

Midwife Missionary or Missionary Midwife?

Creating Sustainable Change for Mothers and Babies

By **CARRIE BLAKE**

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Moussa asked me to come to his home and see Rahila, his wife, who had just given birth. He was worried about the baby, who was crying inconsolably. He has four wives and at least 18 living children. One day I asked how many of his children had died. Five. Five children had died before they were 12 months old: three of them on the first day of life.

They traveled on from Bethel, and when Ephrath [Bethlehem] was still some distance away, Rachel went into labor—and her labor was hard. When the labor was at its hardest, the midwife said to her, “Don’t be afraid, for you are having another son. ... Rachel died and was buried on the way to Bethlehem.” (Genesis 35:16-17 NEV, paraphrased)

Midwives most often usher in life. But, as with the few mentions of midwives in the Bible, midwives are often dealing with death. In the year 2020, roughly 210,000 women died during and following pregnancy and birth. 86% of maternal deaths occur in Sub-Saharan Africa and Asia—the 10/40 Window—and most are preventable. The World Bank shows the neonatal (first 28 days of a baby’s



life) mortality rate in eight of the 10/40 Window countries to be above 30 deaths per 1000 births (2020). The World Health Organization (WHO) reports that one third of all neonatal deaths occur on the day of birth. In Pakistan alone, 153 babies are born alive on any given day—and die on that same day.

The women and babies in the 10/40 Window are dying before they hear about what happened on that night long ago when God arrived on earth, fully human. They are living without knowing and following Christ and dying of preventable causes in pregnancy, birth, postpartum and early childhood. As we work to make Christ known in the 10/40 Window, **how can we equip Unreached People Groups (UPGs) to save the lives of their mothers and babies and improve overall health without creating dependency?**

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For the past 100 plus years, missionaries have set

up clinics and hospitals, run and primarily staffed by outsiders. While these institutions and projects are good, they are not sustainable due to outsider initiative and dependence on outsider skills. The institutions answer the command to care for the “least of these,” but they most often do not address and solve endemic issues of poverty (physical and spiritual), nor do they equip the people to create their own sustainable healthcare infrastructure.

The WHO recommends all births be attended by Skilled Birth Attendants (SBAs). Births in the 10/40 Window traditionally take place at home, attended by village midwives (commonly called Traditional Birth Assistants and referred to as community midwives in this article) who are not skilled according to the WHO. These community midwives are: often illiterate and almost always under-educated; respected and trusted members of their communities; and the midwives who witness death far too often. They are skilled in providing care at the time of birth and immediately postpartum—to the level of what they have had the opportunity to learn.

SBAs have skills and knowledge that are useful regardless of where they are in the world. It is the SBA’s job as a missionary to walk *alongside* the community midwives and introduce them to Christ, providing example and teaching of vital medical skills, but not taking over the midwifery role. Approaching healthcare from the grassroots of community midwifery can and will result in sustainable change as these core members of UPG communities add to their skillset and understanding of Christ.

I arrived at Moussa’s house—five bedrooms lined up, each with a “front porch” of grass mats—and he led me to the newborn and her mother, lying on a porch mat, dust swirling around them as children scuffled nearby. The baby was crying inconsolably. “When was she born?” “Who was there?” “Tell me about it.” I asked them to call the community midwife to come over so that we could talk. The community midwife was open, and I learned from her the tradition of not having the baby latch until the milk was in on day two or three due to a belief that there is nothing available for the baby in those first days. In truth, the available colostrum is crucial for the baby’s well-being. I wracked my brain for a way to honor the tradition yet get the baby to the breast, which is what she needed most.

The community midwife told me she thought the baby was cold and asked what I thought we should do. I asked her what she thought we should do. Eventually, we agreed to try putting the baby skin-to-skin with Rahila. Within four minutes, the baby squirmed her way to the breast and latched on, thus ending her frantic crying.

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“Midwife Missionary” is traditionally defined as someone who is trained in childbirth and women’s health and uses these skills to provide Christ-centered care in a cross-cultural environment. A midwife missionary can easily work in a hospital or clinic in any 10/40 Window community. She can easily spend her life caring for families and providing Christ-centered care. History has proven, though, that when the outsider midwife missionary leaves, progress is not sustained. We know that *outsider initiatives* do not result in long-term change without dependence.

When midwives enter as doers (as medical missionaries traditionally have), they and the people with whom they are living become performance-based rather than Christ-focused. Perhaps missionary midwives should enter communities, not hiding that they are midwives but not actively practicing either. They should invest their time and energy integrating into the culture and building relationships (which midwives are expert at doing) without the safety net of practicing. Rather than initiating practice, SBAs ought to wait for the community midwives to discover how they want the SBA to enter the UPG’s sacred world of midwifery. If we remove the expectation that midwife missionaries work in a hospital or clinic and instead set the expectation that the *missionary* call comes before the *midwife* call, then we can more reliably move toward sustainable healthcare and people movements because community midwives will be the ones with

ownership of any change, rather than the outsider.

Moussa and I were talking a few days later and I asked how the baby was doing. He lit up and told me she was the happiest baby of any of his children and that she was still at the breast “constantly.” He proceeded to remind me of how I would earn favor with God for my good deed of helping his family. I responded, “You know, this is the difference between your faith and mine. In your Muslim faith, you do good things in hopes of earning God’s favor. As a Christian, I do good things because I believe that through Christ God has already given me favor. I do good things out of gratitude.” His eyes widened and he exclaimed, “No Christian has ever explained this to me! Now I understand!”

Just as we must be willing to allow Christianity to unfold contextually, missionary midwives need to be willing to allow birth to remain in cultural context, likely never being the primary care providers. Given this, how can missionary midwives facilitate indigenous health infrastructure and changes in practices related to pregnancy, birth, postpartum and early childhood?

The king of Egypt said to the Hebrew midwives, whose names were Shiphrah and Puah, “When you are helping the Hebrew women during childbirth ... if you see that the baby is a boy, kill him; but if it is a girl, let her live.” The midwives, however, feared God and did not do what the king of Egypt had told them to do; they let the boys live. Then the king of Egypt summoned the midwives and asked them, “Why have you done this? Why have you let the boys live?” The midwives answered Pharaoh, “Hebrew women are not like Egyptian women; they are vigorous and give birth before the midwives arrive.” (Exodus 1:15-20)

Traditionally, Shiphrah and Puah are assumed to be Hebrew. However, it is more likely that they were Egyptians. If they were not Egyptian, how could Pharaoh command them to kill the Jews? And, if they were Hebrew, why wouldn’t they have shared his command with their people? Recent parchments (the Genizah fragment), clearly list Shiphrah and Puah as Egyptian women. Shiphrah and Puah were outsiders who had become alongsiders to the Hebrews.



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The missionary midwife integrates into the community, becoming an alongsider who is *available* to add to the community midwives’ knowledge and skills *when the community midwives express a desire for this*, but who does not take over the birth practices. Community midwives are expert at “performing” for outsiders who enter their communities as “doers” because historically, performance results in financial gain. This expectation can be minimized when the community midwives are the initiators, and the outsider is a member of the community through relationship (not profession).

A missionary midwife who is an alongsider can, in time, teach the community midwives healthcare

skills that will save mothers and babies. By using a community health evangelism model, the knowledge and skills learned by the community midwives can be the basis of an indigenous maternal/infant healthcare system that is not dependent on outsiders for sustainability. Missionary midwives share their faith in one-on-one relationships and by integrating the gospel into lessons and discussions about nutrition, relationships, resuscitation, stopping hemorrhage, breastfeeding, and any other topic in which the community midwives are interested. Structuring the learning in a manner that sets the expectation that the community midwives will carry forward what they have learned and share it with their people is vital. The community midwives are inside community members' houses sharing wisdom and skills, not the missionary midwife, thus allowing contextualization. In people movements, the insiders further the movement. Likewise, in improving healthcare structure and wellbeing, the insiders continue and grow the movement. Just as we pray for People of Peace who will be integral to moving a UPG toward Christ, we need to pray for the community midwives of peace who will be integral to moving the people toward physical and spiritual health, rather than instituting outsider initiatives.

When Jesus was born, a community midwife was likely present. She didn't know that the baby born that night was fully human and fully God. But she was present with Mary and likely became a trusted friend. Perhaps she was one of the women who followed Jesus during his ministry. Perhaps she then began sharing the Good News with every family with whom she worked, while at the same time continuing the cultural traditions practiced during birth, which probably included the recitation of Psalm 121. Integrating the Good News into her care was natural and did not require her to culturally change what she was doing. Missionary midwives can likewise be diligent to encourage community midwives to "do" midwifery as they always have while integrating their new skills and understanding of God in culturally appropriate ways.

The highest impact missionary midwives can have on the spiritual and physical lives of unreached people is as alongsiders. For the purposes of

sustainability, it is key that missionary midwives enter communities as learners instead of doers, waiting until they are asked to participate *alongside* the community midwives before teaching or practicing. Missionary midwives are in a unique position because their vocation naturally allows them entry into deep relationships with the UPG. As an alongsider who has been invited to facilitate growth and change, the missionary midwife has the capacity to equip the people group for lasting change—physical and spiritual—that is independent of her presence. Through the missionary midwife's relationships—professional and personal—with the community midwives, we can sustainably equip UPGs to save the lives of their mothers and babies.

I realized at that moment that God had used midwifery and my willingness to come alongside the community midwife on Rahila's and her babies' road to Bethlehem to forever change the trajectory of their family's life through a simple relationship with a man named Moussa.

Two years passed and Moussa came to me with news that Rahila had given birth again and that, this time, the community midwife put the baby skin-to-skin with Rahila soon after birth, allowing the baby to latch at the breast. I asked if I could pray for the baby. He said, "Of course!" I went and prayed a simple prayer, ending it with "In the name of Christ, Amen." I heard him repeat the phrase, "In the name of Christ, Amen." and I realized at that moment that God had used midwifery and my willingness to come alongside the community midwife on Rahila's and her babies' road to Bethlehem to forever change the trajectory of their family's life through a simple relationship with a man named Moussa. 