Childbirth and medical pluralism in multiethnic Mexico

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Introduction

This chapter asks how intersecting birth models in Mexico might unfold on the physical and social body in disparate ways, depending on the geographical context, socioeconomic status, and education level of patients. I address the hybridization of birth attendant roles and medical pluralism with respect to birth practices. As different birth attendants engage in "traditional", biomedical, and humanized birth models (each described in detail, below), at times, their "awkward engagement" (Tsing 2005) has a profound impact on the health of women and newborn children. The contradictions produced by hybridization can be examined to reveal profound structural inequality in Mexico. Only through problematizing pluralism in birth practices in Mexico can we truly understand the challenges that continue to undermine gender equity, reproduce maternal mortality, and limit the development of effective and appropriate health care across ethnicity, space, and place. I examine the models and methods applied by different groups of birth attendants in Mexico – "traditional" and "professional" midwives (the terms "traditional" and "professional" will be problematized, below), obstetricians, and obstetric and perinatal nurses – to respond to the reproductive health care needs and preferences of Mexican women across ethnic groups, socioeconomic class, and geopolitical divisions. While studying the multiple struggles about gender, health, birth, human rights, and inequality in which these different groups engage, I avoid either/or types of analysis (Montoya 2011). That is to say, I resist the temptation to condemn obstetricians and romanticize midwives, and vice versa. I am attentive to the ways medicalized birth, cesarean section, and technological interventions are desired and provide reassurance for

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some women. Also, it is possible that even the humanized birth movement can perpetuate certain forms of violence and discrimination.

Methods

In December 2010, I first traveled to CASA (Center for the Adolescents of San Miguel de Allende), Mexico's first accredited professional midwifery school. Subsequently, I performed sixteen months of in-depth fieldwork related to medical pluralism surrounding birth, ethnicity, and class, and how these three vectors are influenced by global flows traversing the Mexican landscape. Following after Rayna Rapp's multi-sited research on amniocentesis (2000; Marcus 1995), I aim to create a montage of midwifery and humanized birth in Mexico, follow the object (Menéndez 1996), and find different "windows" through which recent shifts in birth practices and health care can be examined (Wilson 2004). I observed the work of humanized birth organizations and indigenous associations as they interacted with midwives; interviewed employees of government bureaus and public health programs; conducted interviews and participant-observation with 24 CASA midwifery students/alumni; "shadowed" professional midwives, nurses, and obstetricians as they engaged with pregnant women in hospital settings; documented the birth experiences of approximately thirty women; and lived with "traditional" midwives in indigenous villages while observing the pre- and postnatal care they provide.

My multi-sited research led me to the States of Guanajuato, San Luís Potosí, Guerrero, Veracruz, Oaxaca, Chiapas, Mexico, Quintana Roo, and Michoacán where I interviewed, observed, and coexisted with Mexicans, Americans, Canadians, and Europeans who are visibly part of the humanized birth movement in Mexico, and with those who participate but are rendered invisible. Using Walter Mignolo's "border thinking" (discussed further, below, Mignolo 2000) and my own "border identity" to engage with subaltern perspectives, I make my work multi-sited not only in the geographic sense but perform research across ethnic and socioeconomic grades. I lived with informants in homes with a pit latrine and no running water or gas, and with informants in luxurious mansions. I researched in the Mixtec, Tlapanec, Purépecha, Tzotzil, and Nahua regions of Mexico. Several key informants and friends are indigenous birth attendants in rural villages, while other informants are from cosmopolises in the United States as well as metropolises in Mexico. Thus, my work is a cartography of biocommunicable birth models across ethnicity, place, and international space.

The three primary field sites were San Miguel de Allende, Guanajuato; the Nahua High Mountains of Veracruz; and the Mixteca region of

Guerrero. As a UNESCO World Heritage Site with one of the largest populations of expatriate Americans in Mexico, San Miguel was ideal for studying the transnational flow of people, ideas, and practices; and for studying politics of birth, and engagement between NGOs and the state. The first accredited professional midwifery school (an NGO) was established in San Miguel 14 years ago, and at the sister hospital, women are able to use universal health coverage to access professional midwife-assisted birth and water birth. However, the reality of who accesses these services is more complicated than the concept of universal health care implies. In the Nahua High Mountains of Veracruz, villagers receive stipends from *IMSS Oportunidades* (Opportunities Program, Mexican Institute of Social Security) due to their abject poverty. These stipends are conditioned upon compliance when engaging with government medical institutions. Research in Veracruz provided me with insight on the process of racialization, the social production of inequality, and the dramatic disjunctures between the perspectives of Nahua villagers and medical personnel in government clinics. At the time of my research, the secretary of health employed 13 CASA alumni in the Mixteca region of Guerrero. There, I studied how these professional midwives use their "awkward engagement" (Tsing 2005) with biomedicine and "traditional" midwifery to meet the needs of impoverished Mixteca in an environment of social violence. These sites encompass urban and rural; "foreign" and "local;" affluent and impoverished; indigenous and mestizo; and mountainous, southern, and central regions of Mexico.

My interviews were generally open-ended and lasted between 45 minutes and two hours. I prepared specific questions for the informants based upon their unique positionality with respect to birth. Questions generally followed these themes: his or her occupation and training, the Mexican health system, positive and negative experiences with birth and different birth attendants, and the shifting political climate with respect to birth models. By not over-structuring the interviews, I resisted scripting or leading the informant, allowing him or her to speak for himself or herself. At the outset of every interview, I asked my informant if he or she is comfortable being audio recorded, or if he or she prefers to forego recording in favor of me taking handwritten notes. My data analysis is derived from the detailed entries in my field diary as well as audio recordings from interviews.

"Border Thinking"

This chapter takes hybridity as its object as well as its methodological project. That is to say, I engage theory from both the United States and

Mexico to examine interpenetrations between transnational birth models and problematize hegemonic dichotomies such as tradition-modernity, north-south, and local-global. In doing so, I aim to use "border thinking" (Mignolo 2000) to greatly advance transnational theory. Anthropologists such as Arjun Appadurai (1996), Aihwa Ong (1999), and Anna Tsing (2005) have asked how categories, technologies, and practices travel transnationally. Appadurai focuses on "flow" and the increasing reduction of barriers in the age of globalization, while Ong argues that "flow" is often disrupted by power and political economy, and that class and privilege are components shaping "flexible citizenship". Tsing proposes her concept of "friction" to provide a nuanced understanding of the disjunctures and deformations of such travel, as well as its productive features. She urges her readers to resist the global/local dichotomy since, for her, the global and the local can never truly be parsed out into two separate entities. In general, however, North American anthropologists studying transnationality have not engaged anthropologists from their respective field sites in the production of their theories about transnationality. With respect to birth and reproduction, important edited volumes such as *Conceiving the New World Order* have included ethnographic insights from researchers at American institutions and a few European authors, but they have not deeply engaged with theorists in other countries (Ginsburg & Rapp 1995).

I aim to place medical anthropology in North America and Europe in conversation with its scholars in Latin America, producing a mutual dialogue instead of an Anglocentric reading of theory. While most scholars in Latin America cite scholarship from both their country or region and the North, the flow of this work from South to North is limited. That is to say, that while Mexican scholars often cite North American and European scholars, North American and European scholars cite Mexican scholars less often. Bilateral discursive engagement helps to conscientiously dismantle the colonial legacies embedded in anthropology. The very practice of invoking North American and European scholars exclusively is, in itself, a colonializing move. Furthermore, the unidirectional flow of frames of reference from the North (primarily the United States) to Latin America has had a profound impact on public health policy in Latin American countries (Menéndez 2009). By engaging with frames of reference from both North and South, medical anthropologists can begin to apply Latin American theory to Latin American policy, and even imagine how theory from the previously colonized world can be applied to places like the United States and Europe. This type of dialogue across borders will not only help to dismantle the discursive structure through which U. S. anthropology positions itself as the primary or exclusive place

to cite theory, but points to the richness of the medical anthropologies around the world, and the immense knowledge and different perspectives that can be gleaned and produced by participating in a truly transnational dialogue about theory.

Research driven by postcolonial theory must necessarily be a double engagement – for this reason, I study bodies in Mexico, as well as the theoretical and methodological debates taking place in Mexico. This type of double engagement stands to transform how North American anthropologists think about reproduction through dialogue with Latin America, while simultaneously considering how the exportation of theory from North America to Latin America results in ideas being recast, rendered more complex, and fractured by Latin American theorists. Mexico is a country with a critical scholarly tradition, and offers a wealth of theory with respect to social medicine. It is an ideal place to do this type of transformative research, because of the insights of scholars such as Asa Cristina Laurell (Laurell 1996; Laurell & López Arellano 1997), who critiques the United States, points to the problematic elements of institutions like the World Bank, and offers alternatives to the current social security system in Mexico; and Eduardo L. Menéndez, who provides methodological genius with respect to multi-sited ethnography (Menéndez 1996).

Hybridity

I draw from Néstor García Canclini's theories on traditionality, modernity, and hybrid cultures, and especially from his classic work, *Hybrid Cultures: Strategies for Entering and Leaving Modernity*. Canclini's concept of hybridization is helpful for deconstructing dichotomies such as tradition-modernity, north-south, and local-global. In conversation with Jaime Briehl (2003), he writes,

> Hybridization is not synonymous with fusion in the absence of contradictions, but rather can help us recognize particular forms of conflict generated by recent interculturality in the midst of the decadence of national modernization projects in Latin America. In this way, hybridization places in evidence the impossibility of establishing 'pure' or 'authentic' identities. In a world so fluidly interconnected, the identiary sedimentations organized in more or less stable historical groupings (ethnicities, nations, classes) are restructured into interethnic, transclassist and transnational groupings (García Canclini 2009: VII).

Through hybridization, multiculturality is converted into interculturality. While multiculturality indicates multiple cultures existing simultaneously, interculturality points to interpenetrations between cultures.

Interculturality suggests that individual cultures are not bounded objects, but, rather, fluid and constantly transformed by processes of hybridization.

With respect to temporality, Canclini argues that tradition is not anterior to modernity because tradition and modernity exist simultaneously – this is what is meant by "entering and leaving modernity" (also see Hobsbawn & Ranger 1992). These sentiments are reiterated by Partha Chatterjee (2004: 23), for whom time, itself, is not what it seems: «Empty homogeneous time is the utopian of capital […]. The real space of modern life consists of heterotopia». He argues that the postcolonial world lives in the heterogeneous time of modernity «the postcolonial theorist […] is born only when the mythical time-space of epic modernity has been lost forever».

Also, Canclini (2009: 20) problematizes the very idea of "modernity" and subsequently "postmodernity", writing, «Why should we go around worrying about postmodernity if in our continent modern advances have not arrived in full, or for all?». For Canclini, Latin America is a site of many contradictions, which he calls "modernism without modernization". Canclini describes Latin America as exhibiting «modernization with restricted expansion of the market, democratization for the minority, renovation of ideas but with low efficacy in social processes. The disjunctures between modernism and modernization are useful for the dominant classes to preserve their hegemony» (*ivi*: 67). In the case of Latin American countries, Canclini underlines juxtaposition and interpenetration of indigenous traditions, Spanish colonial Catholicism, and the forces of modernity. «Despite the attempts to give the elite culture a modern profile, restricting 'the indigenous' and 'the colonial' to popular sectors, an interclassist *mestizaje* has generated hybrid formations in all of the social strata» (*ivi*: 71).

I argue that we must be attentive to the First World's role in authoring Mexico's "troubled" modernity. Through development programs, Northern countries have, in part, scripted and mandated Mexico's national trajectory. Arturo Escobar offers a skeptical view of development in *Encountering Development: The Making and Unmaking of the Third World*. He argues that the Third World has been produced by development discourse, which itself began in the early post-World War II era. Escobar maps the invention of development and subsequently destabilizes the concept of Western modernity by revealing it as a culturally and historically specific phenomenon. He urges us to «examine development in relation to modern experiences of knowing, seeing, counting, economizing, and the like» (Escobar 1995: 12). The unquestioned desirability of economic growth, technology, modernization, and industrialization created a space called development in which only certain things could be said or even imagined.

Escobar turns to Latin America «where traditions have not yet left and modernity has not settled in» to highlight the hybridity of this continent (García Canclini 2009: 13). Escobar (1995: 219) writes, «If we continue to speak of tradition and modernity, it is because we continually fall into the trap of not saying anything new because the language does not permit it. The concept of hybrid cultures provides an opening toward the invention of new languages».

Birth Models in Mexico

Using Canclini's model of hybridization, I highlight the medical pluralism that characterizes reproduction and childbirth in Mexico today. I have observed three birth models at work in Mexico. These models are by no means discrete and bounded objects. The actors I will describe, below, often straddle different birth models, and there are plenty of examples of communication between actors across birth models. Below, I identify the three birth models according to the popularly perceived length of each model's existence in Mexico (the "traditional" model is perceived as the oldest model, while humanized birth is perceived as the newest model). I argue, however, that none of the three models are static, and all three models have been and are evolving, often through contact with the other models. "Traditional" birth today is not what it was 100, or even five years ago. On the other hand, humanized birth, if interpreted as birth offered by kind, caring, humane birth attendants, has certainly existed for ages.

"Traditional" birth is one that is attended in rural, often indigenous, villages and communities by a "traditional" midwife. Herbal remedies, *sobadas* (massage, often to reposition the unborn baby), and "traditional" vertical birthing positions are often used during the birth. Religious faith is also an important component of "traditional" birth. However, biomedicine is being employed more and more, sometimes dangerously, by "traditional" midwives. Throughout this chapter, I reject the tendency to leave "traditionality" unquestioned. Thus, my use of the word "traditional" between quotes indicates that this phrasing is emic – *partera tradicional* ("traditional midwife"), and less so, *partera empírica* ("empiric midwife"), are terms used by mothers, biomedical personnel, public health officials, community workers, and NGO employees to describe rural birth attendants who lack academic training in midwifery. The way they practice midwifery should not be held as the counterpart to "modern" midwifery, and the births they attend are by no means "unmodern". These birth attendants are extremely heterogeneous as are the births they attend. (I will describe this heterogeneity in more detail later in the chapter.) They often identify themselves as *parteras* (midwives), sans

modifier, except when contrasting themselves to *parteras profesionales* (professional midwives) who possess academic training, biomedical knowledge, and, in some instances, a license to practice midwifery that explicitly identifies them as *parteras profesionales*. In this chapter, I will simply refer to "traditional" midwives as *parteras*, just as they most often refer to themselves, thus avoiding the value-laden term "traditional". I will refer to parteras profesionales as *parteras escolarizadas*, thus using academic training instead of professionalism to distinguish them from parteras. It is important that I use this terminology because all parteras, regardless of their academic training (or lack thereof) are professionals.

Biomedical birth takes place in hospital settings and involves biomedical interventions such as episiotomies, placement of an intravenous therapy line, mechanical monitoring of the mother's "vitals", use of the Doppler fetal monitor to detect the unborn baby's heart beat, local anesthesia or epidurals, the lithotomy birth position (lying down with feet strapped to stirrups), hospital mandates restricting birthing women's movements and prohibiting eating during labor, vaginal explorations to determine dilation, and cesarean sections. Concern about the risks and consequences of unnecessary cesarean sections is especially pertinent since cesarean section rates in Mexico soar above the World Health Organization's recommendations. While the WHO recommends that the cesarean section rate should not be higher than 10 percent to 15 percent, in Mexico the cesarean rate is 44 percent in public hospitals and 85 percent in private hospitals (Ruth Rodriguez, "Nacimientos por cesárea, una práctica en abuso", *El Universal*, March, 28, 2011). These statistics suggest the biomedicalization of birth in Mexico leads to what some of my informants (a physician, an obstetric nurse, and the co-founder of an NGO) have called "obstetric violence". Obstetricians, nurses, and, at times, professional midwives, are the actors involved in biomedical birth.

"Humanized birth", an emic term that is widely used by its practitioners, is emerging in Mexico as the result of a transnational movement that aims to reduce biomedical hegemony and improve women's birth experiences[1]. This chapter examines the social arrangements that mediate the humanized birth model in diverse social-cultural contexts. In Mexico, parteras escolarizadas are some of the key proponents of humanized birth, and the humanized birth movement is supported by transnational NGOs founded by Americans (CASA in Guanajuato and *Mujeres Aliadas* [Allied Women] in Michoacán) where parteras escolarizadas are taught to combine biomedical acumen with certain "traditional" techniques; for example, the use of herbal remedies to resolve maladies during pregnancy, childbirth, and postpartum; the *rebozo* (a large shawl) to correctly position the unborn baby for child birth; and alternative therapies (such as Reiki,

aromatherapy, and homeopathy) to minimize unnecessary biomedical interventions. Specific techniques related to humanized birth include not rushing the birth and allowing the woman's body to progress through the stages of birth naturally, without the use of synthetic hormones like oxytocin or synthetic prostaglandins like misoprostol; teaching the birthing mother not to fear pain, to use relaxation techniques, and to avoid pushing unless it is a natural physical reaction; changing birth positions often (at least once an hour); having the birthing mother eat and ambulate as she wishes during labor; and not performing unnecessary vaginal explorations, but rather to use external signs (the length of the puerperal line on the mother's back or the mother's breathing and facial expressions) to determine the stage of birth. For some birthing mothers (intimately related to social class, as I explain later in this chapter), humanized birth means water birth, either at home or in an expensive private hospital. However, in other instances, for example, in the Center for Maternal and Infant Research and Gender (CIMIGEN) where obstetric and perinatal nurses attend births, humanized birth has less to do with the specific techniques described above, and more to do with respectful consideration of the patient and the new family (described in more detail, below).

Actors and Medical Pluralism

Now that I have described the three birth models unfolding in Mexico, I will describe the different groups of actors involved, as well as internal subdivisions and examples of hybridity within groups of actors, and how this relates to medical pluralism.

Parteras

Parteras (those referred to as *parteras tradicionales* and *parteras empíricas* by most of my informants) are a heterogeneous group. Alejandra Álvarez, the Program Director of Global Pediatric Alliance in Chiapas, has spent the last several years working intimately with approximately one hundred *parteras* in the Yajalón region to create a civil association. The goal is to strengthen the civil association so it can become self-sufficient, make collective decisions, and negotiate the *parteras'* role within the local health system. During my formal interview with her, Alejandra identified three types of *parteras*. My own informants have included *parteras* from all three of these groups, and Alejandra's observations mirror my own:

The first is what she termed the "*partera generacional*" (the generational midwife). She explained that the "*partera generacional*" inherited the post from another family member – for example, her mother, grandmother,

or aunt. These *parteras* are also *curanderas* (natural healers) and "*hasta son media-brujas*" ("are even half-witches"). These *parteras* often correctly identify, through touching the pregnant woman's belly, the number of weeks of gestation, the fetus' position, and even whether the child will be a boy or girl. If the unborn baby is in breach position, they know how to massage the woman's belly and animate the unborn baby to rotate, thus preventing difficult child labor and cesarean section. They do not rush the labor process, and after the baby is born, they often stay with the new family for up to a week, helping with household chores, preparing nutritious foods for the mother and baby, and making sure the postpartum period is off to a right start. During this week, the *partera* uses inherited techniques (for example, herbal remedies, massage, and cupping glasses) to support the woman's healing process. After the postpartum period has passed, she treats the woman's gynecological maladies for life, and the child's pediatric illnesses until he or she is an adult. The children whose births these parteras attend often grow up calling them "*abuelita*" (grandmother). *Parteras* generacionales do not think of attending births as work but, rather, as a divine calling. They do not expect payment. Alejandra repeated to me what she heard from a *partera generacional* concerning payment: «Why would they pay me? That's what I'm here for».

The second group is *parteras*, generally young women, who apprentice with a *partera generacional*. While the *parteras generacionales* teach them how to attend births, their entrance into midwifery is not due to a divine, inherited calling. Their role within the community is much more limited – they are not *curanderas*, and they do not stay and help the new mother after the birth. After the birth has concluded, their role ends.

The third group of *parteras* is women who gave birth to their own child(ren) alone, without any complications. Later, other women in the village ask for their help and accompaniment during their births. They practice intuitively, and while they offer basic support, they do not employ learned techniques like massage, herbal remedies, and cupping. Alejandra told me these *parteras* can be "*duras y rudas*" (hard and rude) on birthing mothers. Some have been known to pressure the woman to give birth faster, because it is their opinion that all women should intuitively know how to give birth, as they did. Alejandra explained that their lack of training and "rude" attitude has sometimes led to unfortunate birth outcomes and infant deaths.

Parteras Escolarizadas

Just as there is more than one type of *partera*, there is more than one type of *partera escolarizada*. Many of the *parteras escolarizadas* I interviewed

and observed are midwives trained at American-founded NGOs like CASA in Guanajuato and *Mujeres Aliadas* (Allied Women) in Michoacán. Since these midwifery schools are relatively new (14 and two years old, respectively), *parteras escolarizadas* are a relatively new type of birth attendants in Mexico. The "professional midwife" was formally recognized as a profession by the Mexican government in February 2011, and as of June 2, 2011 professional midwifery services at CASA were included under *Seguro Popular* (public health insurance) and is accessible at no cost to women giving birth. *Parteras escolarizadas* are trained with the goal of becoming government employees and occupying hospital-based posts. At CASA, patients are Mexican women from the State of Guanajuato, and women from around the world. At Mujeres Aliadas, they are from the Patzcuaro region, and are approximately 40 percent Purépecha and 60 percent Mestiza, according to one professional midwife's estimate. For these professional midwives, humanized birth means reducing unnecessary biomedical intervention and cesarean sections, educating women about available options, and convincing women of their innate power and ability to have a natural birth. Many of the practices these professional midwives defend not only reflect their exposure to natural birth in the United States, but also their awareness of the recommendations of the WHO and of the shifts in countries like Argentina, where the National Law 25.929 of Rights During Birth ensures a woman's right to be informed about her options, to be treated with respect, to have a natural birth, to be accompanied, to keep her infant at her side, and to be the protagonist of her own birth experience; i.e., to choose the birthing position of her choice, etc.

I have also interviewed and observed, however, *parteras escolarizadas* reared and/or trained in the United States and Europe. They hold certifications in other countries but are not certified to practice in Mexico. Two of them are very involved in the education of professional midwifery students at CASA and Mujeres Aliadas; thus, how they envision humanized birth and their patients are closely aligned with the previous group. Many other foreign-born and/or foreign-trained professional midwives practice independently from the previous group, opening their own birth centers, and, as one of them has self-identified, attend to affluent couples, intellectuals, and couples influenced by international exposure. Couples aware of home birth or water birth and able to pay as much as $32,000 pesos (a figure that excludes most Mexicans) describe a demographic that seeks out these professional midwives. They base their work on group sessions, prenatal education, continued accompaniment during the prenatal period, and psychotherapy to resolve emotional and psychological obstacles impeding a natural home birth. They often work in multi-disciplinary teams (with doulas, obstetricians, homeopaths,

psychotherapists, and specialists in artistic fields), and offer services and therapies such as prenatal exercise, art therapy, music therapy, biodynamic treatment, and massage. I suggest that this type of humanized birth points to a fine, disappearing line that distinguishes citizens from consumers (see García Canclini 2001). As individual choice and midwife-assisted birth are being recast as citizenship-based rights in the State of Guanajuato where, hypothetically, at least, women have universal health care to access free midwife-assisted birth or water birth, how is it that a different kind of humanized birth is emerging as a commodity for the elite? What does it mean for this commodified humanized birth to be the product of a transnational network for which many aspects of what is desirable are defined in the United States or Europe?

Obstetric and Perinatal Nurses

Another important group is nurses either trained in nursing and obstetrics at the bachelor's level, or trained at the technical level and specializing in perinatal health. One example of where these nurses are attending births is in CIMIGEN. There, obstetric nurses are attempting to wrest away autonomy from physicians, while also practicing in interdisciplinary teams. For them, humanized birth means speaking to their patient directly, looking into their patient's eyes, and knowing their patient's name. Whenever possible, it is about respectful, continuous care with a single provider instead of a slew of medical specialists. These nurses are part of the public health care system; what they offer is not a commodity, but, rather, care that aims to reduce obstetric violence and maternal and infant mortality.

Obstetricians

There are several types of obstetricians attending birth in Mexico. My perspective is similar to that of Robbie Davis-Floyd who, at the 2012 American Anthropological Association Annual Meeting, presented on the "good guys and girls" of Brazil (Davis-Floyd 2012). Davis-Floyd identifies "good guys and girls" as obstetricians who have reduced their cesarean rate to equal or less than the WHO's recommendation. In my fieldwork in Mexico, I observed these obstetricians to be individuals who, through reading texts on humanized birth written by American authors, have altered their practice to incorporate more patient choice, less medicalization of birth, and more accompaniment during labor. Their numbers are few. The multi-disciplinary teams they work in, the demographic of their patients, and the variety of services they offer often

resemble the foreign-born and/or foreign-trained professional midwives already described. In contrast, Davis-Floyd indicates that "nice guys and girls" are obstetricians who are very kind and respectful to their patients, but continue to have high cesarean rates. Her distinction is similar to the one I made, above, between the definitions of humanized birth according to *parteras escolarizadas* and according to obstetric and perinatal nurses. While the first group links humanized birth to distinct techniques that avoid unnecessary biomedical intervention, the second group practices humanized birth through respectful, personable treatment.

In addition to these two groups of obstetricians, I also observed obstetricians who are very biomedicalized and range from not particularly personable, to unkind, to blatantly cruel to patients. I observed again and again over the course of my research that the treatment birthing mothers received had a great deal to do with class, gender, and ethnic inequities.

Hybrid Actors

Not all birth attendants fit cleanly into the groups I have described above. These hybrid actors draw attention to disjuncture between formal classification strategies and the messy and fluid realities they claim to represent.

For example, important mechanisms inadvertently lead to some dangerous forms of hybridization. As a group, many *parteras* receive "capacitation" workshops from various sources (government health programs and institutions, NGOs, doctors, nurses, and *parteras escolarizadas*). Instead of teaching them how to deal with birth complications, most of these workshops teach *parteras* how to identify risk factors so they can refer "high risk" births to the regional hospital[2]. Maricruz Coronado, former General Director of CASA and current Advisor at the Center for Gender Equity and Reproductive Health, opines that, as a result of these "capacitation workshops, *parteras* become "*distociadas*". In doing so, Maricruz is drawing a metaphor with shoulder dystocia – a case in which, after the delivery of the head, the anterior shoulder of the infant cannot pass below the mother's pubic bone and the infant is trapped in the birth canal. She went on to explain that these workshops result in the *parteras* being *torcidas* (twisted) and doubting their capabilities. Since they are not carefully taught how to deal with birth complications during "capacitations", *parteras* who either choose not to refer the birthing mother to the hospital or do not have enough time to transport a birthing mother who is already in active labor often end up using their incomplete biomedical knowledge to meet difficult circumstances, sometimes with dire consequences. These cases often lead

to obstetricians having their prejudices against *parteras* reaffirmed. For example, while performing fieldwork in Chiapas, a *partera escolarizada* told me that *parteras* insist on giving birthing mothers injection after injection of misoprostol before the woman's body is ready for the birth to happen. As the result, the *partera escolarizada* has participated in ambulance transfers to the regional hospital of women who have been labor for over 24 hours. Upon arriving, the exhausted birthing women are received by disgusted obstetricians who, at this point, are left to deliver dead infants. This case was confirmed when I interviewed an obstetrician at the regional hospital. This same obstetrician, Dr. Flores, told me that while he shutters to think of parteras attending births, he is happy to work with *parteras escolarizadas* in the hospital setting because of the academic training they possess.

With respect to *parteras escolarizadas*, CASA intends to produce hybrid actors. Maricruz describes CASA's model in these terms: «The CASA model is holistic, integral, and is applied throughout the pregnancy. It rescues traditional techniques and combines them with modern medicine in a way that is complementary. It resists unnecessary intervention and attempts to be a conjugation of knowledges» (my translation). However, these *parteras escolarizadas*, hybrid actors who occupy both "traditional" and "modern" medicine, are re-hybridized in the direction of biomedicine when they enter into biomedical contexts. While *parteras escolarizadas* were trained to attend humanized births, my research showed that many of these midwives, when hired by the secretary of health to work in biomedical contexts, often rarely practice many of the humanized birth techniques they learned as students of professional midwifery. Those who complete their year of service (similar to medical residency) or go on to accept formal posts in a government hospital are, in the words of current CASA midwifery students, "contaminated" by the medical environment and often lose sight of the unique ethos of humanized birth. According to these critics, *parteras escolarizadas* should not let humanized birth fall to the wayside in favor of being "*micro-doctoras*" (a term used by my informants). In contrast, according to proponents of further medical training, *parteras escolarizadas* who go on to practice their skills in hospital settings are more aptly equipped to intervene in obstetric emergencies, skillfully combining both humanized birth with biomedical acuity.

The tension between humanized and biomedical approaches to childbirth comes into stark relief in hospital settings where *parteras escolarizadas* and obstetricians work side by side. I have observed that this tension, depending on the individual actors involved, can produce either positive or negative results. Carmen, a recent CASA graduate, is currently completing her year of social service in a rural, government hospital in

Veracruz that serves an almost exclusively indigenous population. When I visited her at her post, she burst into tears and confided in me that her supervisor, a physician, orders her to perform episiotomies as a routine procedure. Carmen is the daughter of a *partera*, Pomerania, who has attended hundreds of births without ever performing an episiotomy. Pomerania, after lubricating the area, uses one hand to apply pressure to the perineum during expulsion. In this way, Pomerania protects the woman's perineum against tears. Having grown up observing her mother use this technique, it is difficult for Carmen to pick up a scalpel and slice through women's perineal tissue. Carmen told me about a particular incident when she, unable to defy her supervisor's orders, prepared to perform the episiotomy by injecting local anesthesia. Her supervisor, observing what she was doing, scolded her, saying, «Don't give these women anesthesia. They aren't princesses and they don't deserve it». Her supervisor left while Carmen attended the birth. After the baby was born, Carmen prepared to suture the episiotomy site. Rejecting what her supervisor had said, she decided to inject local anesthesia before sewing up the woman's perineum. However, when she was administering the anesthesia, her supervisor spotted this act of defiance and told her, «I already told you once, and I'm going to tell you again. These women are not princesses. They don't deserve anesthesia».

However, Carmen's commitment to her mother's "traditional" methods is not shared by all *parteras escolarizadas*. Yesenia, a *partera escolarizada* and granddaughter of a *partera*, feels what distinguishes her from her grandmother is her ability to intervene using biomedical methods if the situation requires it. I first interviewed Yesenia when she was a CASA student, subsequently traveled to her natal village to interview her grandmother, and most recently observed her perform a postpartum visit at her patient's home. I also traveled to San Luís Potosí to observe her work in the large urban hospital where she was completing her social service. While we sat together in the hospital cafeteria eating lunch, Yesenia told me that she was taking advantage of the opportunities in a biomedicalized setting to practice as many episiotomies as possible so that some day, when she is attending a birth alone and needs to do an episiotomy, she will know how to do it quickly, safely, and effectively.

While some *parteras escolarizadas* are biomedicalized (either forcefully or by choice) through contact with biomedical institutions, others teach the physicians they work with to utilize humanized birth methods. After interviewing Ofelia when she was a student at CASA, I interviewed her and her supervisor in Chiapas where she was performing her social service at an urban government hospital. Ofelia was a community health

worker before she studied midwifery. As a community health worker, Ofelia had a dream where she was attending a birth; shortly thereafter, a woman arrived to the community clinic in active labor and Ofelia had to attend the birth, alone, as she had in her dream. This dream was like a premonition, and the experience convinced her to become a *partera escolarizada* so she can attend births with more skill and knowledge. In Chiapas, Ofelia's supervisor, Dr. Flores, was pleasantly surprised by the positive outcomes of Ofelia's non-biomedicalized interventions. Throughout her year of social service, Dr. Flores allowed Ofelia to intervene using methods from her midwifery training before proceeding with the biomedical interventions he had planned. On one occasion, he observed as Ofelia manipulated a patient's belly, animating the unborn baby to shift from breech position to cephalic position, thus avoiding a cesarean section. On another occasion, he supervised Ofelia as she attended a primigravida (a woman who is pregnant for the first time). He advised that she perform an episiotomy to prevent a perineal tear. Ofelia explained to Dr. Flores she was confident she could deliver the baby without performing an episiotomy and without the birthing woman sustaining perineal damage. Dr. Flores allowed her to try and was surprised when Ofelia fulfilled her word. When I interviewed Dr. Flores, he expressed that he has learned a great deal from Ofelia, and that after watching her practice, he will no longer perform episiotomies because he has seen with his own eyes that they are not necessary.

I have shown how many *parteras* and *parteras escolarizadas* become more biomedicalized than the "traditional" and humanized birth models suggest. While some of this biomedicalization is imposed by government actors exercising biomedical hegemony, *parteras* and *parteras escolarizadas* possess agency, and many intentionally seek out biomedical knowledge and strive to incorporate more biomedical techniques into their practice of midwifery. Since *partería escolarizada* claims to be everything "traditional" midwifery is, plus biomedical knowledge, some *parteras* feel that by entering into midwifery schools like CASA, they will be achieving some value-added. One of my informants, a *partera*, later became a *partera escolarizada* so that she could better serve the women she attends, and, at the time of this writing, another *partera* is in the process of applying to become a *partera escolarizada*. She hopes her academic training will lead to more respect by medical personnel in the region where she practices, increased admiration from birthing mothers, and a better salary. While this trend towards biomedicalization suggests that many *parteras* and *parteras escolarizadas* feel that possession of biomedical knowledge legitimates midwifery practices, there are few examples of individual biomedical actors who seek hybridization in

the opposite direction. For example, I interviewed a physician whose deep commitment to humanized birth techniques and non-intervention has led her to present herself to patients as a "*partera profesional*". She explained to me that she identifies more closely with this group of birth attendants than with obstetricians.

Rejecting Linear Progress

Roger Bartra (1987) points to the ways writers like Juan Rulfo and Carlos Fuentes have described rural and indigenous zones being enveloped by a mythic time - a time that advances more slowly, or not at all. Thus, *campesinos* (rural peasants) are considered to constantly occupy a different time register, implicitly located in the past (see, also, Fabian 1983). Bartra argues, however, that Western time is also a mythical time – a time that makes use of myths such as linear progress, the future, and the Gregorian calendar.

Similarly, I want to emphasize that the three birth models and different types of birth attendants I propose are not steps on a scale of development, starting with the most traditional, and progressing towards the most modern. One could say that the humanization of birth is the most modern, and certainly the most recent, movement related to childbirth in Mexico. There are many examples of *both* parteras and gynecologists embracing modern techniques and championing humanized birth. I argue (echoing Canclini) that through the emergence of *partería escolarizada* in Mexico, some birth attendants are attempting to recuperate the past and reconstruct it as something distinctly modern. The past is *in* the present, and, in large part, describes the future of humanized birth in Mexico. The hybridization of birth attendants in Mexico is a strategy for entering and exiting modernity – an example of tradition and modernity existing simultaneously. This coexistence is not without contradictions. Rather, the contradictions produced by hybridization can be examined to reveal profound structural inequality in Mexico (discussed in detail, below). Only through problematizing pluralism in *prácticas de partería* (midwifery practices) in Mexico can we truly understand the challenges that continue to undermine gender equity, reproduce maternal mortality, and limit the development of humanized birth.

Just as I argue against placing birth models and different groups of birth attendants along a scale of "progress", I also reject any suggestion that these categories fall along a line of elevating value. While differential salaries point to pervasive and powerful hierarchies, I argue that this does not necessarily correspond with quality of care. Birth attended by an obstetrician is not necessarily better than birth attended by a *partera*.

While it is true that medical physicians often have more tools and knowledge to adequately handle obstetric emergencies, to automatically identify hospital and physician-assisted birth to be higher quality, or even safer, than if the same birth were to be attended by a *partera* is to neglect the social factors involved.

An anecdote may help clarify this point: Traditional-professional midwives in the Nahua mountains of Veracruz are warned by medical and legal authorities that if a maternal or infant mortality were to occur while they are attending the birth, they would be sentenced for murder and placed in prison. These midwives are fearful for themselves, but they must continue to practice midwifery. Their vocational and ethical commitment to their fellow villagers demands it. Pascuala, a traditional-professional midwife, was in tears when she told me about a recent infant mortality. Obeying government mandates, she sent a mother in labor to the regional hospital because she recognized the situation to be high risk. She pleaded with the doctors and nurses to pay close attention to the woman as her labor progressed. A few days later the patient returned to Pascuala's home to tell Pascuala that the medical team had ignored her throughout the entire labor, and the baby had died as a result of their negligence. The regional hospital is notorious for its hyper-saturation of patients. When there are not enough hospital beds, patients are given pieces of cardboard and told to lie down in the hallway. How can Pascuala ethically send her high-risk patients to a place where they almost certainly will be mistreated and perhaps severely harmed? How can she not attend a birth when it is already in progress, and when she calls the paramedics to her home, they refuse to come to the secluded mountainous villages where the Nahua live? I do not draw on this example to paint *parteras* as saviors and physicians as negligent. I have already described some *parteras'* failures that could have been prevented by timely biomedical treatment. Instead, I am using this example to question the politics behind these government mandates. Obviously, the medical doctors were not charged with murder, while the midwife would have been had the child died in her hands.

Perhaps the nurses and doctors chose not to attend to Pascuala's patient because she is of Nahua origin, speaks Nahuatl instead of Spanish, and, due to chronic drought in her village, bathes infrequently. Perhaps they were repulsed by her "ignorance" and perceived filth. Perhaps the nurses and doctors chose not to attend to her because of the covert or overt racism toward indigenous people that still often shapes social interactions in hospital settings, constructing her as dirty and of lesser worth. While doing fieldwork in a different government hospital, the director of Obstetrics admitted to me that while he does not consider himself outwardly racist, some of his own practices are inadvertently

discriminatory. He said that when presented with a waiting room full of patients, some who bathed today and some who bathed three days ago, he first attends to the more clean patients and the less clean patients are left to wait. Regardless of the reason, the medical treatment Pascuala's patient received at the hospital was most likely not better quality than if she had been attended by Pascuala in her own home, as it produced a tragic outcome: the death of the child.

It is misleading to say that all *parteras* provide good care. However, my research has shown that many *parteras* are more attuned to the structural difficulties that impoverished, rural, and indigenous patients face, and, thus, the care they provide often meets the patient's needs more adequately than the treatment provided in biomedical hospitals. In general, *parteras* are attuned to these social challenges in ways that many biomedical doctors, due to the institutionalization of their practice, simply cannot be. They interact with pregnant woman within their everyday social contexts, whereas many physicians examine the pregnancy in the context of the consultation room. My research suggests that the different birth models that exist in Mexico often undermine one another instead of complementing each other.

The Challenges Midwives Face

The challenge for midwives in Mexico is to fight to be respected. Even though *parteras* possess valuable knowledge that enables them to respond to the unfavorable socioeconomic conditions of their patients, legal restraints and the paternalistic posture of the Mexican government cause some traditional-professional midwives to feel as if the quality of their birth-attendant skills is inferior. They are often required by the government to attend "capacitation" courses given by nurses and doctors who rarely attend births – and even by neophyte CASA professional midwifery students. Ana Carrillo (2010: 5) critiques these training programs directly when she writes, «People who taught these courses frequently had very little or no experience in assisting childbirth, which lessened their technical and moral authority to teach traditional midwives, who, more than anything, have experience». Carrillo comments on the problematic relationship between physicians and midwives, stating, «Many times physicians and health authorities attacked traditional midwives, even though, to observing anthropologists, it was obvious that these midwives worked with considerable skill and regularity […]. Health authorities considered the midwife a temporary resource and a subject who needed to learn what she had to do, and persistently evaluated her activities negatively» (*ivi*: 6).

In training courses, *parteras* midwives are taught all the situations in which they are *not* qualified to attend birth, and in which they are required to send their patient to the regional hospital. For her part, Miriam Padilla, a current CASA midwifery student and a staunch defender of traditional midwifery, argues that these midwives, referred to as "empirical" by the Mexican government, are not "empirical" but "wise". What Miriam means is that *parteras* are not just practiced baby-catchers; they also possess a great deal of valuable knowledge due to their accrued experience. This experienced-based knowledge is not inferior to academic biomedical knowledge. She suggests that perhaps, instead of giving them "capacitation" courses, other birth-attendants should open themselves up to the possibility of knowledge sharing across disciplines. This, however, has thus far not been the case. Instead, due to hierarchies in knowledge and power that put biomedical birth over other birth models, *parteras* have been used as a resource for the biomedical institution.

In *Physicians 'Who Know' and Midwives 'Who Need to Learn'*, Ana Carrillo points to the WHO's interest in "utilizing" midwives in the public health structure of developing countries to frame Mexico's approach to training courses for *parteras*. She writes:

> Midwives have been involved in actions linked to the strategy of primary health care: basic sanitation, feeding and nutrition, prevention and detection of acute diarrhea and respiratory infections, mother-child health, medical care and universal vaccination, promotion of breastfeeding (which actually is and has always been part of their practice), in addition to collecting health information (through the simplified epidemiological surveillance system of the midwife) and reference of patients for family planning. All this has made it easier for the institutions to manage their health programs at a low cost. Some midwives complain that they perform these tasks for the institutions, but they do not receive any compensation or medical care and they do not have any legal protection either (Carrillo 2010: 13).

Her observations are entirely congruent with my observations of IMSS and Secretaria de Salud Training Workshops and of traditional-professional midwives as they practice in their homes and villages. These midwives are trained by the Mexican government to refer pregnant women to the regional hospital. In exchange for their village-level surveillance, they receive a pittance monthly stipend. Meanwhile, they are forbidden to attend births. The limits placed upon these midwives by the biomedical institution, backed by carceral force, drive them to engage in clandestine traditional birth practices – often to the benefit of their patients, but to their own potential detriment. *Parteras*, perpetually indoctrinated to believe that they "can't", often practice under difficult conditions while doubting their abilities. Carrillo opines, «They have resources and skills to

cope with most of these situations (which many of their patients present), but their training courses have caused them to doubt their capabilities» (*ivi*: 10). According to Maricruz, these midwives have been "deformed" by their absorption into government programs.

Likewise, students from CASA have often expressed to me during in-depth interviews the difficulties they encounter in the General Hospital – they are rarely allowed to participate, and when they are given permission, they are required to intervene as would a nurse or physician's aide, not as a *partera escolarizada*. As a result, some critique the medical institution for not recognizing the value of their profession and the skills they have acquired during their four-year educational career. This situation was supported by a nurse who told me, «The midwife who works in the hospital where I work, we nurses don't understand her. She has these ideas about vertical birth and all that, and her ideas are totally different from ours. We just can't work with her».

The Challenges Physicians Face

I interviewed Barbara Harper at The Association for Prenatal and Perinatal Psychology and Health 2012 Meeting. Barbara is a water birth activist and "celebrity" in the world of humanized birth. She travels around the world training and certifying obstetricians to attend "gentle", water birth. "Gentle" birth is, in many ways, a synonym for humanized birth, and emphasizes minimal intervention. Barbara also attends water birth, but instead of seeing herself as a proactive participant, she offers herself as a witness to the beautiful births of new human beings. Barbara opines that all people who go into the healing professions, including physicians, are primarily driven by their care for others. While their career choice may also be driven by money and prestige, she suggests that this is secondary to their sincere desire to help others. She argues that we can't simply string up doctors and blame them for the failings of the biomedical system because most of them are only doing what they have been taught is the best and safest intervention for the situation.

While performing fieldwork in government hospitals across central and southern Mexico, I have observed the structural deficiencies that limit the ways physicians are able to attend births. While in Veracruz and Guerrero, I examined the inventory in multiple rural clinics and found even the most basic medicines to be lacking. On a supervisory trip of *parteras escolarizadas* in Guerrero with Maricruz, we happened to pass by when an indigenous woman, Juana, was bleeding to death due to severe hemorrhage. There was no ambulance or even a pouch of intravenous fluid to stabilize Juana in the rural clinic, and if Maricruz and I had not passed

by in a secretary of health truck, the woman would have died. Maricruz, ever prepared, pulled a spare pouch of intravenous fluid out of her bag and kept Juana stable in the bed of the truck for three hours as the truck winded and lurched to the nearest hospital with the necessary supplies to treat Juana's case. Under these conditions, low-risk births that could be more personably attended in rural clinics are referred to oversaturated regional hospitals because physicians in rural clinics are (rightfully) afraid of the potential consequences if the birth were to go dangerously awry.

Once the birthing mothers arrive to the regional hospital, other structural deficiencies hamper the attentive care most doctors would happily provide. While observing in a government hospital in San Luís Potosí, I noticed that most of the labor ward was under construction and the obstetric team was limited to one small section. When I interviewed the *partera escolarizada* posted there, I found out that this infrastructural problem is ongoing. Birthing mothers are kept on narrow gurneys instead of hospital beds because two birthing women must often be crammed into one approximately sixty square foot cubicle. The birthing women are then shuffled from one cubicle to the other as nurses struggle to fit too many women into too small a space. At this hospital, where there are often more than a dozen women in active labor at any given time, there is only one doctor per shift. While I was observing, the doctor muttered under his breath, «This job is pure stress», as he rushed from the operating room to the delivery rooms where interns were attending births unsupervised. When he arrived, one neophyte intern had already performed three episiotomies and was reaching for the forceps when the birthing woman had only been in the delivery room for six minutes. The doctor told the intern to hold off with the forceps - what the woman really needed, he explained, was time. Unfortunately, the doctor could not afford more than a few minutes more, especially since other women would soon need to be transferred to the delivery room. Instead of forceps, he told the woman he was going to «help her push the baby out», and applied forceful downward pressure on the woman's belly. The baby was born two minutes later.

At the nurses' station, the medical personnel, including the doctor, told me that it would be wonderful to let fathers accompany mothers during the birth, but there simply isn't enough space. When I spoke with the hospital director, he concurred, but said that right now, the most pressing issue (even before carrying on with the renovation of the labor ward so that more space will be available) is to hire another doctor. This sentiment was reiterated by the *partera escolarizada* who said her excessive workload does not provide her with enough time to attend humanized births. Limited funds lead to a situation in which doctors are

overwhelmed with too many patients and do not have the space required to attend to their patients as they would like. This frustrating situation highlights the consequences of structural and bureaucratic violence on birthing women's bodies.

Structural and Bureaucratic Violence: A Backdrop

As of February 2012, CASA's accreditation by Seguro Popular has expired, and CASA must now be certified in order to continue treating women free of cost using third-party reimbursement. However, CASA, and the professional midwifery movement in general, are facing challenges due to lack of meaningful commitment by the current secretary of health and the inefficiency of the Mexican government. Maricruz is currently Adviser for the National Center for Gender Equity and Reproductive Health in Mexico City. From this post, she has shared with me her frustrations with the bureaucratic process, and the way minimal effort is made to accommodate individuals at the community level.

Her dissatisfaction was foretold by Menéndez who, three decades before, commented on lack of record keeping and continuity of medical treatment; recruitment of science to distort social reality (such as the true causes of maternal and infant mortality); political management of information; masking of danger using convenient classification systems; poor knowledge of couples' sexual behaviors; technologic incapacity with respect to accurate diagnosis; lack of collaboration between private and public medical systems; "blindness" due to medical fashions; and massive production of paper trails instead of substantive treatment (Menéndez 1981). He pointed to a model of structural violence in which the government – the hegemonic figure controlling the health sector – jeopardizes the health of its citizens through its negligence and cruel lack of concern for the nation's poor. He writes, «We observe a structure of domination/subordination that always supposes the autoexploitation, autoelimination, and autoinferiorization of one party, and in all the cases it is the subaltern stratum» (*ivi*: 377, my translation).

Menéndez proposes integral primary attention at the community level – that is, an ongoing exchange between popular and professional knowledge – as a solution to the mistreatment he describes. Escobar expands on Menéndez by highlighting the preeminence of the local, and that development programs unfold within local contexts in ways that are not the simple appropriation of Western models. However, I want to express that "home grown" development programs like Oportunidades are not what Escobar intended. Maxine Molyneux's piece, "Mothers at the Service of the New Poverty Agenda: Progresa/Oportunidades, Mexico's

Conditional Transfer Programme", provides a critical examination of the "co-management of risks" and co-responsibility models associated with recent approaches to social welfare internationally, and in Mexico specifically. With respect to Oportunidades, co-responsibility has, in actuality, meant the responsibility of mothers (not fathers) for the health, education, and well-being of their children. Molyneux writes,

> The responsibility of the 'entire community' is perhaps better described as being devolved to mothers who are those designated as being primarily responsible for securing the Programme's outcomes. Co-responsibility is formalized through quasi-contractual understanding that, in return for the entitlements offered by the Programme, certain obligations are to be discharged by the two parties, that is, the Programme and the participating mother (Molyneux 2006: 434).

Molyneux (*ivi*) argues that Oportunidades is obviously aware of gender differences; however, it does little to dismantle gender inequality. Oportunidades, like many anti-poverty programs in Latin America, places maternalism and female altruism at the service of the state. In these programs, the social construction of need places children at the center and derives its success from the exploitation of the gender divide. While a cursory glance may lead one to believe that these programs are empowering to women, they actually reproduce gender inequality by using mothers as the conduits of policy. Molyneux argues that men should also be implicated in co-responsibility, and that only through men's equal participation in anti-poverty programs and the reorganization of the domestic sphere can equality be achieved. She argues that instead of stipends, more should be done to enhance the capabilities of women (for example, through training and education) so they can engage in meaningful paid work and secure for themselves permanent relief from poverty.

What is really needed, however, is the elimination of corruption and wasteful spending within the Mexican government so that investments can be made in a truly universal health care. Such a transition, however, will not happen on its own. Asa Cristina Laurell points out that while health is guaranteed by the fourth article in the Mexican Constitution, no single entity is obligated to provide these services, and Mexican citizens must use political engagement to actively force the government to meet its obligations[3]. Furthermore, the current condition of health care in Mexico is not simply due to the mismanagement by the Mexican government, but has also been influenced by global forces. Structural adjustment programs authored in the North have resulted in the unequal and polarized distribution of income and wealth (and as a result, health care) in Mexico. The Mexican government, dedicated to the neoliberal

ideology disseminated by the World Bank, provides a limited number of cost-efficient services to the poor as "neocharity" (Laurell & López Arellano 1996).

Thus, what Maricruz is really seeking is an unwavering dedication, by both government and non-government actors, to human rights and the empowerment of women. There are few indications, however, that this will happen anytime soon. The structural inequality I have described in this section is buttressed by layer upon layer of social inequality in what one of my informants, unintentionally echoing Gutmann, has called "many, many Mexicos" (see Gutmann's description of "Mexican national identities", 2007: 250).

Ethnicity, Class, and Place

When I attended a training workshop for traditional midwives given by Mexican Institute of Social Security in Zongólica, Veracruz, I witnessed a striking moment when a single woman's body became a site of contestation about race, class, gender, and power. The room was divided into two glaringly distinct spaces – male doctors with white coats stood in front of the room, and traditionally-dressed indigenous midwives sat in the audience. An elderly *partera*, Leonila, stood up in the very last row. Leonila told a story about how the neglect of medical doctors and staff led to the unnecessary death of an indigenous woman's baby. The pregnant woman had arrived at the hospital in active labor, and the nurses refused to attend to her. The desperate mother rushed to the restroom and gave birth to a stillborn child. The dead infant was born into the toilet. Having never been assigned a hospital bed, she left pools of blood on the hallway floor, and the nurse scolded her for making a mess and forced her to clean up the blood. Leonila ended the wrenching tale by yelling, «I, too, could put on a white coat!». The hospital director asked Leonila the name of the community worker involved in the case. When she answered him with the female, indigenous community worker's name, he nodded, as if to say, «Ah, yes», and stated aloud that this community worker has been involved in several unfortunate cases. If the community worker had succeeded in getting the birthing mother to the hospital sooner, he suggested, the case would not have ended tragically. He promised Leonila that he would reprimand the community worker. While this seemed to appease Leonila somewhat, I was less satisfied with this resolution. In a matter of seconds, the female, indigenous community worker became the scapegoat for a health system that is failing at multiple levels. The medical personnel at the hospital were, by a sleight of hand gesture, let off the hook. The hospital director quickly directed the workshop attendees away from this

"disruptive" anecdote and toward other matters. However, the incident lingers in my mind. The woman's hemorrhage and the infant's life-that-never-was had been the site of contestation, but they were not the real objects of the debate. This anecdote echos Nazar-Beutelspacher's (2007) assertion that in Mexico, the approximation of institutional services to indigenous populations is an encounter between two cultures, and is embedded in unequal relations with respect to the value of knowledge and distinct medical practices.

Over the course of 16 months of fieldwork I have observed, again and again, how ethnicity, class, and place script who will attend a woman's birth, and how her birth will be attended. While there are exceptions, the three birth models I outlined above are applied to distinct populations. Less educated, poor, mestizo or indigenous women tend to use government health services provided by Seguro Popular. Thus, their births tend to be attended by biomedical personnel in hospitals using the biomedical model. While there are significant attempts to insert the humanized birth model into biomedical settings by placing CASA graduates at government hospitals, I have noticed that since these CASA graduates are not involved in prenatal care, patients are often unaware that midwifery services are available, and there is little opportunity to develop the trusting relationships between patient and birth attendant that facilitate humanized birth. Unfortunately, most of the women having humanized births across Mexico are urban, elite, fair-skinned, able to pay out-of-pocket, and have exposure to international discourse on home birth, water birth, and professional midwifery. They often seek out parteras escolarizadas or humanized obstetricians after reading English-language texts on humanized birth, or hearing about a friend's positive humanized birth experience. When this population has not been exposed to humanized birth literature and is not acquainted with others who have had humanized births, they often choose the most "modern" biomedical option available to them: scheduled cesarean section. Women who have their births using the "traditional" model are mostly indigenous, rural, poor, and sometimes unable to pay even a meager amount for the partera's services. Sometimes, instead of money, these women pay the partera with food, such as a chicken or a bag of hibiscus tea. This form of payment would likely not be routinely accepted by most nurses, obstetricians, and parteras escolarizadas.

Conclusion

José Alejandro Almaguer argues that marginalization is a determinant for illness, and that problems such as cultural barriers, mistreatment,

dissatisfaction, difficulties with communicating, distrust, unempowerment, and differing cosmovisions with respect to health and life lead to inadequate health care for indigenous people. He suggests that health structures, equipment, and medication are designed with urban contexts in mind and fail to incorporate local cultures. Thus, Almaguer argues for an intercultural focus, the integration of traditional and institutional medicines, equity and access, and community participation by both female and male indigenous people. Almaguer defines interculturality as «fomenting a relationship between people from different cultural groups who share the same territorial spaces, that is realized with respect and horizontality, favoring that the health personnel appropriate elements that permit them to comprehend the perception of reality and the world of the other, fomenting dialogue, recognition and respect of peculiarities and individualities» (Almaguer 2007: E86, my translation).

Similarly, Nestor García Canclini explains the multiculturalism in the United States means separatism (García Canclini 2001). Through conservative multiculturalism, White Anglo-Saxon Protestants (WASPs) learn about other ethnicities in an effort to be politically correct. Liberal multiculturalism recognizes the innate equality of all races, and interprets inequality as evidence of unequal access. Arguing against these notions of multiculturalism, Canclini asks for interculturalism: a legitimation of multiple ways of knowing, recognition, solidarity, and revindications of each group. For him, pluralism of cultural heterogeneity is part of what it means to be a nation. These sentiments echo the ethos of the "critical epidemiology" advocated by Briehl (2003) that reflects on gender, ethnic, and class inequality. Critical epidemiology is dialectical and democratic. Briehl writes against empiric and quantitivistic reductionism, which uses eurocentric, androcentric, and unicultural rationality and creates totalizing theories.

With these arguments in mind, I argue that medical pluralism in Mexico has allowed different types of birth attendants to employ techniques from different birth models to meet the needs of Mexican women in strikingly disparate contexts. As one of my informants, Guadalupe Hernandez, an obstetric nurse at CIMIGEN, expressed to me, each type of birth attendant is the best suited for the particular "e*scenario de actuación*" in which they work. That is to say, like actors upon a stage, each type of birth attendant fills their intended role. Each is uniquely positioned to serve the population they attend in the environment where they work. While I agree with her perspective in many cases, I am sensitive to the inequality (socioeconomic, gender, and racial) that medical pluralism often meets and comes to represent, and I argue that the positive capacity of medical pluralism to meet the disparate needs of people in different geographical,

cultural, and ethnic contexts should not be distorted or used to disguise and obscure the suffering of people living in poverty, and victimized by racial discrimination and structural persecution. In Mexico, medical pluralism surrounding birth is flourishing, but medical interculturalism surrounding birth has yet to be achieved.

Notes

1. My research has proven, however, that improvement of women's birth experiences is highly relative. I have interviewed women who were deeply unsatisfied with their humanized birth experiences and prefer biomedical birth. For these women, biomedical birth involves less pain and suffering, is more hygienic, and the services rendered are of better quality.

2. I have placed "high risk" between quotes because I have observed how the social construction of risk leads to almost all women in many impoverished, indigenous communities being categorized as "high risk". This topic could fill an entire chapter and deserves to be developed elsewhere. Here, I will provide one simple example: While observing in a Mexican Institute of Social Security clinic, I noticed the physicians use a height and weight table meant for European bodies to diagnose obesity in pregnant indigenous women. The population for which the table is being used tends to be shorter and stouter than the European population for which the table was intended, thus leading to nearly all pregnant women in the region being labeled "obese", and, thereby, "high risk".

3. 1997 Interview with Dr. Asa Cristina Laurell: Secretary of Health of the Legitimate Mexican Government, headed by Andres Manuel Lopez Obrador (AMLO). Social Medicine 2 (1): 46-55.

References

Almaguer, J. A. 2007. Modelos interculturales de servicios de la salud. *Salud pública de México*, 49: 84-93.

Appadurai, A. 1996. *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis (MN): University of Minnesota Press.

Bartra, R. 1987. La jaula de la melancolía: Identidad y metamorfosis del Mexicano. México D. F.: Grijalbo.

Briehl, J. 2003. *Epidemiología crítica: Ciencia emancipadora e interculturalidad*. Buenos Aires: Lugar Editorial.

Carrillo, A. M. 2010. *Physicians "Who Know" and Midwives "Who Need to Learn"*. Unpublished paper.

Chatterjee, P. 2004. *The Politics of the Governed: Reflections on Popular Politics in Most of the World.* New York: Columbia University Press.

Davis-Floyd, R. 2012. *The Paradigm Shift of Holistic Obstetricians: Brazil's 'Good Guys and Girls'* (paper presented at the annual meeting for the American Anthropological Association, San Francisco, California, November 19, 2012).

Escobar, A. 1995. *Encountering Development: The Making and Unmaking of the Third World*. Princeton: Princeton University Press.

Fabian, J. 1983. *Time and the Other: How Anthropology Makes Its Object*. New York: Columbia University Press.

García Canclini, N. 2001. *Consumidores y ciudadanos: Conflictos multiculturales de la globalización.* Mexico D. F.: Editorial Grijalbo.

García Canclini, N. 2009. *Culturas híbridas: Estrategias para entrar y salir de la modernidad*. México D. F.: Debolsillo.

Ginsburg, F. D. & R. Rapp 1995. *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press.

Gutmann, M. C. 2007. *Fixing Men: Sex Birth Control, and AIDS in Mexico*. Berkeley, CA: University of California Press.

Hobsbawm, E. & T. Ranger (eds.) 1992. *The Invention of Tradition*. Cambridge, UK: Cambridge University Press.

Laurell, A. C. 1997. *La reforma contra la salud y la Seguridad Social: Una mirada crítica y una propuesta alternativa*. México D.F.: Friedrich Ebert Stiftung.

Laurell, A. C. & O. López Arellano 1996. Market Commodities and Poor Relief: The World Bank Proposal for Health. *International Journal of Health Services*, 26, 1: 1-18.

Marcus, G. E. 1995. Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, 24: 95-117.

Menéndez, E. L. 1981. *Poder, estratificación y salud: Análisis de las condiciones sociales y económicas de la enfermedad en Yucatán*. México D.F.: Centro de Investigaciones y Estudios Superiores en Antropología Social.

Menéndez, E. L. 1996. *De algunos alcoholismos y algunos saberes: Atención primaria y proceso de alcoholización*. México D.F.: Ciesas.

Menéndez, E. L. 2009. *De sujetos, saberes y estructuras: Introducción al enfoque relacional en el Estudio de la Salud Colectiva*. Buenos Aires: Lugar Editorial.

Mignolo, W. D. 2000. *Local Histories/Global Designs: Coloniality, Subaltern Knowledges, and Border Thinking*. Princeton: Princeton University Press.

Molyneux, M. 2006. Mothers at the Service of the New Poverty Agenda: Progresa/Oportunidades, Mexico's Conditional Transfer System. *Social Policy & Administration*, 40, 4: 425-449.

Montoya, M. J. 2011. *Making the Mexican Diabetic: Race, Science, and the Genetics of Inequality*. Berkeley: University of California Press.

Nazar-Beutelspacher, A., Salvatierra Izaba B. & E. Zapata Martelo 2007. Atención del parto, migración rural-urbana, y políticas públicas de salud reproductiva en la población indígena de Chiapas. *Ra Ximhai*, 3, 3: 763-779.

Ong, A. 1999. *Flexible Citizenship: The Cultural Logics of Transnationality*. Durham: Duke University Press.

Rapp, R. 2000. *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge.

Tsing, A. L. 2005. *Friction: An Ethnography of Global Connection*. Princeton: Princeton University Press.

Wilson, A. 2004. *The Intimate Economies of Bangkok: Tomboys, Tycoons, and Avon Ladies in the Global City*. Berkeley: University of California Press.

Abstract

This work is based on sixteen months of in-depth fieldwork related to medical pluralism surrounding birth, ethnicity, and class, and how these three vectors are influenced by global flows traversing the Mexican landscape. How do intersecting birth models in Mexico unfold on the physical and social body in disparate ways, depending on the geographical context, socioeconomic status, and education level of patients?

The article is sensitive to the inequality (socioeconomic, gender, and racial) that medical pluralism often meets and comes to represent, and argues that the positive capacity of medical pluralism to meet the disparate needs of people in different geographical, cultural, and ethnic contexts should not be distorted or used to disguise and obscure the suffering of people living in poverty, and victimized by racial discrimination and structural persecution. How do the methods applied by different types of birth attendants ("traditional midwives", "professional midwives", obstetricians, and obstetric nurses) respond to the reproductive health care needs and preferences of Mexican women across ethnic groups, socioeconomic class, and geopolitical divisions? Only through problematizing pluralism in birth practices in Mexico (i.e., "traditional", biomedical, and humanized) can we truly understand the challenges that continue to undermine gender equity, reproduce maternal mortality, and limit the development of effective and appropriate health care across ethnicity, space, and place.

This article takes hybridity as its object as well as its methodological project. I engage theory from both the United States and Mexico to examine interpenetrations between transnational birth models and problematize hegemonic dichotomies such as tradition-modernity, north-south, and local-global. Thus, the article resists the temptation to condemn obstetricians and romanticize midwives, and vice versa. Using "border thinking" and my own "border identity" to engage with subaltern perspectives, I make my work multi-sited not only in the geographic sense but perform research across ethnic and socioeconomic grades.

Key words: Mexico, ethnography, midwifery, inequality.

Riassunto

Questo lavoro si basa su di una ricerca sul campo di 16 mesi relativa al pluralismo medico che sta intorno alla nascita, all'etnia e alla classe e a come questi tre vettori sono influenzati dai flussi globali che investono il panorama messicano. Come mostrare l'intrecciarsi di modelli di nascita che si dispiegano in modi differenti sul corpo fisico e sociale a seconda del contesto geografico e dello status socioeconomico e del livello di scolarizzazione dei pazienti?

L'articolo è attento alle diseguaglianze (socioeconomiche, di genere e di razza) che si incontrano nei contesti di pluralismo medico, e afferma che la capacità positiva delle situazioni di pluralismo medico di venire incontro ai disparati bisogni degli individui in differenti contesti geografici, culturali ed etnici non dovrebbe essere usata per nascondere la sofferenza di quanti vivono in povertà, e sono vittime di

discriminazioni razziali e persecuzioni strutturali. In che modo i metodi adottati da diversi tipi di levatrici ("levatrici tradizionali", "levatrici professionali", ostetriche e infermiere ostetriche) rispondono alle preferenze e ai bisogni di salute riproduttiva di donne messicane di diversi gruppi etnici, classi sociali e luoghi geopolitici? Solo problematizzando il pluralismo nelle pratiche di parto in Messico (ad esempio "tradizionali", biomediche e umanizzate) si possono realmente comprendere i problemi che continuano a minare l'eguaglianza di genere e la mortalità materna, così come i limiti dello sviluppo di una sanità appropriata ed effettiva che attraversi l'etnicità lo spazio e i luoghi.

Il contributo assume l'ibridità come suo oggetto e come progetto metodologico. L'autore si confronta con testi degli Stati Uniti e del Messico per esaminare interpenetrazione di modelli di parto transnazionali e problematizzare dicotomie egemoniche quali tradizione/modernità, nord/sud, locale/globale. In tal modo, l'articolo resiste alla tentazione di condannare le ostetriche e romanticizzare le levatrici, o viceversa. L'autore fa uso di un "pensiero di confine" e della sua propria "identità di confine" per confrontarsi con la prospettiva subalterna, producendo un lavoro multisituato non solo nel senso geografico, ma perché attraversa livelli etnici e socioeconomici.

Parole chiave: Messico, etnografia, levatrici, ineguaglianze.