Women, Pregnancy and Health: Traditional Midwives among the Bunong in Mondulkiri, Cambodia  

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Introduction
In Cambodia, many women deliver their babies at home with the assistance of a traditional midwife, or contact her at least once before, during or after giving birth. This is particularly the case for indigenous people. For the Bunong, one of the indigenous minorities in the north east of Cambodia, traditional midwives, or kru njut ndüll – the traditional healer who holds the belly – have offered their services to pregnant women and mothers as far back as people can remember. Accordingly, there is no doubt that the traditional midwives play an integral part during pregnancy, delivery and the time of early motherhood. In general, their role is to take care of mothers as soon as labour starts, to massage their abdomen, to cut the umbilical cord, to wait for the placenta to be expelled, to advise the women to drink traditional medicine and to eat the right food. She will prepare weng oing, the fire that warms the woman’s body, and will visit her regularly during the first few days after she gives birth. Prenatal visits are only carried out in case of problems and pain. The traditional midwife is usually a relative or a close friend of the family, and needs to be informed a few weeks before the couple would like to call on her skills for the upcoming event.

The high level of activity of traditional midwives is reflected in official statistics. According to the most recent Cambodian Demographic and Health Survey (CDHS, 2006: 144-145) conducted in 2005, 83.2% of the deliveries in Mondulkiri are assisted by traditional midwives and 90.6% of newborns are delivered at home. These numbers might be even higher if they focused solely on the Bunong. A study by the international NGO, Health Unlimited (HU), in Ratanakiri Province showed that 99% of the interviewed village women gave birth with the assistance of a traditional midwife or a family member (HU, 2006: 13). Unfortunately, similar studies are lacking in Mondulkiri. The end of the midwife’s services that she offers during pregnancy, delivery and early motherhood is usually marked with a ceremony. This paper looks more closely at this ceremony and at the status of traditional midwives within Bunong communities in Mondulkiri Province, Cambodia.

Trends towards marginalization
The indigenous people in Mondulkiri province are facing increasing pressures
caused by fast changing transformations in terms of land issues, immigration, a weak public health system, difficulties of accessibility, and international and local agencies that underestimate or ignore local practices (NGO Forum, 2005: 12; Seidel, 2005: 312; Maffi, 2006: 7). Therefore, indigenous communities in general and indigenous women in particular, are challenged and pushed toward the margins. In a context where the health system is weak and villages remote, one of the main challenges lies in the problem of accessibility. Overall, public health care facilities are difficult to access; the roads are in especially poor condition during the rainy season, the distances wide and health staff often absent from the health posts or health centres. However, even though the villagers sometimes have the opportunity and the possibility to access public health care facilities, they still decide to give birth at home with a traditional midwife. To understand why women hold onto traditional childbirth practices, it is crucial to consider historical, political, cultural and economic factors that influence the women’s and family’s decision.

National and international policies in relation to midwifery
The maternal mortality ratio is very high in Cambodia (472 per 100,000 live births; CDHS 2006:120). This fact has led the Cambodian Ministry of Health (MoH) to state: “As such a high maternal mortality ratio is one of Cambodia’s most pressing health concerns to which the Ministry of Health and its development partners are committed to addressing as a priority. […] For the MoH, midwives are one of the critical cadres for achieving the overall improvements in health, especially in rural and hard to reach communities” (MoH 2006: 2). The Ministry of Health has developed a Safe Motherhood policy and set up strategies and activities in a five year plan (MoH 2001: 10) where the MoH sees professional midwives at the health centre level as the key for safe motherhood activities. Even though the policy recognises that traditional birth attendants (TBAs) are contributing to the provision of community and maternal health care, and that they are the care providers most used in the villages, it holds the opinion that:

The TBAs are not officially integrated into the health services workforce and there is no plan to do so. TBAs are not considered skilled birth attendants; they are traditional practitioners who are valued for their role as birth attendants (MOH 200: 33).

The Ministry of Health’s position is in line “with the most recent trend at WHO and UNICEF toward diminished support for traditional midwives coupled with increased support for professional midwives” (Davis-Floyd 2003: 6). “[S]afe motherhood initiatives worldwide are based on the premise that pregnancy, childbirth and postpartum care are safer when provided by skilled birth attendants
in a modern health care facility” (Hoban 2002:12).

In the 1970s, the WHO began to promote the training and incorporation of traditional birth attendants into formal health systems in many places around the world (Pigg 1998; Goldmann/Glei 2003). Since that time, TBAs have caught the attention of researchers, development and governmental agencies. These trainings usually do not seek to replace other medical practices, but try to enhance them by improving health services in relation to delivery through cooperation with existing indigenous systems. But as Pigg (1998:2) argues: “Many programs fall short of the ideals of ‘enhancement’ and ‘cooperation.’” This is because it is not easy to identify who needs to be trained or to introduce new practices and techniques into existing routines. As a matter of fact, most training programs simply try to redefine the practices of the trainees (ibid: 15). Governments and development institutions define birth assistance as a “medical” fact, subsuming the varying social, emotional and protective roles that the trainees might actually be playing. By classifying the traditional midwives as “TBAs,” the international community is implying that their knowledge does not count in the global system. As a result, recent anthropological ethnographies question the appropriateness of this approach (Davis-Floyd 2003:6). While the positive impacts of TBA trainings on safe delivery practices remain controversial (Hobson 2002; Furey 2004), evaluation reports show that TBAs can reduce mortality rates, if referrals are possible and if training occurs as part of a multi-system approach. Nevertheless, training courses for TBAs have been criticized for their pedagogy and ideology. The general purpose is mainly to educate the traditional midwives in how to identify risks and to improve prenatal and postnatal care. But the content of such courses are often inappropriate to local realities and always designed by biomedical personnel (Davis-Floyd & Jenkins 2005). “Because in most places 30 years of TBA training programs have not resulted in any demonstrable drop in maternal mortality, UNICEF and other agencies are now withdrawing support for TBA training all over the Third World and increasing support for midwives who meet the WHO definition” (Davis-Floyd et al. 2001:9).

But birth is never simply a biological act. It is as Brigitte Jordan (1993:1) states: “Birth is everywhere socially marked and shaped.” On the one hand, ideas and practices related to illness are inseparable from the domain of religious ideas and practices. On the other hand, health beliefs are related to social organization, for example, illness has a meaning for the community and not just for the individual. Therefore, local systems of medical care are rooted directly in everyday social relations. “Illness, in short, is not simply a physical or physiological state: it is symbolic of moral issues that implicate the patient and others in a web of social rivalries and jealousies” (Pelto & Pelto 1997:150). Besides these essential cognitive
components, the economic, material, and political factors must be joined for a full-scale understanding of behavioural patterns, in the present case the understanding of treatment-seeking behaviour and decision-making processes (ibid:161).

The term “traditional birth attendant” – as it is introduced by the WHO and taken over by development workers – implies that these women form a homogeneous category. However, variations exist even within one country, not only in what these women actually do, but in the nature of their relationship to the women they assist (Pigg 1998:10). The only real unity among them is their international classification as “traditional birth attendants” (Davis-Floyd 2003:4). Although such variations are sometimes recognized by researchers and health planners, and attempts are made to understand the full medical and social significance of the ideas and practices, national programs such as TBA trainings are always designed to contain a certain amount of generalizations and are structured so as to systematically remake the trainees in the image of the midwife.

The status of traditional midwives
Traditional midwives are well-known and found in many rural villages, as well as in many urban neighbourhoods worldwide and throughout Southeast Asia (Rogers & Solomon, 1975; Hoban, 2002). However, age, status and skills of midwives worldwide vary considerably. In Southeast Asia, their prestige and status within the community is generally high. Rogers & Solomon (1975: 126) point out two reasons for this: The first reason concerns their perceived “safety,” due to the similarity between their socioeconomic status and lifestyle and those of their clients; the second factor is related to their “competence,” due to their advanced age, religiousness, and special knowledge and skills. If this is compared to other regions such as South Asia, the same high social status among traditional midwives cannot be found. In India and Bangladesh for example, the dai usually belongs to a low caste, as contact with blood from birth is perceived as polluting and defiling (Obermeyer, 2000: 186; Hoban, 2002: 56).

Because human blood, in this case from parturition, can also be a source of power, one has to be careful about who comes into contact with it. Obermeyer (2000: 186) showed that that in Morocco spilled blood during pregnancy can be used for sorcery to create a dispute between the new mother and her husband. This fact has consequences for the traditional midwife and her status: it is crucial to call a midwife who can be absolutely trusted, and she is the only one who washes the mother’s clothes and stays with her a few days after the delivery. The midwife’s role in this case is far from being despised; rather she is a person with whom the mother has a special bond of trust. Moreover, if a woman cannot find the right midwife, she would rather go to deliver at a public health facility, than risk
becoming a victim of black magic.

Among the Bunong, it is known that the time around delivery is highly dangerous for the mother and her child in relation to spiritual intervention. Therefore, we will explore what consequences this insecure period has for the status of the traditional midwife. Our aim is to describe and analyse the link between the respect given to the traditional midwife and the fact that she puts herself in close contact with spirits.

**The main objectives and methodology**

This paper highlights aspects of a broader social anthropological research project that is being carried out on behalf of Nomad RSI Cambodia. It looks at the Bunong’s perceptions, attitudes and practices when dealing with pregnancy, delivery and early motherhood. In order to fully comprehend the decision-making processes, all opinions and impacts resulting from it must be included as part of the context (Pelto & Pelto, 1997: 154). In addition, this issue is examined in light of Brigitte Jordan’s concept of ‘authoritative knowledge’. Jordan observes that, for any particular domain, when more than one knowledge system exists, one kind of knowledge often gains ascendancy (1993[1978]: 152). The legitimizing of one way of knowing as authoritative often leads to the devaluation of all other ways of knowing. Therefore, one system of authoritative knowledge appears to be natural, reasonable and right. It is accepted as legitimate, is socially sanctioned, and serves as grounds for action (Sargent & Bascope, 1996: 214).

Within this conceptual framework, the main focus for this paper is on the traditional midwife, especially her status in the communities, her role, duties and responsibilities. This research presents one specific ceremony, carried out by the majority of people interviewed, and performed in honour of the traditional midwife a few days after the delivery. From an account of this ceremony, the core subject matters are derived: on one side the pregnant women and the new mothers respectively, and on the other side the traditional midwives. Through this event, some of the most important issues revolving around traditional midwives in these communities are revealed: the tremendous respect afforded the traditional midwife, the critical role that spirits play as part of the birth process, and the fearful motivation that potential maternal death plays for the community as a whole.

A classical social anthropological approach is used to accomplish the research. The methodologies applied include participant observation, semi-structured and open-ended interviews, as well as key informant, expert and group interviews. On the basis of the women’s narratives about their birth experiences and the observations made, this article seeks to understand their health-seeking behaviour
and their decision-making processes, and to identify the resources mobilized and the social networks engaged when dealing with a delivery. To get a broader idea of the present practices, beliefs and perceptions, semi-structured interviews are conducted among the villagers in the respective villages. These surveys include more general questions about health and illness, with the specific focus being on pregnancy, delivery and motherhood. Besides this research in the selected villages, key informant and expert interviews were carried out, for example, with “professional” midwives in the health posts and health centres, with people from the referral hospital in Sen Monorom, and with representatives from governmental institutions and NGOs that are working on maternal and child health issues.

The villages where the research was carried out were chosen according to different locations and access conditions to public health services and facilities. Lauka is the closest village to the provincial capital and can be reached within ten minutes by motorbike. The road condition is good all year around and there exists no public health facility in the village. Roveak, on the other hand, is the most remote of the places selected. In dry season, it can be reached by motorbike within five hours (approximately one hour to the next health centre/health post). In the rainy season, it takes at least eight hours to get from the provincial capital to Roveak. In all of the sites chosen, indigenous people are in the majority.

**Bunong communities**

The research was carried out in Mondulkiri province, which is located in the eastern highland region of Cambodia, bordered by Vietnam to the east and to the south. It has a population of around 49,000 inhabitants and covers 14,682 km² of land, which largely consists of forest landscape. The roads are often very poor. Most of the villages are remote and isolated and therefore difficult to access, especially during the wet season. According to the latest numbers from the Department of Planning for 2006, approximately 60% of people in Mondulkiri province belong to an indigenous group. Most of them are Bunong (54%). Stieng, Kreung, Kraowl and Tampuan make up 1% or less, ethnic Khmers 34%, Cham 4% and Lao 2% of the population. Sen Monorom is the provincial capital, inhabited by approximately 7,000 people.

The Bunong are mainly subsistence farmers. Like other indigenous groups, they traditionally practice swidden agriculture, gather forest products for food and sale, raise livestock, and practice fishing and hunting. Today, they still carry out these activities, but some people pursue them more intensively, due to technological, economic or environmental developments and changes. Nevertheless, the Bunong are largely dependent on access to natural resources. Guérin (2003) states the
The primary resource of the Mnong is the forest, from which they draw almost everything of what they need. The ethnologists speak of "society of vegetation" to mark the overlap of human social life in the framework of the forest, more or less cultivated, and perceived by some groups as controlled by supernatural powers (p.19).

Research shows that resin tapping is the main income source of the Bunong (Evans et. al., 2003). Most Bunong families farm hill rice as their main form of agriculture, often inter-cropped with a wide variety of vegetables, though in areas where paddy rice cultivation is possible it is often adopted.

The traditional belief system of the Bunong is animism. They believe in spiritual forces which are present in the natural environment – like the forest, sky, earth, hills, stones, water and rice, as well in the houses and household items like jars. These spirits have the power to influence the health, well-being and prosperity of the villagers (White, 1996; Bequette, 2004) and play an important role during pregnancy, delivery and early motherhood, as these periods are considered very dangerous in terms of spiritual activity (White, 1995: 60). The spirits of the ancestors are highly respected as well, and have the power to protect or to harm people. Therefore, a wide variety of ceremonies are carried out to appease these various spirits.

Typically, villages are autonomous, self-governing entities where village elders exert traditional jurisdiction. A settlement has two to five elders, who are known for their skills in conflict resolution, are asked for their advice, implement customary law, and can be distinguished from other villagers by their understanding and comprehension of Bunong culture. People respect and trust the elders and they influence village life, but their authority is not absolute (Leclère, 1908; Guérin 2003). Customary law governs different aspects of life, such as social and economic behaviour, and is coupled with obligations to the spirits and to the ancestors (White, 1996: 353). This is key to upholding community harmony and traditions. Harmony must be maintained with the world of the spirits. For this reason, the traditional legal system still works, because people believe that the spirits will know if a person is not telling the truth or lying in front of the elders, who are linked with the spirits and can bring great misfortune to a dishonest person. But traditional leadership and arbitration of conflicts has been and remains largely in the hands of men (Ironside, 2007). Even though the Bunong, like other indigenous communities in north-eastern Cambodia, are highly egalitarian in many ways, there exists a strong gender division regarding certain areas, tasks and activities in daily life (Berg, 1999: 3). Women and girls are much more involved in reproductive activities than men, but at the same time are taking care of many
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agricultural tasks that leads to a heavier workload and less free time for women. The general level of education among the Bunong is low and is even lower among women. Wealth is traditionally controlled by the wife’s family. However, nowadays, men individually have more control over their money. They engage more often in wage labour, market transactions (selling resin, wild animals or land) and therefore have assumed greater control over many high value resources (Bequette, 2004).

The relationship between men and women here is based on the desire for solidarity, especially as they face a harsh and challenging environment. “Solidarity is aimed first at the survival of their family, kinship and group, leaving little room for more mundane considerations” (Maffi, 2006: 72). Despite the gender division of labour, men and women interact as equal, behave as full members of the same community and share the same space without any sign of one gender being submissive to the other. “The indigenous society as a whole does not seem to share the same misogynistic trends that characterise Khmer culture” (ibid: 75).

To summarise, women do have influential roles in the community, such as spirit women and healers, traditional midwives and as the head of the family. Spirit women are usually selected by the spirits through dreams; they are able to cure sickness caused by spirits and black magic or any other kind of inexplicable illness. As head of the family, the woman is responsible for looking after children, collecting firewood, cooking, fetching water, managing the family’s property, leading the family level ceremonies, and controlling the family members (Ironside, 2007).

Nevertheless, the fast-changing environment is strongly affecting indigenous women. “Indigenous women have been forced to find new sources of livelihood and have multiplied their activities and intensified their work and skills. The system of belief, their identity and their social status within the communities have been strongly shaken by these changes” (Maffi, 2006: 7). At the same time, a generalized trend toward the disruption of solidarity links between men and women has been noted. The status of indigenous women is transforming, even though the consequences of this remain to be fully understood. As mentioned before, the kru njut ndüll, the traditional midwife, takes over a central role for women and their families in Bunong communities before, during and after childbirth. In order to understand her roles and responsibilities better, the ethnography of the ceremony in honour of her is briefly recounted below.

Ethnography of ceremony for the kru njut ndüll

Cam, the husband, is busy. He just returned from Sen Monorom, the provincial capital, where he bought two chickens and a few litres of sra sor (distilled white wine). Children are running around, a few people sitting on the floor, drinking and talking in a lively
manner. The wife Peng, mother of four children, is sitting on her bed, separated by a few wooden boards from the rest of the room, holding her three-day old son in her arms. Today, the ceremony for the kru njut ndüll, the traditional midwife, is taking place. It is also time to stop weng oing, the roasting. kru njut ndüll means lighting a fire under or next to the mother’s bed after delivery for around three or four days, or, depending on her health status, even longer. Around her, the preparations are going full steam ahead. Her sister is chopping vegetables, her husband is plucking the chickens, and a few children are looking after the fire in front of the house where a big pot full of water is boiling to cook the chickens. People arrive; three wine jars are placed next to the wall and filled up with water. Chuch Den, the kru njut ndüll, is laughing; she assisted the delivery together with another midwife. Because labour lasted for many hours, Cam, the husband, called the second one after a while. However, Chuch Den was also the one who looked after the mother during weng oing. During these three days of weng oing, the mother and her baby are especially vulnerable to any kind of spirit intervention. In particular ndreng ong, the fire spirit, is feared, as this spirit can cause the mother and her baby to die if he enters their bodies. To prevent any kind of spirit interference, a ceremony is usually done before the delivery, during the mother’s eighth month of pregnancy. Despite this protection ceremony, it is absolutely necessary that the midwife and the husband always be around the mother and her child after she gives birth, to take care of them. So today is the time to repay the midwives’ services by arranging the ceremony. Besides the kru njut ndüll, relatives and friends are invited to join the celebration. As visitors arrive, they are offered sra sor, glasses of alcohol which are empty quickly. The smell of food spreads throughout the room, plates are filled up with rice, and more alcohol is served, this time from the wine jars. But before opening the jars, it is necessary to pray to the spirits, to thank them for their help and support. Cam prays loudly together with a few relatives, offers a small part of the chicken to the spirits and spreads some drops of blood on the pot. Next, the visitors are invited to drink rice wine with a straw out of the jars and as soon as everybody has arrived, people start to eat. After the feast, bowls of uncooked rice with money on top are prepared and handed over by Cam to the midwives, their husbands and to the relatives who were present during the delivery. The mother joins the group and sits down with her son in her arms. It is the first time since her delivery that she leaves her bed. The visitors start to bless the baby by tying a string with some money around his wrist which was dipped in blood and wine, and wish the baby good health, a lucky and wealthy life. Peng starts to recall her experiences and memories from the delivery, telling those present how she felt, what she did and who came to help her. The atmosphere is very cheerful and happy. The party goes on for hours, but even though the ceremony will be completed soon, Peng is still not able to leave the house for another five days. Her body is not dried yet, an expression that refers to her bleeding, which means that she could attract
the spirits’ attention to her, putting everybody in the village in great danger of death.

In order to understand the different meanings, values and necessities behind this ceremony the following sections put the various elements in a broader context. The purpose is to explore why the traditional midwife is so valued, respected and consulted in the visited villages and what kind of considerations influence the villager’s decisions and strategies when dealing with a delivery and motherhood.

The necessity to respect the traditional midwife
Because Bunong communities, like other indigenous groups in this region, are largely based on principles of reciprocity (White, 1995: 23f.), arranging a ceremony post-delivery is indispensable. The family has to repay the services offered by the traditional midwife during the time of pregnancy, delivery and *weng oing*. Therefore, this ceremony marks the end of the traditional midwife’s engagement with the mother and her family.15

During pregnancy, women will visit a traditional midwife only in case of pain and indisposition. Through massaging the abdomen and the provision of traditional medicine the midwife releases her from discomfort. At the moment when labour starts, it is the husband’s duty to look for the midwife and call her to their house. The midwife is never going to assist a delivery on her own initiative, even if she knows that a woman is giving birth soon. The husband has to call her; anything else is considered impolite. In case the traditional midwife is not at home, he will try to find her in the fields, in a neighbouring village or wherever she might be at that moment. If it happens that she is not available, they will have to call another midwife or any woman regarded as having the necessary skills. In most cases, more than just one traditional midwife is present in one village, some of them more experienced than the others. Those with substantial experience will be more frequently in charge of assisting the delivery. The couple will choose the one they know best; sometimes she is a relative or a close family friend.

The way of becoming a traditional midwife varies and it is possible for any woman to acquire these skills. Either a woman gains the knowledge from an experienced midwife, who does not necessarily need to be a relative, through accompanying and watching her, or she has to do it on the spot, as certain situations require. One woman in Valyeung village described how she had to help her sister deliver the baby. They were in the field far away from the village, they did not have any means of transportation to return home and there was nobody else around to help. Therefore, she acted as the midwife, and since that time people call her to assist deliveries. Additionally, a few women reported, they have been called by the spirits to become a traditional midwife or had a specific dream. One traditional
midwife from Lauka village recounted the following story:

I had a dream. At that time I was 27 years old and not yet married. In this dream a woman came to me and handed me over a gourd filled with uncooked rice. The woman asked me to press on the gourd; if the rice dispersed it would be a sign to become a traditional midwife. I pressed on it and the rice dispersed. Thus, the woman said, it would be very easy for me to become a traditional midwife. The dream did not teach me what to do to assist a delivery, but after that I just started to do it. I observed other midwives through which I gained my knowledge.

To deliberately stop being a traditional midwife is not possible; as long as people call on her skills, a midwife cannot refuse to assist a delivery. One midwife in Lauka village shared the following:

In fact, I don’t want to be a traditional midwife anymore, because it is tiring and I am already old. But the neighbours keep on calling me, they ask me to come when somebody is in labour, so I cannot refuse. But to assist a delivery is very exhausting. Sometimes I have two women in one night and I cannot sleep and I am very busy.

As soon as the midwife arrives at the woman’s house or birthing hut, she will start to check her abdomen, massage it and give her traditional medicine to drink. She will ask the husband to boil water; she will put a string from wall to wall where the mother can pull herself up during her pains; and she will wash her and clean the bed. After the baby is born, the umbilical cord is cut with a blade and tied with cotton and strings. The placenta is buried next to the house to prevent animals from eating it. Some people use a special hut for the delivery that is built a few weeks before, and where the woman will stay until she is allowed to go outside again and return to her house. Losing blood after the delivery can still attract the spirits and put the woman in danger. The use of a birthing hut is not practised by everybody in the same way. Some people move to this hut, which is usually situated next to their house, only for the birth itself, and as soon as the baby is delivered they return to their home. Others stay in the hut for several days, together with their husband and children. The reasons for using a birthing hut are various: Depending on the family size, a couple sometimes prefers to have a quiet place. It is very common to have up to ten people living in the same house and, often, they do not have separate bedrooms, but all sleep in the same room, only using curtains to have some privacy. Other people reported that giving birth in the house could cause problems with the house spirits, as they do not like to be disturbed; therefore, they would use a birthing hut. Occasionally villagers do not dare to go inside and visit the mother and baby if she stays in the main house for fear of the spirits. Therefore, the birthing hut is seen by some people as a place where there is less potential for
spiritual interference and where they have a more intimate space.

Regardless of whether the villagers use a birthing hut or not, they all practise *weng oing*, the roasting. This practice is common throughout Cambodia, as well as Southeast Asia (Hoban, 2002: 1).

As soon as the baby is born, the traditional midwife lights a fire either under or next to the mother’s bed. As the body is believed to be cold after the delivery because the mother loses a lot of blood, the heat of the fire is needed for warmth and to bring back the mother’s strength, energy and good health. Besides maintaining the fire, the midwife massages the mother’s abdomen several times per day. The frequency depends on her health status and level of pain. The midwife’s pressures are deep, strong and very precise. The mothers feel relieved afterwards. The traditional midwife will also prepare traditional medicine for the mother and advise her on how to take it. Most of the women interviewed use parts of bark from three different trees. These pieces are either mixed with local distilled wine or prepared as hot tea. The purpose of taking it varies: it is either used to enhance the production of breast milk, to have good health in general, to encourage a healthy appetite, or to clean the body of the remaining blood in the mother’s abdomen. It was also reported by a few women that they eat *kun*, a certain kind of ginger, after the delivery to prevent spirit activity. The midwife also gives the mother advice on her diet and explains what kinds of food she is allowed to eat. During pregnancy, women eat mostly as usual and are not restricted to certain kinds of dishes. After the delivery, diet is generally reduced to rice, salt, and some kinds of fish, pork and beef. Vegetables are often not eaten, as people think it will give the baby diarrhea.

On the fourth day after delivery, the husband arranges the ceremony for the midwife. Some families organize it at a later point of time, depending on their financial situation. This is a very important event, practised throughout all the villages included in this study. For the first-born baby, the sacrifice of a pig is required, as the family is very relieved that everything is over and has gone well, since the first delivery is considered more risky than those that follow. For the next children, they only sacrifice chickens. Depending on the family’s economic condition, the event can either be held in a small family circle or involve many relatives, friends and neighbours with substantial food and alcohol provided for the guests and visitors.

Most of the people interviewed stated that they prefer to deliver at home in the presence of a traditional midwife. They feel more comfortable with her and all the relatives around to help and support. Sometimes, the villagers mentioned the high costs of delivering at the hospital or the health centre which includes transportation, medicine, payment for the delivery itself (which is between 10’000 and 20’000 Riel, approximately 2.5 - 5 US$) and the cost of living in the health
facility for the husband or other relatives. However, if this is compared with the costs of a ceremony for the traditional midwife, which includes 20'000 – 30'000 Riel (5 - 7.5 US$) for the midwives, small amounts of money for relatives present during the delivery, a pig and/ or a few chickens, the jars of rice wine, the local distilled wine and the food provided for the visitors, it can be estimated that a delivery carried out in the village is more expensive than one in the hospital. One can argue that this preference relates to the problem of accessibility, as roads are often poor and it is difficult for a woman in labour to travel long distances. But in fact, if women do give birth at the health facility, they will still perform a ceremony after returning home. Therefore, the choice of the place has no impact on whether a family carries out a ceremony or not; they will do it in any case. As a result, the expenses are higher if visiting the health facility because costs are almost doubled when including the ceremony once returning home. This situation certainly affects decision-making regarding delivery choices; however the beliefs and practices surrounding the spirit world are even more significant factors.

The necessity to respect the spirits
Among Bunong communityies illness is often understood to be created by the anger of spiritual forces, especially in long-enduring cases which cannot be treated and where the causes are unknown and inexplicable. People consider the time during and after delivery as potentially very dangerous for the mother and her child in relation to spirit intervention (White, 1995; Brown et al., 1996; Hoban, 2002; Crochet, 2001). These authors conducted research about women, pregnancy and delivery in Cambodia and all – despite the differences of settings – talk about the precarious situation regarding spiritual activity at this specific stage of life. White and Brown et al. worked with indigenous people in Ratanakiri province. Brown et al. found that most of the pregnant women contact the traditional midwife as their first choice. If they have a problem and her treatment and the advice does not help, they look for the traditional healer to find out what kind of spirit is causing the problem and what steps need to be taken: “Only once the sacrifice had been performed would the woman be allowed to leave the village to seek ‘modern’ health care (ibid. : 214).” White (1995) states that “children are considered more vulnerable and prone to sickness caused by particular spirits (ibid.: 45).” Hoban and Crochet researched the role of traditional midwives in Khmer communities and found similar results regarding the danger of spirits.“These spirits are all harmless if properly propitiated. However, if individuals or families disrespect, anger or fail to thank the supernatural beings, retribution in the form of illness or death could befall the perpetrator or their family” (Hoban, 2002 : 142f.).

Therefore, it is essential to set boundaries of protection for mothers which
prevent spirits from entering her body, making her physically and mentally sick or leading to death. One protection ceremony is carried out in the eighth month of pregnancy, where the *kru boran* (traditional healer) or the traditional midwife ties strings around the woman’s wrists, ankles, waist and neck. At the time of the delivery, a few branches of thorn bushes are put under the bed, under the house or next to it to avoid the appearance of spirits, as they like to eat the blood that might have dropped down during delivery. The protection from the strings is often renewed a few days after the child is born, by tying new strings around the mother’s body.

One of the spirits that is feared the most is *ndreng oing*, the fire spirit. It is the one that is primarily present during the delivery and the phase of *weng oing*, as the fire is constantly burning. If this spirit enters the mother’s body, people reported that she will fall unconscious, talk in a strange way as being another person, walk around in the birthing hut or the house and she will be in great risk of death. One woman interviewed in Sen Monorom recounted a time when a woman tried to pour petrol onto the fire at that state. It was also reported that if the fire spirit appears, the mother will see a rainbow or a flame. The *ndreng oing* can only be seen by the women giving birth and is not visible to any other person. Yet having the fire is obligatory, as the mother depends on it to recover from the strain of labour. The fire-wood needs to be selected carefully, as certain kinds of wood are more likely to draw the attention of the fire spirits. For this reason the fire is not only beneficial but, at the same time, precarious if not watched carefully. Therefore the husband and the traditional midwife, who are not at risk from these spirits, are around the mother all the time and should never leave her alone. Besides the protection through the strings, there is another way to keep the fire spirit away during delivery. The *kru hom* chews on a piece of *kun* (a kind of ginger) and spits it on the mother’s forehead which will keep the fire spirit away. Various types of *kuns* exist that are used in different ways and for numerous reasons. Some of them are used for ‘simple’ diseases such as fever, headache, stomach pains etc. and some of them only if spirits or black magic are involved (Schmitt, 2004: 59; Crochet 2005).

The mother is not allowed to leave the house for about ten days after the delivery, especially not to wash herself or her clothes next to a well, pond or river. Her blood would contaminate the water sources, anger the spirits and attract their attention. “The mother can only leave her house and wash herself at the well when her body is dried and not weak anymore,” as one villager stated. But she is allowed to receive visitors in her home and contact with her is not considered dangerous for them. To wash, hot water is used together with sour leaves that are believed to have a revitalizing effect on her body. These spiritual beliefs play a strong role in the decision-making processes of villagers when they decide where to give birth, who
to involve and how to behave. However there is another dimension of spiritual beliefs when it comes to the death of a woman in the village, or to the death of somebody that take place outside the village.

The case of maternal death
Fear of maternal death is overwhelming. If a woman dies during pregnancy, delivery or shortly after, nobody from the village is allowed to attend the funeral except the closest relatives. Friends and neighbours are prohibited from entering the family’s house or joining the ceremony. Every single material belonging of the mother has to be burned, including all the assets belonging to the rest of the family members and the house itself. Ignoring this rule puts every villager in great danger of death – these belongings attract the bad spirits. For the funeral, when the closest family members bury the mother, a big ceremony must be carried out, including the sacrifice of a buffalo or a cow. The mother’s death can be explained in different ways: either the ceremony during the eighth month of pregnancy was not carried out, or not in the proper way, the mother might have done something to anger the spirits (for example not respecting the rules concerning the forest spirit) or another person may have cast black magic upon her. To summarize, the time around delivery is extremely dangerous in relation to spiritual activity – a time when the woman and her baby are very vulnerable. Moreover, it is not only death that is feared, but also the possibility of dying outside the village. If anyone dies outside the village, the whole community is put in danger. A large ceremony needs to be performed, including the sacrifice of a buffalo or a cow to satisfy the spirits. Everybody has to take part in this ceremony and if they do not, every villager puts him or herself at great risk of death.

These spiritual concerns and their consequences strongly influence the Bunong’s decision-making processes regarding choice of delivery location. The likelihood of giving birth in a public health facility is evidently reduced.

Discussion
The ceremony for the traditional midwife is an important event. First, it is necessary to repay the midwife for all her time and skills used during pregnancy, delivery and early motherhood. During that time, she is a central person for the family and the woman. She contributes to the woman’s and baby’s wellbeing, makes them feel comfortable, creates a space of intimacy for them and advises on medicine, food and drink. Even though the traditional midwives interviewed share some general characteristics in how they assist a delivery, they do have different levels of expertise, functions and roles. This heterogeneity in the roles of people who provide birth assistance has already been demonstrated in previous
anthropological research on birthing (Davis-Floyd et al., 2001: 8). Some Bunong midwives have more experience, some have broader knowledge of traditional medicines, and some have the skills to set protection boundaries for the spirits to prevent spiritual interference. The process of learning and the motivation to become a traditional midwife also differ. Furthermore, some midwives received trainings and delivery kits from national training programs while others have either never been invited to such training, or have refused to take part in it. Those who rejected training said that they did so because they already know best how to assist a delivery, that they have years of experience and do not see any incentive for changing their practices and attitudes. Thus, the category of traditional midwives is very heterogeneous. Nevertheless, the traditional midwives in general do enjoy a high status within the communities, they are respected, totally accepted, and their advice much sought-after and followed.

The Bunong do use modern medicine; in fact they are very fond of taking all kind of pills and getting injections. During the research, nobody was interviewed who followed just one health system, only the traditional or only the biomedical one. People use these medical resources pragmatically. They usually combine different paths of treatment, and if one method does not have an effect on the patient's health status, another way is sought, often using them simultaneously, even if these approaches are contradictory or opposite to each other. Indigenous people in general in Cambodia, and Khmers, have behaved this way for some time (White, 1995; Hobson, 2002; Baird, 2008: 332). This poses questions about why the villagers do not use public health care facilities more frequently when dealing with pregnancy, delivery and early motherhood, especially if taking into account the various complications they face.

As outlined above, spiritual beliefs have a strong influence on how villagers decide to use health care options. Fear of angering the spirits, dying outside one's village and maternal death are widespread in the communities. In addition, using a traditional midwife to assist a delivery is common. It has been a widespread practice for as long as the Bunong can remember. Wiley's study (2002) describes different factors influencing people's likelihood of using biomedical maternity care. She concludes that communities with strong traditions of using traditional midwives meet the introduction of biomedical facilities with indifference, which has also been found in this study, to an extent. However, discussing only the strong culture and traditions for not using public health facilities is too simplistic. As Obermeyer (2000: 182) argues, such a culturalist trap should be avoided, as well as its opposite – the view that culture does not matter. Multiple factors influence and affect people's behaviour and decision-making. Other issues that must be considered are a lack of transport and the inaccessibility to public health facilities,
low trust in these “modern” systems, as well as in the “professional” staff members themselves, and other economic and financial constraints, such as the necessary expenses to stay in the hospital or health centre coupled with the additional ceremony back at home.

It is well known that the majority of women in Mondulkiri prefer to deliver at home. Different agents in this area have tried to deal with ‘traditional birth attendants’ by developing training programs and giving education in safe delivery practices, prenatal and postnatal care. However, little information exists about the Bunong’s customs, beliefs and perceptions regarding pregnancy, delivery and early motherhood. Attempting to estimate the impact that TBA training has had on the traditional midwives’ practices and behaviours is difficult. Many of the interviewed trained midwives stated that, from their point of view, they did not change anything. Den from Lauka village explained it as follows:

I didn’t change the way I assist a delivery. They [the people who trained her] provide me with a kit (soap, knife etc.). I think these things are very useful. And at the training they explain everything about hygiene. Now, I have to note the date of the delivery and the weight of the baby. After, I will give this information to the hospital. If I report back to them, they will provide me with more material. But I don’t know the difference between me and the midwife in the hospital; she only has more modern material.

However, Den, for example, is now much more respected in her village because she received various trainings. When pregnant women and mothers in this village are asked which traditional midwife they would choose to assist their delivery, the answer is usually Den. She is considered more competent and able to deal with difficult situations than other midwives from the same village. Even though traditional midwives do not always believe that their practices changed demonstrably as a result of trainings and courses, there was an effect on how some villagers perceived, respected and valued the midwives’ status, skills and role.

Conclusion
This paper presents some findings from a broader, ongoing research project about childbirth practices, perceptions, attitudes, decision-making processes and transformations related to pregnancy, delivery and early motherhood within Bunong communities in Mondulkiri province, Cambodia. The main findings for this paper include the following: Many factors are influencing the decision-making process of villagers when deciding who to contact and where to give birth. The most important point concerns the feeling of comfort, safety and security in a well-known environment – women want to deliver in their village, surrounded by family and relatives at home, or near to it. Due to the potential danger of spiritual
interference, pregnant women and new mothers like to have the traditional midwife nearby. She is the one who can be trusted and asked advice; she is experienced, knows how to react and what kind of measures to take. Even though the kru njut ndüll gives instructions to the prospective woman and the relatives present, she does not put herself in a superior position. The woman can set her own pace and can have a say in the process. For example, she and her family have to determine the moment to call the midwife, they decide who to choose, where to give birth, if they want to have a spirit protection ceremony or not, and who else to involve in the procedure. This reinforces the traditional midwives’ status within her community. This paper has reflected on the high levels of respect that traditional midwives are treated with. On the other hand, economic, infrastructural and social factors are also significant as the individual weighs up difficulties with lack of transportation, inaccessible roads to travel, the disinclination towards public health facilities and their respective staff, additional costs, and poor knowledge about basic health problems and issues. In this sense, the villager’s decisions depend on various internal and external factors and in each case they have to judge the specific circumstances.
Notes
1. *kru njut ndüll* is the Bunong expression for traditional midwife. In Khmer the term is *chmoab boran*.
2. This number includes the percentage of Mondulkiri and Ratanakiri province.
3. Maternal deaths are defined as any death that occurred during pregnancy, childbirth, or within two months after the birth or termination of pregnancy.
4. The WHO (1996) uses the following definition for midwife: “A midwife is a person who, having been regularly admitted to a midwifery educational program duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.”
5. Nomad RSI is a France-based NGO, established in 1997, which specialises in research and action relating to health and health practices among remote and ethnic minority communities in developing countries. The organisation has been working in Mondulkiri province since 2000, focusing on appropriate health education and the improvement of village level health care for ethnic minority groups. The research is supported by the French Embassy. See as well www.nomadrsi.org. The information presented in this chapter is part of an ongoing research project. Its findings do not claim to be completed yet as the author is still carrying on with the research. Therefore, this paper only highlights some of the results.
6. Sen Monorom is the provincial capital of Mondulkiri where the only hospital in the province is located. Sen Monorom itself is 380 km or a one day journey by car away from Phnom Penh, the capital of Cambodia.
7. These numbers are derived from the Department of Planning in Mondulkiri from 2006.
8. “La resource première des Mnong est la forêt, don’t ils tirent presque tout ce dont ils ont besoin. Les ethnologues parlent de ‘civilisation du végétal’ pour marquer l’imbrication de la vie humaine et social dans le cadre du végétal, plus ou moins domestiqué, et perçu comme gouverné par des puissances surnaturelles.” (Free English translation from the original text). *Mnong* is another way of writing “Bunong.”
9. Reproductive activities include running the household, like cooking, collecting firewood, fetching water, cleaning etc. Productive activities on the other hand consist of planting rice and vegetables, weeding, collecting wild vegetables and fruits, looking after pigs and chicken, fishing etc. (Berg, 1999 : 3).
10. Recent research showed that the roles of women leaders in indigenous communities are diverse and differ from village to village, as well within the families in each village (Ironside, 2007).
11. *weng oing* is Bunong and can be translated as “lying next to the fire.” The Khmer term is *ang pleung*.

12. In case of pain or problems for the mother, the traditional midwife will still come and treat her even if the ceremony already took place.


14. More explanation about the use and purpose of *kun* will follow in the next section.

15. The bigger the sacrificed animal, the more important the ceremony. This applies to every kind of ceremony among the Bunong.

16. In present day Cambodia, Khmer beliefs are rooted in an animist folk religion; therefore Theravada Buddhism co-exists with animism (Hoban, 2002: 129).

17. The *kru hom* is different from the *kru boran*. Both are traditional healers, but while the *kru boran* gained his skills and knowledge through studying and accompanying another *kru boran*, the *kru hom* was selected and taught by the spirits in the dream. The *kru hom* is usually called if the sickness is believed to be caused by spirits or black magic.

18. In Khmer the term *protiel* is used.

19. Almost every woman interviewed reported having lost at least one child, either during pregnancy or within a few months after the delivery.

20. The first TBA trainings in Mondulkiri were done by Médecins du Monde in 1998. After they stopped in 2002, the Provincial Health Department and the Operational District, supported by the NGO Health Net International, continued to work with TBAs and still provides some support.
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