Death of a Midwife

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"*Shaifa al-awlad di kullaha?*" Um Ali all of a sudden asked me, "do you see all these children?"[1] We had been comfortably leaning out of Um Ali's first floor window in the community of El Tayibin, in Giza, the western part of metropolitan Cairo for the last fifteen minutes when Um Ali, immersed in watching some children in the alley had addressed me with this question.

"All these children that you see down there in the alley," she answered her own question, "I have brought them into this world. I know them all, their names and their mothers. This is what I have done for all my life," she added.

When I first met Um Ali in 1989 she was living and practicing midwifery in El Tayibin. In her late 50s, Um Ali lived alone in a room in her late husband's family's house. Her daughter was married and lived in Bulaq Al-Dakrour. The daughter, her husband and children frequently came to visit Um Ali. Her son had been working in an Arab country for many years and she only occasionally heard from him. Sometimes Um Ali hosted her nephews from a provincial town, when they came to Cairo to study, to look for work or for other purposes. Um Ali's days were busy: when not called for assistance in birth and matters related to her work, she was visiting her many neighbors, friends and relatives in El Tayibin (and sometimes beyond). She maintained an extensive and dynamic social network, and wherever we went together, she was received with the utmost of respect and friendship. In many social gatherings she was the center with her warm and humorous personality and sharp mind. Drawing on her experiences as a midwife she had many stories and anecdotes to tell.

The community of El Tayibin is one of the older villages in central

Giza that had been engulfed by and become part of the modern me tropolis many decades ago. It shares features with many other low-income urban neighborhoods in Cairo where people work hard to make ends meet. El Tayibin is far from being internally homogenous, families of eight sharing one room in an old dwelling live next door to residents of small modern apartments in recently rebuilt concrete and brick buildings. Small scale street vendors, successful car workers, occasionally employed unskilled workers, migrant wives, small government employees and poor old widows live next to each other, and with each other in El Tayibin.

In decades of devoted midwife practice Um Ali had established an excellent reputation in El Tayibin and beyond. Sometimes she was called to attend births in the more prosperous and newer neighborhood of Sharia Al-Tawil, located at a close distance to El Tayibin. Similarly, she was asked for her services in the newer so-called informal neighborhoods around the old villages of Bulaq Al-Dakrour, Saft Al-Laban or Moatamdiya west of the Upper Egyptian Railways. Many of the younger generation – like Um Ali's daughter – from El Tayibin had moved there as space became scarce in the old community.

Residents of El Tayibin frequently praised the work of Um Ali, her expertise, and the special care and attention she gave to the women who sought her help[2]. In the early 1990s, however, Um Ali had to slowly withdraw from her work as her health increasingly failed her. For a while she only followed calls from people whom she knew particularly well, families with whom she had worked for decades, or those who simply lived nearby. Eventually she had to give up even those obligations. As she slowly retired there was nobody in the community to take over her position and women were forced to either go a much longer way to find a *daya* (midwife) like Um Ali, or to give birth in hospitals in the surrounding area, whether they liked those or not.[3] Um Ali died in 1994. Um Ali's death constituted a turning point for her community and those elsewhere who had relied on her services, as she left nobody to follow her and take over her work. Many women greatly regret the fact that there is no longer a *daya* like Um Ali close by to consult. The death of Um Ali and the end of *daya* practice in El Tayibin is not an isolated phenomena or an odd local coincidence but is representative of the larger trend of marginalizing

and eliminating the practice of *dayas* and its larger context of time-honored popular female wisdom.[4]

Examining the experiences of Um Ali and other midwives in El Tayibin over the last century, I will illustrate aspects of midwife practices, and the slow disappearance of midwife services. I will analyze these developments within the context of transformations within a larger medical, social and cultural context. The work of a *daya*, the way Um Ali and many like her practiced it, was not merely a "professional" activity but was deeply embedded in a social and communal context. This, of course, was a very specifically female context. Um Ali's ways of work and times of work were immensely flexible and highly individualized in their social and economic aspects. Her scope of expertise and activities went far beyond pregnancy and childbirth and extended to a multitude of other aspects of reproductive, sexual and child health. Women and families who consulted and asked for her help knew her capabilities.

Hence not much needed to be said and she was discreetly called upon when need arose. This smooth and discrete practice of *dayas* created a perception that they stood outside the control of authorities, and hence were increasingly perceived as offensive to the rationalities of modern institutionalized medicine.

Starting from the early 19th century existing forms of midwifery in Egypt had come under attack from nascent western medical models and the emerging modern state. From the perspective of institutionalized modern medicine, existing forms of midwifery came to be viewed with contempt. Midwifery practices were labeled irrational, backward, ignorant and even dangerous. Taking the example of the midwives of El Tayibin, I will show that midwifery practices were none of the above. Instead, midwives were skilled practitioners who offered a large scope of physical treatments and social services.[5] In order to place the work of Um Ali and her predecessors, I will first introduce the community of El Tayibin.

El Tayibin

In the 1870s Princess Fatma Hanem, a daughter of Khedive Ismail, was endowed by her father with an estate in the lavish countryside on the western Nile bank opposite the city of Cairo. Surrounded by

fields, the estate attracted or recruited a number of peasant families who settled in a cluster of houses outside the gates of Fatma Hanem's palace.

Um Ibrahim, a sixty-year-old residents of El Tayibin whose family has been settled in the community for three generations remembers accounts she heard about the early history of the community:

> The community of El Tayibin has not always been in the same place. A long time ago it was down by the main street, where the small mosque still is today. When Fatna Hanem was still alive, she used to live further down from there in her palace. When she was leaving or entering her estate with her carriage [*hantour]* she had to pass the old *ʿezba* [village]. Driving by there, she was frequently bothered by village children. The children took great pleasure in running after the splendid royal carriage, which was drawn by eight beautiful horses, and was often announced and flanked by footmen dressed in white and red. The noisy and mischievous children annoyed Fatna. One day a child was hit by the carriage and injured. This incident convinced Fatna that it was better to move the community away from her driveway. Subsequently she selected forty families and gave them an entire feddan of land, divided into forty equal lots, at a short distance from the old *ʿezba*. Forty houses were built in four identical alleys. Only the old mosque remained in the place where the *ʿezba* had originally been.[6]

The resettlement of the forty workers and their families in the new community dates back to about 1915. From a cluster of houses the workers/peasants were moved into a modern model village. Contained in four alleys, each with ten one family dwellings, the peasants were to fulfil the new role of an orderly and productive peasantry in a modern nation. Fatma Hanem had joined the ranks of landowners who were entertaining and debating new ideas of workers' housing, productivity, order and hygiene, and were experimenting with the latter's implementation. Alleys should be regular and accessible, and the community as a whole orderly and conveniently supervisable. The forty houses were assigned to forty nuclear families.

Among those given a house in the model village were Sitt Khadiga, her husband Hassan Yunis and their five children, the youngest of whom was only one year old. Their oldest daughter, Um Soliman was already married or about to get married and together with her husband

was assigned another one of the forty houses. Sitt Khadiga had been born in the early 1880s in a village in a rural province. There she had learned midwifery from her mother who had practiced in the village. Later Sitt Khadiga and her husband moved to Fatma Hanem's workers village. Sitt Khadiga took her skills to the new community and continued to practice there. In addition to working as a midwife, Khadiga also worked in Fatma Hanem's palace. Sitt Khadiga was immensely respected as a midwife in El Tayibin. Even today, fifty years after her death, older people fondly remember her and praise her excellent work.

In the 1920s residents from a small community further east, on the Nile front, had been removed from what had turned into prime real estate, and were assigned land adjacent to the forty houses of El Tayibin. At the time El Tayibin was an agricultural village surrounded by a lush landscape of fields and orchards.

The new neighbors had brought with them their own midwife, Um Ragab. As long as Um Ragab was alive she worked for her community, as one older man remembered: "She was ours, that's why we consulted her, but when she died we 'took' over Sitt Khadiga and those who came after her."

Over the next two decades the two communities grew together and shared life, experiences and increasingly a communal identity. Sitt Khadiga became the midwife of the new community which now was several times its original size.

In the 1920s most of the original families of El Tayibin engaged in agriculture. Yet, with the rapid expansion of modern Cairo to the west bank, agricultural land became scarce and some men started to work as guards, gardeners and helpers in the new neighborhoods and institutions. Others took up work across the Nile in Cairo. El Tayibin slowly integrated into metropolitan Cairo and by the 1950s the agricultural community became an urban low-income neighborhood.

Midwifery and the Midwives of El Tayibin

The skills and practices of *dayas* were extensive. They included anything related to pregnancy and childbirth, infant care and infant health, ear piercing, assistance in wedding nights, the administering of *subu's* (celebration of a birth after seven days), female circumcision and

occasionally abortions. The *dayas'* expertise included herbal and other remedies. Some aspects of their practice were performed discreetly and behind closed doors. Um Zaki, a sixty-five year old resident of El Tayibin described details of the practice of *dayas* in the past:

> Sometimes a servant girl who worked in a rich household [*and al-bashawat*] might have gotten in trouble with her employer. She could go to a *daya* who might get rid of the fetus. I remember a case in the village where my sister lived. Their *daya* took in a servant girl to whom such a thing had happened, and treated her. The girl had nowhere to go, so the *daya* pretended to the villagers that she was a distant cousin who had come to stay with her. Eventually the *daya* was even able to marry the girl to a decent man in the village.

The scope of *dayas'* practice was deeply embedded in female social ties and networks. A good *daya* could save the life of a girl or woman in more than one way.

Sitt Khadiga taught two of her daughters, Um Soliman and Um Hamid, the skills of midwifery. The three women practiced in El Tayibin and in the emerging modern neighborhoods in the vicinity of El Tayibin. In the 1930s, the neighborhood scheme of Sharia Al-Tawil was laid out. Yet, it took almost two decades to completely fill in with small apartment buildings. The neighborhood was largely inhabited by the new Egyptian middle classes of bureaucrats and professionals. Based on their excellent reputation, the clientele of Sitt Khadiga and her daughters expanded. Many women in the new middle class neighborhood preferred the established wisdom and all-female supportive environment that marked the practice of a *daya*. Despite their position in the new cityscape and the availability of modern hospitals, these middle class women maintained their faith in the practice of *dayas*. In the case of Sitt Khadiga and her daughters, ideas and practices radiated outward from El Tayibin appropriating momentary spaces in the modern city. Sitt Khadiga and her successors found open (front) doors in the new environment and moved in its streets as respected practitioners while some of their male neighbors, in contrast, were "conscripted" to the new cityscape as workers and helpers.

Despite efforts by the colonial state to formalize and control medical practice in general and midwifery in particular, Sitt Khadiga and her daughters continued practicing relatively undisturbed in El Tayi-

bin and beyond, until the middle of the twentieth century. Um Ali and others recounted that around the middle of the century, an official decree was issued specifying that only licensed midwives were allowed to assist births, and, more importantly, to register births. Licensed midwives were equipped with a record book (*daftar*) where they officially registered births. Such measures to license and supervise *dayas* were elements of a long chain of developments that aimed at limiting or eliminating the practice of midwives. For an understanding of the course of events in the lives of Sitt Khadiga and her daughters, it is necessary to briefly review these developments.

Midwifery: Attacks and Reforms

Starting from the early 19th century, a rhetorical war was waged against *dayas* in Egypt by Dr. Clot Bey, the French physician who worked under Mohammed Ali starting from the 1820s on the establishment of a modern (military) medical system. Existing midwifery for Clot represented "'old-wives-medicine' with its magic potions, charms, and incantation, and he did everything in his power to undermine her persistent popularity" (Kuhnke 1992: 129).

In 19th century Europe, midwives were losing ground against the emerging dominance of a male bourgeois class of physicians and general practitioners. The integration of existing forms of midwifery into the new medical landscape was of little importance. Efforts to "license, regulate, and instruct midwives" had, for example, been defeated numerous times by the British Royal College of Physicians (ibid.: 220-221, note no. 45). These changes affected developments in places where European influence became increasingly dominant.

Clot Bey realized that if he wanted to include women into his new medical schemes he needed female practitioners. If he ever was to eliminate "old wives practices" he had to produce scientifically trained replacements. Subsequently, he established a school for midwifery.[7] The curriculum of the school aimed at educating *hakimas*, or "doctresses" whose field of expertise was to transcend midwifery to include basic medical tasks.[8] *Hakimas*' field of expertise was similar to the *dayas* yet they practiced under government supervision. The fact that *Hakimas* received their education at the new school, eliminated the continuity of older practices. Nevertheless, their practice, remained

relatively independent and community-oriented. The majority of women, however, continued giving birth under the attendance of *dayas*. No attempts were made in the 19th century to integrate *dayas* into the new governmental health system.[9]

By the turn of the century colonial authorities made hygiene, health and medicine central – albeit ideological – elements on their agenda. Existing forms of midwifery continued being a target for attack and reform. At the same time, midwives were needed as handmaidens in the emerging modern state's efforts at ordering and counting its populace. Only through midwives could statistics about births be accumulated. In terms of medical reform, the colonial authorities did not invest significant sums in either health or health education for the colonized.[10] Women's health is conspicuously absent from the colonial agenda, except that colonizers insisted that it was their task to save women from the "barbaric" treatments suffered at the hands of local midwives (Arnold 1993: 257).[11]

While viewed with suspicion, midwives constituted an essential element in counting the colonized population, and hence needed to be incorporated into the governmental system of control and dominance. *The Egyptian Gazette*, the colonial newspaper, announced in 1906 that a test for midwives was being held at the central public hospital of Qasr Al-Aini (EG 1.6.1906) indicating testing and licensing practices with regard to (European) midwives. One month later, the Gazette published the authorization that was given to one Mme. Susanna Backman "to practice as midwife" (EG 19.7.1906). Midwifery was separated along existing ethnic and power lines with foreign midwives treating the colonizers and Egyptian midwives treating the colonized.[12]

Although the British built hospitals for the colonial population with such technical innovations as an "electric dynamo for lighting" and water pumps (EG 21.1.1904), "native" health remained a lesser concern. Efforts at improving women's or children's health were left to charitable ladies as the following notes illustrates:

> A free dispensary for sick children was opened in Boulac at the new house in Sharia Maatba al Ahlia, near the Cotton Mill, yesterday. Mothers with sick babies may bring them from 8 a.m. till 10 a.m. daily for treatment gratuitously.

This dispensary has been founded by Lady Cromer and is entirely supported by voluntary contributions.

(EG 21.2.1906)[13]

A year later a brief notice in the Gazette about the Boulac dispensary for mothers and children observed that the dispensary is attracting patients from as far as Shoubra, Maaroof and even from the other side of the Nile in Embaba and Giza which is an indicator of the scarcity of such facilities in other parts of the city and beyond (EG 28.5.1907).[14]

Starting from the turn of the century, the gynecologist Dr. Naguib Mahfouz worked on the integration of obstetrics into the structure of the modern hospital of Qasr Al-Aini. In 1904 he started a small gynecological outpatient clinic attached to the hospital (Mahfouz 1935: 77). Soon after "a ward of 10 beds was reserved for Gynecology and Obstetrics" (ibid.: 78). The surgical work was performed by two English doctors while Mahfouz himself was in charge of obstetrics. Dr. Mahfouz and his colleagues appropriated aspects of a field hitherto left to female practitioners.

Nonetheless, *dayas* continued to practice. They still performed most of the births and could not be ignored by the colonial authorities. Again, private initiative preceded official action. In 1912 a committee of British and Egyptian ladies headed by the Khedive's mother was formed to found a Maternity Training School with the goal of improving the standards of *dayas*. Two years later, the school closed for lack of funds (ibid.: 84-85). The Ladies Committee eventually handed over its work to the Sanitary Department which took on the task of opening maternity schools. "By the end of 1932 nine such schools were opened by the Provincial Councils and Municipalities under the supervision and inspection of the Department of Public Health" (ibid.: 85). Courses at the maternity schools for *dayas* lasted six months and the graduates were given "green permits" upon graduation (ibid.: 86). Mahfouz further mentions, but provides no details about the existence of courses for the "old type of daya" that lasted only two to six weeks at General Hospitals where "white permits" were granted upon sitting for exams. He notes, however, that "the Department of Public Health abolished this kind of training on January 1, 1928" (ibid.: 86). Dr. Clot

Bey's School of Midwifery continued to exist but had gone through a number of changes. By the 1930s the school was attached to the Faculty of Medicine. After graduating from the School of Nursing, students attended an eleven months course for the Diploma in Midwifery.[15]

The 1920s witnessed first steps toward the establishment of a larger network of maternal and child health institutions. A special "Child Welfare Section" was created in 1927 within the Public Health Administration which was to run

> a certain number of permanent and travelling Child Welfare Centres in various localities of Egypt and supervise the work of the Child Welfare Centres, the work of the Child Welfare Centres, Children Dispensaries and *Dayah's* schools belonging either to the Provincial Councils or Municipalities. Travelling Inspectresses in the Section are entrusted with the inspection of dayas and their work in the chief towns, towns and villages.
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> (Ibid.: 88-89)

Some travelling centers were eventually transformed to be permanent ones.[16]

Sitt Khadiga and Her Daughters: Precarious Practice

Many of the political and institutional changes had little implications for the practice of Sitt Khadiga and her daughters. They were busy working and made a good living. Um Hamid had been divorced at a young age and left with four children to raise by herself. Her siblings supported her by giving her the right over a water tap in their parental house (the sole tap in the community) from which the family sold water to their neighbors before the community was given public water taps. Um Hamid's practice as a midwife and the (small) income from the water tap, helped her tremendously in raising her children. Her expertise as a midwife allowed her to escape the only other possibility that women of her generation had in term of work: to work as a domestic servant.

Based on their expertise and reputation, the services of Sitt Khadiga and her daughters were in high demand in El Tayibin and beyond. A

decree which specified that only licensed midwives were allowed to perform births and more importantly to register births, however, did affect their practice. Only licensed midwives had a *daftar* (a big official account book) where they officially registered births. A *daya* in a neighboring village had both the license and the *daftar*. As Sitt Khadiga and her daughters practiced, they kept track of their activities and the *daftar* holding midwife came for occasional visits and entered all these birth into the *daftar* at once. The other midwife, of course, charged Sitt Khadiga and her daughters fees for her services.

Um Ali: Legitimate Practice

In the late 1940s, when Sitt Khadiga no longer practiced, Um Soliman and Um Hamid became increasingly annoyed with having to pay a fee to the licensed *daya*. Shorter courses at the maternity schools continued to exist. *Dayas*, usually those with years of practice already, could attend a six months to one year training program whereupon they received a license. The only prerequisites for the course were "good health and literacy" (Simon 1981: 33). After obtaining their licenses, the licensed *dayas* had to attend a refresher course at a Maternal and Child Health Clinic once a year. Yet, neither Um Soliman nor Um Hamid were willing – at midlife and after decades of practice – to sit for training, tests and licensing. Subsequently, they brought in their young niece, Um Ali, who had recently been divorced, to teach her midwifery skills, and, very importantly to send her to the six months training course at the famous Giza hospital of Um Al-Misriyin.[17]

Um Ali was the daughter of Sitt Khadiga's third daughter, whom Khadiga had never initiated into the world of midwifery. Um Ali's daughter was married to a relative from Sitt Khadiga's old village at a very young age and thus had left her mother's house a long time ago. As only a married woman could be trained in midwifery and attend birth, it was impossible for Um Ali's mother to learn these skills from her mother. Returning to El Tayibin a generation later, Um Ali obtained the long-term training provided by her aunts, passed down from her grandmother and great-grandmother, the hospital training, and the desired license. "I received the doctors' bag including even the white gloves," Um Ali insisted, when asked about details of

her training.[18] The doctor's bag and the white glove were a symbol of her legitimate practice and they were frequently referred to by her relatives and neighbors.

Early in her career, Um Ali was working under the close supervision of her two aunts who controlled even parts of her income as their sense was that Um Ali owed everything she was to them. Meanwhile the aunts had escaped the control of the licensed *daya* from down the road and saved the fees they had been forced to pay for her registration services. Um Hamid taught one of her own daughters, Um Hani, midwifery but Um Hani never gained the expertise, nor the official license as Um Ali did. Um Hani did practice midwifery – more as a side line – but eventually moved away from El Tayibin. For many years Um Soliman, Um Hamid and Um Ali practiced side by side with Um Ali registering all their births. Um Soliman practiced well into the 1960s, as one of her granddaughters remembered:

> My grandmother was always called to people's houses for her services. When she had a *subuʿ* to perform she would sometimes take me along. But she was a tough woman. Sometimes, the family that had the *subuʿ* was generous and gave me a small coin. On the way home, my grandmother would always check whether I had received a gift and would take it away form me. But I still liked to go out with her.

After Um Soliman and Um Hamid resigned and passed away, Um Ali was left to practice alone in El Tayibin. Her schedule was a busy one: checking on women in the last days of pregnancy, telling them to be patient and that they would still take a few days, spending long hours attending births, conducting wedding nights ("when I do the *dukhla*, it always bleeds nicely," Um Ali), checking on newborn babies and many more tasks. Her work surrounding birth was time-consuming and involved many trips back and forth to the house of the expectant mother, and long hours of sitting by the side of laboring women.

Um Ali charged her patients according to their ability to pay. Many of them she did not have to "charge" at all because they offered the appropriate sums of money or gifts without being asked. Furthermore, gifts of money came her way at the *subuʿ*, the celebration of a birth after seven days, which she would conduct for the new baby. Some of the poorer women she treated for free. The most unfortunate and

miserable women, she occasionally even hosted in her own house after birth and fed them from her own supplies. Um Ibrahim, who is also a granddaughter of Sitt Khadiga, remembered:

> Um Ali was not after money. Sometimes, if a woman was very poor, she might let her stay for a few days in her house. She would even slaughter a chicken from her own for the woman.

Um Ali: Precarious Practice

The late 1960s brought yet another round of changes in official policies with regard to *dayas*: in 1969 the Ministry of Health changed its policies once more, and all "licenses were revoked, and the practice of training the *dayas* was discontinued" (Simon 1981: 5). Underlying was "the conviction that *dayas* had become redundant" as large numbers of trained nurse-midwives (*hakimas*) had become available (ibid.: 5). However, the practice of the latter was set in the context of hospitals and mother-child centers and lacked the independence of *dayas*, and the first 19th century *hakimas*. In the early 1970s finally

> the Ministry of Health declared *dayas* [sic] practice illegal, in a fresh move to staff MCH (Mother Child Health) units with assistant midwives and trained nurses … . Since then, older licensed *dayas* have been performing their trade informally, but no less actively.
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> (Ibid.: 34).

Women in El Tayibin continued giving birth with Um Ali in the 1960s and 1970s. Simultaneously, many women signed up at the new maternity centers, as Um Ibrahim remembers, but often only late in pregnancy. She recounted: "we signed up at the center because when the baby was born we would receive free milk powder and other things. But we delivered the babies with Um Soliman, Um Hamid and Um Ali."[19]

The centers were staffed with physicians, nurse-midwifes or *hakimas*, nutritionists and a number of helpers and assistants (Simon 1981). The professionals all had received modern training. Simultaneously, however, as Simon observed in 1981 in the Maternal and Child Health

Clinic in Sayyida Zeinab *dayas* would often "cooperate actively with the MCH center" sending their patients there for supervision (ibid.: 4). Since physicians' at the centers knew that women delivered with the help of *dayas*, they often supported the work of those *dayas* who they felt were most experienced and reliable in their work. Simon noted that *dayas* felt protected in their (now illegal) practice through cooperation with the centers (ibid.: 43). Some of the helpers (*tamargiyas*) in the Sayyida Zeinab Center, Simon observed, were unlicensed *dayas* who occupied a central social position in the center as they were from the community and well-respected. Despite the professionalized set-up of the clinic, Simon found close and well-integrated cooperation between medical staff and *dayas*, often even united within one person's different fields of expertise and practice. Despite personal and meaningful cooperation on the level of the center, the fact remained that *dayas* practiced within a context of insecurity which required them to search for either the protection of the center, or to practice at a complete distance from the center. Their former independence and security was irretrievably lost.[20] Simultaneously, however, women's continued trust and respect for midwives' more individualized and socially oriented services allowed the continuity of midwives' practice. In many cases economic aspects also played a role in women's decisions about where or with whom to give birth. The work of *dayas* continued but behind closed doors. While on the one hand the *daya's* practice carried with it the uncomfortable sense of its own illegality, in its everyday reality this was of little relevance, as the following encounter illustrates.

In 1990, when Um Ali was still practicing regularly, I attended the initial phase of a delivery with her. Before we went for the actual birth, Um Ali had already been checking on Nabila, the expectant mother, several times (it was her first baby) and told her that it was still early and she would come back in due time. Nabila's mother, Um Abdel Rahman, was a good friend of Um Ali's, and together with Um Ali, I had frequently visited the household of Um Abdel Rahman and had gotten to know her and her daughter quite well. They did not object to my presence in the early stages of Nabila's labor. Um Ali and I arrived in Um Abdel Rahman's house late in the afternoon as Nabila's contractions had started to come more regularly. Nabila was half sitting half lying on plastic mats and a blanket on the floor, propped up

against a number of pillows. Her mother and her mother's sister were also present. Um Ali immediately went to work. She slightly readjusted the pillows to make sure that Nabila would be as comfortable as possible. Covering Nabila's body with a thin cotton blanket, Um Ali did a vaginal exam to check on the progress of the birth. After she felt that Nabila still had quite some time to go, Um Ali started a conversation with Um Abdel Rahman and her sister that soon made everybody, including Nabila laugh. Um Ali and the other women continued their story telling and between painful contractions, Nabila joined them in their laughter and talk. Um Ali did not just provide the physical care but was also was in charge of the entertainment or distraction for the laboring mother. I only stayed for a half an hour and then left. The same night Nabila gave birth to a healthy girl. Nobody involved wasted a thought or note on the "illegal" context of this delivery.

Um Ibrahim, however, remembers an instance of how Um Ali's public role had become precarious:

> Many years ago, Um Ali had commissioned a black sign with white writing on it, the kind doctors hang outside their buildings. The sign included her name, and stated that she was a midwife. Um Ali wanted to fix this sign to the wall of Sitt Khadiga's house, so that everybody who came into El Tayibin could see it. She was very happy about the sign. But then several of the relatives suggested that she not hang the sign as she was no longer officially allowed to practice and the sign might attract the eye of the authorities [*al-hukuma*]. In the end she never used the sign. She stored it away in my house. Years later, when we fixed the stairs, we used the board. It is still there on the side of the stairs. You can go and see it there.

Hospital Births

As long as Um Ali practiced, most of the women of El Tayibin continued using her services. A few women, however, started giving births in government hospitals. Initially for free, fees for various extra services and tips for nurses and attendants eventually added up to considerable sums. As one woman put it: "Every time the nurse brings you something, you have to pay a tip."

From the late 1970s prosperous labor migrants to the Arab Gulf started sending their wives back home in Egypt to more expensive private hospitals to deliver their babies. As a marker of prestige and concern of their husbands, some migrant wives will proudly mention the private hospital and the cost of their deliveries. Um Zaki noted: "My daughter delivered her first baby in a private hospital. Her husband send LE 800 from Qatar for this delivery."[21]

So long as Um Ali was practicing, government or private hospitals were a matter of choice, prestige and available funds. As she slowly gave up practicing, women had less of a choice and were forced to travel to hospitals. With limited funds, most women had no choice other then go to public hospitals whose facilities and services have been deteriorating over the past decades. Many woman were afraid of treatment and services in public hospitals. Um Kamal a friend and neighbor of Um Ali had given birth to four children with the help of Um Ali. In the early 1990s, years after her last birth, she became pregnant once more. When she was ready to give birth, Um Ali had fallen sick and had momentarily moved to her daughter's house and was unable to take the trip to El Tayibin. Left with no other choice, Um Kamal gave birth in a public hospital and afterwards noted:

I would much rather have given birth with Um Ali. She had delivered all my other children and everything had gone well with her help. But this time I had no choice, so I went to the hospital.

One of the most outstanding changes accompanying hospital births was and is the dramatically high rate of Cesarean births performed there.[22] From informal observations and conversations in El Tayibin it seems that almost one in three or four hospital births in recent years had been a Cesarean.[23] Um Ibrahim, complained about the fact that all three of her daughters had delivered their children in recent years with Cesareans in hospitals. Um Ibrahim recounted:

When Um Ali and before her Um Soliman and Um Hamid assisted women in birth, there were no Cesarean births and all the babies came out in the end. Um Ali was very patient, she would sit with a woman for hours, or go home and come back the next day if things were not ready yet. And if a baby was in the wrong position, Um Ali would carefully insert her hand and she could turn the

baby around in the womb, so that it could be born head first. No woman ever died giving birth under Um Ali. She knew her work well, and she knew the women and she was very patient. In the hospital things are different.

Another neighbor recounted that only in very difficult cases Um Ali would advise a woman to go to a hospital. This neighbor attributed this to Um Ali's excellent knowledge and sense of responsibility, as he noted "she knew her work very well, and she had an official license." It is interesting to note that this male voice, more than the female ones, insisted on Um Ali's license as her basis of professional knowledge and legitimacy.

Um Hisham, a young woman in the neighborhood, just recently delivered her first baby in a public hospital by Caesarean. Upon my question why she needed a Caesarean she said the doctor had told her that the baby had been stuck in her pelvis. In the same conversation another neighbor offered an explanation for frequent Caesareans in general:

Look, when it is four o' clock or so in the afternoon the doctors want to go home, so they do Caesareans, that their day will be over. Also, remember a regular birth in a public hospital is for free, a Caesarean is a surgery and then they can charge the woman money for it. This is why they are so many Caesareans.

In the case of a Caesarean, like with other surgeries, patients have to supply the necessary materials themselves. Um Hisham recounted her recent delivery: "Then my husband had to run out of the hospital and buy the *bink* (anesthetic) and the cotton wool for the Caesarean." Older women, like Um Ibrahim, tend to be more critical about the Caesarean practices, she insisted: "I gave birth seven times with a *daya* and I was fine, there was no need ever to cut back then."

Frequent caesareans, bad services and high costs are the most frequent complaints about public hospitals. Neglect and indifference is another as the following incident illustrates. Um Zaki recounted the encounter of her niece who had given birth in a public hospital on the outskirts of Cairo:

My niece, Zeinab, was going into labor in her eighth month which is a dangerous time. Seven month babies have a good chance at living but eight months babies often die. So her husband rushed her to the public hospital. The baby was born but it was small and weak and died after a few hours.

When I asked Um Zaki whether the hospital had an incubator, she said, "yes, they did. But it costs more than 50 pounds a day and the doctors knew that my niece was poor and that she would not be able to pay for an incubator for a long time. So they did not bother."

Whether or not the story of Zeinab is representative, the underlying point remains, that women feel that even though advanced technologies might be generally available in hospitals, it might not be available for them in particular. Consequently, the argument that hospitals provide a better environment for complicated cases looses its credibility.

While in the practice of Um Ali, births were a social event with a few female relatives to distract and support the mother, hospital births and Caesarians in particular have turned into rather individualized and lonely procedures. Fear of mistreatment and suspicion often prevail. Um Hisham recounted her experiences and feelings:

After little Hisham was born, I had my husband and my mother take the baby to my mother's house the next morning. We were afraid that they would do something to the baby, steal him or exchange him for another child. My mother or my husband brought the baby at least once a day for nursing and apart from that they gave him water with sugar at home until I was released a week later.

Whereas the midwife would check on new mothers and their babies in the first days and weeks after birth, women who deliver in hospitals are left on their own in this initial period. As women in El Tayibin tend to return to their mothers' houses for births these circumstances are, however, greatly alleviated by the availability of a larger pool of advise from experienced older women. And it is in this context that female wisdom continues to flourish and dominate women's lives. As much as women consult physicians and hospitals, they also rely on available wisdom and remedies.

Replacing Um Ali?

Families in El Tayibin all have their stories about trips in the middle of the night to Cairo's renowned Abu Rish Children's Hospital because of sudden infant fevers and diarrheas. Abu Rish Hospital general practitioners and pediatricians are well-trusted and frequently consulted. But at the same time elements of older discourses of health and healing are also employed.

When infant Hisham was suffering from serious diarrhea his mother took him to Abu Rish Hospital but the next day her own mother took the baby to Um Abbas, an old woman in the neighborhood who gives therapeutic massages. I went with Um Hisham's mother to Um Abbas's room. Upon arriving there Um Abbas took a good look at the baby, then told me to fetch a small container with some cream from her kitchen cabinet in the hallway. Meanwhile she had undressed little Hisham and put the naked baby on her stretched out legs. First she gave him a tough massage from the back for some minutes, then turned him around and systematically rubbed his stomach. Hisham was screaming all the while. After about fifteen minutes she finished her work and wrapped a bandage-like piece of fabric that we had brought along around the baby so that it crossed over tightly both on his back and front. After he had been screaming throughout the treatment, little Hisham was surprisingly quiet afterwards. It needs to be noted that Um Abbas is not a midwife but a practitioner of particular types of beneficial massages. In this particular instance her field of expertise overlaps with aspects of the *dayas*. Yet, a similar question arises to her practice as with regard to Um Ali's practice: who will continue her work in the future?

The death of Um Ali, and the situation of El Tayibin devoid of such expertise does, however, not equal the end of a series of practices associated with older forms of midwifery. *Subu'*s, continue, but are now administered by grandmothers, or a few women in the community who are known for their verbal and other skills needed for a successful *subu'*.

Female circumcision, long ago outlawed by the Egyptian government, has been appropriated within the practices of general practitioners.[24] In the poorer quarters of Cairo, physicians will perform the operation for a fee starting between 20 to 30 LE, while the family of

the girl supplies the cotton and sterilizing materials. In this context modern medicine's 19th century claim to a new medical universe has taken an ironic turn in its 20th century market oriented and male dominated universe: for a good fee modern physicians perform this highly controversial surgery.[25]

Wedding nights have largely become the private affair of the newly weds, or knowledgeable older women are brought in, should problems arise. Such women, however, are not always easy to find. In the mid-1990s a friend of one of Um Ibrahim's daughters got married in Bulaq Al-Dakrour. Problems arose for the young couple in the wedding night and the marriage could not be consummated. The next day they went looking for a midwife, but could not find one in their neighborhood. Two days passed and the wedding night was still not "happening" and the couple and their relatives frantically searched for a *daya*. Knowing that Um Ibrahim was the granddaughter of Sitt Khadiga and related to the midwives of El Tayibin, the friends also approached Um Ibrahim's daughter to ask her mother whether she could perform the wedding night (*dukhla*) for them. Um Ibrahim declined. Later she said:

> I know how many of these things are done, because I watched my grandmother and my aunts in the past. But I don't want to get involved in these things.

Every great once in a while, she will however perform a *subuʿ* for people whom she highly appreciates.

One of Um Ali's young nieces, Samira, was interested in working in the medical field. A few years ago Samira went into nursing school – a three year vocational training after the completion of nine years of regular schooling – and hoped to specialize in obstetrics in line with the family tradition. Upon completing her nursing degree, she worked as a nurse in a hospital which is more of a helper's position and not even remotely comparable with the independent work and expertise of Um Ali. Back home in El Tayibin, Samira administers injections to diabetic neighbors which gives her neither the recognition, prestige nor financial rewards that Um Ali and the other midwives had once enjoyed. Since Samira was not doing too well at school, she could not continue her schooling and specialize in obstetrics.[26]

Reordering Dayas' Practices

With these few examples of the reassigning of earlier *daya* practices, it becomes clear that a large scale shift of bodily control from midwives to a male market-oriented medical establishment has been taking place, or in many aspects has already been completed. The practice of midwifery has been stripped of its social, female and communal aspects and has largely been allocated to male practitioners as 19th century European physicians had called for. Births have increasingly been assigned to hospitals where women are left alone in an unfamiliar environment faced with doctors' decisions which they have no means to challenge and oppose. The women of El Tayibin unequivocally agreed in their sentiments and opinions about public hospitals: Caesarians were many, services were bad and one should leave these places as fast as possible. In contrast, *dayas*' practices that demand less expertise (*subu'as*, ear piercing, wedding nights) can be performed by experienced older women and are hence redistributed within female communities.

Only for a brief few decades, in the period between the early 20th century and 1969, attempts were made to upgrade midwives' expertise. This brief spell of interest in *dayas*, and giving them a recognized space in the medical system, in hindsight appears as a temporary make-shift solution within the larger flow of events surrounding politics of institutionalized medicine and obstetrics. Only institutionally trained nurse-midwives were integrated into the modern medical system at subordinate positions, enjoying nowhere near the prestige and independence as *dayas* did (and still do).

At the same time, similarities in tasks and expertise, and the continuing popularity of and respect for *dayas* among segments of Cairene society have allowed some *hakimas* to moonlight as independent midwives (Sourial 1969), as much as they enabled *dayas* to practice under the indirect protection of the more powerful institutional context, while yet other *dayas* chose to continue practicing at a safe distance from authorities. While the legal context and official picture are that of institutionalized obstetrics, at the level of everyday practices, circumstances are much more diverse and practices have been articulating in a multitude of ways. Despite these dynamic processes of articulation and negotiation of female wisdom, health, birthing and related practices, the fact remains that *dayas* and their knowledges have irreversibly

been pushed to the margins, and indeed to "illegal" margins. Less and less young women are willing to enter a field that enjoys no official support and could easily get them into legal trouble. Without a government certificate, the practice of *dayas* has become a field that is looked at by young women as for those who are illiterate and "backward" and hence not worthy the consideration of a educated woman (Simon 1981). The more "appropriate" way is what Samira chose, which however left her as a helper in a large institution.

Debating or Ignoring Midwifery?

Debates about indigenization of knowledge, Islamization of knowledge, and the continuity of Islamic medical practices are conspicuously silent about forms of popular female wisdom, and most importantly the practices of *dayas*. The confrontation between various medical discourses is a male, abstract and supposedly rational one, and ultimately centers around the issue of which male (textual) discourse should have control over bodies, and for our case that would be female bodies. *Dayas* have no spokeswomen in such debates as their practice is based on long genealogies of female wisdom not written down in manuscripts, treatises and books. Male proponents of various discourses have little knowledge of *dayas'* practices as those have always been closely guarded among women. Moreover, these men have no interest in sharing their envisioned fields of medical (social and political) practices with possibly illiterate females.

The death of Um Ali symbolizes the slow death of age-old female wisdom and practices, as much as her life and work demonstrated the very feasible option of successfully inserting more recent knowledges into time-honored practices. Um Ali practiced within the female social context that had worked so well for midwives and women in the past, into which she integrated her new knowledge, while referring the few critical cases to hospitals. Some of her practices will be dispersed into the communities and kept alive by women, while others will completely disappear. The most important aspect, however, that of birthing and reproductive health has been taken over by the male medical establishment effectively stripping women and female communities of control of their bodies. In the context of hospital births women are isolated from the support of other women. While the *daya*

was a well-known social equal, or at least member of the same community, poor women who give birth in hospitals are at the mercy of doctors who are socially distant from them in terms of gender, class, education and most importantly power. How could a poor uneducated woman speak up or enter into a debate about her body across such severe social dividing lines?

The statement that *dayas*' practices were irrational, superstitious and backward was never doubted or critically challenged in debates about medical practices. The possibility of upgrading older forms of midwifery was briefly practiced but eventually dropped in favor of institutionally trained and institutionally based nurse-midwives. Anti-colonial, national or Islamic movements have shown little interest in challenging the process of marginalization and elimination of midwifery set in motion 150 years ago. *Dayas* themselves have been too busy with the immediate demands of their challenging work to engage with authorities. Moreover, the structure of a modern society where only educational certificates, professional syndicates, written texts and treatises give legitimacy to one's projects and demands, from the start provided no space for *dayas*, who work in a different discursive universe, to voice their concerns and discontents.

The Future of Dayas?

The deep respect of women for *dayas* and the resilience of the latters' practices alone accounts for the continuity of *dayas* after 150 years of official onslaught and interference. How much longer *dayas* will practice, remains to be seen. Official disrespect, rhetorical war and decrees that made *dayas*' practices illegal, have rendered midwives' practices precarious. Few young women are willing to enter a field that is looked upon with contempt and is fraught with legal problems. Women like Um Kamal who gave birth with Um Ali and later were forced to use hospitals are the most outspoken at present for the case of midwives. Many younger women who from the beginning had no other choice than give birth in hospitals have little to compare other than the stories of their mothers and aunts. Taking hospital births as their only option, they accept them as a necessary "evil" but try to leave as fast as possible to escape the bad services and high costs.

Notes

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1 All the personal names and most of the place names are pseudonyms. To further guarantee the anonymity of individuals and their families I have slightly changed some of people's personal circumstances.
2 I am careful here not to use the term patient as it is not used in this context. "Women" is the straightforward term that Um Ali herself used to refer to those who seek her help and assistance.
3 I will use the term *daya* in English in order to distinguish between midwives who were trained (or mostly trained) by older experienced *dayas* and modern institutionally trained midwives, *hakimas* (see below). It will become clear in the course of my argument that lines between *dayas* and *hakimas* in actual practice are often blurred.
4 Needless to say here that the point of the following analysis is not to prove that one type of medical or health practice is better than the other, as Foucault noted in the preface to *The Birth of the Clinic* when he wrote that his book was not "written in favor of one kind of medicine, as against another kind of medicine, or against medicine and in favor of an absence of medicine. It is a structural study that sets out to disentangle the conditions of its history from the density of discourse." (1975: XIX)
5 I am using the past tense with reference to El Tayibin only. *Dayas* still practice in other parts of Cairo.
6 Um Ibrahim calls Fatma Hanem "Fatna Hanem" using the popular form of Fatma.

7 For details, see Mahfouz (1935).
8 The five year course at the school included: "(1) Arabic language. (2) Theory and Practice of Midwifery. (3) Ante-natal and post-natal care. (4) The treatment of simple diseases. (5) The principles of elementary surgery including bandaging, vaccination, dry and wet cupping. (6) Elementary dispensing." (Mahfouz 1935: 73).
9 In terms of attempts of integrating or using local practitioners, there was an interesting period when for lack of personnel, local barbers were trained to perform small pox vaccinations. These efforts were rather specific and relatively short-lived and never amounted to creating spaces for these practitioners in the emerging medical system which would be viable for the future (Kuhnke 1992: 111).
10 Arnold notes for the case of 19th century colonial India: "The diseases that preoccupied colonial medicine in the nineteenth century were epidemic diseases, the communicable diseases of the cantonment, civil lines, and plantations, the diseases that threatened European lives, military manpower, and male productive labor" (1993: 254).
11 Others rhetorically supported the campaign against midwives. For example, British anthropologist, Winifred Blackman, writing about Upper Egyptian peasants in the 1920s had little to say about actual *dayas'* work and skills, but emphasized that the various primitive medicinal remedies, well known to, and used by all villages matrons, are of such a nature that one wonders how any child manages to survive at all (1968: 42). Blackman complains that peasant women do not trust physicians' advice, and object to consulting physicians. She describes these women as hopelessly backward and superstitious (ibid.: 61). Blackman's narrative in the end does not leave much doubt that whatever it is that women practice, it is doomed to extinction in the face of the "brighter" scientific future looming on colonial horizons.
12 Statistics of births and deaths were frequently published in the Egyptian Gazette. Figures were neatly separated between "foreign/European" and "native" births. See, for example, "Vitality Statistics" (EG 19.6.1904 or 13.9.1904).
13 Already in 1898 Lady Cromer had initiated a foundling hospital, also by "public subscription" (Mahfouz 1935: 80).

14 Arnold describes similar circumstances in 19th century colonial India where a charitable fund, the Dufferin Fund, initiated by the "vicereine" Lady Dufferin at the urging of Queen Victoria was set up "to promote medical aid for India's women" (1993: 262).
15 The curriculum included "instruction in Obstetrics including Forensic Medicine in relation to Pregnancy and Midwifery, Gynecology, Pelvic Anatomy and Embryology" (Mahfouz 1935: 87).
16 For the case of the center in Sayyida Zeinab, opened in 1927, see Simon (1981: 16-17).
17 Um Ali mentioned Um El Misriyin to me as the place where she got her training. Simon, however, notes that these courses were held at a school by the name of Madrassat el Kabilat, which was also located in Giza. It remains to be found out whether the second was actually located within the premises of Um El Misriyin Hospital (Simon 1981: 33).
18 Simon also notes the importance of the bag: "At the end of the training course they were licensed, and provided with a simple midwifery kit with items needed for normal deliveries – scissors, dethol, gauze, a white *galabeya*. The licensed *dayas* that I observed still have their midwifery kit in perfect condition …" (1981: 33-34).
19 Simon noted similar rationales of the women in Sayyida Zeinab for signing up at the Mother and Child Health Center (1981: 25).
20 In the meanwhile, *hakimas* were staffing the centers mentioned above and maternity wards of hospitals. A study about *hakimas* conducted in 1968 in the maternity ward of Qasr El-Aini hospital described the *hakimas*' education which had essentially remained as described by Mahfouz in the 1930s (Sourial 1969: 26). While their 19th century predecessors had been independent practitioners, Sourial observed in the hospital "that the *hakimas* participated in the delivery only to pass tools, gloves and antiseptics to the doctors when needed" (ibid.: 15-16). Similar to Simon's experience Sourial noted that one of the *hakimas* whom she had come to know in the hospital treated her own patients outside her place of work (ibid.: 8). In these examples Dr. Mahfouz's earlier policies have come full circle: *hakimas* (and some *dayas*) as subordinates within institutionalized medicine.
21 In 1997 LE 3.3 roughly equalled 1 U.S.-$. At the same time a

lower level government clerk earned about LE 100-150 per month. Young women in El Tayibin who worked in stores and factories earned between LE 65-100 per month.

22 Both public and private hospitals have high rates of Caesarean births.

23 These are only my informal observations based on a limited sample of women. No matter what the exact figures are, the fact remains that they are indeed very high.

24 As I am finishing this paper, in late June 1997 a decree was issued by an administrative court that "struck down a Health Ministry order that banned the ritual [female circumcision] from public and private hospitals and clinics" (Al Ahram Weekly 26.6.-2.7.1997). It is beyond the scope of this paper to trace the chain of events that fueled the recent debates and decisions, suffice to note that some of it goes back to heated debates around a film at the 1994 International Conference for Population and Development.

25 I will not enter the larger discussion of female circumcision in Egypt as it is an issue that is frequently debated both within and beyond Egypt. Western feminists' interference in this debate has for the most part been inappropriate and even more so detrimental. Some of it comes unfortunately close to earlier colonial interferences both in discourse and language.

26 Only the students with the best grades in nursing school are able to continue their training and specialize at a nursing institute or the *hakima* school.

Selected Bibliography

Arnold, David (1993) *Colonizing the Body*, Berkeley/CA: University of California Press.

Blackman, Winifred (1968, 1927) *The Fellahin of Upper Egypt*, London: Frank Cass.

Foucault, Michel (1975) *The Birth of the Clinic,* New York/NY: Vintage Books.

Gallagher, Nancy (1993) *Egypt's Other Wars*, Cairo: The American University in Cairo Press.

Kuhnke, LaVerne (1992) *Lives at Risk,* Cairo*:* The American University in Cairo Press.

Mahfouz, Naguib Bey (1935) *The History of Medical Education in Egypt,* Cairo: Government Press, Bulaq.

Simon, Dagmar (1981) *Dayas in Urban Health Care: Activities, Problems and Prospects for the Future*, unpublished M.A. Thesis, Department of Anthropology, American University in Cairo.

Sourial, Aida Fahmy (1969) *The Hakima. A Study on the Socialization of a Professional Role*, unpublished M.A. Thesis, Department of Anthropology, American University in Cairo.