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Towards a Framework for Constructive Friction Processes

What Childbirth Practices in the Global South Teach Us about Destructive and Constructive Friction

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This paper proposes a simple framework to understand constructive friction processes. In the framework, constructive friction is understood as a symmetrical integration between different bodies of knowledge and practice, and has three manifestations: integration occurring within actors, between actors, and at an institutional level. To explain this framework, we apply it to a recent study on childbirth practices in Latin America, specifically the changing relationship between midwifery and Western medicine. Latin American midwives have resisted destructive friction processes and are starting to participate in constructive friction processes in which their work is horizontally integrated with—and not into—Western medical practice. In our paper we also argue ethnographers have an advantage to apply the framework to understand and even engage in friction processes, because of our critical and methodological disposition.

Keywords: Global South, Western medicine, childbirth practices, displacement, assimilation, integration

INTRODUCTION

A good way to start a discussion about friction is to look towards the Global South[1]. The history of these regions has arguably been one of constant friction processes between two or more agents. These processes have been destructive—when one of the agents is displaced, annihilated, or assimilated by other agents—or constructive—if different, sometimes opposing agents achieve non-hierarchical integration.

This paper focuses on constructive friction seen in the Global South, which we understand as a symmetrical integration between different bodies of knowledge and practice. Its main contribution is a simple framework to identify and thoroughly understand constructive friction processes as something that may occur (1) within actors, (2) between actors, and (3) at an institutional level. We also argue ethnographers have an advantage to apply this framework to understand and even engage in friction processes, because of our critical and methodological disposition: while our mindset is to question the universalizing tendencies of Western modernity

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(Escobar 2018), our methodologies enable us to study cultural flows and processes rather than fixed and inalterable cultures (Desmond 2014).

To demonstrate the validity of our framework, we apply it to a recent study on childbirth practices in Latin America, specifically the changing relationship between midwifery and Western medicine. We will show how Latin America midwives have resisted destructive friction processes and are starting to participate in constructive friction processes in which their work is horizontally integrated with—and not into—Western medical practice. What at first glance sounds like a niche subject should be considered a success story of revisiting historic and current phenomena from the perspective of friction. Our hope with such a story is to encourage fellow practitioners to apply our framework elsewhere and to consider it as a tool to advocate for constructive friction processes.

Also worth mentioning is the fact that, with this paper, we hope to contribute to the study of women's historic and present role in medicine, a role that can certainly benefit from a discussion about friction. We're glad to be doing this as researchers working in the Global South, a voice that feminists interested in healthcare and medicine can benefit from. Furthermore, with the hopes of exciting the reader about midwifery, it should be contemplated that practices revolving around childbirth are often considered a reflection of a society (James and Reed 2020) and that hospital childbirths, which are the norm in Western societies, are actually a very recent historical development that is best described as "an active takeover by male professionals." (Ehrenreich and English 2010, 28).

Our paper is divided into three main sections: first we will describe what destructive friction processes look like in the case of midwifery and Western medicine. This will provide a historical context to more accurately understand the second section, in which we introduce our constructive friction framework and its three manifestations (constructive friction within actors, between actors, and at an institutional level). Finally, in the third section, we argue why ethnographers have an advantage in terms of applying this framework to understand and even engage in friction processes.

DESTRUCTIVE FRICTION

Rather than attempting to provide a thorough history of midwifery, in this section we focus on those specific moments in history where destructive friction between midwifery and Western medicine (not just in Latin America, but globally) is most evident: the displacement of midwives as a result of doctor's monopoly on childbirth—destructive friction by displacement—and the medicalization of midwifery as means to incorporate midwives into Western medical practice — destructive friction by assimilation.

Destructive Friction by Displacement

Childbirth experienced significant changes during the nineteenth century, as a result of more encompassing societal transformations that were also taking place. It was during this period of time that "expert knowledges" disrupted previously "taken-for-granted practices" in modern societies (Escobar 2018) and that Western knowledge established itself as more objective and universal and thus more legitimate (Nieto 2019). Likewise, the firm belief in applying technique, calculation, and technology to overcome bodily limitations—a legacy of the Industrial Revolution mindset—became widespread (Hernández 2012). These transformations affected childbirth in a way that is best described as destructive friction. Childbirth was reduced to a physiological process, one devoid of emotional and spiritual dimensions and beyond the scope of the midwife. Doctors, medical protocols, drugs, and hospitals became the norm and permeated not just childbirth, but pregnancy and childbearing as well (Ehrenreich and English 2010). The disciplines of gynecology and obstetrics consolidated during this time replicated this belief, and thus contributed to the Western hegemony on childbirth.

There are at least two reasons why this displacement of midwives is destructive. First, in the Western medical paradigm, childbirth became something that is done to women, rather than something women do. Women undergoing labor were—and still are—immobilized and not fully informed about drugs and procedures used. This was reinforced by the fact that childbirth was taken out of the homes and into hospitals, something worthy of attention if one applies the body-territory extension present in feminist theory (Borboleta and Nicté 2020). Second, the way doctors perceived and approached puerperal fever, an infection that occurred in women shortly after childbirth, actually increased maternal deaths. It was thought that a woman undergoing labor could be "auto-infected" by her own bodily fluids, so the logical solution was to disinfect her genitals—instead of having the doctors use medical gloves (Hernández 2012).

In this discussion about destructive friction, we prefer to talk about displacement rather than annihilation. After all, midwives continued their practice throughout the nineteenth century and beyond, without institutional support and in the periphery, that is, places relatively untouched by the medical paradigm (Hernández 2012). This coincides with Ehrenreich and English's observation on the historic role that women have played in medicine as autonomous (non-institutional) healers or healers of the poor and vulnerable (Ehrenreich and English 2010). This, however, doesn't mean destructive friction should always be understood as displacement; fellow practitioners interested in studying phenomena from the lens of friction processes should consider if these processes are destructive due to displacement or annihilation, or both.

Destructive Friction by Assimilation

The professionalization or medicalization of midwifery during the twentieth century introduces us to the notion of destructive friction by assimilation (rather than displacement). During this period, it became possible for women to enroll in university programs and obtain the title of midwife or "licensed obstetrician" (Marina, interview). This was encouraged via healthcare reforms, at least in Latin American countries, where we've conducted most of our ethnographic fieldwork. And it is precisely because of this fieldwork that we've understood that what might seem like a genuine effort to integrate the midwives' vision to Western medicine is actually an assimilation, or the absorption of an agent perceived as passive by an agent perceived as active.

There is one particular actor that has contributed the most to our understanding of destructive friction by assimilation, which is Latin American independent midwives[2]. Unlike traditional midwives (usually found in indigenous or afro-descendant communities, and whose practice is an extension of their community's cosmovision), independent midwives do not limit their practice to a specific ethnic group. Some of them even have a background in medicine, but have resisted the medicalization of midwifery and practice it "independently". They describe assimilation as midwives being trained to become (and reduced to) the collaborators or assistants of the still authoritative doctor (Borboleta and Nicté 2020; Marina, interview). On a similar note, feminists have used the following remark to refer to women nurses, but it applies just as much for twentieth century midwives: they were "…incorporated as workers into an industry where the bosses are the men." (Ehrenreich and English 2010, 26).

Fellow practitioners interested in our approach to friction should acknowledge assimilation can be just as destructive as displacement or annihilation, as it implies a *total rejection* of the forms of knowledge and practices that the midwife—or any agent considered passive—brings to the table. Latin American independent midwives we've conducted ethnographic interviews with argue university or state-led programs on midwifery do not contain anything derived from traditional midwifery, despite there being a rich tradition in these countries. A concrete example is a certification program for aspiring midwives in Mexico, which restricts (and not just advises against) the use of medicinal plants and enforces the use of synthetic oxytocin (Proyecto Matriz, interview)—despite the empirical evidence in favor of plant use in the long-standing midwife tradition in the country.

Another example of the destructive properties of assimilation is the fact that traditional, non-Western midwifery is valid only in the absence of medicine, science, and development. The work traditional midwives do in their rural and/or ethnic communities is praised and admired but just until medical and scientific progress reaches these communities (Borboleta and Nicté 2020); from there onwards, they become subject to assimilation. This results in the exoticization of midwifery:

something less developed peoples practice for lack of a better option, before being exposed to modern science and medicine.

Our examples illustrate why independent midwives emphatically distance themselves from midwives that have been assimilated into Western medical practice, or midwives that have become "just another pawn" of the hegemonic medical system (Marina, interview). They argue that, in the context of assimilation, exercising independent midwifery is an act of resistance (Borboleta and Nicté 2020).

THE CONSTRUCTIVE FRICTION FRAMEWORK

Having explained how destructive friction can be understood as displacement or assimilation, we will now address constructive friction—understood as the symmetrical integration between different bodies of knowledge and practice—and how it can happen within actors, between actors, and at an institutional level. These three manifestations of constructive friction make up a framework, which is this paper's central contribution, in the sense that it can be applied to understand friction processes beyond midwifery and medicine.

Manifestation 1: Constructive Friction Within Actors

Integration processes usually imply there should be at least two actors or entities that are to be integrated. However, just as constructive friction occurs between actors (see manifestation 2), it can also occur *within* actors. What makes a single actor a carrier of constructive friction? Fellow practitioners should watch out for the following characteristics:

1. Actors that have willingly pursued or been exposed to more than one body of knowledge practice, background, profession, discipline, belief system, etc.

2. Actors that usually are self-taught: they don't learn about their preferred combination in a formal education setting, which makes them recursive, empirical, and permanent learners.

3. Actors that feel comfortable integrating different bodies of knowledge and practice and see this as necessity rather than experiment.

4. Actors that, by recurring to different bodies of knowledge and practice, have a great capacity to run holistic diagnosis and identify the root causes of specific problems, and are thus more critical.

Applying this to midwifery and Western medicine, it is clear that independent midwives are actors of constructive friction:

1. Many independent midwives we've encountered in the field have a background in Western medicine (physiotherapists, general practitioners,

etc.). This means that, although they have emancipated, they still conservate and hand-pick specific medical practices in their work.
2. Independent midwives are indeed self-taught, due to a lack of formal education on independent midwifery. This has led them to become mentors of aspiring independent midwives.
3. Besides combining elements from traditional midwifery and Western medicine, independent midwives are applying and mixing alternative medicines, gender studies, herbology, technology, epigenetics, and many other bodies of knowledge. They have a large and ever-changing repertoire when it comes to pregnancy, childbirth, and childbearing, and thus see more conventional and one-dimensional actors (doctors, but traditional midwives as well) as more limited.
4. Independent midwives see obstetric violence experienced by women during pregnancy and childbirth as gender-based violence embedded in the medical system (Borboleta and Nicté 2020) and thus understand being a midwife is also being an advocate for women's sexual and reproductive rights.

Manifestation 2: Constructive Friction Between Actors

This second manifestation of constructive friction occurs when two actors with different (and sometimes opposing) bodies of knowledge or belief systems recognize and respect each other's strengths. This can lead to:

1. Both actors not overstepping or outshining each other

2. Symmetrical cooperation between actors

In the case of midwifery and Western medicine, we have examples of both:

1. In Mexico, we observed a tacit agreement between some independent midwives and doctors about roles and responsibilities: these midwives are in charge of healthy women, while a Western doctor would be activated for specific cases, like women with hypertension or similar pathologies, as well as women who require surgery. In specific cases, the independent midwives willingly refer women in their care to these doctors. So rather than rejecting Western medicine as a whole, what is rejected is the idea of Western medicine always determining the standard protocol for assisting childbirth (Borboleta and Nicté 2020; Sara, interview). This agreement is desirable and very different to what happens between these two actors under destructive friction: for example, other Mexican independent midwives argue that some doctors react negatively and judgmentally when they attend to a woman in labor who was previously under the care of a midwife and experiences a pregnancy-related emergency (Proyecto Matriz, interview).

2. An illustrative example of total cooperation is the "intercultural midwifery" practiced by the Mujeres Bachué Foundation in Colombia. The foundation's promoters consider themselves "weavers" of traditional, indigenous midwifery, Western medicine, Western science, and Colombian legislation (Sara, interview). The diversity of the staff and how they're trained, as well as the services offered (consultations, workshops, courses, and ceremonies), are all founded on the principle of interculturality, so assimilation and hierarchies between traditional midwifery and Western medicine are avoided. The foundation also plays an activist role: they lobby with decision-makers to establish a legislation on midwifery and participate in protests revolving around women's sexual and reproductive rights and indigenous rights. There are more examples of intercultural hospitals in Latin America that provide healthcare services in general, not just those related to pregnancy and childbirth. The Makewe Hospital in Chile has been administered by the indigenous group of the Mapuche since the 1990s. The hospital has implemented a detailed model of intercultural healthcare: indigenous medicine is combined with biomedicine, non-Mapuche staff are trained in Mapuche culture, and patients can access both pharmaceutical and herb medicines in the hospital pharmacy (Torri 2011).

Although these forms of cooperation involve institutions (hospitals), we do not consider them constructive friction occurring at the institutional level, which is our third manifestation. This due to the fact that they depend on the will of specific actors and not on state-led initiatives which limits their capacity to be replicated beyond specific sites.

Manifestation 3: Constructive Friction at the Institutional Level

This third manifestation of constructive friction occurs when different bodies of knowledge and practices are integrated in formal institutions, and is usually the result of state-led initiatives or public policy reforms. In the case of midwives, and specifically those in Latin America, although some institutions still promote assimilation and thus destructive (rather than constructive) friction, there are institutional efforts worth pointing out. The World Health Organization's 1985 Fortaleza Declaration, as well as its 1996 "Care in Normal Birth: A Practical Guide", called for the humanization of childbirth and thus include recommendations inspired by the midwife's holistic approach. Colombia's Law 2244 of 2022, which roughly translates as "Law for respected and humanized childbirth", is a more regional example. Or the more recent Law 2310 of 2023 ("Law of empty arms") to address women's mental health when miscarriage occurs. Independent midwives in the country argue laws like these support and vindicate the practice of midwives, both independent and traditional.

A Western medical guide or protocol that perceives pregnancy and childbirth the way midwives do can also be considered constructive friction at an institutional level. Hospitals institutionalizing the method of kangaroo care (skin-to-skin contact) for premature babies, as opposed to incubator care, is an example of this. Among the recognized benefits of this care method is the emotional bonding and stress reduction for the newborn and the parent (Kambarami et al. 1998), which means factors beyond the physical are being considered. Another example is Western medicine's current debate on whether hyperemesis gravidarum, or severe vomiting during pregnancy, could be aggravated by social and psychological factors, as no physical cause has been detected (Munch 2002). Such examples demonstrate how views on pregnancy, childbirth, and neonatal care that are often seen in midwifery can be successfully incorporated into Western medicine protocols.

Independent midwives and scholars argue that these institutional efforts occurring within healthcare must be embedded in broader societal transformations to become truly sustainable. It is hard to imagine how an intercultural health policy can persist if indigenous communities still face structural inequality or if they cannot access intercultural citizenship (Torri 2011). This is why independent midwives have high regard for legislation that strives towards interculturality in general, not just in healthcare. Article 246 of the Constitution of Colombia, for example, states indigenous groups can exercise jurisdictional functions within their territories, as long as they do not conflict with Colombian Law.

When looking for this third manifestation of constructive friction, our recommendation is to rely less on ethnographic fieldwork and more on desk research, considering institutional efforts will almost always be expressed in official documents, such as laws, guides, and protocols.

ETHNOGRAPHY AND THE CONSTRUCTIVE FRICTION FRAMEWORK

Having explained our constructive friction framework, we have a final objective: to convince the reader that ethnographers are well-equipped to apply this framework and thus understand friction processes. This advantage is due to our critical and methodological disposition.

Critical Disposition

Regarding our critical disposition, ethnographers have the ability to not just describe, but acknowledge and even validate different cultures. This ability has arguably been present since early twentieth century anthropology and it is best seen in the way English anthropologist E.E. Evans-Pritchard describes the role of witchcraft in the Azande community in Sudan. Evans-Pritchard is more interested in conveying that, among the Azande, witchcraft is a reasonable explanation for falling down or for pots breaking, than in proving them wrong (Geertz 1983).

This acknowledgment and validation of multiple realities has also been discussed by Colombian anthropologist and post-development thinker Arturo Escobar, who invites ethnographers and designers to open up to the pluriverse and thus challenge the universalizing tendencies of Western modern thought: "The understanding of the world is much broader than the Western understanding of the world." (Escobar 2018, 68). We really can't think of a better mindset one should adopt when studying friction processes, specifically processes in which there are Western and non-Western agents, as is the case of midwifery and Western medical practice.

Likewise, the contribution of postcolonial theory—best summed up as the interpreting power relations in the context of colonialism and its legacy—is relevant for ethnographers wishing to study friction processes in the Global South: understanding power enables us to understand whether integration efforts are constructive (integration) or destructive (assimilation). And a final example of the ethnographer's adequate mindset is Susan Sontag's "Illness as metaphor", a work that has enabled those of us working in healthcare to always contemplate the societal and symbolic dimensions in medical conditions. In the case of midwives, adopting this mindset enabled us to understand the violence implicit in reducing childbirth to a physiological process.

Methodological Disposition

There are several ethnographically based methodologies that can be used to successfully study friction processes. In our study, we applied Demond's relational ethnography, in which boundaries (not bounded groups) and processes (not processed people) become the ethnographic object (Desmond 2010). Thus, our ethnographic object was not Latin American midwives, but *the relationship* between midwives and Western medicine. Having defined our objective using this framework enabled us to design a pointed research agenda (recruitment scripts, guides, debriefs, etc.). Since it challenges bounded groups, relational ethnography also enabled us to challenge imaginaries revolving around "the midwife"; it became easier for us to quickly grasp differences between traditional midwives, independent midwives, and licensed obstetricians. Desmond's recommendation is aligned with Olwig and Hastrup's comment on there being a shift in the anthropological object, from bounded group culture to cultural flows (Olwig and Hastrup 1997). This should encourage ethnographers to design and conduct studies that revolve around processes, such as friction processes.

Also regarding methodology is the vindication of anecdotal and qualitative evidence as the best evidence to understand friction processes. In the case of midwives, it is due to ethnographic fieldwork that we, and researchers before us, could understand there can be a hierarchical, unbalanced, and implicitly violent integration—assimilation—that is just as destructive as displacement. This form of violence been impossible to document and decipher from statistical forms of evidence. The vindication of qualitative testimony is especially important for

ethnographers working in healthcare, considering the establishment of the evidence-based medicine (EBM) paradigm. EBM prioritizes evidence from biostatistics, engineering, and epidemiology and questions the reliability and truthfulness of testimonies and anecdotes (Adams 2013).

Two final methodological recommendations: critical discourse analysis encourages ethnographers to detect how language reinforces power and inequalities (Blommaert and Bulcaen 2000). Although we did not use this methodology in the present study, we have applied it in other studies to understand how Western hegemony on medical practice is perpetuated through language, both in informal conversations and formal communications. It has been key in our understanding of the frictions present in patients' experience with HIV, menopause, obesity, and diabetes. And there is also Portes's invitation to look for "elements of social life" (values, norms, skills, and roles) that underly institutions and institutional change (Portes 2006). This is relevant for our framework, because it suggests constructive friction can occur at an institutional level.

CONCLUSION

In this paper we have presented a constructive friction framework that ethnographers can apply to understand friction processes. We have attempted to demonstrate the utility and robustness of the framework by applying it to a study on childbirth practices in Latin America, specifically the changing relationship between midwifery and Western medicine. We would like to conclude with a discussion that came up during the elaboration of the paper, and it's whether ethnographers should understand friction processes to necessarily *engage* in these processes—or whether *understanding* them is enough.

On one hand, understanding without engaging in friction processes does seem good enough, if we consider that it is already a novel thing to revisit past and present phenomena from the perspective of friction. Additionally, understanding these processes is not a passive exercise, if it is an exercise that inspires or becomes input for decision-makers. This is aligned with what some of our colleagues believe about not judging the social scientist's work solely on whether they are actively engaging in societal transformations. And it is also where we stand with our study on midwifery, considering we haven't engaged in the friction processes we're understanding.

On the other, it is provocative to think how our paper could be a call-to-action, a manifesto of sorts for ethnographers to not just understand, but advocate for constructive friction processes. This is relevant in the Global South, where some scholars argue practicing anthropology is inherently political, in the sense that we are studying "ourselves" or communities within our territory (Clarac de Briceño et al. 2016). An explicit example is the case of anthropologists working in conflict resolution and peace-building efforts in countries with severe civil conflict such as Colombia and South America (Castillejo 2017). It is also the stance of medical

anthropologists Nancy Scheper-Hughes and Paul Farmer, who have emphasized the role of the "engaged anthropologist" in mitigating health disparities and social inequalities.

The critical and methodological dispositions that we have described apply regardless of whether ethnographers wish to understand or to understand to engage. Also, the first step is *always* to understand unfolding friction processes in a structured way, which makes our framework essential regardless of the final purpose of the ethnographer.

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María Paula Toro is a Colombian lawyer with special interest in migration and the rights of migrant women. She currently lives in France and works for the French Red Cross, helping missing people in humanitarian contexts. Her passion for childbirth practices and the fight to reclaim this rite of passage led her to become a doula. She is founding member of the feminist organization Siete Polas, which ceased its activities in 2023.

NOTES

1. In this paper we use the concept of Global South to refer to those regions of the world that in the 1950s were suddenly labeled as less developed and thus subject to expert and technical interventions: Asia, Africa, and Latin America. In the words of Colombian anthropologist and post-development thinker Arturo Escobar, "As Western experts and politicians started to see certain conditions in Asia, Africa, and Latin America as a problem, a new domain of thought and experience, namely, development, came into being, resulting in a new strategy for dealing with the alleged problems." (Escobar 1995, 6).

2. We conducted ethnographic interviews with independent midwives from Mexico, Colombia, and Argentina. The main objective of these interviews was to discuss the historic and present relationship between midwifery and Western medicine in Latin America. All independent midwives interviewed were aware the interview was being conducted for an academic paper.

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