby, requiring women to avoid cold and seek heat, advising them that they should avoid strenuous activity, such as climbing trees. Moreover, most indigenous midwives use a variety of herbal therapies, massage, and binding for pregnant, laboring, and lactating women (see below). And surely, past, and in some
places persistent, strictures, such as protracted and widespread sexual abstinence after birth for both mothers and fathers, are hardly “natural,” but rather entail tight cultural controls on lactation, sexuality, and fertility (see Jolly this volume, chapter 6; Jolly 2001a and 2001b; Underhill-Sem 2000). Thus, technologies of intervening in the maternal or reproductive body cannot be simply equated with the tools of biomedicine.

Sites and Safety

Very often the difference between natural/traditional and medical/modern birthing is imaged in the site of the birth. In Australia this is canonically constructed as the difference between home births and hospitals, with the birthing center within a hospital being seen as a mediating third place between these poles. In the Pacific context this is often rather constructed as the difference between the “village” and the “hospital.” In fact most village births are today home births, in the sense that they happen within the home or the household of the birthing mother. This is often an important transformation of past practice, usually consequent on Christian conversion. In many places in the precolonial, pre-Christian Pacific, menstruating and parturient women moved to a separate site—a place in the forest or a special hut outside the settlement—where they stayed apart for the period of the bleeding or birthing. Such practices, discussed below, were a potent sign of the dangers inherent in recreating life.

Many contemporary surveys plot comparative rates of infant and maternal mortality and morbidity across the region (see above). There have been many associated efforts to establish birth incidences and relative “safety” by sites. In most parts of the Pacific the number of births in hospitals, health centers, clinics, or aid posts has sharply increased. Thus Morton (this volume) reports for Tonga a sharp rise in hospital births from 9.7 percent in 1954 to 37 percent in 1971 to a high of 89.2 percent in 1986. This then declined to 80.1 percent in 1987, as more women had home births with medical assistance (and importantly, rates of infant mortality still continued to decline sharply). In Vanuatu the number of births in hospitals and clinics is regionally variable, between urban areas and more remote outer island situations. In 1984 it was estimated to be a majority overall, but varying from 90 percent in urban areas to a low of 41 percent in the remote islands of the south (Osteria 1984, xiv; see Jolly this volume, chapter 6). In 1988 it seems that about 70 percent of births through-
out the archipelago were “medically attended” (primarily births in health facilities, such as hospitals, dispensaries, and health centers, with only a small proportion of village or home births attended by medically trained personnel).

As Mallett points out in her chapter (this volume), prescribing the place of birth prescribes the way to be born and the significance of place to birth. This insight derives from her experiences of Nua’ata Island in the Massim, Papua New Guinea. Moses, the community health worker, tried to recruit her as an ally in his biomedical approach to birthing and maternal and child health, but he found that although she was a dimdim, a “white person,” her approach to Western medicine was more critical and conflicted than his own. In strongly contrasting the aid post or health center and the village, he advocated the greater sterility and safety of the health center. Moses was shocked that women gave birth in the village on the bare ground, “like dogs.” The ground here evokes not just the dirt of possible infection but the bestiality of birthing on the earth rather than on a bed or a mat on a clean concrete floor. In a contrary valorization of village birth, many traditionalists would rather insist on how the place of parturition secures attachment to place through the blood spilt there, a groundedness further enhanced by planting the exuviae of birth—placenta, umbilical cord, or both—in the earth to affirm the attachment of the body of the child to the land, a practice common not just in Papua New Guinea but throughout the Pacific (see Mallett, Fiti-Sinclair, and Jolly this volume, chapter 6; Merrett-Balkos 1998).

Mallett (this volume) stresses how birthing by the biomedical model is conceived in terms of illness and danger to the body, rather than being seen in broader corporeal and spiritual terms. Moses’ critical concerns were for sterility, safety, and survival—of being able to deal with emergencies, such as postpartum hemorrhage, puerperal sepsis, or retained placenta. But of course many aid posts in Papua New Guinea, as throughout much of the Pacific, lack so much equipment and personnel that this image of the clinic as a clean and safe haven is rather a fantasm.

Similarly, Morton (this volume) has suggested for Tonga that the image of the hospital as a safe and clean site is dramatically at variance with her own experience of birthing there in 1981 and 1989. She reports that the obstetric unit at Vaiola hospital was “sparsely equipped” and reliant primarily on donations from charities. Moreover, much equipment could not be used: two out of four donated hu-
midicribs were broken and unable to be repaired, and an ultrasound
scanner was useless in the absence of a manual or trained personnel.
Some richer Tongan women travel to New Zealand to birth. Moreover, Morton notes the disjunction between the idealized image of a
clean hospital that women sustain and the reality of her own experi-
ence of the maternity ward—moldy, dirty, and cockroach infested.
The same is no doubt true of many other underresourced hospitals
and clinics throughout the Pacific.

However, notions of “safety” are not just about relative cleanliness
and survival rates but about the cultural comfort of the mother in a
terrain of choice that is charged with intense moral and political val-
ues, as Mallett (this volume) suggests. The Maori promotion of the
concept of “cultural safety” is a particularly resistant valuation of in-
digenous medicine in the context of Pakeha biomedical dominance
(see Ramsden 1994). Although this particular concept has perhaps
not spread far beyond Aotearoa New Zealand, it is clear from many
essays in this volume that the assessment of the relative safety of sites
is saturated with a politics whereby the “modern” and the “tradi-
tional” also evoke a contest between the continuing power of colo-
nialism and resistance to it.

Midwives, Traditional
Birth Attendants, and Nurses

As well as the distinctions made on the basis of postures and sites,
strong distinctions are drawn between “traditional” and “modern”
birthing on the basis of who attends the mother. Fiti-Sinclair (this vol-
ume) stresses the significant familial and communal support in the vil-
lage as against the strangeness, loneliness, and hierarchical distance of
the hospital environment.

There may be a broad truth to this generalization, although, again,
it is important to concede the range of ancestral practices in relation
to birth attendants in the past. First, in some parts of Papua New
Guinea, the Solomons, Vanuatu, and Fiji, women birthed alone.
Townsend reports that of the sixty-six societies surveyed in Papua
New Guinea, in six, mostly in the highlands, women were unattended
(Townsend 1986, 21). Sometimes they were attended if it was their
first birth or if complications were anticipated. Merrett-Balkos reports
that Anganen women birthed alone in the past in the engi and
“mother house,” situated in a fallow garden beyond the settlement.
They performed all the procedures of birthing themselves—cutting
the cord, planting the placenta, and cleaning up—and only “called out” for assistance if they were in extreme pain or distress or if complications had occurred (1998, 219–220). In such contexts the danger of birth was thought to be such that no others—not even close female relatives—should expose themselves to it. Whether this implies a notion of sacred danger or of pollution is moot (see below and Dureau 1998, 249). What is clear is that from 1960 the assistance of Catholic sisters in birthing at the aid post was a welcome alternative to this traditional isolation for Anganen women, even if they were initially shocked by the disposal of placenta and umbilical cords as hospital waste and successfully protested to change this practice.

But in most parts of the Pacific women were, and are, assisted by other women—either specialist midwives, healers, or relatives. In many places it was simply older female relatives—mothers, sisters, mother’s sisters, or father’s sisters. In strongly patrilineal and virilocal cultures in the highlands, Fiti-Sinclair (this volume) notes that female affines, such as the husband’s mother or sister, or even co-wives may assist. Elsewhere there was, and is, some specialization of birthing expertise—so we can talk of indigenous midwifery. We should be cautious, though, of the now conventional label—“traditional birth attendants” and its abbreviation tba—since this tends both to deny the variety of birthing practice in the Pacific and to unduly portray those who attend as midwives. Women were often more generically healers, wise women, or merely mature women of authority and experience (cf. Davis-Floyd 1996, 124). Salomon’s depiction of Kanak midwifery in contemporary New Caledonia, Lukere’s of Fijian midwifery past and present, and Morton’s discussion of the Tongan māʻuli provide interesting similarities and differences both in past patterns, historical transformations, and contemporary configurations in the relation of indigenous birth attendants to nurses, and, more broadly, of “traditional” to “modern” medicine.

Salomon (this volume) detects an important difference between the therapeutic modalities of men and women in a Kanak society of the Grand Terre. In her analysis, men dealt with the transcendent and the spiritual, divining ancestral spiritual forces or sorcerers who caused the life-threatening “made sicknesses.” Women on the other hand dealt with the immediate and the corporeal and used plant medicines, massage, and manipulation to heal the more benign “true sicknesses.” Women were exclusively responsible for what we call gynecology, obstetrics, and pediatrics. The skills of midwives extended from practices to secure or restrict fertility, through pregnancy, delivery, lactation,
and the broader care and rearing of infants and children. Midwives differed in their skills: some had the “commonplace competence” of older women; others had more dedicated talents for dealing with complications such as posterior presentation or placental retention; others specialized in abortion, contraception, or infertility. Knowledge was typically passed from mother to daughter or, more rarely, mother-in-law to daughter-in-law, and midwives were rewarded for their services with shell money, cloth, coins, or tobacco. Although becoming a midwife was less formal and less lineal a process than becoming a male diviner, some expert midwives presumed to see themselves as a diviner’s equal.

The power such women exercised was affected first by missionary “improvements” and then, later, by the strenuous medicalization of birth on the French continental model. Salomon suggests that initially female healers were less the subject of attack than male healers, whose skills more patently engaged demonic spirits. Still, the destruction of older Kanak-style settlements from the 1930s transformed the gendered spatiality of the past. The separate spaces of women and men were conjoined as the sexual prohibitions between conjugal couples were eased and the separate women’s huts for menstruation and childbirth abandoned (see Jolly and Macintyre 1989). Missionaries encouraged asepsis and the supine posture for birth. But all their efforts were ineffectual compared to the later medicalizing efforts of the state. Salomon dates the dramatic shift to births in dispensaries from the late 1970s and 1980s. In such clinical settings, unlike Fiji and Tonga, there has been no effort to integrate indigenous midwifery with biomedical procedures. Indeed, since the Matignon Accords of 1989, certified French midwives have been progressively introduced into bush dispensaries. In the regions of Grande Terre where Salomon researched, 10 to 15 percent of women were choosing to birth at home in 1993. But those who birthed in clinics still used some indigenous medicines before and after birth and still sought advice from midwives. And so, despite the state’s endorsement of the strict segregation of “traditional” and “modern” by site, practice, and attendants, Kanak women selectively use both.

From the archives of Fiji, coupled with contemporary observations, Lukere offers a history of a different pattern in the relation between “traditional” and “modern.” She views birthing from the vantage point of the Native Obstetric Nurse, or NON. She situates her in relation both to the traditional midwife and the male Native medical prac-
titioner. Lukere notes that, with the exception of northwestern Viti Levu, midwifery was common throughout the Fiji islands, though it differed in form. Midwives were often called buinigone ‘grandmother’, a name that implied age and experience. Some had particular specialisms—in abortion and contraception, for instance. Others practiced techniques that had a more general application, such as massage or internal manipulations through the body’s orifices. Although all midwives were women, many resembled general practitioners, in offering a range of therapies.

The exclusively feminine character of midwifery was stressed by colonial officials, who viewed them as part of a “female domain that was inaccessible, pernicious, and resistant to necessary and beneficial change” (Lukere this volume, chapter 4, 107). Midwives were seen as especially culpable, along with Fijian mothers in the context of the 1896 commission into depopulation and beyond—in promoting contraception, abortion, even infanticide, or at least needless infant deaths by malpractice. Lukere notes how such caricatures paralleled the caricature of midwives in Britain itself, but how, in the Fijian context of very high infant mortality, the midwife became not just a quack but tantamount to a murderess. Improvement was sought not so much via male doctors, but in training Fijian women as nurses, to replace the “superstitious and dirty unsanitary habits” of traditional midwives (Lukere this volume, chapter 4, ibid.). As in Vanuatu, and throughout the Pacific, the trope of enlightenment in a world of darkness merged the salvation of Christianity and of Western medicine (White 1994; Jolly this volume, chapter 6).

Lukere infers that some of the first Native Obstetric Nurses were sincere evangelists of both Christian and medical missions. But they initially failed—primarily through the resistance of Fijian mothers who remained unpersuaded by women who were themselves young and childless, and often foreign to the regions of their work. Moreover, the negativities associated with an invasive colonial medicine to “save the race,” and the Fijian fear of hospitals, inauspiciously called vale ni mate ‘places of death’, no doubt sullied the reputation of the nones, too. They had none of the extensive repertoire of knowledge and skills of the traditional midwives—who not only attended births but also helped with fertility and infertility, knew how to abort or contracept, and could assist in menstrual irregularities or menopause.

But, as Lukere shows, young women kept training as nones and, in the later period from the 1920s, processes of translation and integra-
tion rather than overt opposition to traditional medicine became increasingly advocated. Male Native Medical Practitioners were newly encouraged by foreign experts and by the government to selectively incorporate traditional knowledge and resources in their work. But they were rarely involved in birthing, partly because they were men and partly because distance and deference was generated by their status. Their long education and the nature of their official position tended to isolate them from local communities. Despite the official advocacy of integration, they were often suspicious of traditional medicine and, indeed, more zealously opposed to it than many foreign doctors.

Lukere argues that it was rather female nurses who became the medium for more intimate medical communications and for the integration of the “traditional” and the “modern.” Especially when Native Obstetric Nurses returned to their profession after having their own children, they became authoritative practitioners, not unlike the indigenous midwife. “So the initial contrast between fresh young non and older village midwife blurred as the constitution of the nursing profession changed to include returning, mature women who combined a colonial role with the indigenous roles of mother and midwife” (Lukere this volume, 116). Although often from chiefly backgrounds too, their practice of the “cardinal female virtues” of collectivity and caring often meant they remained more connected to other Fijians, even after long periods of education.

Lukere suggests for contemporary Fiji that the relation of trained nurse and traditional midwife can be one of mutual respect. She also speculates that this “decorous harmony” is shaped by the global revaluation of traditional and Western medicines, by the need in poor, developing countries for cheaper local alternatives to expensive drugs and biomedical technologies, and finally by the greater efficacy and acceptance of biomedicine in Fiji in the wake of successful state-sponsored campaigns—vaccinations, immunizations, and family planning. The historical trajectory in the relation of “traditional” and “Western” medicine has proved rather different both in New Caledonia and in neighboring Tonga, despite their similar global situation. The greater intransigence of French medical policy may derive in part from the dynamics of relations between settlers and the indigenous population in what is still a French settler colony, but the several independent states considered here display diverse trajectories too.

In contrast to Fiji, Morton notes a dearth of historical information
about Tongan māʻuli or midwives, beyond the fact that they were senior women and that they had the “power of life and death over babies and parturient mothers” (Rogers 1977, 180, cited by Morton, this volume, 38). Their contemporary position is, however, likely very different from their position in the past, and their significance as birth attendants is declining. Māʻuli usually sustain close support with the pregnant woman before, during, and after birth, offering a range of herbal treatments, manipulations, and massage. They advise her against overwork and getting cold; they also suggest following taboos about food—such as not cutting meat or eating octopus. During labor most māʻuli use massage to ease pain and plant-based medicines to facilitate delivery and expel the placenta. They often push the uterus back into place after birth, apply scented coconut oil to tears, and bind the stomach with tapa or cloth. For such services they receive koloa (pandanus mats or decorated barkcloth).

Most become practicing māʻuli after marriage and children, but some start young, even as teenagers. Most learn by observation and instruction from mothers and grandmothers, although some also study medical textbooks. Some have only generic skills, while others have specialist knowledge; and, as in Fiji, some practice more generally as healers. Morton notes the diversity of practicing māʻuli and their variant relations to the biomedical system, which labels them all “traditional birth attendants.” Some have formal training, while others do not. Some practice within hospital contexts, while others work only in homes, but still deploy “Western” practices—in the sterile and immediate treatment of cutting the cord, for instance. More rarely, hospital-trained nurses incorporate elements of Tongan practice, such as massage, and call themselves māʻuli. The Ministry of Health is trying to use māʻuli to motivate women to attend antenatal clinics and hospitals and to plan families, eat well, and breast-feed. But many doctors and nurses are still hostile to māʻuli and many māʻuli oppose hospital births, seeing them as desirable only if there are complications.

Morton reports many complaints about medical staff from mothers in Tonga: they are often perceived as strangers, overworked and unable to offer the continual solace and support of a māʻuli. There is little privacy, and most women feel embarrassed by the presence of male staff. Some mothers are kept waiting in hospitals, even in the middle of their labor. Women complain that many procedures (breaking the waters,
forceps delivery, episiotomies, and even cesarean sections) are not explained, but issued as orders as if the medical staff were ‘eiki ‘chiefs.’ Such complaints echo those Fiti-Sinclair (this volume) reports for Port Moresby General Hospital—overworked staff, isolation and lack of support during labor, oppressively strict schedules, and nurses who “talk down” to mothers.15 Even in the far more benign setting of Moses’ community health center on Nua’ata, Mallett observed the “talking down” of medical authority and bureaucratic distance: the roll call of women in alphabetical array; questions posed in English, inviting reticent responses; the failure to engage in conversation beyond the immedacies of diagnosis; the maintenance of a sense of his distinction, biomedical expertise, and education. Perhaps in this way the values of what Davis-Floyd (1996) has called a “technocratic culture” with its emphasis on professionalism and distance can be communicated without the high technology of birthing machines.

Yet, as Moses acknowledges, part of the dynamic of distance is women’s reluctance to attend his clinic because he is a man. “[T]hey feel shy to come, because I am a male, single worker. They are shy because of the sexes, I mean making themselves public to me” (Mallett this volume, 136). What, then, might we say about men’s relation to childbirth and reproduction more generally, in both the past and contemporary Pacific?

Men, Birthing, and Reproduction

It is easy to equate this shyness, this sense of modesty about bodily revelation with the introduced values of Christianity. And in some parts of the Pacific, in the Massim for example, a far more relaxed corporeal relation prevailed between men and women, and especially between single people in the past (see Reed 1997; Weiner 1988). But in many other parts of the Pacific the erotic and the reproductive potentials of sexed bodies were rather seen as dangerous, requiring forms of sequestration or separation. In many parts of the Pacific, menstruating and parturient women secluded themselves in separate dwellings on the edge of settlements or even deep in the forest. Such practices have been widely discussed in the literature and debated between those who see this as evidence that women are seen as polluting and those who rather insist that it is women’s sacred danger and proximity to the ancestors at such times that require their separation.
Salomon, in her depiction of Kanak concepts, opts for the first—that women are seen as impure and that such impurity imparts a bad odor, like the putrid decaying flesh of a dead animal or of rotting food. Menstruating women constitute a particular peril to male activities such as hunting, fishing, and yam gardening. Yams exposed to impurity, like men, would rot. Thus, although menstruating women live with their families today, women still do not pass through yam gardens, and they carefully bury the blood of menstruation and childbirth and the placenta. Newborn babies, boys, and girls go through purification rituals. Boys later undergo circumcision, which, as is characteristic of many such rites, both mimics menstruation and childbirth and devalues it, aspiring to remove the bad blood of women through masculine spirit eclipsing feminine matter. Thus Salomon suggests, as many have before, that men appropriate women’s procreative powers to themselves and claim “prepotency” or primacy in fertility.

But where is it women’s impurity and where their sacred danger? Although Salomon sees the first interpretation as “Melanesian” and the second as “Polynesian,” the notion that women in such tapu states are polluted and polluting has been challenged not just for Polynesia (e.g., Hanson 1982; Ralston and Thomas 1987) but for parts of Melanesia too. Thus Keesing (1985 and 1989) writing about the Kwaio of Malaita (Solomon Islands) revised his earlier view that women were seen as polluting and argued that the indigenous concepts and practices were better translated as “sacred danger.” He observed that the same term (abu) was used to mark women’s menstrual and childbirth seclusion and the seclusion of men when they were communicating with ancestors. The life stories and narratives Kwaio traditionalist women told Keesing and Shelley Schreiner suggest that women did not perceive themselves as forced to retire because of their polluted state, but rather that they removed themselves and by this separation sustained a life of cleanliness, harmony, and ancestral order. Women in these kastom or traditionalist communities thus celebrated their moral superiority over their Christian neighbors (Keesing 1989).

I made a similar argument for the kastom adherents of South Pentecost, Vanuatu, observing the similarities between the states of seclusion associated with birth, with circumcision, and with taking rank in the graded society. The important notion here is not one of corporeal putrefaction, but of the danger presented by the leaking of divine or ancestral powers into the quotidian (see Jolly 1994a, 149, 192).
The processes of “purification” after birth are better described as a process of “desacralization.” But other ethnographers of Vanuatu, from McMillan in the 1880s to Walter in the 1980s, prefer to speak of purity and pollution (see Jolly this volume, chapter 6).

Whether it be to avoid pollution or dangerous sanctity, it does seem common that men in the Pacific were, and still are, excluded from birthing. This is confirmed by the several essays in this volume, though exceptions are also noted. In Tonga, for instance, Morton (this volume) observes that husbands sometimes accompany their wives in labor. Mallett (this volume) comments that, while men on Nua’ata are reluctant to involve themselves directly in birth, they may attend the delivery of their own children or children of their maternal kin. Salomon (this volume) notes that in the Grande Terre when a chief’s wife was about to give birth, a man closely related to the husband would remain, presumably to safeguard against any attempt to kill the child. But there is a further more generalized exception. It is commonly reported that in the case of difficult deliveries, and of long and obstructed labors, a male healer or diviner might be called in. Thus, Walter and Bourdy (1986) report that the male healer (nahuropu) of Espiritu Santo (Vanuatu) attends in such instances, since an unconfessed adultery might be the source of the obstruction and require the exorcism of a vengeful ancestral spirit (see Jolly this volume, chapter 6). Fiti-Sinclair also reports for coastal Papua New Guinea male magical specialists—divining, calling on spirits, and using leaf medicines. Elsewhere, women’s sexual morality is linked not just with their own survival in childbirth but with that of men in war. Thus Dureau (1998) reports for Simbo in the western Solomons that a woman who has a premarital or extramarital affair imperils her brother’s life in battle.

But these male healers of the Pacific past and present appear rather different from the “man-midwives” of eighteenth-century Europe who tried to usurp the power of wise women in birthing, although their rare appearance to exorcize spirits does perhaps witness the gendered hierarchy of female matter and male spirit that Salomon (this volume) discerns in New Caledonia. Moreover, although men might have been routinely kept apart from childbirth, they were still crucial actors in the broader practices and politics of fertility. Elsewhere I have noted how, for South Pentecost, Vanuatu fathers as much as mothers were subject to the food and behavioral taboos surrounding pregnancy, birth, and the postpartum period. Throughout much
of the southwest Pacific men were abstinent when their wives were lactating. And in the past men were vitally involved in reproductive affairs, not just as fathers to their own biological children, but as brothers and as kinsmen. Thus, although birthing might constitute a “separate” female sphere, men were crucially involved in the broader domain of reproductive life, and indeed often dominant over women therein (Jolly 2001a).

Salomon also observes that Kanak men were vitally concerned lest women were barren or aborted or committed infanticide. Male children were especially desired. A woman might choose to kill a male child to spite her husband, but in so doing she also attacked his lineage or clan. I quote Salomon on this: “The female control over reproduction was then, in certain cases and especially apropos the political future of the group, contested and reappropriated by men. There was a male fear that if women were left to their own devices, they might act in a manner prejudicial to the objective of perpetuating the patriline” (this volume, 89). Of course, reproductive relations were different in regions where matrilineality or cognatic kinship prevailed (see, for instance, Weiner 1988).

Ancestral philosophies routinely connected human and natural fertility and saw both as dependent upon and derived from ancestral powers (Jolly 2001a and 2001b). Thus, there is a constant series of practical and metaphoric connections drawn between growing crops and growing babies, even when the particularities of practice require their separation—as do Kanak precepts about the blood of women endangering yams. In many Pacific places men presumed to eclipse the bodies of women through transcendent rituals of fertility—on boys as much as on yams—and claimed thereby greater proximity to and efficacy over the ancestral spirits, which were the source of all regenerative life.

Extruding Fathers, Conjugating Mothers, and Children
Elsewhere I have argued that Pacific fathers, and men in general, have been progressively extruded from the processes of fertility and family planning, as biomedical and demographic practice progressively fixated on the mother-child dyad (Jolly 2001a). Both these processes are reflected in the very concept of maternal and child health and its abbreviation mCH. Not only are fathers left out, but the conjugation of maternal and child suggests their identification. This undue ten-
dency to equate the interests of mother and child and an associated habit of subordinating maternal interest and well-being to that of the child has been often reported for Europe, Asia, and the Pacific (Davin 1978; Denoon 1989, 103; Griffen 1994; Manderson 1998, 97). In her critique of the Port Vila declaration Griffen (1994) lamented that the developmentalist goals of demographers and economists seem more directed to population problems and the well-being of children than they are to the “human resources” of the mothers.

The potentially divergent interests of mother and child are acutely dramatized in difficult births, which can entail a tension between saving the mother or the child. Although maternal and infant mortality rates are both falling in most countries (see above), they do not follow identical paths. Both in the plotting of regional and national graphs and in the intimacies of corporeal survival, maternal and infant mortality are to some degree independent. Babies die and mothers live, mothers die and babies live, and sometimes birth attendants have to make agonized choices about whose life is saved. Of course the interests of mother and child are even more divergent in the practices of abortion and infanticide—widely reported across the region in the past. Both have been outlawed by state and church edicts (Pulea 1986), but though shrouded in shame and secrecy, abortion persists in many places. Some women still deploy indigenous methods of herbal medicines, massage, and dangerous athletic feats to dislodge the fetus (see Bourdy and Walter 1992; Walter and Bourdy 1986), while others use the even more dangerous techniques of overdosing with malarial drugs or other biomedical preparations. Not much is said about abortion in this volume (but see McDowell 1988) and, indeed, little research has been done on the patterns of abortion in the contemporary Pacific.

I raise this here not just to point to a lack in the literature but to redress an overwhelming tendency to assimilate the interests of Pacific women and their children. Different, even divergent, interests may be discerned even in the most seemingly mutual process of breast-feeding. There is no doubt that, on the whole, “breast is best”—for both maternal and infant well-being (but see Maher 1992, 153; Gray 1994 [1982]). Breast-feeding has remained the preferred practice throughout the Pacific, despite early attempts by colonial authorities in Fiji and other places to promote cow’s milk and other breast milk substitutes (see Lukere this volume, chapter 4; Ram and Jolly 1998). Suckling on demand and for a protracted period is still the preferred rou-
tine throughout most of the southwest Pacific (see Marshall 1985). The persistence of this pattern has been further enhanced in recent times by programs promoting breast-feeding (see Mallett this volume).

But Pacific mothers like mothers anywhere may have problems of milk supply or may be unable to continue breast-feeding because of mastitis, poor nutrition, or illness. In the past such problems could sometimes be solved by having lactating sisters or other appropriate female kin suckle the infant in lieu of the mother (as happened also when mothers died). But today, some Pacific mothers resort to bottle-feeding because of the exigencies of new work and domestic rhythms or because they think it more convenient or “modern.” This seems especially pronounced in urban areas of Hawai‘i and Micronesia (see Look, Sylva, and Baruffi 1998; Takashy 1994). The hazards of breast-milk substitutes are well established—in terms of inadequate nutrition, reduced immunity, and the high risk of contamination and infection, especially in tropical environments (e.g., van Esterik 1989a and 1989b; Marshall 1985)—but not always widely appreciated. Formulae and bottle feeding can still exert a “glamor” associated with modernity. Still, even if their choice is unavoidable, mothers who bottle-feed risk incurring criticism from kin and medical authorities for failing to properly nurture their child and for being too “flash.”

These tensions between the interests of mothers and children, these negativities and difficulties about birthing and mothering I raise partly to subvert undue romanticism about Pacific mothers. Dureau (1993) is probably correct when she perceives a historical transformation from an earlier European pattern of denigrating and bemoaning Pacific mothering as insufficient and primitive to a tendency, in the works of later feminist writers, such as Sheila Kitzinger (1972), to portray them as more naturally nurturant. Certainly Dureau’s female friends on Simbo Island in the Solomons had negative views of Australian mothers as insufficient and callous toward their children, and celebrated their own superiority as mothers. Elsewhere I have observed how pervasively Pacific women are authored as mothers in the texts and images of contemporary Christian and nationalist movements. Women’s relation to both the church and the state is canonically constructed through a model of maternity (Jolly 1994b and 1997). But such ethnic typifications, such rarified images of “mothers of the nation” can seem remote from the raw realities, the daily difficulties, and the fluid tensions of “being a mother” in the Pacific as anywhere.
Conclusion

This gap between the poetics and the pragmatics of mothering has been poignantly plotted by Nancy Schepers-Hughes (1987). She discerns a tendency on the part of American and French feminist theorists to romance the maternal body and the subject position of the mother in a way that is remote from the grimy realities, the politics of survival of the Brazilian mothers with whom she worked. But what we have discerned in the Pacific is perhaps more a triangulated relation, whereby the dark pragmatics of maternal and infant survival vies not just with a romantic Western poetics of motherhood but with a countervailing romance, a poetics of Pacific motherhood (see Jolly this volume, chapter 6).

Idealized images and caricatures of Pacific mothers are entangled with the history of colonial control and of decolonization in the context of persisting aid dependency. An image of the bad Pacific mother emerged in the early colonial period when the scourges of introduced diseases were at their height, when the demographic decline of Pacific peoples was ongoing and their “dying out” seemed imminent. As Lukere (1997) has so consummately shown, the “decrease” in Fiji, though primarily due to the destructive impacts of European infectious diseases, was largely blamed on bad mothers and, to some extent, on their allies, nefarious midwives (cf. Jolly 1998b). The picture of Pacific health has dramatically shifted since then, and although malaria, respiratory infections, and gastrointestinal conditions continue to be the main diseases that threaten health, they are today rivaled by the chronic diseases of “modernity” or “development”—such as hypertension and diabetes, which like the introduced infectious diseases of old pose particular threats to pregnancy and childbirth (see Morton this volume; Lukere this volume, conclusion). As the ghost of depopulation has given way to the specter of overpopulation, dominant images of Pacific mothers have also shifted (see Jolly 2001a). Negative images of Pacific mothers, which author them as victims, pervade the contemporary epidemiological and development literature on infant and maternal survival, while paradoxically in the large demographic literature they are also implicated as agents in overpopulation. More positive, even romantic evaluations of Pacific mothers proliferate in ethnographic texts that celebrate indigenous culture and in Christian, feminist, and nationalist writings that vaunt the centrality of women as mothers not just of children, but of communities and nations (see Jolly this volume, chapter 6).
Such opposing views of mothers, like the binaries that are regularly applied to the postures, sites, and processes of birthing itself, are embedded in the contemporary politics of revaluing the relation of indigenous and foreign, of traditional and modern in the context of colonialism and decolonization. Long ago, Frantz Fanon (1978 [1970]), in discussing the predicaments of colonial medicine and of the native doctor in particular, stressed that the hospital was not just the site of modern science but the place of the whites (cf. Mallett this volume). Despite the long struggle for decolonization and the fact that many Pacific peoples, like African peoples, not only use but practice biomedicine, such associations persist. The contrast between “ways of being born” in the Pacific is not just between the organic and the technocratic, between feminine and masculine modalities, as has been suggested for North America and Australia (Davis-Floyd 1996). It is also imbricated with a racialized temporality of pasts, presents, and futures. The organic and the traditional are unduly linked with the indigenous while the technocratic and the modern are intimately entangled with the foreign. Pacific mothers, in the raw and visceral processes of giving birth, are also embodying the tensions between moving toward the “modern”—desired in part, but that even as they make it theirs still bears the sign of the *palangi* or *dimdim*—and revaluing the “traditional”—not so much for what was, but rather for what will be, recuperating the good of the ancestral, as a way of moving toward a more indigenous future.

Notes

1. Space precludes even a cursory review of this vast literature, but for an excellent recent review with a Pacific inflection see Byford’s chapters “Active and Supine Women” and “Beginning with Birth” in her thesis (Byford 1999). On the history of childbirth in England and North America major works include Adams (1994); Badinter (1981); Donnison (1988 [1977]); Ehrenreich and English (1979); Jordanova (1980 and 1989); Oakley (1980 and 1984); Scully (1980); Versluyssen (1981). On contemporary practices in developed countries see Davis-Floyd (1992); Davis-Floyd et al. (1998); Haire (1972); Handwerker (1990); Kitzinger (1982); Michaelson (1988); Oakley (1979 and 1984); Sargent (1989); Sullivan and Weitz (1988). Key texts in the cross-cultural or comparative study of birth and mothering include Davis-Floyd and Sargent (1997); Ginsburg and Rapp (1995); Hunt (1999); Jordan (1978); Kay (1982); Laderman (1987); MacCormack (1994 [1982]); Ram and Jolly (1998); Raphael (1975); Rice and Mander- son (1996); Scheper-Hughes (1987).

(among many other things) the intimate associations of modernity and biomedical birthing.

3. Ram and Jolly (1998) had a wider focus both thematically and regionally, considering the rubric of “maternities” (not just pregnancy and birth but mothering more broadly construed) and divergent “modernities” in several states of the Pacific and South and Southeast Asia. Lukere and Jolly (n.d.) consider questions of gender and health across the Pacific more broadly, although some essays in that volume specifically examine maternal and child health.

4. The worldwide infant mortality rate is 59/1000 and 70/1000 for less developed countries excluding China. The Pacific Islands in recent time have achieved lower levels of infant mortality than most other developing countries, with the dramatic exceptions of Papua New Guinea with 82/1000, Kiribati with 67/1000, and the Marshall Islands with 63/1000 (spc 1998, 11).

5. Statistics are everywhere molded by the exigencies of collection and computation as well as by political imperatives. Many adjudge statistical information on Papua New Guinea as especially unreliable because of the enormous logistical problems in data collection in the context of massive funding cuts to health, National Planning, and other government services over the last decade. Underhill-Sem (2000) in her recent analysis of demography and family planning in Papua New Guinea suggests a tendency on the part of national planners to accept higher rather than more reliable lower estimates of the total fertility rate in order to contribute to the sense of urgency about family planning, which would yield greater funding for aid from donors.

6. The dates for the earlier and later data for this table are not given. Lewis (1998, 648) in her excellent review of gender and health in the Pacific quotes slightly different figures, deriving from South Pacific Commission data for 1990 (spc 1993) and the Economic and Social Commission for Asia and the Pacific for 1995 (un 1995). The earlier and later infant mortality rate for different countries quoted in descending order by initial rate are Papua New Guinea 67/1000 to 65/1000; Vanuatu 52/1000 to 43/1000; Solomon Islands 43/1000 to 25/1000; Fiji 26/1000 to 22/1000; Tonga 47/1000 to 17/1000 and New Caledonia 21/1000 to 20/1000.

7. MacCormack (1994, 1–2) notes that whereas in many poor countries the lifetime risk of dying from pregnancy-related causes is 1 in 15, in some parts of northern Europe the risk is 1 in 10,000. She observes the “curious way” in which rich and poor countries are connected—women in rich countries having more cesareans than they need while women in poor countries cannot get them even in urgent need. She stresses that what is needed is not expensive technologies or large hospitals but culturally appropriate local services.

8. These authors suggest, on the basis of earlier demographic and health surveys by the National Statistical Office (in Chimbu and other parts of the highlands for the period 1982–1986), that these high estimates of maternal mortality are exaggerated and that the maternal mortality rate would be closer to 370 per 100,000 for the country as a whole.

9. Lewis (1998, 649) again cites very different figures, which are quoted per 1,000 but must be per 100,000. These estimates in descending order are Papua New Guinea 700–1,000; Solomon Islands 549; Vanuatu 92–138; Tonga 70–80; Fiji 68–150. No data for New Caledonia are quoted.

11. MacCormack (1994, 2) stresses that maternal deaths are “only part of the tragedy” and quoting a study for rural Gambia, observes that untreated trauma of birth include incontinence, uterine prolapse, and infertility. Lepowsky (1993, 81ff.), too, offers harrowing accounts of women who died or had extreme difficulties in birthing in Sud-Est, a remote island in the Massim. Especially poignant is the account of Rara, a young woman who was in labor for six days with her first child, probably stuck in a transverse position. Neither cesarean section nor massage and an advanced cephalic version were available. She was supported through her ordeal not just by kinswomen but by her father, husband, and several male diviners who with ginger root and incantations removed the “obstruction.” The baby moved its position. Both he and Rara survived, but she was left infertile and suffered enduring pain and discomfort after the trauma of her first birth.

12. “Technocratic” is the term used by Davis-Floyd (1996) to denote not just heavy reliance on technology but a broader view of the self in the world predicated on the split between mother and child, mind and body, and professional and personal life in contemporary America. Davis-Floyd’s research, done mainly with middle-class and professional women, distinguished between those mothers who espoused the hegemonic technocratic view and those who were committed to a more holistic approach in which mother and child, mind and body, professional and personal were seen as connected. She is clearly an advocate of the second view with its stress on inner knowing and intuition rather than hierarchically organized, authoritative knowledge. However, she does not dismiss the views of women who desire births on the technocratic model as suffering from delusion or false consciousness, as some have done. I might note here that, insofar as she plots a binary between the technocratic and the organic models, the content of the oppositions is very similar to that marked by traditional and modern or indigenous and foreign in the Pacific literature. But in the Pacific context the difference also marks race as well as temporality or, as I argue in the conclusion, a racialized temporality of past, present, and future.

13. I here telegraphically refer both to the earlier debates in feminist anthropology provoked by Sherry Ortner’s discussion of the differential relation of women and men to nature and culture (1974; see MacCormack and Strathern 1980 for a set of important critiques) and to the rich if problematic stream of writing referred to as ecofeminist.

14. There is much controversy in the literature about whether this derived from a view of women’s reproductive bodies as polluting or unclean and that women were thereby in a state of forcible sequestration or whether it was rather a state better seen as one of sacred danger and proximity to ancestral and divine forces and that women created such separations themselves to maintain order and harmony. See below.

15. Lukere is concerned that such portrayals may harshly caricature nurses. They are at odds with her dominant impressions from Fiji (Lukere, pers. comm., October 1998).

16. Maher (1992, 153) points out that there are circumstances in which the injunction for women to breast-feed for long periods requires them to meet from
their own heavily taxed bodily resources the costs of local and global inequalities. And in some communities, such as the Enga of the PNG highlands described by Gray (1994 [1982]), women’s premature aging and short life expectancies are due to a syndrome of depletion, which in some part derives from frequent or almost incessant lactation.

17. Appropriate kin could not always be found of course, and even if they could there were often great difficulties for the wet nurse in suckling two infants at once, as the early study by Gray (1994 [1982]) of Enga women affirms (cf. Lukere 1997).

18. Although it should be noted that there was a countervailing tendency in some earlier literature to portray “primitive” mothers also as more caring and natural and to see “primitive” childbirth as easy and painless (Gebbie 1981; Lukere, pers. comm., October 1998).