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Haiti's political and economy history has led to a maternity care system that lies out of reach, geographically and financially, of most Haitians, resulting in excessively high maternal and infant mortality. The most common birth practitioners are homebirth midwives (matwòns), who attend roughly three-fourths of all births in Haiti (UNICEF), often without the benefit of emergency obstetric services. In this ethnographic study, I examine how matwòns experience caring for mothers and babies in extraordinarily low-resource and high-risk settings. This qualitative research employed a critical approach and feminist research methodologies. In in-depth interviews I asked participants to describe the challenges they find in their work. Then, in an innovative style of group meeting called Open Space, matwòns reflected on those challenges collectively, with an aim to ameliorate their current situations. Data analysis utilized a modified grounded theory approach, which allowed the matwòns' own narratives to determine the categories

of analysis. Emergent themes resulting from this analysis revealed four main challenges in the work of matwòns, as well as matwòns' own strategies to mitigate those challenges. The four broad challenges, which include physical risks, social/spiritual threats, a lack of livelihood, and an obligation to practice, are experienced either as episodic hazards or chronic stressors. Matwòns' personal mitigation strategies centered on two broad approaches, providing protection, and offering service. However, the Open Space meeting created an opportunity for matwòns to strategize collective mitigation efforts through professional organization. Based on these findings, I argue that a more nuanced understanding of matwòns' experiences reveals their adaptive skills, which, in part, resemble Davis Floyd's (2007) notion of a postmodern midwife, and offers opportunities for mutual accommodation (Jordan 1997). Recommendations include support and advocacy for the self-organization of Haitian matwòns, as well as their greater inclusion in efforts to improve maternal and infant health outcomes in post-earthquake Haiti.

“A Fragile Job”: Haitian Traditional Midwives (Matwòns) and the Navigation of Clinical, Spiritual and Social Risk

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Annaliese Watson

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Director of the School of Language, Culture, and Society

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Annaliese Watson, Author

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Chapter 1: Introduction

In this study, I examine the lived experiences of those who attend women who birth at home in Haiti. Known as *matwòns* (the Kreyol translation of *matrone,* which in French refers to a midwife attending institutional deliveries), these practitioners serve the majority of Haitian women. Using the lives of matwòns as a lens, I examine how Haiti's intricate history of both colonial and neocolonial exploitation, as well as its unmatched claims for independence, have shaped the work of matwòns. Specifically, this study attempts to answer: Given the tremendous risks associated with attending childbirth in Haiti, how do matwòns experience and contend with the challenges inherent in their work? Using a modified grounded theory approach to analyze matwòns' reflections on their life's work, two broad categories of challenges emerged, along with individual and collective strategies to mitigate those challenges. Based on an analysis of these themes, I argue that matwòns are strategic in how they address the bio-social realities of childbirth in Haiti. Furthermore, this data illustrates that matwòns possess the critical and reflexive thinking necessary for self-determination and professional organization, which are among the defining characteristics of Davis-Floyd's (2007) postmodern midwifery. By examining the experiences and life histories of matwòns we find a holistic picture of the obstacles to providing maternity care in the Haitian setting, as well as adaptive, context-specific solutions to the complex issues surrounding maternal health in Haiti. Finally, by

following what are truly Haitian-led initiatives, the global health community may gain insights into how to support the practitioners attending the majority of Haitian women in childbirth.

Haiti in Historical Context

The earthquake of January 12, 2010 focused the world's public and political attention, for a short time, on Haiti. The flurry of commentary also presented an opportunity to reverse the gaze away from Haiti itself in order to observe the popular and persistent interpretations of Haiti generated in international political and social discourses. That Haiti has been and is still largely misrepresented by the media and political analysts alike is a common critique among Haitian scholars (Dubois 2012, Farmer 2003, Schuller and Morales 2012, Trouillot 1995, Ulysse 2010a, 2010b, 2011, 2012). Post-earthquake discourse analyses of media coverage (Brown 2012) and of policy statements by foreign bodies acting in Haiti's reconstruction (Hartwig 2011) draw attention to the ways in which rhetoric depicts the Haitian government and Haitian people as incapable of determining their own needs and acting in their own best interest.

Haitian-born anthropologist and performance artist Gina Athena Ulysse has focused much of her scholarly and artistic work on issues of representation, specifically that of Haitians, at home and in the diaspora. In her post-earthquake commentary, anthologized in *Tectonic Shifts*, a collection of earthquake and post-earthquake accounts by Haitian scholars, organizers and activists, Ulysse describes how "mainstream news coverage of the disaster reproduced long-standing narratives and stereotypes about Haitians. She concludes that: "The day when Haitians as a people and Haiti as a symbol are no longer representatives of or synonymous with poverty, backwardness, and evil is

still yet to come" (2010:37). Using CNN news reports as text, Ulysse argues that a "dehumanization narrative" and "subhumanity strand" convey the news with "a subtext…about race" (2010:38–39).

> Haiti and Haitians remain a manifestation of blackness in its worst form because, simply put, the unruly *enfant terrible* of the Americas defied all European odds and created a disorder of things colonial. Haiti had to become colonialism's *bête noir* if the sanctity of whiteness were to remain unquestioned. (2010:39)

That race has been a fixation of foreign authors writing about Haiti is evidenced in the book titles found on the shelves of Oregon State University's library: *Black Haiti; Black Democracy; The Black Man; Black Bagdad*; and even *Cannibal Cousins*.

Ulysse's comments about race focus on the threat Haiti has posed to colonial (and by extension neocolonial) powers by the very fact of its independence. Descriptions of Haiti are incomplete if they simply mention that Haiti was "the world's first black republic" (as is common in the media), without acknowledging that it was the world's first and only successful slave revolt, insofar as it is the only colony of slaves to ever throw out their masters and create an independent, self-governing nation. The absence of this fact from most popular mentions of Haiti in the United States today mirrors a tactic made explicit by U.S. politicians over 200 years ago, when refusing to mention Haitian independence allowed the U.S. to deny formal and equitable relations with the new nation (Farmer 2003).

In *Silencing the Past: Power and the Production of History*, Haitian historian and anthropologist Michel-Rolph Trouillot asserts that the act of writing history is not "neutral", but an act of power (1995:28). Trouillot titles his chapter on Haiti's revolution "*An Unthinkable History: the Haitian Revolution as Non-Event,"* highlighting how the

revolutionary independence of the world's wealthiest slave colony so defied colonial conceptions of racial (including intellectual, moral, political) superiority that colonial powers refused to acknowledge its reality. A histiographer, Trouillot recognizes such blatant omissions of historical facts as intentionally enforcing dominant power arrangements. More recent scholarship on Haitian history by Dubois (2004, 2011) and Farmer (2003) is intent on filling in the centuries-old omissions. Noting the differences between Haitian and non-Haitian interpretations of Haiti's revolution, Paul Farmer notes:

> It was at that moment of independence, too, the first major divergence of Haitian and non-Haitian readings of Haiti would be born. The locally prevalent notion of Haiti as a *singular place embedded in a system hostile to the ideal of equality* has flourished, even in a climate as inegalitarian as that of Haiti. This collective reading is quite different from dominant notions of Haiti as *singularly estranged from the civilized world*. (2003:63 italics in the original)

The two hundred years since the revolution and Haiti's founding independence have seen at least several noteworthy historical episodes that have been received vastly different interpretations, depending on the focus of analysis. These episodes are most commonly described as:

- political isolation for most of the century following independence, during which time France mandated a large indemnity[1] in exchange for diplomatic recognition of the independent Haitian state;
- military occupation by the United States (1915-1934);
- the Duvalier dictatorship (1957-1986);
- recent experiments with democratic electorate, notably the populist president Jean-Bertrand Aristide, alternated with coups (1991 and 2004) and a violent military regime (1991-1994);
- the United Nations military occupation beginning in 2004 to present day;
- post-earthquake reconstruction until the present day.

[1] The indemnity of 150 million francs was said to compensate slaveholders for their losses. Dubois (2012) estimates that price to be equivalent to roughly $3 billion dollars today.

The versions of Haiti's history produced by dominant actors, such as France or the United States, and reproduced in media or agency reports, can be seen as acts of power, legitimizing dominant positions and structures. These representations seem to necessitate the foreign aid and the strictures of foreign financial institutions that have shaped Haiti's economy, the foreign agencies that determine and control Haiti's limited social services, and the foreign military occupation (MINUSTAH) claiming to protect the Haitian people.

Mark Schuller (2007) identifies the two dominant perspectives from which Haitian history is typically viewed: the state and international bodies. A brief discussion of those approaches reveals which analyses have been most influential for this research. The most common approach to interpreting Haiti employed by dominant outside forces focuses on the state apparatus. Ranking in the top ten of Foreign Policy magazine's "Failed State Index"[2], commentators and policy makers alike seldom look beyond Haiti's internal politics when assessing current conditions of life in Haiti. Certainly, an understanding of Haiti's political history is a necessary element, and Trouillot's detailing of the corruption and inequality inherent in the Haitian political system in his definitive book, entitled *State Against Nation* (1990b), provides rationale for the inequity that marks Haitian society. However, when domestic political actions are viewed alone, the analysis lacks context. The resulting conclusion -- that Haitians are incapable of self-governance -- can be (and has been) used to justify all manner of foreign involvement, including the military occupations carried out by the United States

[2] Foreign Policy bases its listing on a composite score of 10 criteria, including social, economic, political & military indicators. (http://www.foreignpolicy.com/failed_states_index_2012_interactive)

and the United Nations, and the activities of a host of foreign non-governmental organizations. Rather than build up or support the state apparatus, these foreign entities attempt to fulfill the responsibilities of the national government by overriding state sovereignty and creating parallel systems. By focusing solely on the state and ignoring or omitting analyses of foreign actors in Haiti, both critics and humanitarians alike legitimize their positions in Haiti, viewing their actions as necessary and legitimate.

Another perspective widens the lens to view Haiti in a web of international relations. Introducing a detailed structural analysis of international relations with Haiti, Paul Farmer's *The Uses of Haiti* (2003) illuminates the historically invisible involvements of foreign superpowers in Haiti's internal affairs over the past two centuries. To explain how the actions of transnational forces affect the daily lives of Haitians, Farmer et al. (2004) introduces the concept of structural violence. He operationalizes the term, first used by liberation theologians, as "violence exerted systematically – that is indirectly – by everyone who belongs to a certain social order…In short, the concept of structural violence is intended to inform the study of the social machinery of oppression" (2004:307). Farmer's works demonstrate how international power relations share responsibility for constructing the poverty Haitians experience, which becomes embodied as increased risks of disease and poorer health outcomes, which, on each individual basis appears simply as "adverse events" (2004:308). Such violence is inherent in structures such as inequitable trade agreements, aid embargos, restrictions placed on the state's social spending, to name a few. Together, these create the conditions in which childbirth in Haiti is riskier than almost anywhere else in the

hemisphere. This long-absent analysis of international relations goes a long way in explaining Haiti's "place in the world" (Ferguson 2006).

However, both the analyses of the Haitian state and of international actors lack an important dimension: the perspectives of the Haitian people themselves. Their voices offer the strongest critique of current power arrangements, whether enacted by the state or by international bodies. They are also the least represented and most often discredited in discussions or decisions regarding Haiti (Dubois 2012, Farmer 2003, Schuller 2007, Schuller & Morales 2012, Trouillot 1995). Given that a majority of Haitians experience extreme poverty and a lack of education, analyses of Haiti from the perspective of Haitians are rare, and usually come from the Haitian diaspora, such as those of Gina Ulysse and literary figure Edwidge Danticat who provide insightful reflections on the position and perspectives of Haitians and call for more balanced representations of Haitians in modern media. Anthropologist Jennie Smith (2001) was the first to offer an ethnographic account of Haitian peasants' political organization, focusing on peasant's own commentary on modernization, and their actions to counter their political marginalization. However, a need remains for greater inclusion of Haitian voices and Haitian organizing, a project taken seriously by anthropologist Mark Schuller, whose work on Haitian civil society (2007, 2012) and post-earthquake conditions (2010, 2012) has inserted Haitian commentary into present discussions of aid and reconstruction in Haiti.

"A complete understanding of Haiti's history" maintains Schuller, "requires a tripartite framework, tracking and theorizing participation of three general sets of actors: foreign powers, the state, and Haiti's people" (2007:141). Thus, in this study, I have

privileged the perspectives of Haitians themselves, placing participants' narratives in an historical context and taking into account how matwòns describe their work within the framework of an insufficient health system, embedded in a political-economy shaped by international forces and unequal relations of power.

Critical Medical Anthropology

I approached this study using the lens of Critical Medical Anthropology (CMA) to examine the perspectives of Haitian childbirth practitioners. Aware that any discussion of Haiti is framed by steep gradients of power that include actors in the international community, the Haitian state and society, as well as communities of Haitians and their individual relationships, I wanted to be explicit in identifying and accounting for those inequities. CMA provides a theoretical framework, along with specific tenets through which to implement research and praxis.

In the founding work of CMA, Merrill Singer (1995) declares human health to largely be the result of various power dynamics manifest as social inequalities. As such, health is inherently a product of political relationships. Any examination of health in a particular population must, therefore, be contextualized within a study of that population's political-economy as it relates to all actors wielding power.

A brief glance at Haiti's health statistics exposes steep gradients of power in which the nation's poor majority find themselves at the bottom (See Table 1). To place these measures in context, comparison with three of its closest neighbors -- the Dominican Republic, Cuba, and the United States -- is helpful.

Table 1: Basic Health Indicators in four countries:	**Haiti**	**D.R.**	**Cuba**	**USA**
Life Expectancy (years)	62	73	79	78
% population living under the int'l poverty line ($1.25/day)	55	4	-	-
Total adult literacy rate (%)	49	88	100	-

Infant mortality rate (per 1000)	70	22	6	8
Under 5 yrs.: stunted (%)	29	18	-	-
HIV estimated in adult population (%)	1.9	0.9	0.1	0.6

(UNICEF)

Though each nation is the product of its own unique history, commonalities do exist. Haiti shares the island of Hispaniola with the Dominican Republic, shares a similar history as a plantation colony with Cuba, and shares a historical legacy with the United States as the two oldest independent states in the Americas, each having gained independence through revolution against a colonial power. Despite these commonalities, Haiti's basic indicators reflect a very different reality in terms of human health. In Haiti, where nearly half the population can't read or write, an even greater percentage (55%, as compared to 4% in the Dominican Republic) lives under the international poverty line. Basic social factors such as these, as well as bleak health outcomes translate into an average life expectancy that is around ten to fifteen years less than in those three neighboring countries.

A further examination of health indicators specific to childbearing contextualizes the challenging work of Haitian matwòns, who are the focus of this study (Table 2). Childbirth proves to be deadly more often in Haiti than in neighboring countries (a Haitian mother is 6 times more likely to die in childbirth related complications than a Cuban mother, and 21 times more likely to die than a mother in the U.S.). Those who attend childbirth in Haiti contend with a host of difficulties that are both rarer and also more treatable in wealthier nations. Moreover, the general statistics that describe Haiti's poor majority applies to matwòns themselves, making them no more able to access resources than the impoverished population they serve. Matwòns' position within their local communities, Haiti's national health system, and international political-economy

allow multiple levels of analysis for this research. Recognizing these dramatic inequalities and the dire conditions of human health in Haiti requires that we look to the dynamics of power as they play out in conception and childbirth.

Table 2: Maternal Health Indicators in four countries:	Haiti	D.R.	Cuba	USA
Contraceptive prevalence (%)	32	73	78	79
Skilled attendance at birth (%)	26	98	100	-
Institutional Delivery (%)	25	98	100	-
Maternal Mortality rate (reported, per 100,000)	630	160	43	13
Maternal Mortality rate (adjusted, per 100,000)	300	100	53	24
Lifetime risk of maternal death: 1 in	93	320	1400	2100

(UNICEF)

Merrill Singer concludes his ovarian, 1995 work on critical praxis by naming five attributes that critical medical anthropology offers to what he calls, "system-challenging movements in health care" (98). These are:

> 1) "a commitment to the principle of self-determination … [through] counter[ing] Western, colonial ethnocentrism…to work in conjunction with struggling communities and groups in responding to their felt needs"
>
> 2) an understanding of "local contexts in relationship to their location in the encompassing world or national system"
>
> 3) an awareness of "the social origin and ideological function of such concepts as disease, medicine, and social development"
>
> 4) an ability to "expand the focus of health-related struggles from immediate to ultimate causes of illness and disease…unmasking the structural roots of suffering and ill health"
>
> 5) an effort to "offset the imbalance in social power across class, race, or other social divisions" by emphasizing "collaboration and coalition building" (1995:98-99).

With these attributes in mind, this study seeks to answer the call of medical anthropologists Pfeiffer and Nichter (2008) to "ensure that the evidence base that frames global health debates is inclusive and represents multiple dimensions of the human experience, including the voices of those whose lives are affected by global processes"

(413). In the pages that follow, I examine matwòns own descriptions of their lives and work, situated within Haiti's current political-economy, and affected by over five centuries of powerful global processes.

In Chapter two, I review two bodies of literature that help to contextualize the lives and work of matwòns. The first locates matwòns in the global health discourse surrounding birth attendants, the second draws together relevant literature on maternal health in Haiti or the Haitian diaspora. In chapter three, I outline the specific methods used during my fieldwork, including the feminist methodologies that acknowledge and intend to mitigate the power dynamics inherent in research with marginalized populations. In chapter four, I report my findings from phase I of my research: in-depth personal interviews; and in chapter five I report findings from phases II and III: Open Space and Reciprocal Ethnography. I discuss these findings in connection to theories of mutual accommodation and postmodern midwifery in chapter six. Chapter seven concludes this thesis with my recommendations for anyone taking action to shape programming or policy around maternity care in Haiti. Here I advocate for the inclusion of matwòns as invaluable experts on the lived realities of attending childbirth in Haitian homes, and as chief strategists for any attempts at improving the system and conditions surrounding childbirth in Haiti.

Chapter 2: Literature Review

To understand the work and perspectives of matwòns, it is necessary to locate their role and position within a larger ethnographic context. To do that, I first examine how matwòns fit (or do not fit) into changing global discourses surrounding women's health, with a specific focus on debates over the role of traditional birth attendants. This body of literature, and the agencies and initiatives that fuel it, purports a narrow vision of women's health, centering on maternal mortality rates around the world, while glossing over or ignoring the specific factors contributing to ill health in each locality. In doing so, it fails to recognize the strengths to be found in different cultural settings, notably, the "traditional" practitioners with expert knowledge of the social conditions surrounding childbirth. Next, I review literature dealing with maternal and child health in Haiti. This body of literature is a loose association of works generally focusing on specific health problems or on cultural beliefs and practices. Though many gaps exist, this literature lays a foundation for the recognition of matwòns as the most-utilized and even preferred childbirth practitioners in Haiti, and highlights opportunities to deepen our understanding of the real conditions and issues associated with their work.

Haitian matwòns in Global Health Discourses

The majority of births in the world are attended by practitioners who fulfill various ethno-medical and social roles in their respective settings. Health policy makers refer to this group generically as "traditional birth attendants" (TBAs), which the World Health Organization (WHO) defines as, "a person who assists the mother during

childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs" (WHO 1992).

This type of practitioner was identified by colonial governments and missionaries as early as the 1920s, when they began medical trainings for local populations. The term came into wider used when a discourse on traditional healers grew out of international health efforts in the 1970's (Leedum 1985, cited in Kruske and Barclay 2004). In 1978, the international conference on primary health care in Alma Ata identified TBA's as an integral part of local communities, and suggested developing further programs to adequately train them in basic biomedical techniques in order to help provide primary health care to underserved populations (WHO, 1978). Then, in 1987 the Safe Motherhood Initiative[3] set a goal to reduce maternal mortality by 50% by the year 2000, and so targeted support toward the most common attendants of birthing women worldwide, TBA's.

The rationale for this type of program reveals a focus on practitioners: If structural barriers (availability of health care, transportation, etc.) meant that poor women in "under-developed" countries could not get to a hospital to deliver safely, then training those who would attend them seemed a logical solution. Also, this solution was seen as cost effective when compared to the cost of building basic health and transportation infrastructure for millions of marginalized women worldwide.

With this new focus by international health agencies, global programs for TBA training received a marked increase in funding and were replicated in numerous low-

[3]A co-creation of major health and development agencies Including WHO, UNFPA, UNICEF, The World Bank, the International Planned Parenthood Federation, and the Population Council which met in Nairobi (Starrs 1997).

income countries with a goal to impart the same lifesaving techniques to all TBAs around the world. The causes of maternal mortality, many argued, were simple to identify: hemorrhage, sepsis and labor complications, to name a few (WHO 2012). With adequate training on sanitation and early diagnosis and transport, it was believed that the solutions could be simple too.

After almost a decade of programmatic focus, however, studies failed to show that TBAs significantly lower maternal mortality rates (Kruske and Barclay 2004, Sibley and Sipe 2006). In discourses that often linked practitioners to birth outcomes in a direct causal relationship, persistently poor health outcomes in childbirth seemed to indicate that the practitioners attending births were not well-enough trained to prevent maternal deaths. Therefore, in the late 1990's, responding to what they saw as a lack of evidence in the efficacy of TBAs (Kruske and Barclay 2004, Sibley and Sipe 2006), the WHO and other health agencies revoked their support of traditional birth attendants, who they no longer considered appropriate practitioners in the international efforts to save women's lives.

Currently, the World Health Organization (2008) differentiates TBAs, *traditional* birth attendants, from SBAs, *skilled* birth attendants. An SBA:

> has the ability to provide competent care and assistance during pregnancy, labour, childbirth, and the postpartum period. A skilled birth attendant can be a midwife, a nurse with additional midwifery education, or a physician with appropriate training and experience, *but does not include traditional birth attendants*" (The Safe Motherhood Action Agenda 1993, emphasis added).

Thus, SBAs are practitioners who have a level of skill recognized by global health experts as adequate to save a woman's life in childbirth. These skills are medical, and to be acquired, it is commonly believed that attendants must have a certain level of formal

education and literacy. Yet, despite these stricter criteria, the quality of care provided by SBA's has still been called into question (Harvey et al. 2004).

The shift in focus and funding from TBAs to SBAs has met resistance in a growing body of literature that problematizes such a sweeping about-face in global health policy (Ana 2011, Bryne and Morgan 2011, Kruske and Barclay 2004, Ray and Salihu 2004, Sibley and Sipe 2006). A number of authors have more recently pointed out that maternal mortality is not a single-origin issue, but that political-economic constraints loom large in people's decision-making, as does the difficulty of transport, and perceptions of care in health facilities (Bryne and Morgan 2011, Kruske and Barclay 2004, Ray and Salihu 2004, Sibley and Sipe 2006, Titaley et al. 2010). Therefore, the ability to save millions of women's lives is not dependent on the skill level of any one type of practitioner, but rather, a functioning health care system and associated infrastructures (like passable roads for transport to the hospital when needed) are required to reduce maternal mortality (Bryne and Morgan 2011, Sibley and Sipe 2006, Titaley et al. 2010).

In addition, several researchers have carried out meta-analyses of the TBA literature in order to summarize the effectiveness of TBA training in terms of lowering perinatal mortalities, improving pregnancy outcomes, increasing antenatal care, and improving access to medical care in obstetric emergencies through referral. Integrating disparate studies into a single analysis allows overarching trends to be identified, even given the inconsistencies among training programs and research design (Kruske and Barclay 2004) that play a role in producing such mixed results. Ray and Salihu (2004) reviewed 15 TBA- and midwife-based interventions and found positive improvements in

each of four different measures, including declines in maternal mortality, improvements in some morbidity outcomes, improvements in referral rates, and high levels of knowledge retention among TBAs. As a result, they conclude that: "TBAs and village midwives contribute to positive programme outcomes" (2004:5). Sibley et al. (2002) and Sibley and Sipe (2004, 2006) performed a meta-analysis based on over 60 studies and found small to large improvements across a spectrum of evaluations, leading them to call for a renewed emphasis on training TBAs to improve health outcomes.

Most recently, Byrne and Morgan (2011) conducted a systematic review of thirty-three articles outlining approaches to integrate TBAs within formal health systems. Their review suggests that TBAs play a vital role in the provision of primary health care in extremely low-resource settings, and that through inclusion in formal health systems and collaborative roles with SBAs that: "TBAs can make a profound contribution to safer motherhood" (133). These findings correspond with the results of a meta-analysis conducted by Darmstadt et al (2009) whose authors proposed that, though the value of TBAs has been debated, the fact that they are the only attendants for millions of women in remote or underserved settings renders them important stakeholders in global efforts to improve childbirth outcomes. In a recent commentary published in the *British Medical Journal* (2011), Christopher Gill of Boston University's School of Public Health reiterates the rationale for supporting TBAs that originated in Alma Ata in 1978: "TBAs exist because they meet an unmet public health need."

Furthermore, to counter the assumption that TBAs are un-trainable and thus a waste of time and money in maternal mortality reduction programs, Gill et al. (2011)

provides evidence of TBAs in Zambia significantly lowering infant mortality after neonatal resuscitation training. The authors conclude the article by summarizing:

> In the context of a highly dispersed, rural African community with limited access to health care, traditional birth attendants were able to master a set of skills that allowed them to significantly reduce neonatal mortality. This was accomplished in a population of women birth attendants with low rates of formal education and under austere conditions, making this example highly generalizable (9).

Ana (2011) asserts that not to allow TBAs to assist in birth, as was once proposed by the WHO, and has been attempted with serious detriments in Malawi, is unethical.

Moving beyond debates over how to reduce mortality and morbidity, the discussion becomes even more complicated when we see TBAs as key bearers of language and culture and as integral and often highly valued members of their communities. Kruske and Barclay (2004) have taken a critical approach to the treatment of TBAs in global health literature and policy statements. After reviewing over 200 documents, the authors identified several major problems in the treatment of TBAs. For one, policy makers define skill in terms of biomedical techniques and so ignore the sociocultural skills of TBAs, a point also made by Ana (2011), who cites TBAs familiarity with the "traditions, cultures, and languages of the women they attend to" as "an obvious advantage during antenatal care and childbirth" (1). Because of this, training programs tend to be authoritarian, and do not allow for feedback, partnership or mutual accommodation between TBAs and hegemonic, biomedical authorities.

Such a uni-directional focus on TBAs is fraught with problems. Anthropologist Stacy Leigh Pigg (1997), who worked in both rural communities and in development agencies in Nepal, calls attention to a multitude of difficulties involved in translating global health discourses into local settings. A fundamental problem involving maternal

health programming lies with the fact that "traditional birth attendant" is an etic concept that does not correspond to any one of the different people who play a role in childbirth in Nepal. Rather, one person may be called simply to cut the cord, a polluting task only appropriate for certain members in the caste society, while another person may be called to manage difficult births, and another to perform healing rituals, though very often it is neighbors and kinswomen who actually assist at delivery. "Care of pregnant women and infants is embedded in myriad customary practices and unspoken assumptions, not entrusted to specialists" (1997:241), Pigg explains. These practices, which do not correspond well at all to the modern concept of traditional birth attendants, leave development workers frustrated as to how exactly to produce trained TBAs with the funding they have designated for that express purpose. Pigg observed that health development agencies recruited for training anyone fitting even one element of the homogenized descriptions of a TBA and expected them all to fulfill this new role in the global campaign to lower maternal mortality, even if unwillingly. These on-the-ground difficulties of translation, according to Pigg, reflect "the problem of relating a medical model that views physical processes as divorced from social contexts to other conceptualizations of well-being and illness (234-235).

This overview of current scholarship makes apparent the near total lack of ethnographic literature on TBAs. After more than thirty years of interaction with TBAs, the majority of research conducted has attempted to gauge how TBAs understand and operationalize the training they have received, or which "traditional" practices they continue to use in birth. Very few have asked how TBA's own perspectives or experiences might shape the discussion.

One exception can be found in the work of Low et al. (2004) who conducted qualitative research with twenty-nine TBAs in northern rural Honduras. Although TBAs are recognized and integrated into the national health system in Honduras, Kane Low's work suggests that: "the complex interplay of biomedical and traditional health services is not adequately understood" (Low et al. 2004:79). My project is similarly positioned; by focusing on lived experiences and ways of knowing about childbirth as described by Haitian matwòns, I seek to bring attention to the priorities TBAs themselves identify for improving their working conditions in situations of extreme resource-scarcity. With an understanding of the shifting policies and back and forth debate over traditional birth attendants, I turn now to the literature on maternal and child health research and initiatives as they have touched the ground in Haiti.

Perinatal Health and TBAs in Haiti

During the 1980's, national and international health agencies spread U.S. style biomedicine into remote and rural areas of "the third world" through both neoliberal reforms and via NGOs targeting specific health concerns. Though the U.S. military occupation of Haiti (1915-1934) initiated some infrastructure for a biomedical health system, that system has remained difficult to access by large portions of Haitian society for both structural and cultural reasons. Using the microcosm of an anthrax epidemic, Coreil (1980) found that Haitians employed both traditional and "Western" medical treatments. She noted how traditional healers demonstrated a willingness to work collaboratively and noncompetitively with biomedical practitioners, a finding the author describes as "contrary to the prevailing sterotypes in the 'adversary model' of pluralistic systems" (1980:102). Nevertheless, the author still witnessed what she described as

"general problems of mutual adjustment" in Haiti's pluralistic health setting, most often where staff in biomedical clinics felt it unnecessary to acknowledge patients' beliefs regarding a spiritual etiology of the illness. A few years later Coreil (1983) focused a study on the "parallel structures of professional and folk health care", concluding that "underlying similarities are evident in patterns of cost, accessibility, specialization, recruitment and training of practitioners in both health sectors" (1983:131). That study's ethnographic data revealed "diversity in traditional healing" and specified five "levels" of healers in Haiti: "shamans (*vodou* practitioners), herbalists (*doctè fèy*, literally "leaf doctors"), midwives (*matron* or *fam saj*), bonesetters (*doctè zo*), and injectionists (*pikirist*)" (133). The acknowledgement of parallel structures in the two health systems is noteworthy when the hegemony of biomedicine has caused many researchers and policy makers to view "traditional medicine" as suspect, illogical, or inconsistent. Especially relevant to this study, Coreil's work recognized the parameters and formalities of matwòns' practice, which include attendance at birth and facilitating a mother's seclusion and treatments in the postpartum period, as well as newborn care and herbal treatment of infant illnesses. Their responsibilities do not generally include the prenatal period, unless called to assist with fetal positioning or in the case of miscarriage.

Contemporary to Coreil, research by Berggren and colleagues (1983) describes the practice of traditional midwives or TBAs in Haiti in an effort to assess their effectiveness in reducing neonatal tetanus. Interviews with matwòns allowed Berggren et al. to provide general descriptions of matwòns' common practices. These descriptions echoed Coreil's, and elaborated further, naming social-spiritual factors that determined a matwòn's scope of practice. For instance, the authors describe what they call a

"superstition against prenatal care by the TBA" because matwòns "apparently fear being blamed if the baby should be malformed or if the delivery should go badly" (1983:81). Instead, matwòns provide on-going herbal support and massage for mother and baby throughout the postpartum period. The authors also outline the history of TBA or matwòn trainings developed by the Haitian government dating back to 1948. Although data collected on one TBA training program did show significant decrease in neonatal tetanus in that region from one year to the next, the authors admitted that a comprehensive immunization campaign was needed to eliminate the disease completely. This conclusion corroborates the body of literature dealt with in the previous section that declares a functioning health system as the single most important factor in improving perinatal mortality, rather than training for individual practitioners. Additionally, Berggren et al. name several unanticipated and confounding factors in relation to TBA trainings. First, where they expected that training "TBAs" would increase those matwòns' popularity and utilization, trained matwòns did not have an increased practice size, but rather, more untrained matwòns identified themselves and requested training, suggesting that medical skills are not the determining factor when people choose a matwòn. Similarly, though matwòns were taught to refer patients to medical services, and families did utilize those services for prenatal and newborn care, the number of births occurring in facilities did not markedly increase. These trends seem to imply that researchers and/or trainers had different expectations of how training would affect matwòn practice than proved accurate for the local context, a point later echoed and expanded upon in Pigg's 1997 work on "TBAs" in Nepal.

Allman (1986) produced a study attempting to gauge the cost effectiveness of the TBA training program sponsored by the Haitian government (Division of Family Hygiene) relative to its measured improvements in TBA practice. Citing the successful reduction of neonatal tetanus, Allman asserted the "usefulness" of the Haitian TBA training program: "Because traditional cultural concepts of certain illnesses do not correspond with scientific etiologies, TBA training has had to adapt to the cultural view of the TBAs in order to get them to change their behavior" (1986:40). Allman's "interdisciplinary approach" utilizing perspectives in both social science and medicine, reveals a pragmatism that seeks to bend "traditional" beliefs and practices into the strictures of biomedicine. While acknowledging the cultural value of TBAs in providing social support, the language Allman uses illustrates the single-mindedness of many public health policy makers: "The training of TBAs is expected to have two basic outcomes. First, the TBAs are expected to perform better deliveries….Second, they should learn when to refer women to health centers and hospitals" (1986:41).

In 1987 Harris published *Beliefs and practices among Haitian American women in relation to childbearing*, a very small study which described Haitian mothers own concerns and priorities in the perinatal period, noting again that prenatal care is not a common practice among Haitians. Harris's participants were all Haitians living in the U.S. That work was followed by three additional studies on Haitian immigrants by Desantis and Thomas (1990, 1992, 1995). Working as a public health nurse in southeast Florida when waves of Haitian immigrants arrived on makeshift boats, Desantis explored issues around feeding and weaning, preventative health care for children, and health education within the new Haitian diaspora. In this research, Haitian mothers demonstrate

what Desantis calls a "transcultural orientation," to healthcare, utilizing both the biomedical and the Haitian ethnomedical system, which includes herbal home remedies and magico-religious practices. With an emphasis on applied, cross-cultural nursing, Desantis proposed tenets by which U.S. medical practitioners could most effectively serve this new population. They include: a recognition of the high priority Haitian mothers place on the health of their children; assessment of home remedies on an individual basis "*if* they adversely affect child health" (1990:12, emphasis added) rather than a blanket stance against Haitian herbal medicine; and a relativistic approach to magico-religious practices, which Desantis claims, "are not directly detrimental to child health, from the perspective of biomedical health care professionals." Desantis asserts "there is little to be gained and much to be lost by attempting to discredit [magico-religious functions] simply because biomedicine does not sanction a magico-religious basis for disease causation and illness prevention" (1990:12). The authors cite political-economic factors as the overwhelming determinants of ill health, more than ethno-medical practices. Furthermore, the social disadvantages immigrants in the U.S. face, "obligate biomedical health care professionals as citizens to work in the sociopolitical arena for their betterment" (1990:12) Desantis & Thomas contend.

With the founding of Critical Medical Anthropology, Merrill Singer and Paul Farmer (independently) brought critical theory to the examination of health-seeking behavior among Haitian childbearing women. In *Culture, Critical Theory, and Reproductive Illness Behavior in Haiti* (1988), Singer uses the lenses of power and political-economy to examine a culture-bound illness called *pèdisyon*, discussed over 10 years earlier by Murray and Alvarez (1973). Singer and co-researchers found Haitian

women describing their health concerns differently to various practitioners based on what they felt the practitioner would recognize as real or valid. Because biomedical doctors dismissed the notion of *pèdisyon*, women would claim a different illness to those practitioners that they felt would be more readily accepted. According to Singer, Haitians "have learned to say what they hope physicians will believe, rather than what they experience and know" (381). This article is noteworthy because it provides the first critical analysis of how Haitians interact with the foreign, biomedical system gaining prominence in their country.

Published that same year was an article by a young physician and medical anthropologist who had spent the previous four years providing medical care to the internally displaced populations in Haiti's central plateau. Paul Farmer, in his (1988) *Bad blood, spoiled milk: bodily fluids as moral barometers in rural Haiti*, joins Singer in forging the new sub-discipline of CMA by placing his analysis of the culture-bound illnesses *move san/lèt gate* (bad blood/spoiled milk) squarely in the context of Haiti's political-economy. Unlike his renowned works of the following decade, Farmer, in his 1988 publication, did not yet implicate transnational forces in the construction of vulnerability and ill-health of Haiti's impoverished peasants, yet he does lay a framework for understanding illnesses in broader contexts and thereby, "avoid(ing) the Cartesian dualism that still marks much medical anthropology" (1988:62).

Bad blood/spoiled milk is also noteworthy for the attention it gives to illnesses that affect pregnant and nursing women. Farmer's work identifies the Haitian concept of vulnerability surrounding childbirth and the nursing mother-child dyad. When pregnant or nursing mothers are not adequately protected from the chronic stressors and violence

of everyday life in Haiti, they can easily develop bad blood or spoiled milk. Though the conditions are treatable by traditional midwives or herbal doctors (and not effectively by biomedical doctors, even Haitian ones), their occurrence, Farmer asserts, provides public evidence of the wrong done to those especially vulnerable members of society.

The 1990's saw a tremendous focus on programs to reduce maternal mortality. Barnes-Josiah et al. (1998) applied Thaddeus and Maine's (1994) "Three Delays Model" to an examination of maternal mortality in Haiti. This research noted the limited ability of "TBAs" to make sure that women were transported in emergencies, citing distance, cost, road conditions, and family considerations as equal or greater factors than TBA referral. The most prominent finding in this study (because it surprised researchers) was that the poor quality of health care in facilities diminished people's confidence in emergency care and actually dissuaded them from seeking care in emergency situations. Thus, the authors conclude that efforts to improve maternal mortality must focus on the actual ability of biomedical care to deliver, and not exclusively on whether TBAs are trained to recognize complications and recommend transport.

Extreme political instability following the 1986 fall of the 30 year long Duvalier dictatorship made research in Haiti more difficult. Researchers Gage and Calixte, at Tulane University, New Orleans and City Med, Port-au-Prince, contributed a study on the state of health care in Haiti after state neglect and neoliberal reforms had dismantled what health development existed before. In *Effects of the physical accessibility of maternal health services on their use in rural Haiti* (2006), they found, "inadequate national resources and substantial reductions in external funding" (273) to have resulted in 30-60% reductions in the availability of obstetric care in many regions and the complete

absence of care in others. These structural barriers prohibit large portions of Haiti's rural population from accessing maternity care.

The theory of structural violence, elaborated by Farmer (2004) and rooted in his long-term experiences in Haiti, asserts that the inequality inherent in social constructs such as political-economic power relations constitutes a systematic or structural violence on those who experience oppression in its many forms. Therefore, structural violence illuminates the ways in which health care is denied to the world's poor majority. The tools provided by that critical approach, when applied to traditional medical systems in Haiti, opens up avenues for research that can explore how traditional practitioners navigate overwhelming structural barriers. This study examines how violent structures affect Haiti's most common maternity care providers, matwòns, who attend women beyond the reach of routine or emergency biomedical care.

In this chapter, I have reviewed the literature surrounding the TBA debate in international health discourses and have provided an overview of studies on maternal health in Haiti in the past four decades. Together, they lay a foundation for this study on Haitian matwòns. In order to ground this critical analysis ethnographically, I employed a qualitative research design outlined in the following chapter.

Chapter 3: Research Methods

The fieldwork surrounding this research took place from late January through late April 2012, situated in an area I call Petit Carrefour[4], outside of Cap-Haitien, a city on Haiti's north coast. The study utilized in-depth interviews (phase I), a specific style of group meeting, or modified focus group, called Open Space (phase II), and reciprocal ethnography (phase III). I engaged in participant observation through regular meetings of matwòns, individual home visits with each matwòn either to conduct an interview or to pay a social call, and through experiencing the social life and structural challenges of living with my family in Haiti.

My entry point into the community occurred through a two week internship at a birthing clinic founded just over a year before by a U.S. NGO. This NGO grew out of a post-earthquake response by a small group of U.S. homebirth midwives. My responsibilities as a student midwife in the clinic included conducting prenatal appointments and attending births in the clinic.

During my two-week stint at the clinic, I sought out an opportunity to immerse my family in the surrounding community for the research portion of my stay in Haiti. Aware that Haitians regularly find themselves at the bottom of sharp power gradients, and because my position as a foreign, non-Kreyol speaking anthropologist posed many potential barriers to the type of information matwòns would share with me, I sought to mitigate such power dynamics in a number of ways: First, I travelled to Haiti with my husband and two young children, ages three and one. There, we sought out an

[4] This name is a pseudonym to protect the confidentiality of study participants.

opportunity to share a home with a Haitian family[5]. Though such positionality is common among anthropologists in the field, it is quite uncommon in Haiti where most foreigners seek to protect themselves with walls, gates, razor wire, armed guards and all-terrain vehicles. We had no such protection and instead attempted to make our vulnerability very apparent to our neighbors. While this arrangement sometimes confounded those we encountered, it also allowed them to approach us with their curiosity and their protective care. Likewise, seeing me with my children at group meetings, in my home, and in visiting their homes allowed matwòns to observe me in my embodied role of breast-feeding mother -- one that most of them could relate to through personal experience or the experience of the women they serve.

To mitigate power and culture differentials in my data collection, I chose methods that would encourage egalitarian relations between myself and participants. I began my encounters with matwòns by sharing my own story of becoming a mother and my midwifery training, so that they would initially be in the position of knowing as we built a relationship. Then, during each interview, and in my final session of reciprocal ethnography, I invited the matwòns to reverse the interview and ask me anything about my personal life they would like to know. This allowed them to direct the conversation

[5] The cement home we shared with a mother, her four teenage children and infant grandchild was a middle ground between the homes of our neighbors, who either lived in wood and mud houses with earthen floors, or the giant cement homes surrounded by cement walls and razor wire built by families receiving remittance money from the United States. This mixed community is uncommon in Haiti, where rural populations typically experience similar levels of poverty, and actually constitutes a semi-rural community where wealthier citizens could access education and employment via a highway leading to a major port city. Therefore, our neighbors included peasants and something like a suburban upper-middle class.

and also allowed us to compare and contrast the experiences of midwives and of mothers in the United States and Haiti. Through these exchanges, I assured them that they were the experts in the study and that I had much to learn from them. Many matwòns took my education of life in Haiti quite seriously and shared in-depth accounts of their lives and work as matwòns.

Study Population

Selection & Recruitment:

I first met study participants at a monthly meeting of local matwòns that convened at birthing clinic where I conducted my initial internship. These meetings were intended by the visiting staff midwife at the clinic as an opportunity for local matwòns to meet amongst themselves, and also to engage in stories and skills sharing with visiting U.S. midwives. During the first few months they met, prior to my arrival in Haiti, the matwòns expressed a desire to learn how to measure blood pressure. Fulfilling a secondary internship for Oregon State University while at that clinic, I offered basic instruction and practice sessions to the matwòns, seeking ways to adapt the necessary skill set to their available equipment and socio-economic context. These meetings also gave me an opportunity to engage in participant-observation, noting how the matwòns interacted amongst themselves, as well as with the foreign interns and staff at the clinic. It was also there that I made my initial recruitment presentation to matwòns, sharing my plans to conduct a study focusing on their life experiences and work. I presented recruitment criteria and basic information on several occasions, and also used a form a snowball sampling (Bernard 2006) by asking matwòns to invite any other matwòns they knew to come to a monthly meeting if they also wished to participate.

The study population consisted of 28 participants (n=28), 20 who participated in-depth interviews and a further eight participants who attended the Open Space meeting. Of the 20 in-depth interviews, the first was an expert interview with a medically-trained Haitian midwife whose mother had been a matwòn, and who worked closely with over 160 matwòns in a training program in another region in Haiti. The other 19 interviewees were all with active or semi-retired matwòns (16 women, 3 men). The additional eight participants who attended the Open Space interview consisted of practicing matwòns and several who considered themselves apprentices.

Data collection

Phase I: In-depth, semi-structured interviews

My one expert interview served to frame all future research by helping to correct and clarify my previously held ideas about Haitian matwòns. Though my research question remained the same, (Given the tremendous physical and social risks associated with attending childbirth in Haiti, how do matwòns experience and contend with the challenges inherent in their work?), the expert informant made me aware of particular elements of the Haitian experience that allowed me to adjust my prompts and to recognize certain information as significant. The remaining 19 interviews elicited an event history of how each matwòn began the work of assisting women in childbirth. My situating myself as a student midwife from the United States informed them of my familiarity with childbirth and encouraged many of them to share with me their modes of practice, pointing out the conditions that they felt were specifically or typically Haitian.

All but one interview was conducted in the matwòn's own home; one matwòn chose to come to my house, citing the difficulty of reaching her house during the rainy

season. I offered to visit their homes because it afforded me a greater opportunity for participant observation of the life circumstances of matwòns, however, I also offered that they could come to my house or we could meet somewhere of their choosing. My desire was that participants would feel most at ease in whatever setting they chose. I was also concerned about inconveniencing them with travel, something that is often a hardship of life in Haiti. Moreover, I wanted them to be able speak from their own territorialized space -- a value important in homebirth (Cheyney 2011) and in feminist research methodologies (Hess-Biber and Yaiser 2004). My visiting their homes allowed them to be in a place where they were known and in greater control, and placed me as a guest in unfamiliar surroundings, dependent on the knowledge and acceptance of others. Because a foreign, white person in Haiti always receives the privileges of race, wealth, and foreign citizenship, I hoped that these privileges could in some small way benefit the matwòns who agreed to participate in my study. As it turned out, home visits did create some degree of social capital for matwòns, many of whom thanked me for coming, citing how it bolstered their reputation in the community. The one matwòn who initially opted to interview at my house later invited me to visit her house several times, which I did to pay her the respect. Several told me explicitly that they appreciated the respect I paid them by visiting their homes. In addition to using my privilege to the matwòns' advantage, I also sought to subvert my privilege through employing feminist research methodologies in phases II and III.

Another benefit of making home visits was that I experienced the difficulty of travel in that region and learned the effort required by some to attend their monthly meetings at the clinic or to attend women in labor. Many of the matwòns interviewed

serve populations pushed to the absolute margins of society, living in communities that cling to the steep slopes of unstable mountainsides. These homes and the small scale agriculture practiced by their inhabitants cause tremendous erosion, so much so that some of the "roads" or paths leading up to them are trash-filled ravines eroded six feet below ground level. Many of those who did not live on treacherous slopes lived in the plains on the former site of French sugar plantations. In those areas, the mud becomes so deep in the rainy season that four-wheel drive vehicles are as useless as footwear; both will inevitably become lodged in the mud. Riding on horses or walking barefoot are the only accessible ways in or out of these communities. By visiting matwòns' homes during daylight hours with a guide, I was able to imagine the difficulties of traversing that terrain alone in the middle of the night with no street lights.

Phase II: Open Space (Modified Focus Group)

Wanting to elicit a collective voice and vision from the matwòns, and suspecting that such a perspective could be unfamiliar to participants, I employed Open Space egalitarian participation (Owen 2008). A distinguishing characteristic of Open Space is its initial lack of an agenda, which is formed by participants. Open Space has been utilized in Haiti for more than 10 years[6], and in that time over a dozen Haitians have received training to be facilitators. Employing a Haitian facilitator ensured that the whole

[6] Open Space has gained some prominence in Haiti through its use with various non-governmental and transnational organizations, including, most recently, its employment in a USAID-funded project to build capacity among local governments in areas where foreign industries are building large new facilities. I attended one such meeting before hosting the meeting for matwòns in order to observe how a group of Haitians encountered such a methodology. After seeing educated Haitians utilize Open Space, I met with several Open Space facilitators to discern ways to adapt the technique to a largely uneducated and illiterate population, as has already been done among Haitian peasant groups.

meeting could be conducted in Kreyol, allowing the group's ideas to flow freely and in their own emic terms. Though a translator was present during the meeting to keep me informed of the direction the meeting was taking, direct translation was constructed from written documents and digital recordings after the fact.

I chose to use Open Space for several reasons: first, I hoped that a group meeting of matwòns would not simply focus on what prompts that I could give them, but actually own the meeting, assuming the space and the power to decide what was important to them. Similarly, I imagined that having a Haitian facilitator would aid the group in opening up, and in listening to one another, rather than performing a discussion for the sake of the researcher.

My underlying goal was that through sharing their perspectives in a group and finding commonality with one another, they might be inspired to collaborate for change in some area(s) of their life situation. This potential is nothing short of the consciousness raising noted in Paolo Freire's critical pedagogy (Freire 1970). Being an applied critical medical anthropologist means that findings from my research should be applied to real life problems and that my work will ultimately involve some level of advocacy for those who experience oppression. I take advocacy to mean playing a supportive role and following the lead of those who are working out their own solutions to the problems they face.

Phase III: Reciprocal Ethnography

The study's final session of reciprocal ethnography (Lawless 1992, Green and Thorogood 2004) was designed to allow study participants access to the information I collected about their lives and circumstances, as well as to provide a role for participants

in data analysis. In this meeting, I presented my initial findings from both the in-depth interviews and the Open Space meeting, asking participants to correct, clarify, or confirm what I believed I had understood from them. I mirrored their experiences and their perspectives back to them, emphasizing what I had understood them to emphasize to me. This opportunity allowed them to know that they had been heard well, and to fill in any gaps in my knowledge of their lives and work. In doing so, it also decreased the sharp power gradient and control over their stories they so graciously afforded me as an outsider. While I retain my own interpretation of the information and experiences they shared, this phase of the research adds reliability and validity, allowing me to present their perspectives with a higher degree of certainty since participants have had the opportunity to correct and expand upon my initial interpretations.

This final session also provided me an opportunity to show my gratitude and respect for the matwòns who instructed me in this study, and to encourage them in work that they do. I also took the opportunity to offer my personal reflections on their strengths and potential as a group organizing for change.

Data Analysis

While in the field I initially identified and coded themes from the first five interviews, according to a modified grounded theory (Charmaz 2006). Out of these emerged a picture of some of the key themes and common experiences of matwòns in this region of Haiti. In the remaining interviews, I was careful to cover these key areas, and thus, was able to reach concept saturation for my theory building around these central elements (Charmaz 2006, Glaser 2001). While fewer interviews could have allowed concept saturation, I accepted all matwòns who were interested in participating in the

time I had available because their personal narratives offered rich illustrations to the themes I had encountered, giving testimony to the lived experiences of women and men working in a resource-poor setting within a Haitian historical context of deeply rooted inequalities and physical suffering. Because each interview was digitally recorded to preserve exact accounts, I aim to describe their reality in their own words.

Upon returning home from the field I transcribed each interview in its entirety and followed the coding and theme identification of grounded theory. Documents from the Open Space meeting were translated while I was in Haiti, however the meeting's digital recordings, which were going to be translated and transcribed by a professional translator in Haiti, were lost in a computer error on that translator's computer after I left Haiti. Fortunately, the written documents had provided good summation of the main points made in the meeting. All transcribed Open Space documents were also coded for themes upon return to the United States. The close and multiple readings required in this method of analysis allowed me to develop a deep familiarity with the data and to discern the emergence of core themes and the interrelations between those themes that I have represented in a visual schema (figure 1, pg. 79).

Study Limitations

The study sample was drawn from a relatively small region of Haiti within a 15 kilometer radius of my temporary home near Haiti's north coast. Though my expert interview was conducted in Haiti's Central Plateau, and anecdotal evidence I received in Port-au-Prince corroborated portions of my findings, this data should not extrapolated to represent all matwòns in Haiti, which, of course, is not the goal of ethnographic accounts. In addition, the data collection itself took place during a condensed period of time. This

constraint only allowed for a short period in which to build rapport, which I sought to advance through sharing my family life with participants. Finally, the final month of my research occurred in the beginning of the rainy season. Due to the challenges of road conditions and transportation during this season, several home visits for interviews were attempted, but unsuccessful.

My initial participants were those matwòns I encountered through monthly meetings at the foreign clinic, all of whom had their own children and had been practicing for some time, if not most of their lives. At the Open Space meeting, however, several younger, apprenticing matwòns attended, and the size of their group and its activities grew. I would have liked to include at least several of these younger, apprenticing matwòns in my study, to learn if their experiences mirror those of established matwòns, or differs in significant ways. The one younger matwòn who enrolled in the study near the end of my time granted me some insight into how his perspectives are both similar to and different from older matwòns, but this single case is not enough to extrapolate about the younger generation of emerging matwòns. Should research in this area be expanded, this population would be key for understanding the ways the challenges faced by matwòns in Haiti are changing over time.

Despite the limitations, however, this study did gather a wealth of ethnographic information about the life and work of matwòns in Haiti. I turn now to those findings.

Chapter 4: Challenges and Mitigation Strategies
Results of Phase I (Individual Interviews)

In the life of a matwòn, you have to know what you're doing, especially being a Haitian woman, …because after God, this person's life is in my hands (Dieula)

During interviews, I asked participants to describe their experiences as matwòns in Haiti. They described the profession of assisting childbirth and its effects on their personal lives as extremely intertwined. Grounded theory analysis of matwòns' interview narratives revealed two pervasive themes: 1) the challenges of their work and 2) the strategies they employ to help mitigate those challenges. I have identified two general sets of challenges that I call episodic hazards, and chronic stressors. These challenges were met by two general sets of mitigation strategies, which I refer to by their emic terms "protection", and "service". As I report each challenge I divide them further, in an attempt to show how the challenge may be experienced. Therefore, episodic hazards include both clinical risks, and social/spiritual threats. Chronic stressors refer to the lack of livelihood, and also to a strong sense of obligation toward the women they serve (See Figure 1, pg. 79). It is important to note that these divisions and subdivisions of key themes are somewhat artificial and imposed, and are a function of my attempt to help clarify some of the central ideas and experiences participants shared. Haitian matwòns would not necessarily see them as distinct, but integrated and spilling across the edges of the lines I have drawn around inter-related concepts. Where differences between the physical and spiritual realms, and the contrast between paid and unpaid work, for example, may seem more distinct to a U.S academic readership, study participant often blurred these boundaries as they spoke about the value and challenges of their work.

Matwòns' narratives often took on a forcefulness that seemed driven by a desire to be heard. This sense of purpose they communicated resembles the way that the *testimonio* method (Gugelberger and Kearny 1991) proclaims the wrongs people have suffered under the powerful forces of governments, militaries, and capitalist entities. I regret that some of the emotive quality of their accounts is lost in my retelling. I have attempted to preserve the passion of participants' original words by using minimal editing. I generally adjusted the language to make it grammatically correct, but did not attempt to translate phrases into common English expressions at the risk of altering their meaning.

Episodic Hazards

You have to be careful when you deliver a woman because you don't know in advance how the mother will come or the baby will come to you. So sometimes you can lose either the bag or the crab." (Florile)[7]

Translator: "It is a Haitian expression meaning you can lose either the mother or the baby."

This initial quote illustrates the unpredictable nature of this first group of challenges that I call "episodic hazards". The hazards involved are not constant, but they are frequent and unpredictable, and because of that, matwòns expressed being continually on-guard for this host of challenges.

Clinical Risks. Poverty, which causes women to suffer from malnutrition and heavy infectious disease load, creates complicated pregnancies in Haiti, where morbidity and mortality levels are high (WHO 2012). Matwòns' emphasized resource-scarcity as a complicating factor in the populations they serve: "We have a lot of kids who cannot

[7] Pseudonyms protect the identity of study participants.

even eat. There are malnutrition problems. The pregnant mothers are skinny. There is no water. The babies are hungry." (Raymonde). Additionally, treatable diseases and other complications can become deadly where there are obstacles to accessing health care and no possibility of emergency transport. Worldwide, the conditions that make the largest contribution (80%) to maternal mortality are: hemorrhage, infection, pre-eclampsia or eclampsia, and complications due to unsafe abortions (WHO 2012). Where a U.S. homebirth midwife might deal with each one of these conditions a handful of times in her entire career, they are common occurrences for Haitian matwòns. In this section, I report two subthemes of risks as matwòns described them: complications and disease.

Complications in pregnancy and birth are low in healthy populations, but occur with greater frequency in women experiencing nutritional and immune compromise. The stories matwòns shared with me when I offered skills courses for them through the foreign birth clinic where I initially interned, provided an indication of the high prevalence of pregnancy complications. The matwòns requested that I teach them to read blood pressure because they understood this to be an early diagnostic tool in the development of pre-eclampsia/eclampsia -- the progression of a hypertensive condition of pregnancy that results in multi-organ failure causing seizures and coma (Cunningham et al. 2009). Pre-eclampsia/eclampsia and related conditions are considered incurable except by the termination of pregnancy (Roberts and Redman 1993), though they can be treated with the administration of magnesium sulfate until delivery can be achieved, usually by cesarean section (WHO 2012). Matwòns did not know or use the term eclampsia, but described the occurrence of seizures, which they acted out based on their experience with the complication in its advanced state. In addition, in my experience

attending births at the clinic for two weeks, I saw multiple advanced cases of eclampsia, reflecting the high rates alluded to by matwòns.

Another condition I observed while working in the clinic was widespread, severe anemia. This condition complicates the immediate postpartum period by making hemorrhage (blood loss) more likely to result in shock. Hemorrhage is most likely in the third stage of labor, when the placenta is delivered. Matwòns discussed their fear of the third stage of labor, indicating their familiarity with one of the leading causes of maternal mortality worldwide (WHO 2012). "What scares me the most about birth is the placenta. Sometimes it doesn't want to come out," Florida told me. Joceline agreed, and named another fear: "Because of the umbilical cord, I was scared to deliver babies. I was scared of the placenta too." Her fear of the umbilical cord represents both a familiarity with the risk of sepsis through unsanitary cord care that can result in neonatal tetanus for the infant and her awareness of the risk of hemorrhage associated with retained placenta.

One matwòn described dealing successfully with a very rare and serious complication known in obstetric terms as *placenta previa* - a situation where the placenta covers or partially covers the cervical opening and so detaches before the delivery of the baby. Without an intact, functioning placenta, the baby will die within minutes and so must be delivered immediately. This is an extremely difficult and risky feat for any midwife, and for this reason, it is treated by cesarean section in high-income nations. Dilia, however, reported managing one such case successfully, to the great surprise of the medical staff of the clinic where the woman was transferred. Dilia summarized her experiences with placenta previa and complications in general by saying: "The deliveries are always complicated. Some of the deliveries I've [attended] were very, very, very

terrible. Sometimes there are mothers coming here for deliveries that were really hard for me. In some deliveries the placenta comes out first."

Though several matwòns described successful breech births, the fact that they have no medical back-up or possibility of transport for emergency medical care makes any variation of normal birth more risky. Raymonde described her experience as such: "I've made a lot of dangerous deliveries. Some of them, it was the feet coming out… At this time [in a possible emergency] I won't ever find an ambulance or a car, because there is a big shortage in Haiti and a security situation."

Because the population they serve is so much less likely to make it to the emergency room, and so much more likely to need one, matwòns experience the gamut of childbirth complications that, in the U.S., would only ever be seen by obstetricians. These complications instill matwòns with fear and sorrow, and fill their work with the threat of the unknown and the trauma of dealing with numerous "adverse events" (Farmer 2004:308).

Even when the births present normally, a second major risk -- the risk of disease -- is ever-present for matwòns. This is especially true given the high occurrence of infectious disease in Haiti, including sexually transmitted infections like HIV and syphilis, as well as water- or air-borne diseases such as cholera and tuberculosis. Haiti's rates of infectious diseases are among the highest, and often the highest reported in the region of the Caribbean and Latin America (UNICEF). Some diseases, like malaria, dengue, and cholera pose higher risks in the rainy season, or after localized outbreaks. The risks to matwòns are exacerbated by the obstacles poor people face accessing health care, and because, unlike professional midwives in wealthy nations, testing and diagnosis

are far outside the scope of practice matwòns can provide. Suzanne's comment illustrates her understanding of the risks related to chronic, infectious disease: "There are some moms who don't get any prenatal care in a hospital or clinic, but if they don't do that they might have some germs in their blood. But if they went to a doctor, the doctor could give them something so that the baby does not get the germ. But if they don't do that, go to a clinic, the baby will get the germs and get really sick after birth."

Childbirth in Haiti is fraught with clinical risks in the form of complications and chronic, infectious disease. Matwòns' knowledge of these risks, though limited in some respects, creates significant concerns for them in their work. Clinical risks are just one category of the unpredictable elements in attending childbirth; social and spiritual threats constitute another major set of challenges that matwòns must navigate.

Social/Spiritual Threats. I refer to these threats as social/spiritual to illustrate the overlap and interplay of cultural and spiritual practices in Haiti. Though often couched in terms associated with Vodou, these threats were recognized by matwòns regardless of their religious practice, including those who identified as Protestant. It is important not to oversimplify Vodou, as etic perspectives on "voodoo" have long done (Ramsey 2011). Current scholarship refers to the "Vodou complex" of beliefs and practices, illustrating the breadth of variation and complexity of its expression (Konsanba, 2012). Thus, in this section, I describe the social and spiritual threats as they were described to me, without trying to name, and thereby misrepresent their religious expression.

When attending birthing women, matwòns perform a symbolic social function, as well as a clinical service. By accompanying women through birth as a culturally recognized rite of passage, they situate themselves in a space fraught with both social and

spiritual danger. Davis-Floyd asserts that: "during birth [a woman] is at the most intensely liminal and sacred -- and therefore at once powerful and vulnerable -- phase of the rite" (2003:21).

Matwòns in this study described the vulnerability of a birthing woman and a newborn as something that can be preyed upon by those who are envious in some way and wish to do them harm. When matwòns place themselves in that liminal space, they put themselves at risk of harm. They described how their work attending women made them the object of threats of a spiritual nature. These threats can be directed either with words, in the form of accusations, or with action, which in Haiti is referred to as *peysecusyon*, or "persecutions." Below I describe how matwòns encounter these threats and at what cost to their social and spiritual safety.

One matwòn, named Ti Paul, proved a key informant for the effort and detail he went in to explaining the social/spiritual dynamics surrounding matwòns. Having lived in Cuba, where he attended a six-month traditional medicine course, he had a comparative perspective that was unique in my sample population. He was also the one matwòn in this study who had received any college education. Ti Paul emphasized the cultural context of midwifery as unique to Haiti, where to become a matwòn he had to learn much more than the skills he acquired through a TBA training in Port-au-Prince, or his herbal medicine course in Cuba. To be a matwòn required that he, "learn the mystical knowledge from other people (matwòns);" for, as he explained: "We have a lot of families of spirits who give us a lot of knowledge on how to make deliveries."

Ti Paul explained how it is not the specific behaviors or practices of any particular matwòn, but rather the conditions of matwòns' work in general that make them

vulnerable to accusations of mal-intent. "Each time somebody has a problem and wants to take the matwòn out of her house at any time in the night, the matwòn never asks for money. That's why everybody says that the matwòns are all *lougawou*." In the culture surrounding Vodou, people are very suspicious of anyone outside at night, as that is the time when spirits are free to roam and may pose as humans (Brown 1991). A spirit, or more precisely a *lougawou* (werewolf), may pose as a matwòn. A *lougawou*, matwòns informed me, would be interested in consuming the soul of a newborn baby, thereby gaining its spiritual force or power. Matwòns have access to newborn babies and are willing to go out at night, and are thus vulnerable to accusations of being a *lougawou*. Because matwòns commonly do not receive any payment for their work, people in their communities are likely to question why they would be willing to go outside at night. Ti Paul pointed out that a gynecologist, who is paid for his work, goes off call at night and would not leave his house. Matwòns, it is presumed, may be seeking spiritual gain (such as access to a newborn soul), and that is why they are willing to face the risks of going out into the spirit world after dark.

When the clinical risks described above do present, many Haitians assume that the spiritual world is also at play. Ti Paul explained how the clinical risks associated with poverty in Haiti are interpreted as the spiritual wrong-doing of the matwòn: "Sometimes, the matwòns make deliveries well and both the mothers and babies are fine. But most are not like that. That's why they always think that matwòns are *lougawou* [that the matwòn caused the problem]. When a spiritual reading is given to the "adverse events" experienced by an extremely impoverished population, causation is more likely to be assigned to those in the community (Bourgois 2002) rather than to the more

powerful state and international actors who play key roles in creating the conditions of vulnerability and inequality within Haiti. When blame is assigned to individuals, institutions that hold power are not critically evaluated. The matwòns are aware of this discrepancy. According to Florile, institutional actors, such as doctors in the hospital, are not submitted to the same social critique as matwòns, regardless of the outcome: "If ever a woman delivers at the hospital and something bad happens, it is ok with the parents. But if you are a matwòn and something happens, they will probably tell you that you are responsible for what happened, and they can say that you know something about the death, and sometimes they can even kill you."

Such accusations create a hostile work environment for matwòns, and breed suspicion and competition between matwòns. When I asked study participants how they became matwòns, very few said they had learned things from other matwòns. This surprised me, because my midwifery training in the U.S. included a year's apprenticeship, which I assumed to be common among midwifery traditions in most parts of the world. Haitian matwòns, however, explained to me that they often keep their work private to avoid criticism. Some study participants did recount stories of families who respected, appreciated, and were truly affectionate towards them. However, stories of accusations were central themes in the interviews, and matwòns recounted them with greater force and frequency than those of appreciation, giving the impression that these experiences significantly impact their work as matwòns, as well as their personal lives. Accusations of wrong-doing have very real social costs for matwòns, and cause them to live in fear that their accusers might choose to act. Such actions are called persecutions, and can be directed at mothers, babies, and matwòns

Traditional Haitian cosmology recognizes both tangible and spiritual forces at play in life events (Brown 1991, Konsanba 2012, Ramsey 2011). In the Vodou complex, mal-intent wished upon others is known as "persecutions," and can be any type of attack intending or resulting in bodily harm or even death. Affirming the notion of birth as a liminal space, matwòns in this study described the birth of a newborn as a time and place where spiritual power is in flux. The life force of a newborn, one matwòn explained to me, is vulnerable, and is susceptible to seizure by others. When matwòns step into that socially constructed liminal space, they can be made targets of attack, sometimes deflecting or sometimes drawing the mal-intent away from the mothers and babies -- an act which can make the matwòn a target for persecutions. Sonia recounted her experience of being persecuted this way: "Sometimes when you make the delivery and other people want to kill the mother and the baby, they treat you really badly. …That's why, if you save the mother and the baby, they call you a *lougawou* and they burn your whole house with everything in it. Because the house I had [which burned], had everything in it. It was full like teeth inside a mouth."

Sonia also described experiencing years of persecution related to a particular delivery: "I made a delivery for a boy, and the boy is now a teenager and they keep saying that I took the umbilical cord with me to wound the boy. So that's why they are always trying to hurt me and my six children." Sonia's perceptions of persecution were echoed by Dilia: "Sometimes they come to call us for a delivery, but it's just persecution, it's not really a birth… Late at night they used to call me in my bed, but it's not really for a delivery, it's for bad things… Sometimes they want to take the babies for bad things, and if the matwòn helps, that gives them a big problem."

Though her allusion to "bad things" seemed quite vague to me when I first heard it, the weight of such mal-intent in Haiti is illustrated in Dilia's discussion of her daughters' perceptions of risk: "Sometimes I have a meeting, and I ask one of the girls to go [to a birth] in my place and she says, 'No, I can't go. I don't want to die young!' ...They are afraid of bad things, not just disease."

Serving as a matwòn means standing in the line of fire, without knowing who is firing; it means constant fear of becoming a target. As Florile describes it: "Faster than the wind, if the person who is trying to hurt the babies cannot do it, they will always try to hurt you as the matwòn. …They never stand in front of you and tell you that because they know you will probably call [it] injustice."Dieula gave further illustration of how mal-intent could manifest: "My sister died after giving birth to a baby. Someone had said they were going to kill her. And after she gave birth to her baby, she got possessed and she wouldn't take her baths, and she died. But I wasn't a matwòn then, I was just a kid at that time."

Matwòns in this study described persecutions as a common occurrence in childbirth. Such occurrences constitute a hazard of the job, and one for which matwòns must be well-equipped. Each matwòn employs his or her own set of strategies to mitigate the composite dangers mentioned above, though several key themes emerged across those individual approaches. The concerted efforts to face the dangers of childbirth were commonly described by matwòns using the term "protection."

Mitigation Strategy One: Protection (Pwotecseyon)

When matwòns spoke of the hazards inherent in their work, what I am calling clinical risks and social/spiritual threats, they concomitantly described their responses to

these challenges in terms of protection. Employing protection was a broad strategy that matwòns enacted in a variety of ways. Mothers and babies are vulnerable to disease, to complications and to persecutions, as are the matwòns who put themselves in a vulnerable position alongside birthing women. As such, matwòns take on the responsibility of protecting women and babies, as well as themselves. Though matwòns spoke of protection in a broad, undifferentiated way, I report their various methods of protection as they correspond to the clinical risks and social/spiritual threats that constituted the challenge titled "Episodic Hazards" of matwòn practice.

Protection against Clinical Risks. Medical anthropology explores how ethno-medical systems around the world, including that of the matwòns in this study, understand disease and injury to have both physical and spiritual origins simultaneously (Glick 1967). Due to this integrated view, both physical and spiritual protection is required when matwòns encounter hazards in birth. As I describe the ways matwòns mitigate dangers through protections, it is important to keep in mind that there is seldom a one-to-one correspondence between a single risk and a single form of protection; but rather, what I call "clinical risks" would likely require both "physical" and "spiritual" protection as Haitian matwòns do not acknowledge a sharp distinction between the physical and the spiritual worlds, the seen and the unseen.

Matwòns use their understanding of germ theory to protect themselves, to the extent they are able, using protective barriers like gloves to limit exposure to disease. Roseline took safety very seriously, and demonstrated her knowledge of disease risk through the preventative measures she regularly takes. In the middle of our interview, she stepped behind the curtain that divided her two-room home into three, and emerged

wearing white pants: "When you are wearing this, if the blood comes out it will hit the pants. The blood shouldn't touch your actual body." She then put on a pair of gloves from her birth kit to illustrate her point. "You wear two gloves. If you don't have two gloves, it's easy to get the sickness that the person might have. Some people have AIDS. Some have diabetes. Some people have TB. Some people have infections. To protect your health, you wear closed shoes and pants so the sickness can't get through to you…Sometimes we bring two pairs of pants, one long one, one short one, in case you get one all dirty. Then you can take the long one off, and it helps to protect your health." To conclude her demonstration, she put on a pair of glasses and stated her position: "It would not be good if that water [amniotic fluid] gets in your eyes. You have to be careful with your body."

Amniotic fluid poses a risk to matwòns, as does blood, and matwòns were aware of the unpredictability of disease exposure. Dilia expressed her understanding of the potential risks of amniotic fluid: "I used to wear boots on my feet because of HIV… I'm really scared of this, [because] sometimes when the mother's water breaks it gets on my feet, so I don't want the water to touch my feet…The diseases are really hard out there, so I just protect myself."

Several older matwòns expressed how their practice had changed with both increasing knowledge and increased rates of disease. Marilene reflected: "A long time ago, we didn't have gloves, but now there are more sicknesses around. You need to have gloves so you don't catch disease…A long time ago we used a razor blade to cut two cords. We would use it and save it, use it and save it. But now we don't do that anymore because of sicknesses. It can give the other baby tetanus." A similar, long-term

perspective came from Raymonde: “The reason why you can’t use your breath to give the baby now is because now there are a lot of people with AIDS. That’s why we use [resuscitation equipment]… Doing this kind of thing is very good.” Not only is it “very good” to protect oneself while attending women and babies, it is an imperative, as Raymonde made clear when she concluded with this remark: “There are a lot of old matwòns dead with AIDS, because they made deliveries with their hands, and they got HIV.” The importance of hand-washing and general hygiene were also mentioned as critical for matwòns to protect themselves, as well as for keeping mothers and new babies healthy. However, when diseases are known to be present, matwòns must refer mother and baby to medical care. When matwòns suspect disease in the populations they serve, they are dependent on mothers’ abilities to access the limited health care in the area for diagnosis and treatment.

Raymonde encourages the women she serves to get some prenatal care at the hospital or a clinic in order to increase safety for everyone: “When the women are pregnant, I always ask them to go to the hospital and get testing so if there is something wrong the doctor can just tell them what is going on and what to do. Sometimes it’s not AIDS, its syphilis. And if that person goes to the hospital, the doctor can give some medicine in advance. Because there are a lot of women with AIDS in this zone, and the doctor has to take care of the mother and also the babies.” Unfortunately, matwòns usually had no way of enforcing their request, and often were called to births where unknown disease status posed significant risk.

Birth complications or pathologies of pregnancy (ie: pre-eclampsia), however, often present more immediate concerns, which alert matwòns to transport women in

pregnancy or labor. Suzanne described the need to detect complications in their early stages: "Sometimes when I meet someone, most of them are teenagers, so I give them advice to go to the hospital. When I see their feet swollen and they have a big headache, I tell them to go to the hospital to get care." Another matwòn, Dieula, described her screening technique in a more general way: "If you notice that all the signs for a good birth is not what the person is giving you, you should not keep them at home. You should send them to the hospital." In these cases, matwòns are proactive about providing protection, in the form of referring women to obstetric care before a complication becomes lethal.

The following narrative shows how matwòns recognize and address the dangers of childbirth in a resource-poor setting. Raymonde's story illustrates her ability to protect a woman and baby both by consulting at a medical facility and by responding to the complication using her own acquired skills at night when that facility was not accessible to the laboring woman. Physical protection using barriers is also prominent in the story.

> At the hospital they know me well. There was a woman with a baby, and the baby was a little bit collapsed inside the belly, so I sent her to the hospital so they made a sonogram and saw what was going on inside. So the doctor said when she is in labor, she should come back to the hospital.
>
> So that same night they called me, so I said, 'it's that woman, I have to go.' So I just saw the butt of the baby coming out. The feet were inside, and the head also, and I just saw the butt. I was so careful to press the head here (gesturing) and you cannot press the belly because you do not know where the feet are. So while the baby was coming out the woman didn't have strength to push, so I asked to make a serum with water, sugar, and salt, so she drank it. And then she felt better so she pushed so the butt and the feet were coming out and the head stayed inside. So I wore gloves and I put my hands inside the vagina and I asked her to push, and she just had to push a little bit and the baby came out. But the baby already drank some water inside, so I put the pump, and the baby drank a lot of blood also. It seemed like in the water, there was a lot blood too.

> Then I took [the gloves] off, and I cleaned the stomach. I just made the mother rest. In 10 minutes, I saw the placenta was still inside so I just put the baby on the breast to feed and while the baby was breastfeeding, the placenta came out. So they just clapped their hands for me and hugged me and were so happy. It was a terrific delivery! Very dangerous!"

In this account, accessing medical care was part of the initial plan to protect the mother and baby, but when medical care proved inaccessible in the hour of need, gloves and a matwòn's own skill were all that could provide protection. Though many matwòns in the study had years of experience, they attributed their skill to spiritual guidance rather than to their own abilities.

Because barriers to contagion and medical care are not actually able to address all of the clinical risks matwòns face, and because many of the clinical risks mentioned are believed to have both physical and spiritual etiologies, matwòns relied on spiritual guidance to receive and provide the protection needed. Such guidance commonly comes in the form of dreams during which some matwòns were shown exactly what they needed to do. "With the dreams, if the person is in danger, you can help them," Elene told me. Receiving guidance did not eliminate the risks, however. According to Roseline: "In Haiti it's…really difficult. I've gotten this far with God, in labor, and I don't want anyone to die in my hands." However, this guidance did grant her a feeling of protection: "I like the work, and I love it so much now because God is with me. I'm not by myself." Guidance in dreams not only granted matwòns protection from the clinical risks of birth, but also against the social and spiritual threats inherent in attending birthing women. To counter these threats matwòns also actively sought spiritual protection for themselves.

Protection against Social/Spiritual Threats: The first step to receiving spiritual protection, as Roseline alluded to in the previous quote, was to align oneself with a

greater spiritual power.[8] Gerda's approach was similar: "Before I go to make the delivery, I just have to say, 'God, you are in front of me and I am in back. You just have to protect me because I don't have anyone else to call.'" Marilene described her need for spiritual protection as a matwòn in a similar way: "I started in 1972, but nobody had big problems. Sometimes babies would come with the butt coming out first or the feet first, but it always turned out fine. If you believe in God and you go to the woman and you say, 'Let's go God, you are the owner, do your work!'" Dieula, echoed the sentiment that the work is God's to do, through the matwòn in saying: "I think God always wants to help me at the births. I am here, but it is not really me doing it, but God is doing the whole thing."

To claim a spiritual power, however, could be to bring accusations upon oneself, and so matwòns were often explicit about differentiating themselves from others who, they suspected, intend to "do bad things". "I only work with God, and nothing else. When I am going to help with a birth, I always pray first to ask God for direction," Florida said. Though many matwòns used the general term *Bondye* (God) when claiming

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[3]This power was most often referred to as *Bondye* (God), which doesn't specify a person's spiritual beliefs or practice, as the term *Bondye* is used by Catholics, Protestants, and *sevite* to refer to one supreme deity. It was unclear to me if study participants used the term to keep their specific spiritual beliefs private, because I was *blan* (a white/foreigner) and traditional Haitian spirituality has been condemned by outsiders since independence, and especially through direct campaigns in the last century carried out under the U.S. occupation of Haiti (1915-1934) and more recently by protestant missionaries and humanitarian aid groups (Ramsey 2011)

spiritual alliance, Sonia, was more explicit about the spirit, or *lwa* (here referred to as a "genius") that protects her in her work: "If you have a genius with you, nobody can hurt you… If the genius agrees with the thing you're going to do, nobody can hurt you… That's why, even at midnight or one a.m. I go, because I know I have someone to protect me." This comment reveals both how a spiritual power grants protection for a matwòn, and also how it can provide guidance, often through dreams. Just as was discussed for clinical risks, guidance from a spiritual power protects matwòns in unexpected and hazardous situations. Dilia described how God protects when she may be called into threatening situations: "When you serve God, God will never allow people to do bad things to you. Sometimes, even in my dreams before, people used to call me for fake deliveries, God will tell me that in my dream. God always tells me that. When I have to go for a good delivery, I know. And when people come for bad things, I know." Thus, protection comes from aligning oneself with a spiritual power and following the spiritual guidance offered for specific situations. When I reflected, in Florile's interview, that she received a lot of guidance in her work, she concurred, "Yes, that's why I am still in the job. If I did it by myself, I would leave the job, because I find a lot of persecution in it. It is a fragile job. Fragile!"

The spiritual protection matwòns receive is also something they can provide for the women and babies they attend. This point was made clear in the following comment by Roseline: "The protection that God gives me, God gives to those people [I'm helping] too. There are some babies who almost die at birth, and I don't even think they will make it. But I still try and people will say things like, 'You're playing with death, because that

baby is already dead.' But now, some of those kids are going to school." She described her protective role in another case by saying:

> One time I went to help deliver a baby and the father of the baby had some sort of bad spirit in him and didn't want the baby to be born. So, I started reading Psalms and praying, and then the baby came out, and the father fell three times in front of the door where the baby was born. He fell three times!
>
> Then the father came to touch the baby, and I said, "No, don't touch the baby! While the baby is in my care, don't touch. After I am finished with the baby and her mother, then you can touch her." The work is dangerous. We need God's help.

Another protective measure matwòns take is "privacy" or attempting to reduce theirs and the mother's social visibility. Dieula explained: "You don't let anybody in the room where she is giving birth because you don't know who likes her or doesn't like her." Florile, an older matwòn with years of experience described the same technique, as well as the rationale and possible outcomes:

> I don't deliver a woman with a lot of people in the room. I just need someone to hold the [laboring woman's] back and after holding the back I just need some people to take materials from me. After that, even the parents of the mother, I just take them away from the room, because it is safer…It is because of persecution. Sometimes in the same family people are trying to hurt the woman. [With] one of these people inside the room, maybe they think bad things can happen and the baby can stay inside of the mother, but the delivery comes fast when there is not anyone inside [the room].

The risk of persecution is captured in Florile's conclusion about birth: "It is a fragile thing and you don't need to do with a lot of people around you."

In this section, I have illustrated matwòns' strategies for dealing with the episodic hazards inherent in attending childbirth in Haiti's poor and marginalized communities. In order to meet this host of challenges, matwòns draw on various forms of protection.

Where physical resources like barrier protections are available, matwòns stress their importance and utilize them. When clinical risks are considered to have a spiritual origin, matwòns draw on spiritual protection for themselves and for the women and babies they serve. I now turn to the final challenges named by matwòns, which I refer to collectively by the theme "chronic stressors".

Challenge Two: Chronic Stressors

This second, broad challenge I refer to as "chronic stressors" because, unlike the "episodic hazards" described in the first set of challenges, these factors are not risky, per se, but rather they add to the hardships matwòns face in life by burdening them with enormous responsibility, but little financial compensation.

*Lack of Livelihood: "*The worst part about this job is that people don't want to pay me when I help them" (Dilia). The most common hardship, reported in every interview but one, was that matwòns rarely get paid for their work. This challenge compounds all the other challenges named. It is not that money lessens the risks or responsibilities of their work, but rather that it both symbolizes appreciation and respect, and also sustains a matwòn in very literal and physical ways. Because I heard this report so frequently, I tried to gauge, through questioning, how common an occurrence not being compensated is for matwòns. Responses included this calculation from Elene: *"*If you deliver ten babies, five will pay and five will not," and this from Roseline: "Many, many, many, many times I do a birth [I don't get paid]. If half of the people I've helped deliver paid me, I would be able to save some money. Sometimes I do ten births in one month, and maybe two will pay me, and then just like half the money, not all the money."

Differences do exist in the populations served, however, which prompts matwòns to differentiate the reasons their work is not paid. Roseline lives in an extremely marginalized community on the steep slope of a mountain, and for her, the reasons for not receiving payment are painfully obvious: "Sometimes I will go to a birth, and I see a woman who is so weak, and they don't have money. So I come back home and get a little bit of money from my husband to make a soup for them or boil some plantains to help them. Or if he planted plantains, and we have plantains around here, I will take that and boil it for them… Haiti is a hard country. That's why some of them pay me and I accept it, but some of them don't pay me." Similarly, Anita, who lives and works in the agricultural communities on the great northern plain that was once the site of French sugar plantations, explained why she could not always expect to be paid: "Some of them don't have money because things aren't easy here. So, I just have to take care of them because money cannot buy everything."

Many times, however, matwòns described not getting paid in terms of "refusal." The amount of effort matwòns invest in a birth is no indication of payment: "We go through a lot of misery. Sometimes they call us at night, and there is a lot of mud. Even if it's raining you have to boil some water and close the mother's body by giving her a shower and even those efforts, they don't pay us." Performing the job well is no guarantee either, as popular matwòn Raymonde attested: "I feel that I am doing a good job because I never disappoint anybody. All the babies that have been born have stayed alive until they've grown up, so I think it's good. When the baby is coming too early, I just have to put them on a towel and go with the baby to the hospital. When it's hard for

the baby to breathe, I just take them with me to the hospital. So I save a lot of babies' lives, a lot of mothers' lives…but they don't want to pay me."

Matwòns interpreted this behavior by families as a refusal rather than an inability to pay, claiming, as Dilia did: "When they go to the hospital, they pay, but they don't want to pay me." Similarly, Anita related a story in which she had removed retained membranes from a woman several days after birth, an act that quite possibly saved the woman from sepsis, yet Anita explained: "They do not understand that. You try to save their lives, but if they go to the hospital they will pay the hospital. But they refuse to pay me." Anita also described an experience of being called to a family's house where she identified that the baby was breech and had died *in utero*. The parents did not believe her, and did not attempt to transport to the hospital. Instead, they called Anita back at midnight, at which time she helped deliver the dead baby. Anita explained that she was never paid for that birth. In another instance, she was called to deliver another baby who had died. She related the experience: "When the mom was pushing, only black blood came out. The two eyes were not good, and her hand was broken. The baby was wasted." Anita, who confided that these recent experiences made her want to quit being a matwòn, also disclosed: "I didn't ask for money for that [birth] because I was very sorry."

When matwòns asked for payment that they felt was deserved, people's refusal could potentially escalate to social/spiritual threats against the matwòns: "Some people even threaten us when we go and ask for money after delivering their baby" (Dieula), and "Sometimes they want to kill you instead of pay you" (Florile).

Receiving payment for their work is important to matwòns for two reasons – it enables them to support their families and it is also of symbolic importance. The physical reality of not receiving payment is that matwòns lack a livelihood with which to support their families. Though no matwòn claimed that money was their main motivation for helping in childbirth, several reflected on their poverty and concluded that the lack of payment has been detrimental to their lives and work. Sometimes the necessity to find other income limited their ability to be a matwòn, as described by Dieula: "The reason I can't always do it is because I am the man and the woman at my house, so I have to work to provide enough for everyone." Likewise, Filo, who was the sole supporter of her family, also described having to limit her practice because she had no money to spend: "After the delivery, you have to visit the mother for three months…to see if the mother acts well with the baby, if it's her first baby. But sometimes you don't even have money to visit them." Gesturing towards her crumbling house, which she declared needed to be torn down, Filo reflected, sadly: "If they would always pay me for all the deliveries I've done, then I would be finished with the house by now."

Livelihood can provide for a person's physical support, but life in community requires social support as well, and at times matwòns saw payment as a matter of respect. "Some people don't pay. Some people respect you and they pay" said Elene. Raymonde, who claimed that people appreciated her work but didn't pay, also described how a spectacular performance on her part could inspire the respect that prompted payment: "I helped a woman with a delivery and the umbilical cord was wrapped around the neck four times and the feet also… And after I made the delivery, everyone was really amazed at what they saw, so they paid me."

When payment is not given, matwòns can become discouraged. Florida describes the challenge this way: "It's sort of like working for free because when you help deliver a baby, the people don't really pay you. The people tell you to come back, but every time you go, they don't pay you. But I'm not getting discouraged. I think that they are doing it to discourage me, but I will never get discouraged." Other matwòns did admit to becoming discouraged, which made them want to stop their work. Florile, a long-time matwòn, well-known throughout her zone, put it this way: "If there is some money or encouragement, this is fine. But if there is no encouragement, it's like you are trying to tear some yarn." These narrative accounts portray the detriment and significance matwòns felt when they did not get paid for their work, a chronic stressors that compounds the other challenges.

Obligation. Once matwòns in this study had taken on the work of attending women in childbirth, they expressed as a strong sense of obligation to continue despite all the challenges they faced. "In Innocent's words: It's a really fragile thing to be a matwòn in Haiti. What makes it fragile is that someone can come to you at your gate and ask you to go with them, and you can't not go. It's like being a slave, because if they come to you and ask you to go and you say no, then if something happens to the mother, they can arrest you. Even if it's 12:00, 1:00 in the morning, if they know you are here, if they call you, you have to go." The sense of obligation included two inter-related commitments: that of serving women, and that of serving the government through the work of public health. Additionally, matwòns felt unable to leave their work because there was no one to continue it for them.

For some, like Filo, being a matwòn determines which actions she can or must take, and which she cannot. "When they call me, I cannot say, 'No, I'm not going anywhere' because I am here to help people, and you can't say no." Filo had, at times, wanted to stop her work, but her desire was overridden by the needs of birthing women: "Even when I want to quit the job, and my children ask me to stop, it is this time that more deliveries come to me. …I cannot let people die because of a question of money or because it is dangerous for me. I have to go and deliver the woman because it is not safe for me to let them die, nor is it safe for me to try to deliver them, because after that people might want to hurt me."

The simple fact that women are in need circumscribes some matwòns' actions, as Gerda described: "Sometimes people come to your house and call you to go, and you don't have any choice You have to go because some of the mothers are so afraid of giving birth, so you have to be here to control [it so that] everything is ok. You have no choice." The hardships of childbirth also demand urgency, as Florile's comment illustrates: "Sometimes when they come and call for us at home, maybe we have food to eat, and don't even have time to eat the food because they tell you to go and wash because the person has a lot of pain, and so we have to go straight to the woman." Marilene felt devoted to birthing women by her emmpathy; "Because I had babies myself, I know it hurts. It's a big pain." When matwòns considered or even attempted to suspend their work, their sensitivities to the needs of women in childbirth was a major force compelling them to continue; another was their commitment to the practice of public health.

Despite their marginal status and virtually no institutional affiliation, matwòns understood their work as a major contribution to Haiti's public health. Several matwòns communicated to me that they play a significant role in the national health system, doing the work that doctors are unable to do. This view of matwòns, upheld by research (Kruske and Barclay 2004), also reflects the opinions of Haiti's ministry of health. This is evidenced by the statements made by instructors at the state-sponsored trainings held in local clinics. Matwòns took their training and professional practice seriously, often citing the vows and commitment they undertook at training. "When we were graduating, they made us swear that we would not let anybody suffer, or die. As soon as somebody needs our help, we have to go," Florida explained. For Marilene, acting out her professional obligation meant accepting the hardships of the work: "When we were getting our diploma, they made us swear that if anyone came calling us, we would go. That means even if the person doesn't pay, you help them deliver anyway."

For Innocent, committing himself to the government improved his view of matwòns' work from that of slavery, as he is quoted in the beginning of this section, to that of profession: "After the training…they gave us a badge, so when we go somewhere and present the badge, it really helps us look professional." However, as previous challenges have illustrated, this profession is fraught with social risks: "You have to be really careful [as a matwòn] because they taught me that even though someone has a problem with me or I have a problem with this person, when it comes time to deliver and they call me I have to go and try to save her life. If ever they call you and you don't want to go, maybe the parents will say you know something about somebody else who is trying to hurt the family, and sometimes they can take you to jail" (Florile). Those risks,

however, are accepted as part of the profession, as Dilia's comment affirmed: "It's my job to go."

The combined obligations to respond to the needs of women and babies, and to fulfill one's role as a public health worker were compounded by the fact that, in most cases, there was no one else to attend births. Several matwòns shared that they initially got involved in childbirth by stepping up to support a woman who needed someone to help deliver her baby. Filo described her first birth as a matwòn: "I was in a house with someone and that person was in labor, and one of the people who were there said, 'There is no one who can make a delivery.' So I just said, 'Ok, I'm going to do it!'" She then added that stepping in where there is need was not unusual in her life as a matwòn: "Sometimes I help people deliver, I am just passing by and I help." An abundance of women in need, and a shortage of matwòns or other health care providers, leave matwòns with little choice. For most, including Florida, being a matwòn was a lifetime of work that will cease, "only if I'm sick or I just can't anymore." Or, in the words of Dieula: "I think I'll do it until I die, or just can't do it anymore….I'm still going to be a matwòn until I just can't do it anymore."

Just as the episodic hazards in the work of matwòns listed earlier in this chapter, the chronic stressors described here as a lack of livelihood and the felt obligation to save women's lives prompted matwòns to take actions and to hold perspectives that are aimed at mitigated those challenges. I group these actions and perspectives in an emic category, which is to consider their work *bon sevìs*, or good service.

Mitigation Strategy Two: Service ("Sevìs")

That matwòns consider themselves doing the work of public health with the expectation that they should be paid for their work, illustrates how matwòns view their work as a profession. Yet their experience is that they are not treated as professionals. To mitigate this discrepancy, matwòns choose to view their work as service to the greater good of their communities, of society, and of God. When they viewed their work as service, they were more confident that God would sustain them or reward their generosity, or at the very least, they could have the satisfaction of doing the "right thing."

Asking for, but not receiving, payment for their work often put matwòns in difficult social situations. In order to feed their families, build and repair their homes, send their children to school, etc., they need the money, yet to demand it would create inter-personal or inter-familial problems for themselves within their communities. A number of matwòns in this study, therefore, chose behavior that would preserve the peace in their community over demanding what was owed them.

Preserve social harmony ("Don't fight"). Matwòns made individual choices about how to interact with families whom they had served, but the common theme was a desire to keep the peace. Raymonde took on an open-handed personal policy of accepting whatever a family could offer, although she concluded that in doing so, she needed to find other work to support herself: "I love the babies so much, so anything they [can give] I just take it. If they give more than 200 goud, if they give 500 goud, if they give anything, I take it. So I'm just looking for something else to do." Others were explicit about the fact that they had a right to payment, but that they were not willing to make trouble for others, even when their rights were disregarded. Florile related her

approach with the people she assisted in saying: "If you want to pay me, you pay me. If you don't, I can't do anything, because I never try to hurt people. Sometimes I give them a big line [of credit] to pay me. Some of them after six months, after two years, I never get paid, but I never hurt anybody for that, I never say bad words to them, never. Even if they never pay me, I never try to hurt the mothers or the babies." Dieula explained how she relied on God instead of on the government to see that she is compensated adequately: "With this badge, if you deliver a baby and they don't want to pay you, you can take the person to court. I wouldn't take someone to court…Because you know God can give you more than that…but you could do that." She concluded: "Even if they don't pay me, God will use someone else to help me. So that's why I don't fight with them." Similarly, Roseline described her relationship to others as determined by her desired relationship with God: "I want my spirit to be at peace with God, so I'm not going to go and fight with people for that [money]."

Viewing God as the authority concerning matters of payment relieved matwòns, at least somewhat, of the ultimate responsibility for making a living in an extremely resource-poor setting where they were seldom paid adequately. According to Dilia, "When you are working for God, you don't have to pay attention to the money. God will make a way for you." Roseline, who felt called to be a matwòn despite her initial fear of blood, claimed that, "[not getting paid] Doesn't bother me, because I didn't want to do it, God wanted me to do it. And also, if you focus more on money, then that means you're not serving God. God speaks with me often, and that gives me strength to do the work." Several matwòns, independently of one another, declared that instead of expecting a livelihood from their work, they just "do it for God." In the following quote, Marilene

employs this perspective, combined with the notion that serving God enables her to receive protection: *"*You don't just look at the personal pay, but you also look at the person's life. If every person who comes, you say, 'they won't pay you,' but the person is suffering and they could die, you just do it for God. Even if the person doesn't pay you, the angels in heaven will protect you."

Give good service ("bon sevìs"). Viewing their work as for God, rather than for pay, is part of the broad strategy in which matwòns conceived of their work as *bon sevìs,* providing "good service" to women and babies. By not expecting the benefits of employment, they are better able to accept what comes and still feel good about the work they do. The following quote by Joceline illustrates how this allows matwòns to continue work in the harsh realities of poverty in Haiti: "If they have money, if they don't have money, I help. I give them service. It's not the money that interests me; it's the deliverance for them. If I go to help deliver a baby and I see that the woman doesn't even have money to pay me, I will help her, if I have money or [with] whatever I have. Because if she had it, she would have given it to me. If she didn't [give it] then she doesn't [have it]. She needs it herself."

This strategy of viewing their work as service mitigates the concurrent challenges of not receiving payment, and also of feeling an obligation to remain a matwòn despite the difficult conditions. "I do my service, and I will continue until the end," declared Ismaelle, who had delivered babies all of her adult life, and is continuing as best she can even now as she is somewhere around 80 years old. Others maintained a similar commitment, as illustrated by Dieula's comment: "I ask God only for good health, but

whenever someone comes or calls me to help them, I will help." Sensing a spiritual value in the work provides the impetus to remain committed.

Viewing their work as service helped to soften matwòns' sense of obligation by strengthening their commitment to serve women, but it still left matwòns with an enormous responsibility. Participants in this study commonly expressed a desire for more matwòns to help share the work load. However, suspicions and accusations around matwòn practice created social risks for matwòns to work together and share techniques with one another, and also may have made the job undesirable for young people. Matwòns addressed the possibility of training a younger generation of matwòns at the Open Space meeting (discussed in the next chapter), but in individual interviews, most matwòns did not discuss finding help in a younger generation of trainees. In her interview, Florida admitted: "If one of my children wants to take it on, that would be nice," but added that the daughter or daughter-in-law would have to want to do it. Dieula expressed a fear that her daughter won't want to learn her skills, because "people don't have much respect for matwòns."

Raymonde, who had trained younger women to help address the needs of birthing women in a crowded urban slum, still did not find a way out of her job as a matwòn: "I would like to quit the job, but I cannot. They call me all the time. Some of the people really want me as their matwòn." Though Sonia faced what she described as years of persecution, her commitment to serve women seemed bolstered by her desire to pass on her skills: "I will always do it. If I ever go, I will show one of my daughters how to do it. Even if I die, I can come in her dreams and show her how to do it." She also offered to share what she knew with me: "I am always available. Any time you need me

to show you how to make a delivery, I will be there. If a woman ever needs to deliver, if it's ok, you don't need to send the woman to the hospital, just call me, and I will show you everything." Matwòns imagined that their work would be eased if there were more matwòns to share the burden of attending women, and though they were willing to train others, most did not find younger people willing to take on the work.

Thus far, I have reported two broad categories of challenges in the work of matwòns, those of episodic hazards and of chronic stressors. I have also described two broad categories, protection and service, which encompass a range of individual mitigation strategies matwòns employ in response to those challenges. To bring their individual experiences together in such a way that a collective voice of matwòns could be sensed, I used Open Space. The results of that meeting are reported in the following chapter.

Ch. 5: Matwòns' collective voice
Results from Open Space & Reciprocal EthnographyPhases

Phase Two: Open Space

In Phase II of this study, matwòns met for a day-long Open Space meeting.[9] Participants included most of the matwòns who had already given personal interviews, plus an additional eight matwòns or matwòns-in-training who learned of the study through snowball sampling. Prior to the Open Space meeting, I met with the Haitian facilitator to share with her the preliminary results of my in-depth interviews. When she had a clear understanding of the issues raised by individuals, she and I together crafted the prompt that would open the meeting. When matwòns met for Open Space, the entire meeting was conducted in Kreyol. After a lengthy introduction, including explanations about the structure and principles of Open Space and the schedule for the day's meeting, the facilitator initiated the conversation with the question: "What can be done to improve the lives of matwòns?"

Before seeking solutions, however, matwòns named the challenges that needed to be addressed. Those initial comments echoed the challenges I had heard in the individual interviews, helping to validate my findings from phase I (Lawless 1992). Rather than a laundry list of specific challenges, however, they spoke to more general feelings about

[9] Due to the technological difficulties experienced by my translator, one of many structural barriers Haitians face, I have not had access to complete transcripts of the Open Space meeting, but only just the written documents from the meeting which were translated while I was still in Haiti. However, the themes relating the challenges matwòns face in their work could still be triangulated with narratives from the interviews and participant observation.

their work. Their comments stressed their needs for respect and for recognition, both from their communities and from the government.

The structure Open Space gave to the meeting allowed matwòns to voice their concerns to one another, and these themes gained force as they were heard and reiterated by other matwòns. In an Open Space meeting, participants set the agenda, offering ideas to the group as topics for small group discussion. Then, "break-out" sessions allow participants to join the discussion that they most want to contribute to. They are free to move and join other groups as their own interests lead. In this meeting, four small groups were formed, one around each of the following questions:[10]

- What can we do to help ameliorate (improve) the lives of matwòns?
- How can we help matwòns feel respected in their work?
- What can be done to help matwòns find gratification (recognition and support) from the government?
- What can be done to have (create/attract/encourage) more younger matwòns?

These questions were designed to provide a starting place, rather than a comprehensive description of their concerns. The responses to these questions, generated in their small groups, provided the type of information that could be analyzed for emergent themes, out of which an inclusive, collective voice was formed. Considerable overlap of ideas between the groups emerged around what matwòns saw as the most salient strategies to ameliorate their life situations. They included: desires for professional organization, for government recognition, communal space for matwòns, and continued training.

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[2] Here I use the direct translation from the meeting documents and offer additional English synonyms in parentheses. This approach seems the closest to the matwòns' own sentiments, along with what I feel are clearer expressions in English.

Theme One: Professional Organization. The theme that received the greatest emphasis in Open Space was matwòns desire for self-organization as professionals. This one strategy provided the means out of which the other aims could be accomplished. Though none had mentioned this in their individual interviews prior to the meeting, in the Open Space setting, self-organizing became their primary and immediate strategy. Each small group listed it as one of the ideas they reported to the group, and several groups listed it several times in writing, using different terminology, including an "association", a "syndicate" (which is closest to the more common French term), and as "coordination". Even though few participants had had much experience with any kind of professional organization, they still demonstrated a relatively thorough understanding of its benefits, as can be seen in the other repeated themes.

The two matwòns who allowed me an in-depth interview after the Open Space meeting both reflected on this new idea. Florile explained the current conditions and social dynamics of matwòns, and also expressed a sense of possibility and urgency that matwòns move beyond their divisions: "We are matwòns. It is not a safe job, but we have to put our hands together and try to put our knowledge together…They are not all trying to stick together. Some of the matwòns…want to work by themselves and just want to hurt you, too.…With matwòns, we are not two groups, we must be one, one group together."

Theme Two: Government Recognition. The most emphasized of the proposed ameliorating strategy, which a professional organization was seen as making possible, involved "demanding government recognition" Though all but one of the matwòns who gave in-depth interviews had been through a training program sponsored by the ministry

of health (MSPP), and even though matwòns are considered by the government to be "community level health service workers" (Telemaque, personal correspondence, April 2012), matwòns still reiterated a need for greater, more demonstrable recognition by their government. Specific forms of recognition suggested included: provision of supplies, granting certification, identification badges, community referral centers which would recommend matwòns to pregnant women in their zone, a pension in old age, and an office for matwòns. To succeed in making these demands of the government, some matwòns suggested a government advocate, though it is unclear to me if they were thinking of a lobbyist of some sort, or rather an agent within the ministry of health that represents their needs.

Matwòns spoke these ideas with a passion that was tied to feelings of marginalization and vulnerability. Many reiterated that they felt they were working hard for the health of the nation's childbearing women, but receiving little help or support for such challenging and dangerous profession. Innocent had pointed out in his interview that matwòns do a job that doctors do not want to do, presumably because they are busy addressing the heavy disease load of a population in poverty: "So, it is us matwòns who can help people with those situations. [The ministry of] health knows that, so they send money for us once in a while. But we don't really get that money. When we ask the doctors and say, 'We know that public health [MSPP] has sent money for us, the doctors say, 'No, that's not true. They didn't send the money. The person you helped deliver their baby, they must pay you, not the health [ministry].'

The participants in the Open Space meeting demonstrated support for the general feeling that they were not getting their dues. They indicated that they feel some degree of

recognition from the health ministry (at least through training or this alleged government money), but wanted substantially more. Group action through a professional organization offered the promise of greater recognition and the support they needed.

Theme Three: Communal Space. In addition to government recognition, matwòns expressed a need for their own communal space. This envisioned space would function as a place where matwòns could bring women to birth, and would be shared by any practicing matwòns in the zone. Such a space would ameliorate a number of the risks matwòns face when attending women in their homes, such as the lack of sanitary conditions, the crowded living quarters, the risks posed by too many attendants/observers, and at least some of the unknown elements of those who seek to harm a mother and babies.

Matwòns mentioned that this space could also be one in which they could share birthing knowledge. This point is noteworthy because in individual interviews, few matwòns expressed that they had or would be willing to learn from other matwòns. Some even rejected the idea as unsafe, suggesting that it would invite suspicion and criticism. However, if matwòns had the opportunity to practice in their own space, it might offer them the chance to meet as professionals, rather than as rivals or suspect players. The idea of a communal space has the potential to demystify and legitimize their practices. Granting opportunities for further learning among peers, a space for practice provides an opportunity for peer review of sorts, a method that shares power rather than reinforces it, as do skills testing or examinations in biomedical training programs. That matwòns welcome such openness regarding their practices is evidenced in one participant's

suggestion during the Open Space meeting that the government evaluate their work, a move she felt would offer matwòns a greater level legitimacy.

Theme Four: Continued Training/Sharing Knowledge. Finally, one last point that received extensive discussion was matwòns' desire for continued training. Several small groups specified a time frame, either every six or twelve months, in which they could review and practice skills, especially those used to address complications that do not occur often. As Ismaelle, who guessed her age to be around eighty, said: "You can never have too much training!"

However, matwòns spoke of more than one type of training. Most had been through a government sponsored matwòn training program that imparted biomedical practices adapted somewhat to the context of Haitian homebirth by supplying soap, gloves, and clean razor blades, as well as birth reports with visual representations of complications so that illiterate matwòns could check the box that (hopefully) describes what occurred at the birth. One matwòn, Ti Paul, had completed a TBA training program in Port-au-Prince sponsored by an international health agency. His awareness of the discrepancies between TBA training and the real work of matwòns is illustrated in his comment that he "*had a chance to study [becoming a] traditional birth attendant, [which is] not really a matwòn*." To Ti Paul, biomedical training addresses just one aspect of matwòn practice. In addition to formal biomedical training, several matwòns expressed a vision of sharing knowledge with one another. Older matwòns felt that they had valuable experience to offer, and would feel respected if they could share it. The few younger matwòns at the meeting were similarly interested in hearing what more experienced

matwòns had to offer. These exchanges seemed to have been made possible by the group's willingness to conceptualize their assets and their goals in a new way.

As illustrated in the schema (Figure 1, pg. 79), the idea of a professional organization offers support to the matwòns own individual strategies to meet the challenges of their work. At the same time, a professional organization provides a framework for new tactics to be created collectively. At the end of the Open Space meeting, participants shared very positive feelings about the day's work, and the facilitator reflected their comments that this collective strategy contains a potential for matwòns to truly transform their experience of serving women in childbirth in their resource-poor setting.

In chapters four and five, I have described the experiences of Haitian matwòns who attend births in situations of high risk and resource-scarcity. The Open Space meeting reported in this chapter provided the opportunity for matwòns to begin forming new strategies, collectively, rather than individually. The new strategies brainstormed in this meeting were: 1) to organize professionally enabling them to; 2) to seek out or demand government recognition and support for their work; 3) to create a communal space where they could bring women to give birth; and 4) to engage in ongoing training. Goals two through four were formulated within the overarching plan for professional organization. Through their intention to organize and create solutions collectively, matwòns' individual mitigation strategies were bolstered as well.

Phase III: Reciprocal Ethnography

My final method of data collection involved a group meeting where I reported my preliminary findings to study participants and requested their feedback on my

interpretation of their narratives and Open Space discussions. This method, termed reciprocal ethnography, provided matwòns with the opportunity to play an active role in representing themselves (Lawless 1992, Green and Thorogood 2004). I began this session by inviting them to listen and to respond to me present my initial findings. I reminded them of the dynamic I described in my initial recruitment presentation by explaining once again that I was a student in Haiti, and they were the experts instructing me on the topic of matwòns' life and practice. In this way, I hoped that participants would share the responsibility of ensuring accurate interpretation of their stories.

First, I presented to the group of participants my initial findings from personal interviews (phase I), which included the challenges and mitigation strategies reported in the chapter four. After that, I paused and asked them to respond with clarification, correction, or confirmation. Many matwòns nodded in agreement, and several made affirmative statements. When I asked again for correction or additions, they offered none. Next, I presented my initial findings from the Open Space meeting (phase II), which I formulated from the documents produced by each of the four small groups in that day's meeting. Little interpretation, if any, was added to this part, since matwòns' own thoughts had been collected and recorded clearly and freely of their own accord in the small groups they formed during the meeting. Again I asked for clarification, correction, or confirmation, and was answered by one matwòn who wanted to add a point to the list of conditions they wanted to demand of the ministry of health. She felt it was important for matwòns to be issued uniforms so that when they die they could be buried in them and so be recognized for their profession. When I asked again for corrections or additions, I was met instead with a round of applause and cheering. One matwòn called

out that I had learned well, and that they considered me to be a good student. I responded by assuring them that they had been good instructors for me by sharing their experiences openly and truthfully.

At that moment, and as I have reflected on it since that time, I was/am aware of limitations in that method. For one, there remains a risk of positive bias, where because I am a foreign (wealthy, educated, white) researcher, they may choose to report what they think I want to hear, in order to remain in good graces with the person who holds multiple positions of relative power. Additionally, because this session was not structured as an Open Space meeting, there was greater likelihood of "natural" group dynamics emerging, in which louder, more confident, or more respected members of the group may have ended up speaking collectively, while dissenting voices may have remained silent.

Despite these limitations, however, I remain fairly confident that my findings are reliable for several reasons. First of all, the efforts I made to subvert power dynamics by declaring them the experts seemed to be met with genuine approval and agreement. In recognizing the truth of that dynamic (my unknowing, and their expertise), many matwòns seemed to take seriously the task of educating me. Many of them spoke slowly and directly, often with a finger in my face, gesturing, questioning my understanding, all with the apparent aim of relaying their perspectives and information accurately. There were many times when I did not understand a cultural reference or had a question about the basic workings of a social construct, and in those instances different matwòns took time in their interview or outside of it to give me a mini-lecture on how those particular dynamics were understood in Haiti. Because I had experienced a number of such encounters throughout the course of my fieldwork, and because the group of matwòns as

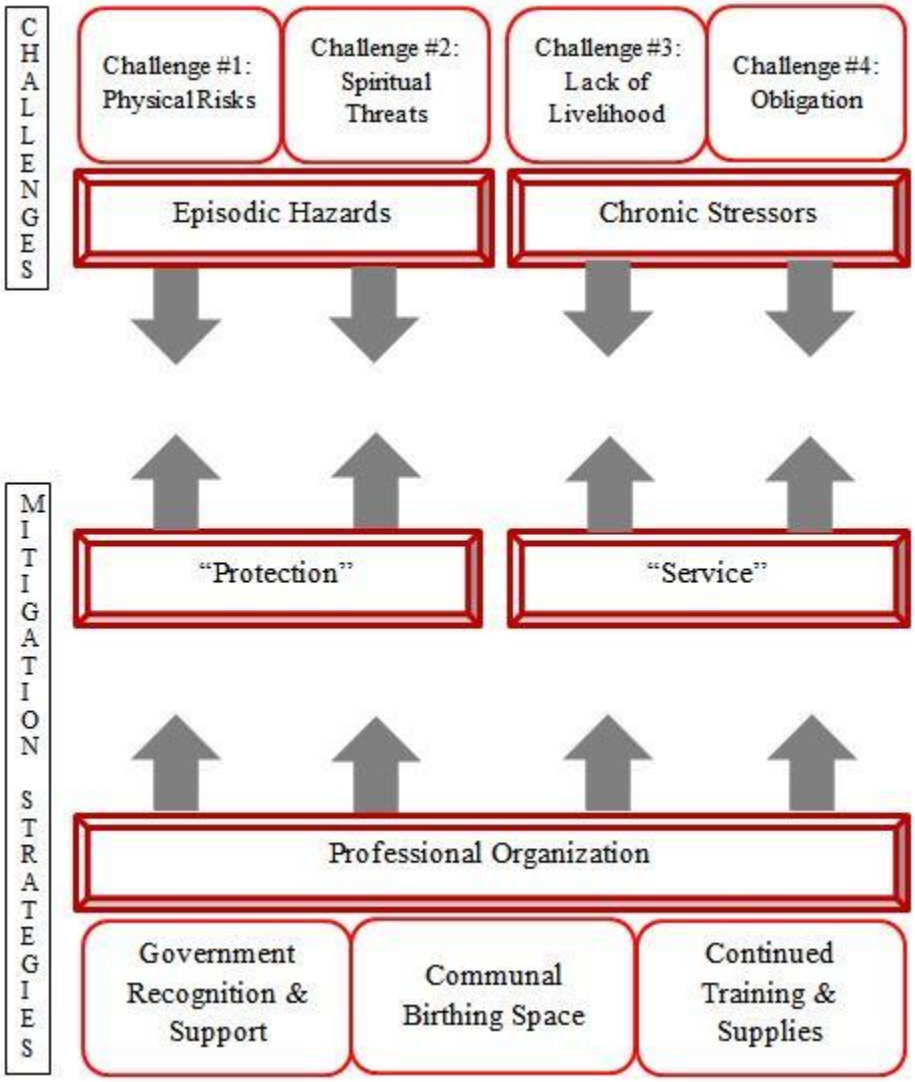
a whole had engaged so actively and enthusiastically in the Open Space meeting, I felt confident that they would have spoken up if any of my reported findings had struck them as fundamentally misconstrued. Also, because one matwòn felt free to make an addition to my report, I felt confident that others would have offered their own suggestions had there been glaring omissions in my findings.

One additional way I sought validity and reliability in my findings was through the exploration of counter-examples (Charmaz 2006). The one matwòn, (Ti Paul) who was atypical of my sample population for his level of education and his international travel experiences, as well as his fluency in several languages (including French, Spanish, and Arabic) could have provided a dissenting opinion of the challenges named by other matwòns. On the contrary, however, Ti Paul not only concurred with many of the points made by other matwòns, but he also went to great lengths to explain to me why certain social dynamics existed in Haiti alone. In recounting his path to becoming a matwòn, he explained that in Cuba he learned the botanical properties of plants, but only in Haiti could he learn the mystical properties of the same plants. In Haiti alone, he contended, did magical practices shape social realities, including the threats faced by matwòns, such as being declared a *lougawou*. Ti Paul provided me with an in-depth introduction to the ways the religio-cultural complex of Vodou shapes the work and social positions of matwòns.

In the two preceding chapters, I have described matwòns' individual and collective responses and stories, dividing their narratives into the challenges of their work and their strategies to mitigate those challenges. In the following chapter, I discuss my interpretation of these results.

Chapter 6: Matwòns as Postmodern Midwives?
Discussion

To explain how the themes I have identified and described relate to one another, I offer the following interpretive schema (Figure 1).



The two mitigation strategies, based on emic terms, address the two broad groups of challenges, which are further divided by type. The challenges referred to as episodic dangers, which include physical risks and social/spiritual threats, are both treated by receiving and offering protection. The challenges relating to the longer-term stressors of managing livelihood and obligation share the response of treating work as service. Furthermore, the individual mitigation strategies meant to contend with the whole host of challenges are potentially undergirded by the group's collective efforts to ameliorate their living and working conditions through the primary approach of professional organization.

While I have chosen these categories because I consider them to be instructive as we seek to understand the experiences of matwòns, I am aware that they are, in many ways, arbitrary. Any attempt at interpretation, especially the task of creating a visual schema, is a process of putting boxes around a wide spectrum of professional and personal experiences. Because the experiences matwòns shared with me are dynamic and interact on many levels, any grouping into categories simplifies a concept that is in reality much more complicated. The conceptual groupings of themes in this schema are thus best understood as bounded by semi-permeable membranes where challenges and mitigation strategies ebb and flow according to an ever-changing array of context-specific factors that matwòns must navigate.

Nonetheless, this grounded theory schema is helpful for several reasons. First, the themes of challenges represent those issues reported by matwòns to have the greatest effect on their work. I have further grouped them as "Episodic Hazards" and "Chronic Stressors" in order to represent more specifically how matwòns experience those challenges. Moreover, the broad mitigation strategies are expressed in emic terms, and so

offer a reflection of matwòns' own perspectives on how they approach the work of attending homebirth in a Haitian context. These various categories of analysis represent the co-creation of researcher and study population (Charmaz 2006) and offers a multi-faceted vision of how matwòns engage their work. In addition, the directionality of the schema represents the flow and force of energy, both structural forces and individual agency, as enacted through the encounter of specific struggles and mitigating or coping with them. The challenges can be understood as heavy burdens that weigh on matwòns as they work and struggle to live. Individually, matwòns counter that weight with their own, individual mitigation strategies. No single matwòn employs every possible strategy, but there is considerable overlap among different matwòns' approaches. Interviews with matwòns, in which they shared their individual experiences, impressed upon me the tenuousness of their life situations. Several matwòns expressed a desire to discontinue their work, yet felt social and spiritual pressures to continue. The possibilities matwòns explored for collective action in the Open Space meeting added another level of strength to counter the weight of challenges, a group effort to lay a foundation upon which matwòns might stand as respected professionals.

Complicating "Traditional Birth Attendant"

The complexity of these themes illustrates the distinguishing bio-social and political-economic realities of Haitian matwòns. Though they share certain similarities with other Haitians and other traditional midwives, their particular place and work in the world is not represented in any scholarship on Haitian women, traditional healers, or on Traditional Birth Attendants (TBAs). For this reason, I return to Pigg's (1997) work on TBAs in Nepal discussed in chapter two. Pigg's research focuses specifically on the

problems inherent in the training of TBAs, though her insights are relevant for anyone seeking a broader, ethnographic view of matwòns. Pigg identifies several "issues of translation" that occur when development agencies create and enact programming for TBAs. The first is the problem of identifying who exactly "counts" as a TBA. Are matwòns necessarily TBAs, by the fact of their attendance at births? Development agencies may have a different answer than the matwòns themselves. This point was aptly revealed by Ti Paul, a matwòn whose experience with formal education gives him a valuable comparative perspective, when he informed me (as reported in chapter five, page 71) that he "*had a chance to study [becoming a] traditional birth attendant, [which is] not really a matwòn*." Though he did participate in the TBA training and incorporate into his practice things that he learned there, his comment points out that the skills imparted by training programs do not address the comprehensive work of matwòns. His point speaks directly to another of Pigg's issues of translation – that is, the "problem of relating a medical model that views physical processes as divorced from social contexts to other conceptualizations of well-being and illness" (1997: 234-235). Matwòns' descriptions of their work privilege the social context and local notions of risk and illness states, to the extent that a strictly biomedical view of their work misses many of the ways that matwòns function in Haitian society.

As the findings of this study illustrate, the challenges matwòns face are extensive, and go far beyond a simple lack of scientific knowledge assumed by proponents of TBA trainings. Instead, those challenges are the products of social constructs that have everything to do with Haiti's place in the world as it has been constructed and reconstructed for over 500 years. This study constitutes the first of any published

literature to seek out matwòns' perspectives, while also offering a structural analysis of the conditions of their work. It lays a foundation for understanding the role of matwòns in the realm of maternal health in Haiti, as well as their relevance in the larger discourse on traditional birth attendants.

Mutual Accommodation

When matwòns discussed their life situations and professional struggles collectively in the Open Space meeting, they recognized the value and necessity of their work, and made assertions that strongly resemble Jordan's 1978 (1997) call for mutual accommodation of knowledge systems. Jordan describes a system in which different practitioners work in conjunction, with respect for their different approaches, complementing care as needed. Matwòns envisioned a similar scenario for improving the effectiveness of their work. They did not express desires to become biomedical practitioners, nor for biomedicine to be eliminated from Haiti. Instead, they expressed desires for their skills to be recognized by biomedical practitioners and the ministry of health, and for the opportunity to collaborate with the biomedical system so as to safeguard the lives and well-being of mothers and babies. The binary options for childbirth, either to get to the hospital or clinic, or else stay home with a matwòn, does not fit the spectrum of needs experienced by birthing women, which include needs for clinical/physiological *and* social/spiritual support.

Cultural-historical and political-economic factors in Haiti have created locally-specific approaches to maternal health. Thus, for women's birthing needs to be adequately addressed, strategies must take into consideration local realities and meanings, as well as make available whatever biomedical techniques and interventions are helpful

and desirable to birth practitioners and to birthing women alike. In the case of Haiti, those with the greatest responsibility are matwòns, who attend a vast majority of births.

Biomedicine, even when appropriately applied, can only address a portion of the issues that present when women give birth in Haiti. The way in which the construct of obstetric care is imported through stove-piped "humanitarian" aid produces a patchwork health care system that still denies access to the majority of birthing women in Haiti. Furthermore, proponents of a strictly biomedical health system feel justified in discrediting the longer-standing, "traditional" health system in which matwòns practice (Kruske and Barclay 2004, Pigg 1997), because of the hegemonic status of biomedicine as authoritative knowledge (Jordan 1997[1978]) and its assumed superiority and efficacy. For this reason, mutual accommodation is especially important in the field of maternal and child health, where practitioners of different health systems work towards the common goal of safeguarding childbirth in Haiti.

"Postmodern Midwives"

Drawing from her work around midwifery systems in a number of different countries, Robbie Davis-Floyd conceptualizes how midwives in various localities have become adept at navigating different birthing systems, and so are able to practice "at the inter-section of various cultural domains" (2007:708). She calls such practitioners "postmodern midwives," and asserts that the term can apply to professional midwives in high-income/more-industrialized nations as well as to what she calls traditional midwives (otherwise known as TBAs) in lower income/less-industrialized nations. The hallmark of a postmodern midwife is that she incorporates the most salient techniques of the knowledge systems operating around her to produce and preserve a midwifery practice

that is women-centered and meaningful. Where modernity grants authoritative knowledge status to all things biomedical, the postmodern midwife resists the lure of the hegemonic. Thus, according to Davis- Floyd (2007:707), the postmodern midwife possesses the following qualities:

- An informed relativism that encompasses science, traditional midwifery knowledge, professional midwifery knowledge, and complementary or alternative practice systems
- Local, global, and historical awareness
- Cultural competence
- A sense of mission around preserving midwifery in the interests of women
- A sense of autonomy as practitioners
- Dedication to the midwifery model of care in its humanistic and transnational sense and to midwifery and women's health care as social movements
- Political engagement, including work with governmental authorities and participation in local, regional, national, and international organizations

My findings suggest that Haitian matwòns currently possess parts of all of these qualities, and also that matwòns' recent plans for professional organization, which grew out of the Open Space meeting, have the potential set them on an alternative path around modernity, to arrive at a postmodernity that fits the Haitian context in which they work. However, this course is unlikely to look exactly like Davis-Floyd's postmodern midwives as observed in other settings.

I begin my analysis with the point on which Davis-Floyd places the greatest emphasis -- informed relativism in relation to science, traditional midwifery, professional midwifery and complementary or alternative practices. Any attempts to gauge the relativism in matwòns' relationship to science must be based on an understanding of the ways in which matwòns have either been denied access or experienced significant obstacles to formal education, and thus their scientific understanding of biomedical knowledge is limited. *Informed* relativism can only be based on an awareness of all the options, and yet, given that all knowledge is partial and situated, I argue here that matwòns display a degree of relativism that demonstrates their critical thought and agency in the practice of attending childbirth. Thus, while the issue of matwòns' attitudes towards science is not one I addressed directly in my research questions, I did hear numerous descriptions of matwòns' relativistic practices, using "scientific" practices alongside of or alternatively with their "traditional" practices. This finding echoes those of both Farmer (1988) and Singer (1988) in two different studies examining the health-seeking behaviors of Haitian women experiencing culture- bound reproductive illnesses.

When I first met the matwòns in this study, they had already asked visiting midwives from North America to teach them how to read blood pressure, knowing that that skill could help them identify the women who were developing pre-eclampsia and so were at greater risk of seizure in labor. They knew that biomedicine had techniques and equipment that could help them, and yet, they maintained many of their own traditional practices to treat headaches or seizures when they were unable to access medical resources. When their work involves the risk of disease, matwòns were adamant about protecting themselves with the barriers (including gloves, glasses, boots, and extra

clothing) they learned to use in the matwòn or TBA training courses, *and* they simultaneously sought spiritual protection, based on their understandings both of germ theory and of the potential spiritual etiology of disease. In addition, matwòns utilize "traditional," "complementary or alternative" knowledge systems when they are called upon by their communities to treat illness states not recognized by biomedical doctors, even those born and trained in Haiti (Farmer 1998, Singer 1998).

When their patients *were* able to access medical care, matwòns showed themselves to be receptive to the benefits it could offer. Several matwòns described instances of collaboration with biomedical doctors when they could access them. However, much of the time matwòns are left to deal with complications on their own as medical care is often inaccessible. In this way, matwòns can be seen to have a selective use of biomedicine, seeking it out for some cases, but handling difficulties on their own when they either have traditional treatments to try or when access to medical care is impossible.

In addition to biomedical practices, matwòns valued their own herbal remedies, which could be seen as both traditional knowledge and complementary or alternative knowledge systems. Though the doctors and nurses at training courses admonished matwòns never to use their herbal remedies, matwòns confided in me that they used them anyway, both because they received spiritual guidance telling them which leaves to use, and because the leaves were effective, sometimes more effective than pills, they claimed. Matwòns used their traditional herbs to ease labor pains, for example, or to strengthen contractions when a mother became exhausted. Matwòns' comments did not reveal a preference for pharmaceuticals over herbal remedies, but rather a criticism of the power

and authority medical practitioners assumed by attempting to limit matwòns' scope of practice. The matwòns who participated in this study demonstrated an understanding of the ways that different knowledge systems address the same condition, and also their pragmatic willingness to use whatever system would allow them to best serve the needs of birthing women.

While matwòns unanimously expressed a desire for greater and continued medical training, they also expressed the desire to pass on their own skills, including manual techniques and herbal knowledge, to future matwòns. This desire again demonstrates an informed relativism regarding traditional midwifery and complementary or alternative practices. It demonstrates their value of multiple knowledge systems (scientific and traditional), and also their ability to use the two in conjunction, rather than one in subordination. In this way, matwòns could be considered bi-cultural in their ability to deal both in biomedical and ethno-medical terms, which they do depending on the setting.

The degree to which matwòns displayed informed relativism towards professional midwifery knowledge went through a dynamic transformation in the course of my research. When I first conducted most of the individual interviews, matwòns only described a professional identity when they spoke of the matwòn training they attended and the responsibility it bestowed upon them as individual practitioners. However, when the matwòns in this study met for Open Space, they initiated a professional organization in which midwifery knowledge would be shared and perhaps eventually standardized. Their plans to create communal birthing space would provide a means for that process to occur. Therefore, the degree to which matwòns in this region possess professional

midwifery knowledge may be evolving, with the potential to increase significantly where matwòns organize themselves professionally.

Davis-Floyd's notion of informed relativism is only partially apt for matwòns, or for any midwives practicing in resource scarcity, which describes the majority of birth practitioners (or TBAs) in the world. Where midwives are poor and face tremendous challenges of poor health in the populations they serve, they also have limited access to education and to medical care. This scenario does not allow for fully informed relativism where midwives' options are so constrained. Because of this, I see Davis-Floyd's postmodern midwifery as a possibility only for those privileged enough to make choices about which health system they use in specific instances. Nevertheless, Haitian matwòns provide an interesting critique and example of postmodern midwifery under the constraints of structural violence.

"A sense of autonomy as practitioners," another one of Davis-Floyd's characteristics of postmodern midwives, does describe how matwòns practice, if not their desired mode of practice. The matwòns in this study practiced autonomously for a combination of reasons, the primary one being that because they serve a population with substantial unmet health needs and receive only minor recognition from the ministry of health, they practice without the benefits of formal employment enjoyed by other health professionals. Therefore, it is important not to conflate matwòns' lack of access to resources with a romanticized notion of autonomy. Instead, their autonomy is, in large part, constrained by the poverty that limits the ways in which they can practice. One idea matwòns named in Open Space for achieving greater autonomy was to have their own communal space to practice birth. In such a space, they would have greater control over

how they can treat issues that arise, including the ability to access medical care more easily than when they attend births alone, far from necessary resources.

"Dedication to women's health care" is easily demonstrated by matwòns' willingness to provide "service" despite personal risks and costs, yet the extent to which they view it as a social movement (Davis-Floyd's qualifier) is not addressed specifically in this research. Matwòns expressed their dedication as a desire that women and babies should not suffer or die, and in that sense, their commitment seems to be born out of necessity. However, matwòns' collective response to the necessity of their work highlighted the value they place on the care they provide, illustrated in a desire to train younger matwòns. Further research on matwòns' possible perceptions of their work either as cultural critique or as a social movement would be illuminating, especially for those engaged in programmatic planning involving "TBAs" in Haiti.

When Davis-Floyd specifies a dedication to the midwives model of care "in its humanistic and transnational sense" as a defining characteristic of postmodern midwifery, she may be excluding from view traditional midwives who do have personal or social/cultural standards of humanistic care, but who don't define that care in response to the dehumanizing practices of biomedical obstetrics. Similarly, Davis-Floyd's "sense of mission around preserving midwifery in the interests of women" presumes options in maternity care which may be made on the grounds of humane treatment or other qualitative preferences. This is not often the case in Haiti, neither for matwòns nor for birthing women. Matwòns in Haiti currently function in a place of necessity, and yet they make qualitative choices about the care they provide within the realms of their agency.

The final characteristic of Davis-Floyd's postmodern midwifery -- "political engagement, including work with governmental authorities and participation in local, regional, national, and international organizations" – is highlighted in matwòns' action items from the Open Space meeting that included multi-level plans for political engagement, mostly in relation to Haiti's own ministry of health. Ti Paul, who had experience in other forms of political organization also shared with me his plans to form, not just a local association of matwòns, but also a regional coordination of local matwòn associations across north central Haiti. Beyond that, matwòns named an interest in forming a relationship with midwives in the United States. In these ways, matwòns are poised to be postmodern midwives, despite their marginalization and limited access to resources.

The methodology of this study revealed and accommodated the dynamic nature of Haitian matwòns, who were constantly responding to their changing world. The challenges they named include those unpredictable and episodic hazards that pose both physical and spiritual risks, and well as the chronic stressors of unending work without a supportive livelihood. This host of challenges can be seen as the current and even random daily struggles of life in Haiti, as well as the product of five hundred years of structural violence. Matwòns described meeting these challenges in a multitude of ways, many of them based on individual strengths or convictions. Additionally, Open Space revealed a potential energy in the group that proved ready to take action to lever these challenges as an organization of professionals. Their individual strategies to mitigate challenges can be powerfully bolstered by the efforts of the collective. And yet, the future remains uncertain as to the path matwòns will chart

Ch. 7: Conclusion
Matwòns as Exceptional Experts in Self-Determination

To conclude, I return to Davis-Floyd's characteristic of the postmodern midwife as one with "local, global, and historical awareness," because matwòns' awareness of their "place in the world" goes beyond midwifery to include illuminating critiques of the current world order. Data from interviews and participant observation indicate that matwòns are well aware of the specific challenges they face in Haiti, as well as the specific skills they have to meet those challenges. Ti Paul began our interview by making sure that I was paying attention, with no preconceived notion that because I have practiced midwifery in the U.S., that I know anything about the realities of attending childbirth in Haiti: "The Haitian matwòn and the American matwòn, very different. OK?"

Ti Paul was also the person to give my family and me a guided tour through Bwa Kaiman, the site of the historic meeting of slaves that sparked the revolt-turned-revolution that won Haiti its independence. He was not the only person to mention its significance though. Many Haitians I encountered, including some matwòns, emphasized the importance of their history as a self-liberated slave colony. Though some Haitians claimed this to be a particular identity of those living in the north, Haitian scholarship indicates that this phenomenon is not limited to one region of Haiti (Dubois 2012, Farmer 2003), as illustrated in the claim by Charles (2002): "The awareness Haitians have of the exceptional circumstances in which their nation was born and how they became a people shapes their view of themselves and of their place in the world" (116-117). As I wrote fieldnotes by lamplight at night, the oldest daughter of the family we lived with recited the details of the gathering at Bwa Kaiman and the revolution that was to follow as she

studied for her school exams. Those facts of history help to create a Haitian identity that is not belittled by the poverty of the present moment.

Yet, paying close attention to the dangers of "Haitian exceptionalism" – the idea that Haiti is singular, unique and defies all comparison or even analysis – as exposed by Michel-Rolph Trouillot (1990a) and built on by more recently (Charles 2002, Dash 2008, Schuller 2007, Ulysse 2012), means that while it is important to name those historical peculiarities that make Haiti, in one sense, unique, it is also important to note what experiences matwòns may share with traditional midwives, healers, or peasants in other low-income, post-colonial, Caribbean or Latin American societies. The one previous ethnographic study of TBAs, conducted by Low et al. (2006) in rural northern Honduras, suggests that matwòns do face some circumstances similar to another resource-poor setting. When matwòns engage politically, especially in international organizations of midwives, they will likely find themselves included in regional Caribbean identities, as well as sharing similarities with midwives from around the world.

This study has sought to describe the processes by which Haitian matwòns encounter and attempt to mitigate or manage the challenging conditions of their work in a particular locality, both individually and collectively. Anthropology as a discipline, using the tools of participant observation, offers "thick" description (Geertz 1973) of the peculiarities of people and place. I have focused my attention on the work of matwòns in Haiti with an awareness of the pitfalls of looking for singularities; and yet, to the extent that the cultural and historical context of Haiti defines how they identify themselves, I contend that their local, international, and historical awareness qualifies them to determine their own solutions to the specific challenges they face.

Therefore, I employ the term "exceptional" to describe matwòns' situated knowledge and lived experiences as informants in the wider discourse around TBAs, traditional medicine, and maternal and child health. Matwòns are exceptional experts in each of these fields as they exist within Haiti, and also as they exist in the region, and the world. Only matwòns can speak from a place of cultural competence in Haitian homebirth, and so they offer exceptional expert knowledge for addressing the needs and concerns of birthing families and homebirth practitioners in Haiti.

Based on this understanding of matwòns' situated knowledge and function in Haitian society I make the following recommendations: First, I propose greater support and advocacy for matwòns professional organization. The purpose of this support is the self-sufficiency and self-determination of matwòns, which I consider one of the highest goals in any sort of development work, not only because it ensures contextualization and local participation for any project, but also because it pays respect to those who experience structural violence. Matwòns themselves are best able to inform and lead the solutions to the problems they face. Currently, the matwòns who participated in this study are actively addressing these needs among the group, forming a professional organization that has already offered its own continued training for its members

Secondly, because matwòns attend 75% or more of all births in Haiti, it is important that they are recognized as the practitioners with the best understanding of the challenges birthing women face. Therefore, matwòns need to be included in the wide array of maternal health programs in Haiti. Doing so would require innovative methodology, as was utilized in this study, to accommodate varying degrees of literacy,

as well as to address the power differences inherent in any interactions with foreign personnel.

Finally, further ethnographic research will illuminate not only the details of the challenges to maternal health in Haiti, but also the resources possessed by those serving on the front lines, that is, matwòns themselves. Because the role and practices of "traditional birth attendants" are local specific around the world, ethnographic research is a necessity in every place where foreign or even national efforts are made to improve maternal health.

As an applied anthropologist, I continue to seek ways to advocate for the self-determination for this population of childbirth practitioners, not so that they can be free of critical analysis within their ranks, but so they may be recognized for the work that they do and be given the respect and mutual accommodation that can improve their work from that of a fragile job, to work that strengthens their profession, as well as the women, babies and families they serve.

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