

UC Berkeley

UC Berkeley Electronic Theses and Dissertations

Title

Supranational Citizenship: (Im)mobility and the Alternative Birth Movement in Mexico

Permalink

<https://escholarship.org/uc/item/1bx9c6p8>

Author

Vega, Rosalynn Adeline

Publication Date

2016

Peer reviewed|Thesis/dissertation

Supranational Citizenship:
(Im)mobility and the Alternative Birth Movement in Mexico

by

Rosalynn Adeline Vega

A dissertation submitted in partial satisfaction of the
requirements for the degree of

Joint Doctor of Philosophy
with the University of California, San Francisco

in

Medical Anthropology

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Nancy Scheper-Hughes, Co-chair

Professor Charles Leslie Briggs, Co-chair

Professor Charis Thompson

Professor Ian Whitmarsh

Spring 2016

ABSTRACT

My research analyzes how the remaking anew of tradition—the return to “traditional” birthing arts (home birth, midwife-assisted birth, water birth, “natural” birth)—has resulted in the commodification of indigenous culture and the re-inscription of racial inequalities on the one hand, and, despite feminist rhetoric about women’s liberation from (masculine) biomedical hegemony, the reconfiguring of parent-child bonds in ways that again place the burden of correctly producing future members of society on women’s shoulders. I focus on the extremes of contemporary Mexican society—disenfranchised indigenous families and members of the global meritocracy—and in doing so, I demonstrate how citizenship retains value for some while being rendered irrelevant for others. More specifically, I argue that the privileged do not position themselves as citizens through claims to public resources; instead, they accumulate cultural capital through privatized services. Through an examination of processes of racialization and patterns of bioconsumption, I critique the broad application of the concept of citizenship, and make a case for the consideration of the bioconsumer (individuals for whom market-based consumption of medical services plays a formative role in how their identities are syncretically portrayed and perceived). The main stakes of bioconsumption are the presentation of self and accrual of cultural capital.

Furthermore, I demonstrate how what is under negotiation in the alternative birth movement is the social-moral body onto which identities get mapped. Close ethnographic study reveals how the so-called “humanization” of birth and the reduction of maternal and infant mortality are distant projects that are collapsed onto one another and produce an emerging ideology of “good parenthood.” In this ideology, children represent parents’ stake in the contemporary global meritocracy. This work therefore uncovers how traditional ways of birthing are being destroyed and reinvented through racialized class privilege, which is based on a model of neoliberal consumption that simultaneously promotes “humanity” and reinforces inequality by infusing transnational movements with reified class logics and racialization. I thus consider Mexican traditional midwifery as a unique lens for examining how indigeneity becomes an object of consumption via ethnomedical piracy within a transnational racialized economy.

Through 28 months of in-depth, multi-sited research across Mexico, from October 2010 to November 2013, this dissertation analyzes the physical and social mobility of some individuals, and the relative immobility of others, through the lens of humanized birth. In writing this dissertation, I aim to make the following interventions:

First, I disrupt notions of citizenship-making by placing under the same lens those for whom citizenship is always just out of reach and those for whom citizenship is not a concern as their privileged access to privatized markets allows for a supra-state existence. I offer the concept of “supranationalism” as a contribution to emerging literature that rethinks states as the consolidation of territory and government, thus opening up other ways of conceptualizing polity and geography. In doing so, this dissertation challenges Foucault’s 1978 framing of biopolitics. I use the topic of birth to provide ethnographic evidence of how biopower is not only imposed by states upon citizen-subjects; but by powerful, extra-governmental, social and economic forces operating in the context of neoliberalism, thus resulting in real material consequences and shaping health outcomes.

Second, I deploy the concepts of racialization (“raza” vs. whiteness, see Roberts 2012b) and power (“reproductive governance,” see Morgan and Roberts 2012) when I critique the ways in which the global alternative birth movement inadvertently appropriates and commodifies

indigenous culture. When “indigeneity” is invoked in the realm of so-called “humanized” birth, the object is fetishized, separated entirely from its cultural, socioeconomic, and geographical context, and repackaged for mass consumption—leading me to rethink the relationship between neoliberal citizenship and consumerism. Instead of directing attention to the body-turned-merchandise (e.g. organ trafficking and surrogacy, see Scheper-Hughes and Wacquant 2006), I use the example of midwifery in Mexico to examine racialized identities-turned-merchandise, with real effects for the bodies of women. Building upon studies that explore the political economy of the body under contemporary global capitalism, I use a transnational context to analyze the political economy of identities vis-à-vis the body.

In this dissertation, I examine the disparate and unequal distribution of “traditional,” and ethnomedical forms of “natural” birth among social collectivities. Building upon Roberts and Scheper-Hughes’ work, the dissertation examines the mobility of humanized birth practitioners and participants who travel across borders to contribute to ideology and practices being produced transnationally, while comparatively immobile women are socially situated in ways that preclude their participation in medical migrations. Thus, while my ethnographic research provides detailed examples of how humanized birth is reshaped and reconstituted in sites that bear stark contrast to the social and geographic locations where the humanized birth model was originally produced, I am more concerned with how politic economic terrains are not only traversed, but are themselves transformed by medical migration.

Finally, I complexify notions of feminist liberation by asking how humanized birth may be the first step within a new regime of pressures and “requirements” presented by modern-day “good parenting.” I resist viewing children only as commodities; however, I do argue that children represent parents’ stake in our contemporary meritocracy—a system that naturalizes extreme inequality by allowing us to believe in democratic structures and the idea that education and proper preparation will open doors for children to a brilliant future. Furthermore, I suggest that the pressure of meritocracy pushes back into the womb. The difference between a privatized and public childhood begins in vitro with prenatal care.

In chapter one, I offer a series of interlacing ethnographic portraits that set the stage for the theoretical interventions I develop in later chapters. I introduce a network of transnational birth attendants—midwives with diverse training—in order to demonstrate how racial politics overlap with socioeconomic class to shape and constrict realms of possibility for consumption and citizenship. This chapter serves as an initial demonstration of unequal participation in the humanized birth movement and (im)mobility among midwives; thus signaling how celebration of “going back to nature,” commodification of indigenous culture, and simultaneous racialization of indigenous “others” are collapsed within the so-called humanization of birth.

Chapter two points to how the humanized birth movement inadvertently commodifies indigenous culture in symbolically cannibalistic ways. Members of the transnational humanized birth community seek “natural” births that reference “traditional” and “indigenous” birthing methods. However, these methods are not adopted wholesale; rather, they are reimagined by the community and reconfigured by capitalist marketing. My work builds off of Brubaker and Dillaway’s 2009 assertions that natural childbirth discourse reflects class and race biases and are based on middle-class rationalist economic ideology emphasizing control and informed consumer choice and requiring access to resources available only to privileged women. While Scheper-Hughes and Wacquant point to how the commodification of the body results in alienation of the self, in this present dissertation the commodification of others’ (imagined) “selves” can lead to violence being unleashed on their bodies.

Chapter three problematizes uncritical notions of liberation by asking how humanized birth may contribute to a new regime of pressures and standards for modern-day “good parenting.” Through ethnographic examples of women who struggle or “fail” to give birth naturally (see Crossley 2007), the dissertation points to how humanized birth may inadvertently represent another way the burden of correctly producing future citizens falls upon women, even as it aims to liberate women from biomedical hegemony. While biopower has often been characterized as the control of populations through “paternalistic” institutional and governmental surveillance, humanized birth practices beg the question of how “maternalistic” biopower might operate through social networks. I bring a critical medical anthropology perspective to health-related “mommy wars” circulating in popular media and analyzes how parents use birth to stake claims to moral superiority.

My ethnographic research in Mexico points to how couples seek inclusion in a global meritocracy by investing time, money, effort, and emotions into being “good parents,” and the criteria for good parenting is largely defined by parenting trends in their social network (humanized birth, extended lactation, organic/holistic nutrition, Montessori and Waldorf education, extracurricular activities, etc.). As couples increasingly consider parenthood and their ability to produce well-nurtured, well-educated, well-rounded, ethically conscious children a marker of their overall success, their relationships to their children are changing. The dissertation aims to add complexity to Jordanova’s remark about considering children as commodities.

Chapter four responds to Brubaker and Dillaway’s assertion that, “We need to conduct comparative research on the subjective experiences of pregnant and birthing women at multiple social locations and multiple contexts, as well the experience and perspectives of midwives and medical providers in order to provide a more critical and meaningful analysis of the complicated intersections of ideology, politics, practice and bodily experience” (Brubaker and Dillaway 2009). In this dissertation, examining multiple social locations and contexts is exactly what I will do. Through contrasting ethnographic examples of how local San Miguelenses experience their hometown as an internal borderland that excludes them from “gringo” spaces (except as service workers), and how urban “outsiders” are excluded from “closed” indigenous communities in the Nahua High Mountains of Veracruz, this chapter signals how “othering” in Mexico is both highly contingent, and a matter of perspective.

The chapter offers the concept of racial i(nter)dentification as a way for thinking about the syncretic nature of racialized identities. Racial i(nter)dentification points to the multiple variables that figure into immediate, unconscious mental calculi structuring encounters of difference—that is, “race,” class, education, and other forms of cultural capital are folded into one another to produce social constructions of racial identity that include and supersede phenotype. While my argument resembles Bourdieu’s habitus (1984), I have developed racial i(nter)dentification as a way of simultaneously acknowledging the readily visible phenotypic differences between those who are served and those who serve.

Chapter five builds upon chapter four by examining how racial discrimination buttresses systemic violence within Mexican obstetrics, thus eliciting complicity from medical personnel, with the greatest violations being unleashed on racialized women’s bodies. While others have written about “race” and racialized biology, my work is about the construction of social identities that allow for the manipulation of “race.” What is being racialized is not the biological body or the national body, but the moral body. Thus, I turn to the work of Michael Montoya, Marisol de

la Cadena, and Elizabeth Roberts to argue that *raza* in Latin America is a complex social category that extends beyond “race” to include class, education, and “culture.”

While chapters three and six explore how whitening is sought through private medical care by educated, urban women, in chapter five I provide ethnographic examples of how “reproductive governance” is applied to the supposedly hyper-fertile indigenous women. In doing so, I critique the concept of “interculturality” and use conditional cash transfer programs like *Oportunidades* as a lens for examining complex and unequal relationships of power between indigenous women and the Mexican government. Poor indigenous women are recruited into *Oportunidades*, shaped into obedient mothers, and required to give birth in government hospitals. My framing signals the inadequate attention of “interculturality” to political economic factors and questions the reification of cultures upon which “interculturality” is premised.

Chapter six builds off of chapter four by examining how citizenship fails to encompass the way privileged women are proactively constructing whiter subjectivities (see Bashkow 2006) through New Age approaches to natural birth and participation in the humanized birth transnational network. This chapter adds to ethnographies on reproduction that have analyzed divergences between foreign interests and local moral worlds and studies problematizing notions of “globalization” when it examines medical migration among the humanized birth community in Mexico. Responding to Roberts and Schepers-Hughes’ edited volume, the dissertation examines the ease with which mobile humanized birth practitioners’ travel across borders and contribute to transnational discourse, while relatively immobile Mexican midwives and families are restricted from medical migrations. Medical migrations and tourism imply big economic stakes for sending and receiving countries, and transnational negotiations of citizenship and capital. My work differs from previous work on medical migration and medical tourism since these discourses are implicitly nationalist and my work explores how identities are forged and leveraged by travelers in a transnational racialized economy.

The conclusion of the dissertation situates the humanized birth movement in Mexico within the broader context of global New Age practices. I explain how the New Age is not only a context for examining the redefinition of social identities, but also for analyzing how consumption, or lack thereof, leads to the accrual of cultural capital on one hand, and social inequality on the other. New Age practices are useful for thinking about how the negotiation of social identities are inscribed with processes of racialization, socioeconomic class, power, and agency. Furthermore, I discuss how New Age practices challenge Euro-American ontologies of time through differential meanings ascribed to “modernity” and “traditionality” by informants with divergent positionalities in society. At the same time, notions of “social whitening” play out through consumption of the New Age on a global stage. Finally, the conclusion addresses the importance of place when planning health programs and interventions.

For my mother and Popo,
the two bold, spirited, and morally courageous women
who have inspired me with their unwavering love.

TABLE OF CONTENTS

Cast of Characters	iii
Introduction	v
Acknowledgements	xxvii
Curriculum Vitae	xxviii
Chapter One Portraits: Racial Politics Among Birth Attendants	1
Chapter Two Commodifying Indigeneity: Politics of Representation	11
Chapter Three Humanized Birth: Unforseen Politics of Parenting	36
Chapter Four Racial I(nter)dentification	58
Chapter Five A Cartography of “Race” and Obstetric Violence	77
Chapter Six (Ethno)medical (Im)mobilities	93
Conclusion	118
References	127
Bibliography	132

CAST OF CHARACTERS

Name	Description	First Appearance
Montserrat ,	professional midwife from Spain, was previously trained under Sagrario,	pg. 1
Paula ,	prenatal educator and professional midwife trained in the US and Europe,	pg. 4
Yanira ,	traditional midwife, regularly invited to international midwifery conferences,	pg. 5
Lucía ,	obstetric nurse, President of the Mexican Midwifery Association,	pg. 8
Emma ,	unlicensed Swiss midwife who rejects being categorized as “professional,”	pg. 9
Sofia ,	saleswoman of “traditional” herbal products in Estación Catorce,	pg. 13
Liliana ,	traditional midwife manning the herbal products table in Sofia’s absence	pg. 13
Arturo ,	Oaxaca State Secretar of Health Physician in Capulálpam de Méndez,	pg. 18
María del Rosario ,	mother, and snack bar owner/attendant in Capulálpam de Méndez,	pg. 20
Francisco ,	father and resident of Capulálpam de Méndez, sought services at the clinic,	pg. 21
Sagrario ,	professional midwife, graduate and former director of CASA,	pg. 23
Doña Eugenia ,	traditional midwife in Zacatochin, High Mounts of Veracruz,	pg. 23
Juana ,	mother, gave birth in Doña Eugenia’s home clinic, defying <i>Oportunidades</i> ,	pg. 23
Don Israel ,	midhusband and traditional medicine doctor, High Mountains of Veracruz,	pg. 27
Doña Agustina ,	traditional midwife in Zacatochin, High Mountains of Veracruz,	pg. 27
Mayra ,	indigenous student at CASA, invited to international midwifery conference,	pg. 33
Dr. Alejandro Almaguer ,	Dir. of Traditional Medicine and Intercultural Development,	pg. 36
Elizabeth ,	British founder of humanized birthing center in Monterey, Nuevo León,	pg. 41
Dr. Tellez ,	physician at the General Hospital in San Miguel de Allende,	pg. 41
Magdalena ,	professional midwife, graduate of CASA, works in the Guadalajara area,	pg. 46
Yasmin ,	Magdalena’s first client in the city of Irapuato, fabric diaper entrepreneur,	pg. 46
Celia ,	mother who successfully achieves vaginal delivery after a previous failed attempt,	pg. 50
Josefa ,	friend of Yasmin, also gave birth with Magdalena, mother of Tobías & Timoteo,	pg. 51
Tomás ,	husband of Josefa, proponent of humanized birth, father of Tobías & Tomoteo,	pg. 51
Dr. Horacio García ,	perinatologist, hospital administrator, and clinical professor,	pg. 52
Javier ,	husband of Celia, father of Sandra and Santiago,	pg. 54
Flor ,	professional midwife and CASA graduate, pregnant during fieldwork period,	pg. 59
Pati ,	my landlady in San Miguel de Allende, housekeeper and mother of two	pg. 62
Frida ,	kitchen worker and pet sitter in San Miguel de Allende,	pg. 70
Fermín ,	medical intern at the IMSS clinic in Zacatochin, trained at UNAM	pg. 70
Padre Filadelfo ,	catholic priest assigned to the Nahua High Mountains of Veracruz,	pg. 74
Paloma ,	traditional midwife at a “capacitation” workshop in Zongólica, Veracruz,	pg. 83
Rodrigo ,	physician, Mayan rights advocate, and board member of indigenous assoc.,	pg. 86
Francisca ,	professional midwifery student at CASA, gave workshops in Zacatochin,	pg. 86
Daniela ,	nurse & public health officer in San Luís Potosí, focuses on maternal mortality,	pg. 90
Maricelda ,	Larissa and Jose Felix’ obstetrician in San Luís Potosí,	pg. 91
Camelia ,	professional midwife and graduate of CASA, daughter of Pamela,	pg. 91
Pamela ,	traditional midwife in the Orizaba region of Veracruz, mother of Camelia,	pg. 91
Martha Lipton ,	water birth educator, gentle-birth guardian & humanized birth celebrity,	pg. 93
Larissa ,	founder of water birth organization Tranquilo, entrepreneur of Port-a-Pool,	pg. 95
Jose Felix ,	husband of Larissa, co-founder/entrepreneur of Tranquilo & Port-a-Poor,	pg. 95
Adeli ,	professional Jewish-Mexican-American midwife trained in the US, lives in Brazil,	pg. 103

Ana , participant in Adeli's traditional Mexican Midwifery popular tourism workshop,	pg. 106
María del Carmen , indigenous woman who suffered from a hemorrhage in Guerrero,	pg. 109
Ignacio , María del Carmen's indigenous husband, sought medical care for his wife,	pg. 109
Verónica , 19-year-old indigenous primiparous woman, determined about home birth,	pg. 111
Valeria , María del Carmen's sister-in-law	pg. 112

INTRODUCTION

It is the middle of the night in the High Nahua Mountains of Veracruz. A woman arrives at the door, her belly contracting fiercely and regularly. While the contractions send waves of pain throughout her body, she is calm and determined. She and her husband have driven along the dark winding path for several hours, family members piled into the back of their pickup truck, to seek out the midwife. The woman is alert and aware of what could happen, but she is unafraid. She has brought new life into this world many times before—the grey hairs sprouting around her temples evince her years of experience nurturing and raising children. But this time she refuses to be humiliated or shunned. Everyone is quiet, as they are all witnesses to a clandestine act. The midwife has agreed to be an accomplice—she will provide her expertise and aid the woman in her defiant plan. The woman and her husband enter into the midwife’s bedroom, and the curtains are drawn behind them. Nothing is heard in the house except for soft whispers of encouragement, until a newborn baby cries out into the black of night.

In the city of Irapuato, warm water caresses a woman’s naked body. She sways back and forth, breathing deeply, timing her movements to the rhythm of the soft music she chose for this moment. Two young midwives reassure her. She is attempting something that has not been done before in her community—she doesn’t know anyone who has been successful—but traumatic memories of being strapped down and sliced open while bright lights blinded her sight give her the bravery to proceed. Her husband is by her side, holding her, waiting with her. Finally, the baby begins crowning at her loins, and moments later he is swimming in the water. His mother supports him with her hands, brings him to the surface of the water, and brings him to her breast.

My research analyzes how the remaking anew of tradition—the return to “traditional” birthing arts (home birth, midwife-assisted birth, water birth, “natural” birth)—has resulted in the commodification of indigenous culture and the re-inscription of racial inequalities on the one hand, and, despite feminist rhetoric about women’s liberation from (masculine) biomedical hegemony, the reconfiguring of parent-child bonds in ways that again place the burden of correctly producing future bioconsumers on women’s shoulders. I focus on the extremes of contemporary Mexican society—disenfranchised indigenous families and members of the global meritocracy—and in doing so, I demonstrate how citizenship retains value for some while being rendered irrelevant for others. More specifically, I argue that the privileged do not position themselves as citizens through claims to public resources; instead, they accumulate cultural capital through privatized services. Through an examination of processes of gendered racialization and patterns of bioconsumption, I critique the broad application of the concept of citizenship, and make a case for the consideration of the bioconsumer (individuals for whom market-based consumption of medical services plays a formative role in how their identities are syncretically portrayed and perceived). The main stakes of bioconsumption are the presentation of self and accrual of cultural capital.

Furthermore, I demonstrate how what is under negotiation in the alternative birth movement is the social-moral body onto which identities get mapped. Close ethnographic study reveals how the so-called “humanization” of birth and the reduction of maternal and infant mortality are distant projects that are collapsed onto one another and produce an emerging ideology of “good parenthood.” In this ideology, children represent parents’ stake in the contemporary global meritocracy. This work therefore uncovers how “traditional” ways of

birthing are being destroyed and reinvented through gendered and racialized class privilege, which is based on a model of neoliberal consumption that simultaneously promotes “humanity” and reinforces inequality by infusing transnational movements with reified class logics and gendered racialization. I thus consider Mexican “traditional” midwifery as a unique lens for examining how indigeneity becomes an object of consumption via ethnomedical piracy within a transnational racialized economy.

Through 28 months of in-depth, multi-sited research across Mexico, from October 2010 to November 2013, this dissertation analyzes the physical and social mobility of some individuals, and the relative immobility of others, through the lens of humanized birth.ⁱ In writing this dissertation, I aim to make the following interventions:

First, I disrupt notions of citizenship-making by placing under the same lens those for whom citizenship is always just out of reach and those for whom citizenship is not a primary concern. (The latter groups’ privileged access to privatized markets allows for a supra-state existence.) I offer the concept of “supranationalism” as a contribution to emerging literature that rethinks states as the consolidation of territory and government, thus opening up other ways of conceptualizing polity and geography. In doing so, this dissertation challenges Foucault’s 1978 framing of biopolitics. I use the topic of birth to provide ethnographic evidence of how biopower is not only imposed by states upon citizen-subjects; but by powerful, extra-governmental, social and economic forces operating in the context of neoliberalism, thus resulting in real material consequences and shaping health outcomes.

Second, I deploy an intersectional approach to the concept of gendered racializationⁱⁱ and powerⁱⁱⁱ when I critique the ways in which the global alternative birth movement inadvertently appropriates and commodifies indigenous culture. When “indigeneity” is invoked in the realm of so-called “humanized” birth, the object is fetishized, separated entirely from its cultural, socioeconomic, and geographical context, and repackaged for mass consumption—leading me to rethink the relationship between neoliberal citizenship and consumerism. Instead of directing attention to the body-turned-merchandise (e.g. organ trafficking and surrogacy, see Scheper-Hughes and Wacquant 2006), I use the example of midwifery in Mexico to examine racialized identities-turned-merchandise, with real effects for the bodies of women. Building upon studies that explore the political economy of the body under contemporary global capitalism, I use a transnational context to analyze the political economy of identities vis-à-vis the body.

On medical migration, Roberts and Scheper-Hughes write, “Not only people and bodies—surgeons, patients, handlers and body parts—migrate, but also sometimes medical therapies that travel across geographical and political economic terrains are reshaped and modified in surprising ways” (Roberts and Scheper-Hughes 2011: 3). For Roberts and Scheper-Hughes, medical migrations emphasize the movement of objects, people, knowledges, therapies and technologies within political-economic configurations of globalized bio-medicine. In this dissertation, I examine the disparate and unequal distribution of “traditional,” and ethnomedical forms of “natural” birth among social collectivities. Inspired by Roberts and Scheper-Hughes’ work, the dissertation examines the mobility of humanized birth practitioners and participants who travel across borders to contribute to ideology and practices being produced transnationally, while comparatively immobile women are socially situated in ways that preclude their participation in medical migrations. Thus, while my ethnographic research provides detailed examples of how humanized birth is reshaped and reconstituted in sites that bear stark contrast to the social and geographic locations where the humanized birth model was originally produced, I

am more concerned with how politic economic terrains are not only traversed, but are themselves transformed by medical migration.

Finally, I complexify notions of feminist liberation by asking how humanized birth may be the first step within a new regime of pressures and “requirements” presented by modern-day “good parenting.” I resist viewing children only as commodities; however, I do argue that children represent parents’ stake in our contemporary meritocracy—a system that naturalizes extreme inequality by allowing us to believe in democratic structures and the idea that education and proper preparation will open doors for children to a brilliant future. Furthermore, I suggest that the pressure of meritocracy pushes back into the womb. The difference between a privatized and public childhood begins in vitro with prenatal care.^{iv}

“Humanized” and “Traditional” Births

In this dissertation, I focus primarily on two contrasting types of birth. “Humanized birth” (*parto humanizado*) is usually used in Mexico and elsewhere in Latin America to describe birth that purposefully resists medicalization and technocratic practices (see Davis-Floyd 1992). This movement is analogous to the home and water birth movements in the United States, Canada, and Western Europe. Births are often attended by professional midwives (although some obstetricians have joined the movement) and accompanied by doulas. In general, proponents of humanized birth criticize power inequality inherent in physician-patient relationships and denounce medicalized practices such as unnecessary cesarean sections, episiotomies, isolation of birthing mothers in hospital labor and delivery areas, labor induction (including the use of hormones such as Pitocin), and the repetitive insertion of medical personnel’s fingers into women’s vaginas to assess dilation. However, some informants expressed a more nuanced definition of humanized birth, explaining that a highly medicalized birth can be considered “humanized” if the interventions were medically necessary and/or if the interventions were “chosen” by the birthing mother. At the same time, some Mexican physicians have railed against the terminology of “humanized birth,” asking if the birth they attend is, by default, “animalistic.” Thus, some prefer the term “respected birth,” since it highlights respect for birthing mothers’ “choices,” which can be prioritized in both medicalized births and births attended by physicians.

Likewise, “traditional” birth (home birth attended by a “traditional midwife”) represents an alternative to medicalized, technocratic, hospital birth. It is also an example of resistance to the hegemonic way of birthing. However, the women who have “traditional” births occupy a highly contrastive positionality within society when compared to their “humanized” counterparts. Their births are less about “choice” and more explicitly about resistance to biopower (see Foucault 1990[1978]) and the Mexican Secretary of Health’s mandate that *all* births take place in hospitals since *every* birth can potentially involve life-threatening complications. The Mexican government uses the conditionality of the cash-transfer program, *Oportunidades*, to incentivize recipients to adhere to the Secretary of Health’s mandate, citing the reduction of maternal and infant mortality as the primary goal. These forms of “reproductive governance” (see Morgan and Roberts 2012) are differentially experienced and understood by poor and indigenous recipients of *Oportunidades*. As Vania Smith-Oka (2013) points out, some women reject “traditional” midwifery and actively seek out “modern” motherhood through medicalized birth. In this dissertation, I focus on indigenous women for whom giving birth with a “traditional midwife” exemplifies their refusal to be racially discriminated against in government hospitals, and socialized as “appropriate pregnant subjects” whose bodies are “sites of risk” (see Howes-Mischel 2009).

In referring to these births as “humanized” and “traditional,” I am simply using the terms I encountered in the field. When “studying up” (see Nader 1972), the alternative births described in this dissertation were most commonly called *partos humanizados* by parents, obstetricians, and professional midwives. Likewise, the women to whom I refer to as “professional midwives” self-identify with this term, are classified as such by their clients, and some (with important exceptions) have undergone formal training and licensure¹. With respect to “traditional midwives,” I am again adopting the terms these practitioners use for themselves. Indigenous midwives most often self-identify as *parteras tradicionales*, while a small minority refer to themselves as *parteras empíricas* (“empirical” or experienced-based midwives). While all of these terms were the ones offered to me by informants, they also come from the realm of policy as *parteras profesionales* and *parteras tradicionales/parteras empíricas* are the terms used by the Mexican Secretary of Health and other governmental bodies like the Mexican Institute of Social Security. Midwives may use these terms to describe themselves as a result of their engagement with government agencies for training, certification, hospital privileges, etc. I am by no means assigning a value judgment to either type of birth attendant, nor am I arguing that “traditional midwives” practices are anchored in the past, while “professional midwives” practices are representative of greater modernity (see Bauman and Briggs 2003). From here on out, I will forego quotation marks when referring to these practitioners.

My research focused on the births of two socioeconomic extremes of Mexican society—what is missing from the story is the vast majority of Mexicans who make out their lives somewhere between these two distinct poles. Likewise, while no data exists as to what percentage of women have “humanized” and “traditional” births in Mexico, these two birthing strategies represent a small minority. The vast majority of births take place in hospitals and are highly medicalized, with cesarean section representing 45.8 percent of births in public Mexican Institute of Social Security (IMSS) hospitals^v and approximately 70 percent of births in private hospitals.^{vi} In spite of these facts, I have chosen to study “humanized” and “traditional” births because of what they together reveal about the mutual imbrication of colonial legacies and transnational economies operating in the present day. My work is not about how the bulk of Mexican society gives birth, but rather about examining life and the process of bringing into life at the extremes of Mexican society in order to understand the unfolding of gendered racialization and the limitations of the citizenship concept in a globalized, neoliberal world. By contrasting racialized *Oportunidades* recipients with members of the “global professional class” (Kapoor 2004), I mean to tell a complex story in a complex way. Through examining these exceptional cases in conjunction, we can begin to see how citizenship is actively sought but not fully attainable for some, while being devalued for others who forego government-provisioned services in favor of the cultural capital gleaned from the “conspicuous consumption” (see Veblen [2006]; also Ritzer 2001) of more socially-valuable bodily practices. My story uses birth as a point of departure, thus seating theoretical arguments in ethnographic accounts describing both sensual and violent moments experienced through the flesh and authored with blood, births unfolding in both symbolically cleansing water and life-producing mud; however, the subject of my theoretical analysis reaches far beyond the object of ethnographic description: a critical rethinking of “race,” citizenship, and the consumption of “culture.”²

¹ I will return to this topic in the conclusion of the dissertation.

² “Culture” as a reified object ready for consumption, not as a set of everyday beliefs and practices pertaining to a particular ethnic group.

This positioning of my ethnographic research at the intersection between processes of gendered racialization and “conspicuous consumption” (see Veblen [2006]; also Ritzer 2001) in Mexico illuminates how participation in the humanized birth movement is used as a form of cultural capital with which to wage claims about “race,”³ gender, and identity on a global stage. While couples practicing humanized birth in Mexico are often urban, middle or upper class, fair skinned, well traveled, and highly educated, they insist the practice does not correspond directly to social class. Repeatedly, I was told the determining factor was how cultured⁴ the couple is. The majority of these couples holds advanced degrees in the sciences and humanities (as opposed to technical) fields, and has read widely in English or French. Their commitment to the humanized birth movement is based in their deep admiration of the work of French obstetricians such as Frédéric Leboyer and Michel Odent, English and American midwifery and “gentle birth” advocates such as Sheila Kitsinger, Ina May Gaskin, Barbara Harper, Thomas Verney, and Robbie Davis-Floyd, and New Age birth methods such as Mongan Method Hypnobirthing. During in-depth interviews, they opine that the truly rich are often mystified by hegemonic biomedicine; however, they, with the fervor of religious converts,⁵ vow to a sort of enlightenment with respect to birth, allowing them to see what others cannot. This enlightenment connects them to a global community, primarily in United States, Canada, England, France, Holland, Spain, Chile, Argentina, and Brazil, based on shared passion for humanized birth.

What their telling erases, of course, are multiple, contingent *processes of gendered racialization* (see DeGenova 2005).⁶ Many of the couples are fair skinned, but their participation in the humanized birth movement is also a process of “social whitening” on a global stage. My use of the term “social whitening” refers to the process through which individuals seek membership in a global meritocracy—a meritocracy that, due to a global history of imperialism and colonization, tends to be white or aspires to social whiteness (see Bashkow 2006). In this context, “white” does not strictly coincide with phenotype, but, rather, refers to a social category

³ As I will explain in more detail below, I am not debating whether “race” is a biological given or a social construct (see Montoya 2011). Rather, my work analyzes the origins and effects of processes of gendered racialization. Also, I have deliberately selected processes of racialization as an analytical lens over “ethnicity” because, while important differences distinguish the various indigenous groups I describe, my overarching argument traces discriminatory politics in Mexico that contrast indigenous and *mestizo* individuals instead of distinguishing between different indigenous ethnicities.

⁴ During interviews, informants distinguished themselves and other members of the humanized birth movement from the rest of society based upon their “*nivel cultural*” (cultural level) as opposed to socioeconomic class. I do not unquestioningly accept this self-identified category as accurate—in fact, I am attentive to how socioeconomic status allows for education and travel, and, thus, exposure to the humanized birth movement as it unfolds in different countries around the world. Therefore, I ask if cultural capital is used to mask economic capital (see Bourdieu 1984).

⁵ During interviews with informants, analogies to religious conversion and descriptions of how humanized birth has influenced their lives, reconfigured their identities, and transformed how they relate to others were common themes.

⁶ I borrow DeGenova’s concept of racialization, but I add the words “gendered” and “processes” to draw attention to the role of gender among multiple, ongoing, interfacing mechanisms that lead to the (re)realization of racialization.

resulting from a dialectic process of perception and performance of an individual's positionality in society—a calculus that includes “race” *and* class, and ultimately maps “race” *onto* class, *and vice versa*. Through humanized birth, participants are able to distance themselves from the majority of Mexican society, which they characterize as entrapped in a political and educational system which limits intellectuality; and with the help of professional midwives representing a foreign or transnational identity,⁷ insert themselves in a transnational affluent, cultured community.

Meanwhile, indigenous⁸ Mexican women and their traditional midwives are excluded (almost entirely) from this community. While there is a celebration of “ancestral knowledge,” the humanized birth movement in Mexico—departing from the work of de la Cadena 2000 in Peru—is not about claiming and enacting “indigenous culture” while attempting to distance oneself from “Indian-ness” through *mestizaje* and the idea of *indigenous mestizos*. In Mexico, indigenous people are distinctly “other,” and this new midwifery is decidedly not the midwifery of the old indigenous hag (see Weismantel 2001). When “indigeneity” is invoked, it is in *à la carte* fashion. The object is fetichized, separated entirely from its cultural, socioeconomic, and geographical context, and repackaged for mass consumption (Comaroff 2009; Chow 2002; Dávila 2012; García Canclini 2001; Mazarrella 2003). During this process of commodification, “indigeneity,” “nature,”⁹ and “tradition”¹⁰ are collapsed onto one another. Similarly, very specific indigenous

⁷ Many professional midwives in Mexico are either foreign nationals or foreign-trained.

⁸ My usage of the terms “indigenous women” and “indigenous people” refers to individuals who self-identify as indigenous, speak indigenous languages, and live in rural, indigenous zones. The indigenous people with whom I worked are from the following ethnic groups: Tlapaneco, Mixteco, Huasteco (Tének), Nahua, Tzotzil, Tzeltal, Maya, and Purépecha. In representing indigenous women as racialized mothers, I am not intending to reproduce universalizations that ignore the diversity of indigenous peoples across Mexico or reduce political economic factors to a mere question of racial difference; however, I recognize that government programs and development discourse often do, employing similar strategies for dealing with reproductive health issues (mostly oriented around reducing maternal and infant mortality) across different indigenous populations (for example, see Cabral Soto et. al. 2000).

⁹ As I noted earlier, I am foregoing quotation marks around terms offered by informants; however, I am placing them around direct quotes and concepts that I am explicitly problematizing. Throughout the dissertation, the terms “indigeneity,” “Indian-ness,” and “indigenous culture” are placed in quotation marks to throw into question the notion of a single, reified way of being an indigenous person. I am drawing attention to the way in which the idea of a singular “indigeneity” is mobilized versus the multiplicity of how indigenous people live their lives. I place “nature” and “returning to nature” within quotes to draw attention to how the notion of nature can be deployed as a reified category to satisfy specific objectives. I am not essentializing “nature” as pure and valuable, nor am I arguing that through humanized birth women are returning to a more natural, and, therefore, more positive state. Such value judgments lie beyond the purview of my work. However, as STS (Science, Technology, and Society) scholars and critical feminists alike would argue, the concept of nature must always be situated within social and historical contexts, and unequal relations of power (see Edu 2015, Haraway 1997, Haraway and Goodeve 2000, and Thompson 2006).

¹⁰ I place “tradition”/ “traditionality” and “modern”/ “modernity” in quotes when I am questioning Euro-American ontologies of time and the chronology of progress, but not when

women—only several across the entire country—routinely attend international new midwifery conferences and forums. At these events they perform their indigeneity, wearing indigenous costume even if this is not their everyday attire, thus buttressing the uncritical claim that new midwifery is, in fact, a descendent of “traditional” midwifery, and that humanized birth means “going back to nature” and recognizing “our shared humanity.”

In contrast, the “traditional” midwifery care indigenous birthing women receive is not celebrated—instead, it must be corrected, rescripted, controlled, and surveilled. Indigenous mothers and the traditional midwives who attend their births are agentive and resourceful decision-makers, whilst facing the challenges of intersecting forms of oppression (see Glenn 2002, Roberts 1997, Grankza 2014, Crenshaw 2014, and Haraway 2014). Professional midwives and international NGOs participate in this process under the guise of *capacitaciones* (training workshops) meant to reduce maternal mortality (see Berry 2013; Molina 2006), their involvement bolstered by “humanitarian reason” (Fassin 2012). In these encounters, the issue of “race” comes to the surface. Racial difference is visually evident in a classroom of indigenous midwives taught by a nonindigenous Mexican health professional, or by a foreign professional midwife. It is discursively evident in interviews of Mexican midwives and of NGO staff when they provide opinions on violence and inequality within the NGO hierarchy, and, in particular, the American NGO founders. While inclusion in a global “white” community is sought by the middle and upper classes, being the objects of humanitarian (white) intervention is often resented by the indigenous lower class.

Thus, this dissertation asks, is the transnational humanized birth movement unfolding in Mexico an example of Renato Rosaldo’s “imperialist nostalgia” (see Rosaldo 1989)? Can these trends be read as mourning for “what one has destroyed” and “the passing of traditional society”? More specifically, what does the simultaneous surveillance of indigenous midwifery practices and the “return” to “traditional” types of birth among nonindigenous members of the humanized birth movement indicate about imperial/colonial legacies operating in Mexico in the present day? While I resist far-reaching and often totalizing terms like “neocolonialism,” I am interested in how colonial histories merge with present-day market logics under a rubric of bioconsumerism, thus binding bioconstitutionalism¹¹ with supranationalism.¹²

Humanized birth affords many examples of “biosociality” (Rabinow 1996); however, this is only the beginning of my story. The ways in which members of the humanized birth movement recognize themselves and others involved as “empowered” actors and conscientious

referring to people and practices that were identified as traditional by informants. In chapter five, I will deconstruct the very presuppositions upon which the “traditionality”—“modernity” binary is based.

¹¹ The ways in which people perceive themselves as biological beings, forge identities through specific biological practices, and wage claims based on these biologized identities.

¹² How “cosmopolitanism” and major political formations of neoliberalism result in medical resources; cultural capital; monetary and ideological exchanges; social networks, belonging, and [bio]socialities; and health-seeking behaviors and mobilities unfolding outside the scope of citizenship to a particular nation or state for an increasing number of high-mobility individuals and ex-patriots. See “A Cosmopolitanism of Connections” (2010) by Craig Calhoun and *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai* (2015) by Marcia C. Inhorn. A useful source when thinking about how our lives and bodies are shaped by market forces is Joseph Dumit’s *Drugs for Life: How Pharmaceutical Companies Define Our Health*.

parents of superiorly nurtured children provokes me to question how people position themselves vis-à-vis transnational communities. At stake are the criteria upon which novel, value-laden, gender-racialized identities are forged. Through ethnographic details, I am not only signaling how one's positionality in society (gender, economic class, skin color, education level, experiences living abroad, etc.) influences one's perception of oneself and others, and in turn how that individual is perceived by others, but also how people and information travel transnationally, and in the case of humanized birth, how this travel often originates in the Global North. In essence, I am pointing to how neoliberal ideologies circulate in the South, and how consumerism mobilizes a rhetoric of "humanity" among the "cultured class" *while simultaneously reinforcing social inequality* by inadvertently infusing transnational movements with class-based exclusionary logics and gendered racialization.

This dissertation describes cosmopolitan spaces in which highly-educated, cultured individuals are fervently spinning meanings about birth, and, consequently, about "race;" and rural contexts in which indigenous women's bodies, the objects of government and NGO interventions, are scripted by racial discourse imposed from "above."¹³ These contrasting spaces are geographically distinct and reflect deep material inequalities (see Langer and Tolbert 1996); however, they are also mutually constituted by relationships of power—neither space would exist in its current form without the other. I take a relational perspective (see Menéndez 2010; Molina 2013). My argument is not that these different spaces are individually bound in ways that diminish their effects on each other; rather, they represent disparate lived realities and signal differential access to power, and, thus, the unequal production of discourse and representations on a global stage (see Fassin 2010; Malkki 1996, 2010).

Furthermore, my multi-sited fieldwork is based on an interdisciplinary conceptualization of place and space.^{vii} The dissertation demonstrates how different spaces (contested, geopolitical, transnational, gendered, and embodied) converge to create specific places. Using the example of the professional midwifery model in Mexico, the dissertation questions the extent to which health models can be successfully applied to different local contexts (see Tsing 2015). The dissertation describes deep social inequality in the picturesque city of San Miguel de Allende, known for its large, semi-permanent population of American retirees, and suggests that this contested space provides fertile ground for an emergent model of care. It gives examples of how this model has spread through geopolitical and transnational spaces, and how it articulates with gendered space and embodied space in other local and institutional contexts (see, for example, Thompson 2005). Essentially, I draw attention to the impossibility of cleanly extracting health models from one local context and implementing them in another.

Background

A great deal of recent anthropological scholarship on "new midwifery" centers around how professional midwives in different countries are helping women reconnect with "nature," teaching them to trust in their bodies, respecting women's "choices,"¹⁴ confronting and defying

¹³ I am not arguing that indigenous women do not describe nor ascribe meanings to their own bodies; rather, I am observing that government bodies and NGO leaders inadvertently perpetuate race-based inequalities when they fail to recognize the "target population" as knowledgeable interlocutors and instead utilize racial frameworks formulated from within a locus of power.

¹⁴ I problematize uncritical notions of free choice by drawing attention to how, for most Mexican women, choices are either nonexistent or prestructured. Women (especially indigenous and

hegemonic biomedical structures, and fighting for women's right to birth as naturally as possible (see, for example, Davis-Floyd 2009; Katz Rothman 2007; MacDonald 2008; Simonds 2007). Often, there is a tendency to position midwives as primary agents of change and main protagonists of the story since pregnant women and birthing mothers are the subjects who are acted upon—they are transformed and “empowered,”¹⁵ their lives changed forever by exposure to the midwifery model of birth.

The work of Sheryl Nestel 2006 on reemergence of midwifery in Ontario, Canada traces how professional midwives, employing a rhetoric of universal womanhood, failed to engage critically with their own (white, upper-middle class) positionality in Canadian society, thus reproducing race inequalities among the midwifery profession. Hers is the counter-history of the reemergence of midwifery, but she fails to critically examine “race” politics among recipients of midwifery care and within the humanized birth transnational community. *My work is the counter-history to the counter-history*: it not only examines how “race” inequalities are reproduced, but asks how novel claims related to “race” are waged on a global stage through consumption of transnational (ethno)medicine. While my argument is not dissimilar to Elizabeth Robert's 2012 description of how Ecuadorian women pride C-section scars that evidence their participation in private medicine and assisted whiteness, I emphasize how distinct racialized identities are constructed relationally and operationalized transnationally.^{viii} Furthermore, my work inverts the relationship between birth and “modernity” that is expressed in Cecilia Van Hollen's 2003 study lower class women's childbirth experiences and decision-making processes in South India.

Reproduction and reproductive technologies form a crucial site for examining how people identify and represent themselves as “modern” individuals.¹⁶ While “the modern” is always evolving, it is always relationally defined by what is considered “traditional,” whether “tradition” is assigned a negative connotation or is romanticized and exalted (see Bauman and Briggs 2003).^{ix} In this dissertation, I push beyond the false “modernity”/“traditionality” dichotomy to ask what can be learned from examining *emergent* traditionalities. That is to say, the dissertation asks how couples identify themselves as modern subjects through a “return” to “traditional” ways of birthing, thus disrupting the Euro-American ontologies of time. What is revealed about the reproduction of social inequity when “traditional” methods of human reproduction are used to question the linearity of progress and the binary nature of modernity/traditionality? Thus, this work takes seriously Donna Haraway's broadening of the category “reproductive technologies” to not only include technomedical procedures, but also

lower class) do not have options when giving birth in public hospitals. The very idea of “choice” emerges from a middle- and upper-class perspective—“choice” is a privilege of those capable of paying for private medical services. My argument is informed by Bourdieu's concept of habitus: class provides the conditions that determine tastes; however, the role of class in determining taste is concealed and the relationship between taste and education is repressed; thus, tastes seem “natural” and are used to legitimate the superiority of the wealthy (see Bourdieu 1984).

¹⁵ I am critical of the notion of “empowerment,” asking what it does and for whom. Who does the empowering? For those who are “empowered,” were they truly “disempowered” before? Is hegemony really challenged if people in the Global South are “empowered” by ideas from the Global North? Lastly, I am wary of how neoliberalism and the concept of individualism and choice informs the notion of “empowerment.”

¹⁶ See, for example, Rapp 2000, Roberts 2012, Martin 2001, and Van Hollen 2003.

economic and biological processes that involve diaper pins, home birth, accounting techniques, population politics, breast milk, and baby formula (Haraway, 1997; Haraway and Goodeve, 2000). Instead of thinking about time in terms of rupture, this dissertation asks what can be gleaned from an ethnographic analysis of instances where the chronology appears to be reversed, and through a binational reading of anthropological literature (for example, considering Nestor García Canclini's work in conjunction with that of U.S. anthropologists)?

My research has been a double engagement: I performed ethnography in Mexico, and, as a visiting scholar at the Center for Superior Research and Studies in Social Anthropology (CIESAS-D.F.) and professor at the National Autonomous University of Mexico (UNAM), engaged in theoretical and methodological debates occurring in Mexico. I aim to transform how U.S. academics think about gendered racialization, citizenship, and consumption through dialogue with Mexico, while simultaneously considering how exportation of theory from the Global North to Latin America results in ideas being fractured, recast, and made more complex by Latin American theorists. Mexico has a critical scholarly tradition and is an ideal place to do transformative research, due to the insights of social medicine scholars like Asa Cristina Laurell (see Laurell 1997; Laurell and Arellano 1996), critical epidemiologists like Jaime Breilh¹⁷ (see Breilh 1998, 2003, 2008a), and, of course, anthropologists Eduardo L. Menéndez (see Menéndez 1990, 1996, 2009, 2010) and Nestor García Canclini¹⁸ (see García Canclini 2001, 2009). I place scholarship in the North in an interdisciplinary conversation with scholarship in Mexico, thus producing a mutual dialogue instead of an Anglocentric reading of theory.

Bilateral discursive engagement helps to conscientiously dismantle colonial legacies embedded in U.S. academia. Also, unidirectional flow of frames of reference from the North to Mexico has had a profound impact on public health policy in Mexico (see Menéndez 2009). By engaging with frames of reference from both North and South, U.S. health scientists can begin to apply Mexican theory to Mexican policy. This type of dialogue across borders not only helps to dismantle the discursive structure through which health sciences in the North position themselves as the primary or exclusive place to cite theory, but points to the richness of different academic disciplines 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. As a dual U.S./Mexico citizen; a woman of Chinese, Mexican, Nahua, and Blackfoot descent; an ethnographer with significant research experience in Mexico; and an interdisciplinary scholar trained in the United States and engaged in theory on both sides of the border, I aim to enact “border thinking” (see Mignolo 2000) to increase dialogue among global anthropologies.

The Mexican Context

My research moves from the realm of everyday reproductive practice to transnational organizations and policymaking, and evidences how women's bodies are often the locus where race, class, and gender oppression converge. I began my research at CASA (Center for the Adolescents of San Miguel de Allende) Professional Midwifery School—an NGO co-founded by an American woman, and staffed by Mexican and American employees and volunteers. For the

¹⁷ While Breilh completed graduate studies in Mexico, he has returned to his natal country of Ecuador, where he teaches and la Universidad Andina Simón Bolívar.

¹⁸ García Canclini is originally from Argentina and is a professor at la Universidad Autónoma de México-Xochimilco.

past 14 years, it has been the only accredited professional midwifery school in Mexico. CASA's ongoing popularity is facilitated in large part by thousands of Canadian and American retirees living in San Miguel de Allende—many of whom are CASA donors. CASA's formal recognition by the Mexican government suggests the successful exportation of the humanized birth model and professional midwifery from the United States to Mexico. However, I ask what might be revealed if this “border crossing” were to be more closely examined. Under the rubric of “commensurability,” how do concepts and medical technologies travel (see Pigg 2001); what are the disjunctures, deformations, and discontinuities of such travel (see Lakoff 2005); and most importantly, what are the productive and disruptive effects of this travel on the socioeconomic milieu and geopolitical landscape?

Due to professional midwifery's formal inclusion in the Health Sector, and CASA's insertion in the universal health system, even the poorest pregnant women in the State of Guanajuato formally have formal access to professional midwifery services and water birth at CASA Hospital. In practice, however, women using the public health care system must request a referral for CASA's birthing services and such referrals are rarely granted. Furthermore, socioeconomically and georacially stratified birthing postures belie uncritical notions of free choice and equal access.

My work will look at how CASA—in cooperation with the National Center for Gender Equity and Reproductive Health, the Panamerican Health Organization, the World Health Organization, and a slew of American and Canadian donor corporations—fosters its clients' sense of belonging through participation in a transnational and deterritorialized community of consumption. Here, I define “clients” as those who “buy into” the product that CASA offers—the humanized birth model. These clients include those who David-Floyd refers to as “postmodern midwives” (see Davis-Floyd 2007), pregnant women seeking professional midwife-assisted birth, volunteers, visitors, and donors. Their community-wide discourse is mired in human rights vocabulary, and suggests empowerment, while obscuring powerful, underlying forces related to neoliberal consumption. My research will ask how this discourse was made, who are the authors, and what may remain hidden in the process.

As CASA aims to expand the reach of the humanized birth model from the State of Guanajuato to the States of Veracruz, Chiapas, and Guerrero as well^x, the spread of this particular commodity across sharply disparate socioeconomic and georacial contexts calls attention to the question of citizenship. For example, while in San Miguel de Allende and in Mexico City, professional midwife-assisted home birth is a source of cultural capital and contributes to identity formation within a global meritocracy, in impoverished villages in Veracruz, traditional Nahua midwives risk imprisonment when they, against government instructions, secretly attend birthing mothers in their homes. These births are cast as the “wrong” type of home birth, since indigenous mothers and midwives *must* submit to the expertise of biomedical physicians. Meanwhile, these same traditional midwives, many of whom have practiced midwifery for decades, are “trained” in workshops offered by CASA professional midwifery students, medical students, and even social workers—many of who have never attended a single childbirth alone.

During my ethnographic research, I observed how indigenous midwives were “taught” how to correctly perform midwifery, threatened with incarceration if a maternal or infant mortality were to occur on their watch, and effectively rendered unpaid hospital referralists at the service of the state (see Carrillo 2002 and Pigg 1997, 2001). Thus, ethnography on the humanized midwifery movement in Mexico unmasks the violent contradictions embedded in

neoliberal consumption, and the relationship between restricted participation in communities of consumption and restricted access to citizenship.



Professional midwifery student teaches a group of traditional midwives using dolls as props.



Traditional midwife with the baby and placenta model she has sewn by hand.

Hyper-self-reflexivity and Critique of How Development Discourse Reinscribes Inequality

Given this dissertation's critique of multivalent processes leading to the inadvertent reinscription of social inequality between disadvantaged and privileged informants, I am both methodologically and ethically committed to Spivakian hyper-self-reflexivity (Kapoor 2004). I will begin by "acknowledging complicity" (Spivak 1988b). While I am a woman of "ethnic" heritage, I am also highly educated, privileged, and raised in urban and suburban United States. I cannot claim to be a subaltern, "native" informant. In many senses, my positionality has been advantageous—I was able to interview and observe both "up" and "down" (see Nader 1972).^{xi} My work attempts to uncover "partial connections" (De la Cadena 2015)^{xii} and bring multiple "situated knowledges" under the same lens, while heeding Haraway's admonition: "There is a premium on establishing the capacity to see from the peripheries and the depths. But here there also lies a serious danger of romanticizing and/or appropriating the vision of the less powerful while claiming to see from their positions" (Haraway 2014: 45). Thus, I readily recognize my "partial perspective" (see Haraway 2014) and admit that my potential as an ethnographer was limited—at times, it was difficult for me to get indigenous women, many of whom are suspicious of *xinol*as (city women) and/or monolingual in their indigenous tongue, to speak openly about their birth experiences.^{xiii} I often had to rely on a translator, which limited my access and changed the dynamic of interviews substantially.

For ethical reasons, I placed women's comfort and respect for their privacy during intimate moments over my desire for ethnographic material. This meant, depending on the circumstances, occasionally choosing not to be present at the moment of birth. I made a conscientious decision to place myself in a learning role when dealing with traditional midwives and never sought out to teach them or correct them. Also, I purposefully limited my monthly budget to five thousand Mexican pesos (approximately four hundred dollars—more than many of my impoverished informants, but much less than my middle and upper class informants) in order to "unlearn my own privilege" (Spivak 1988a:287, Spivak and Harasym 1990:9).

In turning to Mexico, and specifically to impoverished and indigenous zones, as the site for my research, I was not seeking a "repository of ethnographic 'cultural difference'" (Spivak 1999:388), but, rather, hoping to illuminate a counter discourse to the pervasive story of development. Too often it has been assumed that interventions originating from the Global North (professionalizing midwives, providing traditional midwives with training workshops from medical personnel, implementation of humanized birth strategies) will produce positive results among the "target population" (reduced maternal and infant mortality among indigenous and impoverished populations).

My research has shown that humanized birth is generally accessed by women who are highly educated, well-traveled, fair-skinned, urban, cultured, etc., and while I witnessed the important ways humanized birth strategies have improved their birth experiences, I argue that the humanization of birth and the reduction of maternal mortality are distinct projects. As I will demonstrate in the dissertation, the respectful, knowledgeable, and attentive care offered by traditional midwives in contexts of scarce economic resources are generally not included under the rubric of "humanized birth" alongside services offered by professional midwives, obstetricians, and doulas—when they are included, they occupy the niche of "traditionality," rendering them needy recipients of expert knowledge from professional counterparts. As a result, the women who tend to seek out humanized births (i.e., home births and water births attended by gynecologists or professional midwives) are not the women at risk for maternal mortality, nor are their children at risk for infant mortality.

Thus, while Spivak argues against the retrieval of information from the Third World for First World purposes (in humanized birth circles, this has usually meant collecting maternal mortality statistics and using them as evidence of the dire need for humanized birth), I am attempting to show how First World strategies can unexpectedly induce gendered racialization processes that deepen inequality. In doing so, I am pushing against false notions of “women’s solidarity” on a global scale, as I agree with Spivak that these notions obfuscate historical, cultural, and socioeconomic differences and colonial legacies.

Methods

I used multi-sited ethnography to follow the object of midwifery and humanized birth in Mexico (see Marcus 1995; Menéndez 1996; Rapp 2000), thus identifying different “windows” through which recent shifts in birth practices and health care can be examined (see Wilson 2004). My decision-making process for prioritizing and selecting actors and field sites closely resembled the “triage method” developed by Charis Thompson in her 2013 book *Good Science*.^{xiv}

My ethnographic research began at CASA. However, after joining CASA students and administrators on a “field practice” trip to the High Mountains of Veracruz, I began to think about the issue of place-based differences and the importance geographical location plays in the reproductive care women receive. This required redefining my preconceived notion of an ethnographic field site. The field I identified was not a “site” per se, but, rather, a network of people. I began with professional midwives in Mexico, a contained and connected group of women, and subsequently gained access to their clientele. Simultaneously, I approached different transnational humanized birth leaders and interviewed them about their respective roles in the movement, both around the world, and specifically in Mexico. Using the snowball technique and through my attendance at multiple humanized birth conferences, I recruited more couples and humanized birth attendants, including physicians and obstetric nurses, to my study. Over the course of my fieldwork, I volunteered at two different transnational NGOs, gaining access to training workshops for indigenous traditional midwives. Having befriended a few indigenous midwives, and while staying as a guest in their homes during repeat visits to their villages, I was able to witness their interactions with indigenous women and the “traditional” midwifery care they provide. Finally, I observed medical professionals and maternity patients in both private and public hospital settings and solicited interviews with physicians and policy makers. This process led me to the Mexican states of Guanajuato, Guerrero, Jalisco, México, San Luís Potosí, Veracruz, Chiapas, Oaxaca, Quintana Roo, Morelia, Querétaro, Puebla, Michoacán, and Nuevo León; additionally, I travelled to California for interviews, and Brazil for brief participant observation in what turned out to be “traditional Mexican midwifery” popular education tourism^{xv}. While the geographic breadth of this “field” is enormous, the specific people I travelled to meet, observe, and interview were very concrete and are conscientiously members of a cohesive transnational community. All the individuals in my study have acquaintances, and often great friends, among the other individuals in my study.

Interviews were semi-structured and lasted from 15 minutes to three hours, with the average being approximately forty-five minutes. I tailored my questions to the interviewees’ positionality within the humanized birth movement (whether the interviewee[s] was/were a mother, a couple, a humanized birth attendant [professional midwife, obstetrician, obstetric nurse], a traditional midwife, or a policy maker), but usually included questions to help me understand the interviewee(s) positionality in society (education level, socioeconomic status,

ethnicity, etc.). In addition, my questions generally followed these themes: his or her occupation, life history, perspectives on gender, the Mexican health system, positive and negative experiences with birth, and the shifting political climate regarding midwifery. By not over-structuring the interviews, I resisted scripting or leading the informants, allowing them to speak for themselves. My data analysis is derived from detailed entries in my field diary, and audio and video recordings from interviews. Upon concluding my research, I engaged in an iterative process that used open coding to identify emergent themes and synthesize higher order constructs.

Outline of the Dissertation

The remainder of the dissertation is divided into six chapters, each engaging with the fields of medical anthropology and anthropology of reproduction in novel ways:^{xvi}

In chapter one, I offer a series of interlacing ethnographic portraits that set the stage for the theoretical interventions I develop in later chapters. I introduce a network of transnational birth attendants—midwives with diverse training—in order to demonstrate how gendered and racial politics overlap with socioeconomic class to shape and constrict realms of possibility for consumption and citizenship. This chapter serves as an initial demonstration of unequal participation in the humanized birth movement and (im)mobility among midwives; thus signaling how celebration of “going back to nature,” commodification of indigenous culture, and simultaneous gendered racialization of indigenous “others” are collapsed within the so-called humanization of birth.

Chapter two points to how the humanized birth movement inadvertently commodifies indigenous culture in symbolically cannibalistic ways. Members of the transnational humanized birth community seek “natural” births that reference “traditional” and “indigenous” birthing methods. However, these methods are not adopted wholesale; rather, they are reimagined by the community and reconfigured by capitalist marketing. My work builds off of Brubaker and Dillaway’s 2009 assertions that natural childbirth discourse reflects class and race biases and are based on middle-class rationalist economic ideology emphasizing control and informed consumer choice and requiring access to resources available only to privileged women.

Nancy Scheper-Hughes and Loïc Wacquant’s edited volume, *Commodifying Bodies*, explores how bodies increasingly enter into global market exchanges. The body can be bought and sold, both whole or in parts, dead or alive, effectively severing the body from the self, tearing it from the social fabric, and bringing it under the purview of market transactions in the form of sperm banks and international trafficking of kidneys, to name two examples. In Scheper-Hughes and Wacquant’s volume, commodification of the body results in alienation of the self, while in this present dissertation, the commodification of others’ (imagined) “selves” can lead to violence being unleashed on their bodies. My research points to how the accrual of cultural capital through the commodification of “others” culture is intimately and often destructively achieved in our neoliberal, globalized world.

Chapter three problematizes uncritical notions of liberation by asking how humanized birth may contribute to a new regime of pressures and standards for modern-day “good parenting.”^{xvii} Through ethnographic examples of women who struggle or “fail” to give birth naturally (see Crossley 2007), the dissertation points to how humanized birth may inadvertently represent another way the burden of correctly producing future citizens falls upon women, even as it aims to liberate women from biomedical hegemony. While biopower has often been characterized as the control of populations through “paternalistic” institutional and governmental

surveillance, humanized birth practices beg the question of how “maternalistic” biopower might operate through social networks. I bring a critical medical anthropology perspective to health-related “mommy wars” circulating in popular media and analyzes how parents use birth to stake claims to moral superiority.

My ethnographic research in Mexico points to how couples seek inclusion in a global meritocracy by investing time, money, effort, and emotions into being “good parents,” and the criteria for good parenting is largely defined by parenting trends in their social network (humanized birth, extended lactation, organic/holistic nutrition, Montessori and Waldorf education, extracurricular activities, etc.). As couples increasingly consider parenthood and their ability to produce well-nurtured, well-educated, well-rounded, ethically conscious children a marker of their overall success, their relationships to their children are changing. The dissertation aims to add complexity to Jordanova’s remark about considering children as commodities.^{xviii}

Chapter four responds to Brubaker and Dillaway’s assertion that, “We need to conduct comparative research on the subjective experiences of pregnant and birthing women at multiple social locations and multiple contexts, as well the experience and perspectives of midwives and medical providers in order to provide a more critical and meaningful analysis of the complicated intersections of ideology, politics, practice and bodily experience” (Brubaker and Dillaway 2009). In this dissertation, examining multiple social locations and contexts is exactly what I will do. Through contrasting ethnographic examples of how local San Miguelenses experience their hometown as an internal borderland that excludes them from “gringo” spaces (except as service workers), and how urban “outsiders” are excluded from “closed” indigenous communities in the Nahua High Mountains of Veracruz, this chapter signals how “othering” in Mexico is both highly contingent, and a matter of perspective. The chapter offers the concept of racial i(nter)dentification as a way for thinking about the syncretic nature of racialized identities. Racial i(nter)dentification points to the multiple variables that figure into immediate, unconscious mental calculi structuring encounters of difference—that is, “race,” class, education, and other forms of cultural capital are folded into one another to produce social constructions of gendered racial identity that include and supersede phenotype. While my argument resembles Bourdieu’s habitus (1984), I have developed racial i(nter)dentification as a way of simultaneously acknowledging the readily visible phenotypic differences between those who are served and those who serve.

Chapter five builds upon chapter four by examining how racial discrimination buttresses systemic violence within Mexican obstetrics, thus eliciting complicity from medical personnel, with the greatest violations being unleashed on racialized women’s bodies. While others have written about “race” and racialized biology,^{xix} my work is about the construction of social identities that allow for the gendered manipulation of “race.” What is being racialized is not just the biological body or the national body, but also the moral body. Thus, I turn to the work of Michael Montoya, Marisol de la Cadena, and Elizabeth Roberts to argue that *raza* in Latin America is a complex social category that extends beyond “race” to include class, education, and “culture.”

While chapters three and six explore how whitening is sought through private medical care by educated, urban women,^{xx} in chapter five I provide ethnographic examples of how “reproductive governance” is applied to the supposedly hyper-fertile indigenous women. In doing so, I critique the concept of “interculturality” and use conditional cash transfer programs like *Oportunidades* as a lens for examining complex and unequal relationships of power between

indigenous women and the Mexican government. Poor indigenous women are recruited into *Oportunidades*, shaped into obedient mothers,¹⁹ and required to give birth in government hospitals.²⁰ My framing signals the inadequate attention of “interculturality” to political economic factors and questions the reification of cultures upon which “interculturality” is premised.

Chapter six builds off of chapter four by examining how citizenship fails to encompass the way privileged women are proactively constructing whiter subjectivities (see Bashkow 2006) through New Age approaches to natural birth and participation in the humanized birth transnational network. This chapter adds to ethnographies on reproduction that have analyzed divergences between foreign interests and local moral worlds²¹ and studies problematizing notions of “globalization”²² when it examines medical migration among the humanized birth community in Mexico. Building on Roberts and Scheper-Hughes’ edited volume, the dissertation examines the ease with which “(ethno)medically situated” humanized birth practitioners’ travel across borders and contribute to transnational discourse, while “socially situated” women are restricted from medical migrations. Medical migrations and tourism imply big economic stakes for sending and receiving countries, and transnational negotiations of citizenship and capital. My work expands upon previous work on medical migration and medical tourism since these discourses often focus on the economic effects for countries where medical tourism unfolds, whilst my work explores how identities are forged and leveraged by travelers in a transnational, gendered, racialized economy.

The conclusion of the dissertation situates the humanized birth movement in Mexico within the broader context of global New Age practices. I explain how the New Age is not only a context for examining the redefinition of social identities, but also for analyzing how consumption, or lack thereof, leads to the accrual of cultural capital on one hand, and social inequality on the other. New Age practices are useful for thinking about how the negotiation of social identities are inscribed with processes of gendered racialization, socioeconomic class, power, and agency. Furthermore, I discuss how New Age practices challenge Euro-American ontologies of time through differential meanings ascribed to “modernity” and “traditionality” by informants with divergent positionalities in society. At the same time, notions of “social whitening” play out through consumption of the New Age on a global stage. Finally, the conclusion addresses the importance of place when planning health programs and interventions.

In this dissertation, I place individuals with disparate socioeconomic and georacial positionalities under the same lens to problematize the appropriateness of citizenship as an analytic in neoliberal contexts. The humanized birth movement seemingly represents a “return” to the past, a reversal of chronology, and a challenge to Euro-American ontologies of time since women seek “traditionality” in a quest to identify themselves as modern. At stake is the relationship between states and individuals who, by reconstituting citizen and consumer subjectivities, are challenging anthropological notions of how biopower operates.

¹⁹ Smith-Oka (2013) argues that the program also produces indigenous women as “modern” citizens.

²⁰ Some eagerly seek biomedical attention while giving birth, while others resist mandates due to prior experiences of racial discrimination.

²¹ For example, Sesia 2007 and Pigg 1997, 2001.

²² See Lakoff 2005; Tsing 2000, 2005; Hannerz 1996; Kearney 1996; Appadurai 1996; and Ong 1999, 2003; Mignolo 2000.

In the following chapters, I will use ethnographic evidence to demonstrate how inclusion in global meritocracies is mediated by both class identification and processes of gendered racialization, resulting in claims to cultural capital and “social whitening” on a global stage. In an effort to describe how colonial legacies continue to shape identity formation, I will point to how gender-racialized identities are relationally constructed and negotiated, and operationalized transnationally with important political and economic effects. Nonindigenous individuals seek inclusion in global “white” communities oriented around commodified forms that conflate “indigeneity” with “traditionality” and “nature;” however, these communities do not unseat deep social inequalities between nonindigenous and indigenous people. Instead, strategies developed in the Global North for the humanization of birth and the reduction of maternal and infant mortality are inadvertently reproducing processes of gendered racialization and reinscribing inequality between global “whites” and indigenous people. Thus, my work underlines how neoliberal consumption in the 21st century simultaneously promotes “humanity” *and* reinforces inequality by infusing transnational movements with reified class logics and gendered racialization.

I point to the simultaneous fetichization of “indigeneity” and silencing/surveilling of indigenous people and their practices; however, I also emphasize the agency and dynamism with which indigenous people engage the commodification of their culture. In doing so, I draw attention to a mix of exploitation and entrepreneurship that throws into question dichotomous notions of victor and victim. When thinking about ethnomedical tourism, I am simultaneously pointing to how the commodification of “indigeneity” collapses multiple ways of being indigenous and repackages them for mass consumption, and also how tourism could potentially revitalize and invigorate individuals’ pride in their culture.

The humanization of birth is a valuable project. Between full-time fieldwork and teaching and research engagements in the Mexican academy, I spent three years and seven months in Mexico, during which time I became very close to a number of my informants. I consider some of my former informants to be good friends and have maintained contact. I do not want my work to undermine their important efforts to demedicalize women’s birthing experiences and reduce the effects of obstetric violence. Furthermore, I do not wish to minimize the amount of love and care the parents I describe have for their children. The women who I interviewed participate in humanized birth because they are committed to giving their children the best opportunities in life, starting with how they are born. While I strongly agree with the demedicalization of birth, this dissertation does not focus on crafting a normative argument that assigns value judgments to different birthing practices. Rather, I am engaging in an analytic endeavor that uses humanized birth as a lens for examining pressing anthropological issues: the commodification of culture, unintended effects of feminist liberation, and the limits of citizenship in our neoliberal world.

ⁱ In this text, the terms “humanized birth,” “gentle birth,” and “tranquil birth” are used interchangeably to signal a movement that aims to “empower” women, reduce unnecessary biomedical interventions and cesareans, and eliminate obstetric violence. I will describe “humanized birth practices” in further detail beginning on page 4. To what degree and for whom these goals are met will be critically examined throughout the dissertation.

ⁱⁱ For perspectives on intersectionality, see Glenn 2002, Roberts 1997, Granzka 2014 (including chapters by Kimberlé Williams Crenshaw and Donna Haraway). On “raza” vs. whiteness, see Roberts 2012b.

ⁱⁱⁱ See Morgan and Roberts' 2012 piece on "reproductive governance."

^{iv} On the privatization of childhood and neoliberal parenting, see Lareau's *Unequal Childhoods: Class, Race, and Family Life*; Charis Thompson's "Three Times a Woman" and *Making Parents: The Ontological Choreography of Reproductive Technologies*; Folbre's *Greed, Lust and Gender: A History of Economic Ideas*.

^v This figure is taken from the IMSS website (imss.gob.mx) and their publication, "Guía de Práctica Clínica: Vigilancia y manejo de parto. Evidencias y Recomendaciones. Catalogo Maestro de Guías de Práctica Clínica: IMSS-052-08."

^{vi} Sánchez, Cinthya. "En México, uno de cada dos niños hoy nace por cesárea." *Eluniversal.mx*. July 18, 2010. Web. Accessed September 21, 2014.

^{vii} Drawing from anthropologists Zuanilda Mendoza González (2010-2011), Setha Low and Denise Lawrence-Zúñiga (2002), Nancy Munn (1996), Miles Richardson (1982), and Marc Augé (1995); sociologist Zygmunt Bauman (1993) and John Urry (2007); geographers Liz Bondi, Mick Smith, and Joyce Davidson (2005), and Yi-Fu Tuan (2001); novelist Jamaica Kinkaid (2000); public health scholar Ana Langer and psychologist Kathryn Tolbert (Langer and Tolbert 1996); and media analyst Joost Van Loon (2005), among others.

^{viii} Furthermore, while the convergence of science and technology studies and the anthropology of reproduction has led to heightened interest in topics such as in vitro fertilization and new subjectivities, laboratory production of embryos and questions of citizenship, and cesarean section in the Global South as a marker of modernity (see Strathern 1992, 2005; Franklin 1995, 1997, 2006; Roberts 2006, 2007, 2012; Bamford 2007; Inhorn 2003; Kahn 2000; Melhuus 2003), this dissertation points to novel ways racialized identities, reproductive governance, notions of citizenship and belonging, transnational communities of consumption, parenting practices, and medical migration converge within humanized birth in Mexico.

^{ix} Through the example of Romantic Nationalism, Bauman and Briggs argue that temporalizing and spatializing practices that are used to construct notions of traditionality and modernity have always been complex and contradictory.

^x At the time of my writing, agreements are being drafted between CASA and officials in Veracruz and Chiapas proposing the opening of new professional midwifery schools modeled after, and administrated by, CASA. Also, in 2012 a state-funded professional midwifery school opened in Guerrero. The Guerrero school is preparing to graduate its first cohort June 2015.

^{xi} "Up" and "down" refer to socioeconomic class and existing power structures. In her seminal piece, Nader argues that while most ethnographic studies have focused on the life ways of the poor, marginalized, and oppressed, anthropologists can glean a lot more insight about how power operates in society by conducting research from within the sites from which power is deployed (that is, focusing on informants who wield power through economic influence and bureaucratic control).

^{xii} De la Cadena takes up Strathern's (2004) "partial connections" to cease thinking about societies as units that inter-relate, sometimes producing hybrids (i.e. *mestizaje*), and instead looks at how collectives are intra-related. Intra-connected (non-unitary), fractal bodies cannot be broken up into parts or wholes because of their kaleidoscopic simultaneity of similarity and difference. "Partial connections" is a relational form that allows for indigenous and mestizo to appear within each other and at the same time remain distinct.

^{xiii} Of course, total honesty and transparency during the ethnographic exchange is an unattainable ideal. See Briggs' 1986 critique.

^{xiv} Faced with voluminous data regarding the “ethical choreography” of stem cell research, Thompson applied the analogy of “triage” to her research, thus developing a method for prioritizing some data over other data. Likewise, the focus of my research has been guided by the underlying principle of pursuing the most prescient frames for diagnosing social inequality.

^{xv} Combining informal interviews, in-depth interviews, and persons whom I have observed, there are 2,069 subjects included in this study, 967 of whom were observed in large group settings (training workshops, “*pláticas*,” conferences, institutional meetings, etc.) and 1,094 of whom I observed on a more individual or family-level basis. Within my study are 111 professional midwives, 166 physicians, 288 traditional midwives, 65 nurses, 14 NGO administrators, 17 Secretary of Health administrators, 18 hospital administrators, 8 doulas, 5 *promotores de salud* (health promoters/community health workers), 12 prenatal educators, 7 medical school professors, 22 professional midwifery school instructors, 9 medical anthropologists, 11 people within the field of public health/public policy, 125 mothers (33 in the postpartum period, 17 in active labor, 7 births), 31 fathers, and 19 pregnant women. Geographically, I have observed 306 subjects in Guanajuato, 137 in Guerrero, 247 in Jalisco, 68 in the Federal District, 296 in San Luís Potosí, 700 in Veracruz, 85 in Chiapas, 72 in Oaxaca, 103 in Quintana Roo, 8 in Michoacán, 18 in Nuevo León, 7 in California (people who also work in Mexico), 3 in Mexico and the United States, 20 in multiple Mexican states, and 40 dispersed elsewhere.

^{xvi} As Elizabeth Roberts documents in her 2015 article “Reproduction and Cultural Anthropology,” feminist anthropology of the 1970s paved the way for critique of reproduction as a category. Since then, anthropologists studying reproduction have demonstrated that reproduction; which had formally been cast as personal, intimate, medical, natural, and biological; is deeply political and economic, a site of global processes, and saturated with stratifications of race, labor, class, and sex (see also Jordanova 1995; Fraser 1995; Murphy 2011). However, the authors of humanized birth (Michel Odent, Frederick Leboyer, Ina May Gaskin, Sheila Kitzinger, etc.) aim to recast birth as a powerful, individual experience that empowers women and celebrates their natural ability bring new life into the world.

Anthropologists have shown how taking reproduction as an object of study has great revelatory effects with regards to “globalization” and local/global disjunctures. For example, foreign concern with overpopulation in developing countries (often originating in the United States) shapes national endeavors to control population size (see Pearce 1995; Barroso and Corrêa 1995). These attempts to reduce population size, even when they are not linked to U.S. aid dollars, often demonstrate a nation’s efforts to become prosperous and modern through the appropriation of Western science and technology (see Greenhalgh 1995). How do we explain the power of the United States over the reproductive patterns of women across the globe? According to Menéndez, the dominance of American biomedicine around the world is an implicit function of the hegemonic medical model (HMM). He explains that the HMM was exported from capitalist countries to Latin America, and derives its hegemonic character from the political and economic relationships implicit between countries (see also Menéndez 2009). This dissertation builds upon these literatures and aims to provide new insights regarding medical migrations, commodification of indigeneity, parenting in a global meritocracy, and challenges to interculturality in the context of racialized reproductive governance.

^{xvii} A great many anthropologists of reproduction have focused on how biopower is exacted on women’s bodies through medicalization, restrictions on abortion, population control, eugenics programs, etc. (see Casper 1998; Erikson 2001; Ginsburg 1998; Landecker 2003; Mamo and Fishman 2001; Morgan 2009; Rapp 2000; Greenhalgh 2008; Anagnost 1995; Kligman 1995;

Barroso and Correa 1995; Morsy 1995; O’Neil and Leyland Kaufert 1995; among many others). Medical anthropologists focusing on midwifery have positioned the midwifery model as a pathway to feminist liberation and resistance to (masculine) biomedical hegemony, (see Davis-Floyd 1992; Katz Rothman 2007; MacDonald 2008; Simonds 2007). At the same time, a number of anthropologists have focused on the relationship between reproduction, modern industrial capitalism, and the intensification of global inequity with regards to material resources (Anagnost 1995; Martin 2001; Ginsburg and Rapp 1995; Colen 1995; Whittaker 2010). Some have turned their attention to the shift from productive children who contribute to the household economy to children who are consumed for by their parents (Layne 1999; Taylor et al. 2004; Rotman Zelizer 1994).

^{xviii} In the conclusion of her chapter “Interrogating the Concept of Reproduction in the Eighteenth Century” (*In Conceiving the New World Order*), Jordanova offers a closing suggestion for future studies: anthropologists should begin to think seriously about children as commodities.

^{xix} See, for example, Kim Tallbear’s *Native American DNA: Tribal Belonging and the False Promise of Genetic Science*; Jenny Reardon’s *Race to the Finish: Identity and Governance in the Age of Genomics*; Marcia Inhorn’s *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai*; and Sahra Gibbon, Mónica Sans, and Ricardo Ventura Santos’ *Racial Identities, Genetic Ancestry, and Health in South America: Argentina, Brazil, Colombia, and Uruguay*.

^{xx} Roberts (2015) indicates that in the industrialized world (nation-states made wealthy through a history of colonial capitalism, biological race is used to define the right and wrong types of reproduction, which in turn shapes policy and practice both nationally and transnationally, especially in the realms of international population policy and migration (Fraser 1995; Goldade 2007; Morgan and Roberts 2012; Pashigian 2009). Nineteenth and twentieth-century battles about slavery, miscegenation, immigration, population control, eugenics, etc. played out both national and global stages, resulting in the categorization of people into fit and unfit reproducers (Douglass 2005; Horn 1994; Nouzeilles 2003; Stepan 1991). She argues that reproduction is increasingly codified as a biological matter of great interest to nations outside of North American and Western Europe (Greenhalgh 2008; Tarlo 2003 ; Unnithan-Kumar 2004). Pointing to how historical, economic, and environmental processes in different places shape one another, she warns against comparisons that portray differences and fixed and arising separately from one another. I will be thinking with Breilh 2003, 2008b; Laurell 1996, 2013; Laurell and López Arellano 1997; and Waitzkin’s 2000, 2011 to analyze of public health systems in Latin America.

ACKNOWLEDGEMENTS

I am grateful to my committee for their suggestions for revision throughout the dissertation writing process. Throughout my graduate career, Charles L. Briggs has urged me to challenge established frames of reference, deconstruct binaries, and begin “as if I know nothing.” With his encouragement, I have embraced “border thinking” (thus traversing disciplinary, sub-disciplinary, and geospatial boundaries) and engaged in binational production of discourse with both U.S. and Mexican scholars. My present ethnographic writing was cultivated and galvanized by Nancy Scheper-Hughes. Her close accompaniment throughout the writing process inspired me to weave stories in a way that provocatively advances the goals of public anthropology, boldly intervenes in ongoing theoretical debates, and does justice to my informants. Charis Thompson has provided me with interdisciplinary perspectives on intersectionality, thus signaling spaces in my work for deeper critique of interpenetrating class, race, and gender inequalities. Ian Whitmarsh has helped me think about how a plurality of ethnic identities are transformed into a science of race, as well as how biologic race is contested by practices around nation, state, and family. His instruction in medical anthropology theory and academic counsel have been foundational to my development as a scholar.

I am also indebted to my colleagues and friends in Mexico, without whom this dissertation would have never been accomplished. Eduardo Menéndez at the Center for Superior Research and Studies in Social Anthropology (CIESAS) served as a generous and stimulating mentor during my time as a visiting scholar in the Permanent Seminar in Medical Anthropology (SEPAM). By inviting me to deliver courses in the medical school and health sciences graduate program at UNAM, Alfredo Paulo Maya and Roberto Campos welcomed me into a vibrant scholarly community that assisted me in matching the content of my theory with the content of my ethnography. Ongoing dialogue throughout the dissertation writing process with members of the health sciences graduate program at UNAM has been formative to this present work. This dissertation benefited from the institutional access authorized by Maricruz Coronado, critically grounded interventions by Miriam Padilla Flores, and research assistance by Gregorio Hernández García. During my three year and seven month stay in Mexico, I enjoyed the friendship and support of David Garza, Jim Blakley, Yareli de Chávez, Reyna Hernández Juárez.

Finally, I am appreciative of the care I have received from family and friends in California. I have been blessed with a lifetime of inspiration and love from my mother, Tuen Yee Wong. My pursuit of a doctoral degree in anthropology was bolstered by the constant encouragement of my late grandmother, King Chun Wong. I am thankful to Kim Hartson for her friendship and for serving as a sounding board on countless decisions. My graduate experience was enriched by the presence of Ned Garrett in the department of anthropology. I am happy to have had his guidance and comradeship throughout the different stages of my doctoral studies.

I owe great gratitude to the funding agencies and fellowships that have allowed me to pursue doctoral research: the Jacob K. Javits Fellowship, UC Regents Fellowship, UC Human Rights Center, UC Global Health Institute, UC Institute for Mexico and the United States, UC Berkeley School of Public Health (specifically Dan and Susan Lindheim as stewards of the Roselyn Lindheim Award), and the Ford Foundation.

CURRICULUM VITAE

Address: Kroeber Hall, Department of Anthropology
University of California Berkeley
Berkeley, CA 94709

Telephone: (510) 813-4620

Email: Rosalynn.Vega@gmail.com -or- Rosalynn@berkeley.edu

Skype Name: Rosalynn.Vega

Citizenship: American and Mexican (dual citizenship)

AREAS OF INTEREST

Topical Interests: Cultural anthropology, medical anthropology, critical race theory and whiteness theory, political economy, transnationalism, knowledge production and circulation.

Geographic Areas: Latin America, emphasis on Mexico and “Greater Mexico.”

EDUCATION

UC Berkeley/UCSF Joint Ph.D in Medical Anthropology, 2009-2016
Co-Diss. Chairs: Nancy Scheper-Hughes and Charles Briggs
Committee Members: Ian Whitmarsh and Charis Thompson

UC Berkeley MPH, Concentration in Epidemiology, 2015-2016
Thesis Chair: Mahasin Mujahid, Academic Adviser: Leonard Syme
Other advisers: Arthur Reingold and Jack Colford

Brown University B.A., Anthropology, 2005-2009
Universitat de Barcelona Anthropology, 2006-2007

ACADEMIC POSITIONS

CIESAS D.F. Visiting Scholar, 2014-2015

UNAM Medical School Professor, 2013-2014

U Guanajuato (León) Visiting Scholar, 2012-2013

GRANTS, FELLOWSHIPS, AND AWARDS

2015-2016 (accepted) Ford Foundation Dissertation Fellowship

2015 (accepted) Complementary and Alternative Medicine/Integrative
Medicine Paper Prize, Society for Medical Anthropology

2015 (declined) UC Dissertation Year Fellowship

2014 (accepted) Lowie-Olson Travel Award

2014-2014 (accepted) Roselyn Lindheim Award

2013 (accepted) Lowie-Olson Travel Award

2013 Social Science Research Council International Dissertation
Research Fellowship Finalist

2013	(accepted)	UC MEXUS Dissertation Research Grant
2012	(accepted)	Dean's Normative Time Fellowship
2012	(accepted)	UC Global Health Institute Women's Health and Empowerment Graduate Student Fellowship
2012		Social Science Research Council International Dissertation Research Fellowship Finalist
2011	(accepted)	UC Berkeley Anthropology Department Award
2011	(accepted)	Lowie-Olson Travel Award
2011	(accepted)	Tinker Grant for Summer Research
2011	(accepted)	Human Rights Center Summer Fellowship
2010	(accepted)	Lowie-Olson Travel Award
2009-2013	(accepted)	Jacob K. Javits Fellowship
2009		National Science Foundation Graduate Research Fellowship Program Honorable Mention
2009	(declined)	Rackham Fellowship, University of Michigan, Ann Arbor
2009	(deferred)	Regents Fellowship, UC Berkeley
2009	(declined)	Ford Foundation Predoctoral Fellowship

TEACHING EXPERIENCE & PEDAGOGICAL TRAINING

Spring 2016		Outstanding Graduate Student Instructor Award
Summer 2015		UC Berkeley Summer Institute for Preparing Future Faculty
Spring 2015		Graduate Student Instructor, Introduction to Sociocultural Anthropology, Professor James Holston, UC Berkeley
Spring 2015		Graduate Student Instructor Teaching Conference, UC Berkeley Teaching and Resource Center
Summer 2013- Spring 2014		Professor, Graduate Program in Anthropology of Health, National Autonomous University of Mexico Medical School Courses taught: <ul style="list-style-type: none"> -“Contemporary North American Medical Anthropology Theory” (graduate students, February-June 2014) -“The Craft of Anthropology: Skills for Graduate School” (prospective graduate students, February-April 2014) -“Interculturality and Birth” (medical school students, June-July 2013)
October 2013		Guest Professor, Professional Midwifery School of the State of Guerrero, “Interculturality and Birth”
Fall 2011		Reader and Grader for “Sexuality, Culture & Colonialism: Global Sexuality” with Professor Lawrence Cohen, UC Berkeley
Fall 2010		Pedagogy Seminar, Department of Anthropology, UC Berkeley

- Fall 2010 Graduate Student Instructor Professional Standards and Ethics Course, UC Berkeley Teaching and Resource Center
- Fall 2010 Teaching Conference for New Graduate Student Instructors, UC Berkeley Teaching and Resource Center
- Fall 2009 English as a Second Language Instructor, East Bay Sanctuary Covenant

PUBLICATIONS

Under Review

Vega, R. Racial i(nte)ridentification and bioconsumer citizenship: Producing theory binationally. *Medical Anthropology Theory*.

Revise and Resubmit

Vega, R. Mexican Newborns and New Midwifery: Processes of Racialization and the Humanized Birth Transnational Community. *Medical Anthropology Quarterly*.

Vega, R. Bioconsumer Citizenship and the Danger of Ethnomedical Piracy: The Case of Humanized Birth in Mexico. *American Ethnologist*.

Vega, R. Recién nacidos y ciudadanos biológicos en México: Procesos de racialización y la comunidad transnacional de parto humanizado. *Eä Journal: Revista de Humanidades Médicas & Estudios Sociales de la Ciencia y la Tecnología*.

In Press

Vega, R. A Tale of Two Births: Reproduction and Medical Pluralism in Multiethnic Mexico. *In Medical Pluralism: Techniques, Politics, Institutions*. Edited volume resulting from European Association of Social Anthropologists 2011 Meeting. Amsterdam: University of Amsterdam Press.

Published

Vega, R. Review of Neoliberalism, Interrupted: Social Change and Contested Governance in Contemporary Latin America. *Cultural Analysis*.

Vega, R. Review of *Conceiving Cuba: Reproduction, Women, and the State in the Post Soviet Era*, by Elise Andaya. *American Ethnologist*, February 2015.

Vega, R. "Humanized Birth as a Human Right." Ethnographic Video. Center for Latin American Studies, UC Berkeley, 27 Oct. 2011. [not peer-reviewed] clas.berkeley.edu

Vega, R. A Tale of Two Births: Transnational Health Care in Multiethnic Mexico. *The Berkeley Review of Latin American Studies*, Fall 2011. Online version: Center for Latin American Studies, UC Berkeley, 9 Aug. 2011. [not peer-reviewed] <http://www.clas.berkeley.edu/Research/graduate/summer2011/Update/index-vega.html>

Vega, R. Nahua Midwives: Human Rights Defenders (Updates from the Field). *Berkeley Law - Home*. Human Rights Center, 18 Aug. 2011. [not peer-reviewed] <http://www.law.berkeley.edu/HRCweb/updates.html>

PRESENTATIONS

- February 2016 “The (Re)invention of Tradition: Commodification of Culture and Supranational Citizenship In the Humanized Birth Movement.” Individual presentation. Department of Sociology and Anthropology, University of Texas Río Grande Valley.
- January 2016 “The (Re)invention of Tradition: Commodification of Culture, Feminist Intentions & Supranational Citizenship In the Humanized Birth Movement.” Guest lecture for Mind, Medicine and Culture Graduate Seminar. Anthropology, UC Berkeley.
- October 2015 “Multi-Sited Fieldwork and Reflections on the Ethnographic Method.” Guest Lecturer, Research Theory and Methods in Socio-Cultural Anthropology, UC Berkeley.
- November 2015 “Humanized Birth: Producing Future Citizens in the New Regime of Proper Parenting.” American Anthropological Association Annual Meeting. Presenter on Society for Medical Anthropology Panel: Proper Births, Proper Parents. Denver, CO.
- September 2015 “Reproducing Neoliberalism.” Ford Foundation Conference, National Academies of Science. Presenter in Academic Exchange, Ethnic Studies. Washington, D.C.
- June 2015 “Uses and Misuses of Cultural Competency: How to Better Engage Diverse Populations.” Joint learning about Culturally Competent Care, Guest Speaker at Kaiser Permanente National Diversity Council Quarterly Meeting, Portland, OR.
- May 2015 “Uses and Misuses of Cultural Competency: How to Better Engage Diverse Populations.” Brown bag lecture, Kaiser Permanente Institute for Health Policy, Oakland, CA.
- December 2014 “Binational Discourse, Bi-Disciplinary Collaborations, and Transnational Health Projects: The Case of UNAM.” American Anthropological Association Annual Meeting. Presenter on panel: Bi-disciplinary Identities: Medical Anthropology–Public Health Hybrids and the Importance of Cross-Disciplinary Understandings. Washington, DC.
- November 2014 “Newborns and New Midwifery: Racialization, Bioconsumer Citizenship, and the Humanized Birth Movement in Mexico.” Individual presentation, Medical Anthropology Fall Dissertation Series, UC Berkeley.

- September 2014 “Recién nacidos y ciudadanos biológicos en México: Procesos de racialización y la comunidad transnacional de parto humanizado.” Individual presentation given in Spanish at the Permanent Medical Anthropology Seminar, Center for Superior Research and Studies in Social Anthropology, México, DF.
- November 2013 “Birth and Seguro Popular in Multiethnic Mexico: The End of Health Care Inequity Or The Beginning of Consumer-Citizenship?” American Anthropological Association Annual Meeting. Presenter on panel: The Politics of Healthcare Access and Belonging. Chicago, Illinois.
- October 2013 “La importancia de la interculturalidad en la atención al parto.” Individual presentation given in Spanish to medical personnel at the General Hospital of Tlapa, Guerrero, sponsored by the Mexican Ministry of Health of the State of Guerrero.
- November 2012 “Human Rights and ‘Humanized Birth’ in Mexico,” American Anthropological Association Annual Meeting. Presenter on panel: Global Flows, Human Rights, Sexual and Reproductive Health: Ethnographies of Crossing and “Translation” in the Global South. Organized by Stacy Leigh Pigg and Maya Unnithan. San Francisco, California.
- November 2012 “How Disempowerment Happens and What Can Be Done to Empower Women in Rural Mexico,” UC Global Health Institute, Women’s Health and Empowerment Center of Excellence Annual Retreat. Individual presentation given at the Ralston White Retreat Center, Mill Valley, California.
- October 2012 “La medicina tradicional y la biomedicina en México.” Individual presentation given in Spanish to “Oaxaca Abroad” UC Davis Chicana/Chicano Studies students in Oaxaca, Oaxaca.
- June 2012 “Parteras profesionales en la Costa Chica y la Montaña de Guerrero.” Presentation given to the Secretary of Health of the State of Guerrero in Chilpancingo, Guerrero.
- November 2011 “A Tale of Two Births: Transnational Health Care in Multiethnic Mexico,” American Anthropological Association Annual Meeting. Presenter on panel: “Geographic Legacies, Embodied Futures,” Montreal, Canada.
- November 2011 “Transnational Health Care in Multiethnic Mexico,” Knowledge/Culture/Social Change International Conference. Individual presentation at the Centre for Cultural Research, University of Western Sydney. Sydney, Australia.

- November 2011 “Medical Technologies and Reproduction in Multiethnic Mexico,” Society for the Social Studies of Science Conference. Presenter on panel: “Technologies of Health Care in Latin America,” Cleveland, Ohio.
- November 2011 “The Future of Childbirth in Mexico: Midwifery and the Medical Imaginary,” Society for the Social Studies of Science Conference. Presenter on panel: “Medical Imaginaries and Technological Futures,” Cleveland, Ohio.
- November 2011 “Conflicted Birth: Transnational Medical Knowledges,” Society for Social Studies of Science Conference. Presenter on panel: “In Search of ‘Lines of Flight’ in Latin America,” Cleveland, Ohio.
- November 2011 “Humanized Birth as a Human Right: The Midwifery Model in Multiethnic Mexico,” Human Rights Center Conference, UC Berkeley.
- October 2011 “Mexican Midwives: Finding Social Justice Through Medical Pluralism and Hybridization,” Tinker Foundation Presentation, Center for Latin American Studies, UC Berkeley.
- September 2011 “A Tale of Two Births: Reproduction and Medical Pluralism in Multiethnic Mexico,” 1st EASA Medical Anthropology Network Conference on Medical Pluralism: Techniques, Politics, Institutions. Presenter on panel: “Reproduction, sexuality, childbirth and medical pluralism,” at Sapienza-Università di Roma, Italy.
- February 2010 “Seizures and Suffering: Epilepsy in Rural Guerrero, Mexico,” Panel on Current Issues in Latin America, UC Berkeley.

RESEARCH EXPERIENCE

- April 2015-Ongoing Qualitative Evaluation of Complex Care Provided to High-Cost Patients at LifeLong Clinics
- May 2012-November 2013 (18 months) Race, Class and Transnationalism, and Their Effects on Women’s Birth Experiences in Mexico, Multi-sited (dissertation research)
- March 2013 Collaborative Institutional Training Initiative Training, Committee for the Protection of Human Subjects
- December 2010-May 2012 (10 months) Race, Class and Transnationalism, and Their Effects on Women’s Birth Experiences in Mexico, Multi-sited (completed prior to passing the doctoral qualifying exam)
- 2010 (4 months) Epilepsy and Rural Poverty in La Costa Grande, Guerrero, Mexico
- 2007-2008 (10 months) Marginalization of the Roma People in Barcelona, Spain
- January-May 2007 (5 months) Biopsychosocial Study of Eating Disorders, Alcohol Use and Comorbid Psychiatric Disorders

VOLUNTEER EXPERIENCE

- May 2011-August 2011 Intern and Resident Scholar, Center for the Adolescents of San Miguel de Allende, Mexico
- Fall 2009-Spring 2011 Delivered “Health and Life” Workshops: Diet, Exercise, Reproduction, STDs and Chronic Disease Affecting the Latino Immigrant Community, East Bay Sanctuary Covenant
- August-December 2009 English-Spanish Interpreter, Alameda County Social Services Agency, US
- June - July 2008 Volunteer caring for AIDS patients, Hogar Nuestra Señora de la Esperanza, Cártaago, Costa Rica

ADVISING AND MENTORING

- Winter 2014-Ongoing Stephanie Gonzalez: I advise Stephanie, an undergraduate, about how to position herself for graduate school in social sciences.
- Fall 2014 Blanca Merary Martinez-Cobian: I provided her with feedback on her statement of purpose for applications to graduate school in medical anthropology.
- Fall 2014 Nick Rubashkin: I provided him with feedback on his application materials to graduate school in medical anthropology.
- Spring 2014-Ongoing Joan Francisco Matamoros Sanín (mentee/advisee): I began mentoring Joan Spring 2014 when he was my student. He has since been accepted to the graduate program in Medical Anthropology at UNAM and I am an external adviser for his master’s thesis.
- Spring 2014 Graciela Muñoz: I helped her formulate a successful doctoral research proposal, acted as a liason to the National Commission for Medical Arbitration (Mexico City), and secured institutional access.
- Spring 2014-Spring 2015 Tomás Loza Taylor (advisee): I was a committee member and external adviser for his master’s thesis.
- Fall 2013 Savonya McAllister: I provided her with feedback on her personal statement for applications to pediatric residency programs.
- Spring 2012-Ongoing Fatima Segura Casillas (mentee): I provided her with guidance through the graduate school application process her subsequent transition into the work force.

September 2011	Graduate Student Panelist, Journey to the Ph.D Brown Bag Series, UC Berkeley
September 2010	Graduate Funding Seminar, Department of Anthropology, UC Berkeley
September 2009	Graduate Funding Seminar, Department of Anthropology, UC Berkeley

RELATED COURSEWORK

Medicine and Medical Anthropology:	Introduction to Medical Anthropology; Discourse and the Body; Topics in Medical Anthropology; Bioethics and Culture; Culture and Health; Gender and Sexuality; Biopsychosocial Approaches to Comorbid Psychiatric Disorders; Introduction to Fetal Medicine
Cultural Anthropology:	Ethnographic Methods; Anthropological Theory and Method; Anthropological Approaches to World Issues; Global Poverty; Anthropology of Kinship; Regional Ethnology; Language and Culture; Cities and Identities: Urban Narratives; Urban Anthropology; Cultural Transmission and Education; Violence in the History of Catalonia and Spain
Public Health and Epidemiology:	Biostatistics; Applied Linear Models; Epidemiology Research Seminar; Public Health Policy and Management; Environmental Health; Epidemiology Methods; Applied Epidemiology Using R; Statistical Analysis of Categorical Data; Social Epidemiology Seminar; Social Epidemiology Methods
Math and Science:	Biology: Foundation of Living Systems; Anatomy and Physiology; Basic Physics; Equilibrium, Rate, and Structure; Organic Chemistry; Inorganic Chemistry; Introductory Calculus; Statistics
Area Studies:	“Greater Mexico”: History of the Mexican Diaspora, Mexican Culture, and U.S./Mexico Relations; Mexican Theorists: Medical Anthropology, Critical Epidemiology, and Social Medicine Theory Produced in Mexico; Health in Mexico;
Spanish:	Eight semesters of university Spanish

CLINICAL EXPERIENCE & TRAINING

Basic Life Support (BLS) Training June 2011	Hospital General Felip G. Dobarganes (PACE) San Miguel de Allende, Guanajuato, Mexico
BLS in Obstetrics Training June 2011	Programa de Actualización Continua en Emergencias San Miguel de Allende, Guanajuato, Mexico
Promotora Training Conference March 2010	Health Initiative of the Americas UC Berkeley School of Public Health
Student Intern, Pediatric Surgery May 2006 – September 2006	Children's Specialists, Sutter Medical Center, Sacramento, CA
Observership, Pediatric Surgery June 2006 – August 2006	UC Davis Medical Center, Sacramento, CA
Observership, OB/GYN June 2006 – August 2006	Kaiser Permanente Medical Center, Elk Grove, CA
Observership, Neonatology September 2005 – May 2006	Women and Infants Hospital, Providence, RI
Observership, Reproductive Endo. September 2005 – December 2005	Women and Infants Hospital, Providence, RI
Observership, Pediatrics September 2005 – December 2005	Hasbro Children's Hospital, Providence, RI
Observership, OB/GYN September 2005 – December 2005	Women and Infants Hospital, Providence, RI

LEADERSHIP

Secretary, Board Member, Strategic Planning 2015-Present	Mujeres Aliadas, A.C. U.S. Organization
Class Representative 2005-2007	Program in Liberal Medical Education, Brown University

LANGUAGES

English: fully fluent, native in speaking, listening, reading and writing
 Spanish: fully fluent, near-native in speaking, listening, reading and writing
 Cantonese, Toishan dialect: native in speaking and listening
 Catalan: some listening, reading and translating
 Portuguese: some listening and reading
 Italian: some listening and reading

PORTRAITS: RACIAL POLITICS AMONG BIRTH ATTENDANTS

Chapter One

The pages that follow will not offer a singular story about birth or midwifery. Rather, this work presents humanized birth in Mexico as a kaleidoscope of fractal, shifting relationships between objects and subjects. In this dissertation's opening refrain, I present a series of interlacing portraits which will allow me to weave together themes and conceptual threads presented throughout. Each person featured in these portraits is complex, and has multifaceted relationships to the commodification of indigenous culture, feminist approaches to women's liberation, racial "othering," and citizenship. This polytonal ensemble sets the stage for the symphonic unfolding of race, class, and gender inequalities within the transnational humanized birth community.

Montserrat

Over the course of my research, I became increasingly concerned with the privilege and power enjoyed by foreigners living in Mexico. Many of these foreigners have resided in Mexico for many years and some eventually gain dual citizenship. Thus, while "professional midwives"¹ with foreign origins and transnational trajectories consider themselves *mexicanas*, counterparts who have lived out their entire lives in Mexico continually label them as foreigners, despite their years of residence within Mexico. This insistence on signaling difference may result from resentment at the perceived ease with which foreign midwives leverage cultural capital emanating from their "Americanness," "Europeanness," and transnationalism to acquire economic resources and positions of power.

After Sagrario² remarked about how her former apprentice's national origin has resulted in greater privilege, culminating into a directive position within the Mexican Midwifery Association, I began traveling to different states to meet with foreign midwives and collect their life stories. Montserrat, Sagrario's former apprentice, lived in Chiapas at the time of our interview. When I walked into her alternative birth center, my attention was drawn to all the alternative treatments, therapies, and supplements for sale in the reception area and the beautiful colors and artwork on the walls. I noticed a poster for a belly-painting workshop for pregnant mothers. The center's New Age approach to "humanized birth" commodifies and juxtaposes homeopathic remedies, with workshops on the midwife's "magic," and groups that celebrate women's bodies and maternity.

Montserrat guided me into a side room where we could have an intimate conversation. She has long, dark blonde hair and bright blue eyes. She began to tell me her story: Montserrat lived in Spain from the time of her birth until she went to the United States to study university. As an undergraduate, she majored in anthropology, and subsequently she earned a master's degree in public health. She began informal midwifery training at a clinic in Guatemala before apprenticing at CASA with the internist and professional midwives. Then Montserrat went to New Orleans where she participated in home births with "urban hippies" and "rural Christians."¹

¹ I am placing "professional midwives" in quotes since the women I am referring to generally align themselves with licensed midwives around the world but do not hold licenses to practice midwifery in Mexico. These women have engaged in academic study of midwifery to varying degrees.

² Introduced in further detail in Chapter 2.

At the time of the interview, she was working with the Red Cross and running her own alternative birth center in Chiapas. Her international training evidences her heightened mobility and is a source of accrued cultural capital. As a transnational figure, she represents a conduit for Mexican clients to European and North American spaces where “whiter” pregnant women are the recipients of similar professional midwifery practices. In this way, Montserrat connects her clients to a transnational community of global professional couples who seek unity through consumption of birthing methods understood as modern because of their traditionality.

Montserrat expressed to me how exasperated she feels by contradictions in the Mexican health system and obstacles she has faced as a result of her transnational training. She studied midwifery online and is a certified nurse midwife; however, the International Confederation of Midwives does not recognize her certification and she is not licensed to practice midwifery in Mexico. Although she is not certified or licensed, her alternative birth center was granted a Health Establishment Code by the Mexican government, allowing her to sign and complete birth certificates. However, professional Mexican midwives who are certified and licensed do not have access to such a code. Also, indigenous women can be certified as “traditional midwives” if they demonstrate specific competencies. However, when Montserrat approached government officials requesting to be certified as a traditional midwife, she was rejected on the basis of her race—only indigenous women can be traditional midwives, she was told. Montserrat realized that “indigeneity” is collapsed with “traditionality” in the figure of the traditional midwife, thus disabling her from obtaining government permission to practice midwifery under the rubric of “traditionality” in Mexico. While Montserrat strives to make claims to “traditionality,” she is racially identified in a way that precludes her from being recognized as a traditional midwife. This disjuncture points to the syncretic nature of racial i(nte)ridentification—Montserrat’s desire to be included as a *partera Mexicana* (a Mexican midwife) is overshadowed by the European identity that others locate within her.

I asked Montserrat what the difference is between professional and traditional midwives. “I [practice midwifery] in a Western way,” she answered. Montserrat’s assertion, “the precedent depends on where you were born,” emphasizes how “race,” class, education, and the color of one’s passport (and whether one has a passport at all) are collapsed into a multivariate social gradient that differentiates some birth attendants from others. However, Montserrat’s attention to class and differences in origin between traditional and professional midwives does not extend to a critical reflection on the socioeconomic and racial grades among “professional midwives.”³ For example, when Flor, a CASA-trained professional midwife, was pregnant with her first child, she began looking for a professional midwife to attend her birth. Flor considered Montserrat, but as a Mexican woman and the wife of a carpenter, there was no way she could pay the 18,000 pesos Montserrat charges.)

On the topic of “traditional midwives,” Montserrat pointed to how these midwives possess varying levels of skill and experience. “The problem with traditional midwifery is that all ‘traditional midwives’ are thrown in the same boat.” As a result, skilled midwives who have accrued lots of experience safely attending births but lack formal academic training are placed under the same rubric by government programs and hospital physicians with midwives who do not know how to safely manage drugs, leading to the overuse of oxytocin injections, the untimely transfer of dystocic mothers to hospitals, and infant deaths.

³ See Sheryl Nestle 2006.

Montserrat offered Yanira as an example of a very capable and knowledgeable “traditional midwife” who is well known in Mexican humanized birth circles and who regularly attends international midwifery conferences. “Yanira is a ‘traditional midwife’ but she could definitely pass a [professional midwifery] certification exam. However, one of the things the Mexican Midwifery Association decided is that professional midwives and traditional midwives cannot be treated the same way.” The Mexican Midwifery Association hopes to administer certification exams and create a professional guild in an effort to lend legitimacy to the work of midwives across Mexico. However, according to the rules established by the directive board (a board that includes obstetric nurses and “professional midwives,” but does not include “traditional midwives”), only midwives who have completed an academic course of study, in Mexico or elsewhere, are eligible for admittance into the guild. “Traditional midwives” shall be excluded until they become “professional midwives” by undergoing an academic course of study—a path that is unlikely for indigenous midwives who practice midwifery out of their rural homes while also raising families. I attended a Mexican Midwifery Association meeting in Mexico City and observed that most of the board was comprised of transnational birth attendants like Montserrat. The disproportional inclusion of transnational birth attendants and stark exclusion of indigenous and traditional midwives is reminiscent of Nestel’s 2006 study of how race inequalities are reproduced among the midwifery profession when professional midwives, employing a rhetoric of universal womanhood, fail to engage critically with their own (white, upper-middle class) positionality.

As the founder of an alternative birth center, Montserrat worked in a small indigenous village for five years training traditional midwives. However, after five years she decided to evaluate her own “savior syndrome” and discontinue her involvement in the village in favor of focusing all of her energies on prenatal education and private midwifery care in the urban center. She said, “Who am I? I have never lived in a [village].” She expressed her anxiety about NGOs that work in villages because, from her perspective, their interactions with villagers represent “a type of colonialism.” She admitted to me that the language barrier between her and “non-Spanish speakers” also led her to rethink her role as a leader of midwifery training workshops.⁴ Over the course of my ethnographic research, I found that Montserrat’s experience is not unique. While the humanized birth movement in Mexico references indigeneity, usurps traditional midwifery practices, and commodifies the image of indigenous women; urban, transnational informants and rural, indigenous counterparts did not engage equitably under the rubric of humanized birth. As my fieldwork progressed, humanized birth became a critical lens for evaluating the challenges to achieving “interculturality” in Mexico, despite its ubiquitous incorporation in public health and development rhetoric.

Montserrat’s comments opened a space for me to ask probing questions about potential “neocoloniality” embedded within the Mexican Midwifery Association’s organizational structure. Montserrat explained to me that in Mexico, there are a lot of “hippy doulas”—“all those women who drink their menstrual blood”—who could better serve pregnant women as professional midwives; but in Mexico, you have to have money to become a professional midwife. Furthermore, a lot of upper-class Mexican women who aspire to professional midwifery go to midwifery school in El Paso, Texas, thus forgoing licensure in Mexico. She opined that professional midwives in Mexico must be independent and rebellious. “We could

⁴ Interestingly, Montserrat signals indigenous midwives’ inability to speak Spanish instead of her inability to speak indigenous languages. See Molina 2006.

care less about the Secretary of Health's norms." According to Montserrat, those who are not sufficiently independent and rebellious disappear from professional midwifery, including those who have completed a full course of academic study such as the one offered at CASA—they get married and become homemakers, or they become nurses or physicians, or do other things. "Being a professional midwife is a hard job."

Paula

Within a week after interviewing Montserrat, I traveled to Mexico City to interview Paula, one of the professional midwives Montserrat mentioned. Paula is an older woman with fair skin and white hair. Her poised movements and demeanor signal a life of privilege, beginning with her childhood and adolescence in Veracruz. She moved to Mexico City to study university, but she quickly fell in love and married, dedicating herself to homemaking and raising children instead of completing her studies. After a traumatic, highly-medicalized birth experience, she familiarized herself with the prophylactic method and became a firm believer that women can have natural, vaginal births. Her conviction impelled her to teach prenatal education courses to "empower" women for 15 years, but after seeing how this "empowerment" vanished as soon as women arrived at the hospital and submitted to biomedical authority, she became increasingly dissatisfied with her work. From Paula's perspective, (masculine) biopower is exercised over women's bodies within a patriarchal medical system, but my participant-observation draws attention to how humanized birth social networks (premised on standards to maximize the benefits of natural birth for mother and child) is an unintentional mechanism through which women, impelled by feminist ideals, exact "maternal biopower" on each other.

Paula decided to return to her studies, completed a master's degree, and worked at a private foreign language school. She began reading about humanized birth and was deeply moved by the work of Sheila Kitzinger, anthropologist and natural childbirth activist in the United Kingdom, and when she and her husband moved to London for his work, she was able to meet Kitzinger and discuss her traumatic birth experiences. Paula then spent time observing births with midwives across Europe—England, Austria, Holland, and Ireland. Upon returning to Mexico, she was determined to become a midwife. She met a midwife/anthropologist in Tepoztlán, Morelos⁵ who connected her to Patricia Kay, an American midwife who was attending water birth for American and transnational couples living in Mexico. Like Montserrat, Paula is most definitely a transnational figure whose accrued cultural capital positions her as a conduit for clients to a humanized birth community of consumption originating in the Global North.

Paula and a group of prenatal educators, along with one obstetric nurse and one acupuncturist, began taking classes from Patricia before traveling to El Paso, Texas to acquire clinical training. (Later, Patricia Kay also gave classes to CASA's first and longest-lasting clinical director, thus playing a foundational role in the midwifery school.) Upon returning to Mexico, Paula led a civil association, traveling to different conferences around the world, lobbying for home birth, and obtaining funds from Japan International Cooperation Agency, Mexico's Secretary of Social Development, and the MacArthur Foundation. The name⁶ selected for the association means "midwives" in Nahuatl and is meant to draw attention to how, in Paula's words, "professional midwifery is the recipient [of knowledge] from traditional midwifery." For

⁵ A town known for a large population of resident foreigners.

⁶ Omitted here.

the last 11 years, Paula has dedicated herself to attending births, and the association she led is no longer registered. Throughout my fieldwork, I observed how encounters between traditional midwives and professional midwives positioned professional midwives as experts and traditional midwives as knowledge recipients, even when these encounters were framed as opportunities for mutual exchange. The dispersal of Paula's civil association throws into question the plausibility and sustainability of positive, equitable engagements between mobile humanized birth practitioners and their immobile, indigenous counterparts. She explained that the midwives of her association "passed the baton" on to other associations in Mexico, Brazil, and the Caribbean. These associations form a Latin American network, and while their connectedness points to the transnationalization of humanized birth, I argue that it does not diminish the "solitary contractuality"⁷ defining how disparate groups interact in Mexico.

Our interview was cut short when two couples, potential clients, arrived at Paula's home seeking information regarding the services she offers. I was happy to sit and observe as the exchange took place between Paula and these two couples. Paula's domestic worker had shown the two couples into the library while Paula and I were talking in the garden. Paula entered into the study and exclaimed, "Here I am, the one who is called 'midwife.'" One of the couples had a rather bohemian style, while the other couple displayed all the trappings of affluence. Paula explained that while she is certified in the United States, her certification is not valid in Mexico, so if there are any complications with the birth, they have to switch to Plan B at a small clinic where a "technical, medical team" comprised of a surgeon, an obstetrician, and an anesthesiologist would place an epidural and perform a cesarean.

Then the moment came for Paula to tell the couples exactly how much her services cost. She recommends prenatal consultations every month until the 22nd week, then twice a month, and weekly during the third trimester. She charges 600 pesos per consultation. She always attends births with a fellow midwife, and they charge 19,000 pesos to be split between them for each birth. Paula also works as a team with a homeopath and a biodynamics practitioner. Thus, the base price for prenatal care and birth with Paula is about 31,600 pesos, plus charges for homeopathic treatments and biodynamic sessions. Considering that minimum wage in Mexico was 67 pesos daily at the time of this research, birth with Paula represents 1.3 years of earnings at minimum wage. The cultural capital of her U.S. training overshadowed her lack of certification in Mexico for the affluent couples she serves. While Paula makes the most of lucrative opportunities afforded by humanized birth despite certification, the traditional indigenous midwives who participated in her extinct association did not enjoy similar opportunities. Paula's heightened mobility, fair skin, and high socioeconomic standing form a nexus that bares stark contrast to the comparatively immobile, indigenous, impoverished midwives she no longer engages.

Yanira

I traveled to Tepoztlán, a short distance from Mexico City—an artsy community comprised of affluent Mexicans and American ex-patriots. There, I spent the day with Yanira, the traditional midwife Montserrat described as possessing as much knowledge and skill as an academically-trained professional midwife. While this was our first meeting, I already knew a bit about Yanira from an American-made documentary on her work. At the time the documentary was filmed, Yanira was attending birthing mothers at a feverish pace. Both

⁷ Urry 2007:156, referring to Augé 1995:94.

Mexican and foreign women traveled to Cuernavaca to give birth in her thriving home clinic. After the documentary, however, Yanira also became the target of kidnapping threats. Shaken to her core, Yanira and her husband abandoned Cuernavaca overnight. Initially, Yanira moved to Veracruz, hoping to take over Adeli's clientele, but ended up opting for a lower-profile lifestyle and a slower-paced practice in Tepoztlán. Her work load has fallen from forty to ten births per month.

I wondered about how Yanira's increased celebrity within transnational humanized birth forums caused interactions to shift between Yanira and members of her hometown. I gently inquired about the specific circumstances causing her to abandon her successful, well-known Cuernavacan clinic, but Yanira told me that the occurrences were too painful for her to talk about. Instead, she told me about how she became a midwife and about the unique position she holds within the transnational humanized birth community.

Yanira's mother, two aunts, grandmother, and two great-grandmothers were all midwives and *curanderas*. Her Nahua grandmother married a Spaniard, and was trilingual in Nahuatl, Spanish, and Latin; however, Yanira is monolingual in Spanish. Yanira began assisting her mother and grandmother when she was seven, and started attending births on her own when she was fourteen.

Yanira was first exposed to the transnational humanized birth community when she met Jan Tritten at a midwifery conference. Subsequently she met the editor of an Italian midwifery journal and accepted an invitation to speak about traditional Mexican midwifery in Italy. As her reputation spread and her birthing clinic grew, Yanira began receiving apprentices from around the world—Austria, Denmark, Norway, Italy, Spain, Brazil, Costa Rica, the United States, and even Israel. She has organized an “exchange” with these apprentices, and has traveled to their countries to speak about her work. Her next speaking engagement is in Moscow. She explained to me that Midwifery Today invites “the most traditional” midwives to speak internationally, all expenses paid.

Yanira is a special case in Mexico since she, along with a few others across the entire country, has constructed an identity that employs place-based knowledge as currency within transnational circles. Yanira's celebrity depends on the balance of two contradictory elements: despite her mono-national origins, she has become transnational, and despite becoming transnational, she continues to be perceived as mono-national. As I delved deeper into my fieldwork, tracing humanized birth-oriented social networks to interview and observe all the “usual suspects,” I began wondering if Yanira's paradoxical position is engendered by the transnational humanized birth community's fetishization of indigeneity⁸--a fascination that allows for several indigenous women to serve as representatives of traditional Mexican midwifery at international conferences, but does not permit merging of traditional and professional midwifery.

When I asked Yanira what a “traditional birth” means to her, she responded, “*parto respetado*” (a respected birth). Her response interested me since I had never heard a traditional midwife use this term. *Parto respetado* is a term used interchangeably with *parto humanizado* among humanized birth practitioners. As biomedical birth attendants increasingly criticize the terminology of “humanization,” arguing that it inappropriately suggests that biomedicalized births are “animalistic,” *parto respetado* has gained popularity as the term of choice.¹¹ I asked her to clarify what she meant. She explained that she respects the woman's choices, encourages

⁸ See Chapter 2.

women to move around during the birth, practices delayed cutting of the umbilical cord, and prepares a birth-inducing drink using chocolate, cinnamon, and *zopatle*.⁹ She uses *la sobada* and *la manteada* as necessary.¹⁰ During prenatal consultations, she inquires about the mother's diet and previous births, evaluates blood pressure, and tests urine samples for protein levels and infections. While Yanira describes her midwifery techniques as “nothing extraordinary,” the amount of attention they have drawn from a global audience certainly is.

Yanira's case piqued my interest since she was selected for being one of the “most traditional” midwives in Mexico; however, she does not speak Nahuatl and practices popularized “traditional” methods. During the course of my research, I had many opportunities to observe midwives who primarily or exclusively speak indigenous languages and whose repertoires are comprised of remedies and techniques unbeknownst in transnational circles, yet these midwives are not present at humanized birth conferences nor Mexican Midwifery Association meetings. However, the delicate balance upon which Yanira's paradoxical identity rests has not gone undisturbed. Her increased mobility provoked violent reactions in her community, resulting in a type of exodus. Ironically, Yanira's mobility in humanized birth circles dictates and limits where she can live, resulting in immobility in everyday life.



Yanira and a Spanish apprentice

⁹ During the course of my research, I have observed that delayed cord cutting is highly valued among humanized birth practitioners. Likewise, chocolate, cinnamon, and *zopatle* is a well-known “folk remedy” that has achieved international “cult status” among those interested in traditional Mexican midwifery. Adeli (see below) taught this remedy to workshop attendees in Brazil.

¹⁰ Described in Chapter 6.

Lucía

I also interviewed Lucía, an obstetric nurse living in Mexico City and one of Yanira's former apprentices. She first met Yanira at an international conference organized by Adeli. Jan Tritten, Founder of Midwifery Today, Robbie Davis-Floyd, author of *Birth as an American Rite of Passage*, and a number of Brazilian midwifery advocates were also in attendance. She explained to me that at the time she was curious about midwifery, but as the mother of two, she could not travel too far from home nor commit to apprenticing every day. She apprenticed under Yanira twice a week for more than a year.

Lucía emphasized to me how generous and open Yanira had been towards her apprentices. Yanira accepted everyone who wanted to learn, allowing her students to sleep and eat in her home free of charge. However, as the mother of five boys, Yanira had to begin assigning apprenticeship dates to her various students so there would not be too many people in her house at the same time.

When it was her turn, Lucía spent two weeks apprenticing in Yanira's home together with another woman from Brazil. At the time, it was common for Yanira to have more than one birthing mother at a time in her clinic. One day, three women were giving birth at exactly the same time. When Yanira informed her two apprentices that the three of them would each attend a birth, Lucía thought, "Me? How?" She had never attended a birth before. The mother she attended was giving birth to her sixth child and the birth progressed smoothly, without any complications. When the woman's water broke, Lucía was bathed in amniotic fluid and was "baptized" as a midwife.

When Lucía felt she had "learned a bit" from Yanira, she joined forces with another obstetric nurse from the Center for Maternal and Infant Research, Birth Studies Group. Lucía is not comfortable attending births alone, but enjoys partnering with another obstetric nurse. She has attended nearly 80 births over the last seven years. In addition, she gives perinatal education workshops at the National Autonomous University of Mexico, Panamerican University, and the National Institute of Cardiology. Most of her time, however, is dedicated to leading the Mexican Midwifery Association, for which she is the president. She started the association using funds from the MacArthur Foundation with the goal of reducing maternal mortality.

Although Lucía has limited experience attending births in comparison to my other informants, as the former apprentice of Yanira, she is able to leverage her proximity to "traditional" and "indigenous" birthing practices in a way that Yanira cannot. Lucía's influential position as President of the Mexican Midwifery Association, helps to illuminate pathways to power and prestige within the humanized birth movement in Mexico. While Yanira's unique and paradoxical position in the humanized birth community provides her with access to transnational meetings, it was also the impetus for the violent backlash that caused her to flee her hometown. Another indigenous informant¹¹ complained to me that her inclusion in a Midwifery Alliance of North America conference in Canada had been solely based on her physical appearance—during the conference she was fetishized as a living "poster" of indigeneity. Thus, I argue that while Yanira serves as a representative of "traditional midwifery" at international midwifery conferences, Lucía's trajectory demonstrates that true cultural capital is derived not from being Yanira, but rather, by being *near to* Yanira.

Lucía does not fulfill logical requirements for the post of President of the Mexican Midwifery Association—she is neither a professional nor a traditional midwife, nor does she

¹¹ See Mayra's story in Chapter 2.

possess extensive experience attending births. While Lucía was a key player in determining that traditional indigenous midwives would be excluded from the professional guild until completing an academic course of study, one could argue that Lucía also has not completed an academic professional midwifery program and therefore should be excluded from the guild. Lucía's qualification for her post is based on her hospital-based training as an obstetric nurse (suggesting continued biomedical hegemony despite positioning of humanized birth as resistance to patriarchal biopower and medicalized birth). The underlying logic that buttresses Lucía's position as President also evidences how deeply the simultaneous commodification of indigeneity and exclusion of indigenous people is embedded within the humanized birth movement.

Emma

Emma is a Swiss woman who works as a midwife in Tulum, Quintana Roo. Before moving to Mexico 16 years ago, she studied naturopathy in university. She has eight children with her Mayan husband. Emma and her family live near the crystalline waters of the Riviera Maya in a small but touristy town that attracts visitors to the pyramids and resorters on holiday. This was not always the case. Before living in Tulum, Emma and her family lived for five years in her husband's Mayan village, but she was never accepted by the villagers—her white skin, blonde hair, blue eyes, height, and body shape were too much for them to look past. She wanted to practice midwifery in her husband's natal village, but the women did not want her to attend their births, saying that a white woman could not really know. As a result, Emma now attends the births of foreigners. Emma's experience echoes that of Montserrat—while she aimed to construct a “local” identity and integrate herself into the community, her European origins, phenotype, and multilingualism (which did not include native Mayan) led to her been racially identified as “Other.” Moments of rejection render visible the syncretic nature of racial i(nte)ridentification.

Despite being rejected by Mayan villagers, Emma's commitment to racial equity made a deep impression on me. As the mother of half-Mayan, half-Swiss children and the wife of a Mayan man, Emma is sensitive to racial inequality in Mexico. She described to me how her husband went to pick up their baby from the hospital on one occasion and was stopped by a police officer on the street and accused of stealing the baby since such a fair baby could not possibly be his! For him to be the father of a baby that fair, the police man reasoned, the mother would have to be Caucasian, and that was just ludicrous! The police officer's assumption that “white” and “indigenous” do not mix points to reified notions of inter-ethnic interaction (and its limits). Racialized categories upon which inclusion/exclusion are based persist despite centuries of biological and genetic admixture.

Emma seemed almost allergic to whatever privilege she might be granted based solely on her skin color. She told me how she is sometimes called a “professional midwife,” and how she makes a point to correct the speaker by explaining that she has never had any formal training, and, thus, should not be grouped with professional midwives just because she has fair skin. In Quintana Roo where she lives, there is a large Mayan population, but in general, professionals and those who are in positions of power tend to be *güeros* (fair-skinned) and have Spanish surnames. For Emma, race and national origin are more salient categories than socioeconomic class. For example, she explained, when she showed a Louis Vuitton-carrying woman from Mexico City a video on water birth, the woman responded, “How nice! But I already scheduled my cesarean.” According to Emma, the women who seek out humanized birth are either foreigners living in Mexico or Mexican intellectuals who can think beyond Mexico's

“paternalistic culture” and “culture of fear.” While I understand the point Emma is trying to make, a key argument of this dissertation that power is not necessarily exercised by men and exacted on women. I use humanized birth as a lens for examining “the matrix of women’s dominations of each other” (Haraway 1990: 155).

In closing, the importance lent to “race” versus class cannot be parsed as simply as in Emma’s determination (see Chapter 4). An important part of my argument is that “race” is mapped onto class and visa versa through processes of racialization. Class can by no means be denied. When interviewing Carolina, a prenatal yoga instructor in the city of Monterrey, I asked her to describe the socioeconomic class of her clients and she responded with one word: “High.” Her work is about “transcendence” through practicing yoga, and she explained that while there exist a few “transcended” people who are “extracts from the lower classes,” these people do not attend her classes. A midwifery student at the same health center described her clients as “middle-upper class, professional, educated, and informed.” Two obstetric nurses in Mexico City insisted that while they attend births of women from varying socioeconomic backgrounds, all of the women they attend are well educated and well read. Later that day, a homeopath and midwife told me that her clients are middle-upper class, informed, and actively seeking alternative care. Given the ethnographic examples in this dissertation, my point is not to deny class in favor of “race,” but rather to explore how race makes class, and how class makes race.

COMMODIFYING INDIGENEITY: POLITICS OF REPRESENTATION

Chapter Two

Mexican midwifery is “good to think with” because it enables us to explore the consumption of cultural *medical* practices and the idea of a traditional past in ways that are exploitative of the very people it claims to celebrate, embrace, and represent. While other anthropologists have deconstructed the complexity of biopiracy¹², Mexican midwifery serves as an entryway for examining the multivalence of “ethnomedical piracy.” Building upon how others have thought about cultural marketplaces (see Chow 2002; Camaroff 2009; Clifford 2013), Mexican midwifery is an example of an emerging global ethnomedical marketplace.¹³ Although indigenous people are often discursively produced as specific types of subjects through research on topics such as land use, casinos, psychological pathology, and drug addiction (to name a few), Mexican midwifery is a unique example of how indigeneity as an object of consumption is sought through reproduction and health. In this chapter, I will offer examples of how people who self-identify as indigenous leverage their own racialized identities in order to use the commodification of “indigeneity” to their favor; however, I also want to think critically about the historical underpinnings at play when ethnomedicine is usurped by transnational humanized birth practitioners.

In this chapter, I offer midwifery in Mexico as an example of “imperialist nostalgia”: “Nostalgia for the colonized culture as it was ‘traditionally.’ . . . Imperialist nostalgia uses a pose of ‘innocent yearning’ both to capture people’s imaginations and to conceal its complicity with often brutal domination.” (Rosaldo 1989:107–108) Using Rosaldo’s terms, I suggest that traditional ways of birthing are destroyed through power, then reinvented through privilege. What is striking about this example, however, is how reinvention of Mexican midwifery provides a pathway to cultural capital, status, and profit. I explore how in Mexico, indigenous people are commonly politically and culturally excluded as ahistorical “Others,” while their “culture”¹⁴ is consumed and marketed as an object of desire.

Consuming the Indigenous “Other”

On a bright and dusty summer morning, I boarded a second-class bus to Matehuala, where I made a connection to Estación Catorce. Before this trip, I had attended several training workshops for practitioners classified as traditional midwives. At each of these events, I was struck by visible manifestations of power inequality. The event in Estación Catorce was billed as an *encuentro* (an encounter, or a meeting of two cultures) between professional medical personnel and traditional midwives. It was sponsored by the Secretary of Health’s office for Traditional Medicine and Intercultural Development (TMID) and was organized by an anthropologist—elements suggesting a forum for mutual exchange of ideas.

¹² See, for example, Cori Hayden’s 2003 book, *When Nature Goes Public: The Making and Unmaking of Biopiracy in Mexico*.

¹³ Another example is the commodification and sale of shamanism to Western consumers, as in shamanic tours to the healing compound of Joao de Deus in the Brazilian Amazon.

¹⁴ While I resist the notion of a homogenous culture among all indigenous peoples, I am pointing to how such a notion is socially constructed and then commodified. See Coombe 1998, hooks 1990, and de Certeau 1984.

At the *encuentro*, nurses, physicians, anthropologists, and professional midwives gave PowerPoint presentations to traditional midwives—again, these professionals emerged as *the* source of expert knowledge. Many are interested in New Age therapies, and some even dedicated their presentations to the benefits of medicinal plants. While watching various professionals teach “traditional” remedies to the traditional midwives, I wondered if I was the only one struggling with the irony of the situation. I perused the agenda for the three-day event. Were the traditional midwives to have an opportunity to share *their* expert knowledge? The last two entries, at the end of the final day, were presentations by “traditional midwives.” While all other entries named the presenting professional and title of the presentation, the “traditional midwives” were unnamed and no indication was given regarding their presentation topics.



Sofia

Looking around, I asked myself what was different about this *encuentro* compared to other workshops I had attended. As I scanned the crowd, I noticed a curious number of piercings and tattoos, foreigners with camping gear, and many people from Mexico City.ⁱⁱⁱ At the entrance to the *encuentro*, beside the registration table, was a display of natural products for sale (shampoos, teas, marmalades, homeopathic remedies, etc.) These products and event publicity materials were branded with a cosmic/floral image in earthy tones, and the word “Nanahtli.” According to the brand’s website, “Nanahtli” speaks to women in the Nahuatl world, represents the resolve to recuperate and dignify the ancestral knowledge of “our people,” and plants conSCIENCE-iousness.¹⁵ Staffing the table was Sofia,¹⁶ a young woman with chestnut-colored hair wearing a tank top and a long skirt (a friend of the anthropologists who organized the event). Traditional midwives were not involved in the production of any items being sold; however, one traditional midwife, Liliana, was given the task of manning the table for a few hours when Sofia was away—the expression of boredom and lack of interest on her face provoked me to wonder about the *feeling* of dispossession. At the registration table was a sign up sheet for those who wished to participate in a nocturnal “*temascal* ritual” (an indigenous healing practice, similar to a sweat lodge), for an extra fee.



Liliana

¹⁵ My translation. <https://nanahtli.wordpress.com/>

¹⁶ For the sake of anonymity, I have changed all of the names of specific individuals.

That night, I searched the hotel where the traditional midwives and professional midwifery students were staying, looking for a few professional midwifery students, friends of mine from earlier research whom I had not seen since they set out to perform their year of social service in different government hospitals across Mexico. The hotel was bursting with guests, and numerous cots were shoved into the rooms. After knocking on what seemed like an endless number of doors, I finally found the right room. The professional midwifery students I was searching for had gone to the *temascal*; their suitemates, traditional midwives, stayed behind.

Curious about the disjuncture between how the *encuentro* had been promoted and its manifest reality, I traveled to the TMID office in Mexico City where I interviewed two planners of government health programs. I asked them to explain the relationship between their published work on “interculturality” and what had unfolded at the *encuentro* they sponsored in Estación Catorce. They did not want to be associated with the event, explaining that while they sponsored the *encuentro*, they were not involved in its planning or execution. Both doctors that I interviewed assured me what I had witnessed is not representative of their work. They have planned and executed more than 50 highly successful Encounters for Mutual Enrichment Between Health Personnel and Traditional Midwives at which traditional midwifery knowledge was “rescued” from the ongoing threat of extinction. I asked when their next *encuentro* will take place, stating I would travel any distance to attend the type of event they described, as it would be very informative for my research. . . . I was told that Encounters for Mutual Enrichment are no longer being planned.

* * *

In this ethnographic sequence, we can observe how subtle processes of gendered racialization surrounding indigenous traditional midwives render them needy recipients of expert knowledge produced by foreigners and mestizo professionals working in urban settings. In *Fit to be Citizens? Public Health and Race in Los Angeles 1879-1939*, Natalia Molina (2006) analyzes the specific mechanisms operating during the first half of the twentieth century in the United States to racialize Mexican immigrants and Mexican Americans. For example, she cites purported lack of knowledge of the English language as a marker, rendering Mexicans uncivilized and inferior to whites in a racial hierarchy socially constructed from positions of power. This kind of logic only worked in one direction; health officials never questioned how their lack of Spanish language skills might have hampered their ability to provide culturally appropriate care. I argue this type of logic, paired with “humanitarian reason,” justify the power differential inherent in all the workshops and *encuentros* I have observed.

Didier Fassin’s 2012 book, *Humanitarian Reason: A Moral History of the Present*, describes humanitarianism as a relatively recent invention resulting from particular ethical constructs, which, in turn, make intervention not only possible but necessary. He is less concerned with bad faith of some and good conscience of others, and more concerned with what is gained and what is lost when a rhetoric of compassion and suffering occurs in lieu of interests and justice, thus legitimizing actions by declaring them humanitarian. He points to domination in the upsurge of compassion—it requires a political asymmetry; it presupposes a relation of inequality.^{iv}

My ethnographic work not only points to the relationship of inequality operating in encounters between government health personnel and traditional midwives, but also how “indigeneity,” “traditionality,” and “nature” are conflated and subsequently commodified/fetichized by nonindigenous “allies” for economic profit. In these settings, the image of “indigeneity” is juxtaposed or overlaid on items or “traditional experiences” for sale,

but indigenous people do not profit from these transactions and often cannot even access the goods that make use of their image. Essentially, I am describing how humanized birth in Mexico is based on rhetoric of shared humanity while not including indigenous peoples; it usurps and reinvents indigenous birthing practices and images. The many contradictions of global humanitarianism, as described by Didier Fassin, are visibly present at the *encuentro* in Estación Catorce:

[Humanitarianism] is both a moral discourse (based on responsibility toward victims) and a political resource (serving specific interests) to justify action taken in the name of shared humanity. Its ambition is thus indivisible (it includes all human beings without distinction of race, class, religion, ideology) but its implementation is always situated (where others are thought to be in need of assistance). (Fassin 2010: 239)

Thus, my work uncovers oppositional forces at work during training workshops like the one described above, and more generally in the humanized birth movement in Mexico: a discursive debate about “humanity” and “humanization of birth” which criticizes the biomedicalization of childbirth and celebrates “traditional” birth practices, and the concurrent commodification of “indigenous medicine” by which non-indigenous individuals consume “indigeneity” while indigenous people are not engaged as equals.

In Mexico, a great deal of political propaganda is being produced around programs meant to provide indigenous populations with culturally-appropriate services, but these programs are often underfunded, if not entirely defunded. For example, while the TMID office is responsible for planning programs related to “intercultural”¹⁷ development and traditional medicine, it does not possess the funding to implement these programs¹⁸. In Mexico’s decentralized health care system, individual state governments are responsible for implementing and funding programs. Even when programs are implemented, they usually lack permanence—lasting only until the next elections. Thus, images of indigenous people, “tradition,” and “nature” lend value to

¹⁷ “Interculturality” is a concept that informs policy in Mexico. It has been deployed by Mexican Secretary of Health in ways that juxtapose allopathic medical services with “traditional indigenous” services, instead of actually integrating them. I have observed on multiple occasions the consistent privileging of allopathic medicine over “traditional indigenous” services offered in disjointed, decontextualized forms. For example, patrons of “traditional indigenous” services are often charged a fee, while allopathic services in government hospitals are always free of charge (resulting in further commodification of “indigeneity” and an upsurge of “traditional medicine” tourism among nonindigenous people while indigenous individuals seek remedies elsewhere). In my opinion, “interculturality” has done little to challenge hegemonic biomedicine, leaving relationships of domination/subordination intact. Further examples will emerge later in the dissertation.

¹⁸ Many individuals, both laypersons and Mexican medical anthropologists alike, would argue that funding for health programs in Mexico not only exists but is plentiful—however, within a context of pervasive corruption, funds are routinely diverted to individuals’ pocketbooks instead of being used to develop programs. In a private exchange with an informant and government health worker, I asked about a specific politician, describing him as “the man who is extorting *Seguro Popular* (Mexico universal health insurance) funds and leaving hospitals in his jurisdiction without medications.” My informant responded, “I don’t know who specifically you are talking about. We all do that! Even me.”

consumer items and political propaganda produced by non-indigenous people in urban settings; however, these items for sale and “intercultural” programs often do not fulfill their intended purpose.¹⁹

My ethnographic observations hark back to *Returns: Becoming Indigenous in the Twenty-First Century*, wherein James Clifford (2013) points to *indigènitude*, a process of rearticulation similar to *négritude*²⁰. As Clifford points out, “*Indigènitude* is sustained through media-disseminated images, including a shared symbolic repertoire (‘the sacred,’ ‘Mother Earth,’ ‘shamanism,’ ‘sovereignty,’ the wisdom of ‘elders,’ stewardship of ‘the land’)” (Clifford 2013:16). Clifford places his work in conversation with Chow’s *Protestant Ethnic and the Spirit of Capitalism* (2002) and Comaroff’s *Ethnicity, Inc.* (2009). Chow and Comaroff link the performance and commodification of ethnic identities to a new regime of cultural production and reception. They argue capitalist globalization encourages differences so long as these differences do not upset the dominant political–economic order. Cultural traditions are preserved as simulacrum, performed in a theater of identities, while ethnicity is produced and commodified in a “global shopping mall of identities” (Clifford 2013:30). This is a realm where ethnicity-for-tourism, folklore as fakelore, and nostalgic “culture” belie neoliberal marketing.

Clifford, however, argues such critiques are all-too-neat, seeing everything as an effect of systemic power. Clifford links the performance and commodification of ethnic identities to a new regime of cultural production and reception^v, however he resists descriptions that portray power as totalizing, and argues instead for dialectical analysis of hegemonic forms and countercurrents. At stake is the issue of agency—people with their own dynamism. This dissertation explores how humanitarian discourse and processes of gendered racialization lead to the commodification of “indigeneity” and the consumption of culture; at the same time, I underline the agentive dynamism of indigenous informants. I add to Clifford’s work by providing complex ethnographic examples that suggest that while unequal power structures are operating in the transnational humanized birth movement, indigenous individuals are also agentive actors who appropriate cards in decks stacked against them.

Through ethnographic examples, I examine the evaluative work on the part of indigenous women to achieve what they consider to be better birth outcomes. My work documents the strategies these women employ when proactively seeking out citizenship-based health services or subversively evading racial discrimination in biomedical settings (see Scott 1985). Building upon Bourgois 2002, I argue that these actions, based on logical responses to an unjust reality, provide

¹⁹ During a seminar I gave on September 10, 2014 at the Center for Superior Research and Studies in Social Anthropology (CIESAS), Mexico City, Alfredo Paulo Maya (co-coordinator of the medical anthropology program at the National Autonomous University of Mexico [UNAM]) argued that “intercultural” programs are exculpation strategies whose true purpose (placating human rights groups by developing programs for which “*indios*” are purported beneficiaries) is routinely and satisfactorily met—thus the continuity of “interculturality” as a political goal over time.

²⁰ Clifford asserts global *indigènitude* is inescapable, and its very existence challenges Western projects of civilization, modernity, and progress. *Indigènitude* deconstructs the opposition of linear and cyclical times in Western etiology: “When these ‘ancient’ traditions are understood to be effectively ‘modern,’ the whole direction of Western historical development wavers.” (Clifford 2013:28) Tradition, Clifford argues (similarly to García Canclini 2009), is an adaptive process and a source of transformation—not practices associated with the past.

dominant sectors of society with further evidence for labeling indigenous women as “backward,” child-endangering irresponsible mothers, and in dire need of humanitarian interventions. Thus, I remain attentive to these women’s limited access to citizenship-based resources and resist the notion of “insurgent citizenship” as, in my opinion, it romanticizes material poverty and exclusionary processes by emphasizing the innovation of people with “differentiated” access to formal citizenship (see Holston 2009).

(Ethno)medical Tourism in Binational Health Policy

In October 2012, I traveled to Oaxaca City, Oaxaca to participate in Binational Health Week, a weeklong policy forum that brought together public health experts and officials from North and Latin America, but primarily from California and the State of Oaxaca. The event drew representatives from academic institutions, such as UC Berkeley School of Public Health and Mexico’s National Council of Science and Technology (CONACYT), public health providers, such as *Seguro Popular* (Mexico’s universal health care coverage) and the Mexican Social Security Institute (IMSS), and international health organizations, such as the World Health Organization and the Pan American Health Organization. While attending the event, I received an invitation from the coordinator of migrant health care for the Oaxaca Secretary of Health to join a group of 11 special guests, mostly Americans, on a day trip to Capulálpam de Méndez, a small indigenous village in the Northern Sierra. I eagerly accepted his invitation.



Mealtime entertainment for binational policy forum attendees.

Capulálpam was named a “*Pueblo Mágico*” in 2008—a designation granted by the Mexico Tourism Board that aims to promote a series of towns across the country by acknowledging their natural beauty, cultural riches, or historical relevance. Upon researching this village online, I read:

The new designation and the healing center were expected to boost tourism. The center, now open, employs traditional healers who provide medicinal plant therapy, massages, *temascal*, and herbal baths. The center has an herbal pharmacy and offers basic training courses about a great variety of medicinal plants. The *temascal* is a type of sweat lodge that gives physical and spiritual purification using the four elements of fire, air, water,

and earth to give relief from the stresses of daily life. Participants may reach a level of consciousness similar to that of meditation.²¹

When we arrived to the intercultural clinic, we were greeted by a Oaxaca State Secretary of Health physician, Arturo. His opening remarks about the clinic prepared us for the ethnomedical tour on which we were about to embark. He explained that traditional medicine is opposed to allopathic biomedicine, which for him is synonymous with European medicine. He argued that Mexicans should strive to preserve traditional medicine, because doing so means defending a shared national heritage.

Immediately striking to me was how the clinic was constructed: although the clinic is described as “*intercultural*,” in actuality, the clinic is divided into two distinct structures, separated by a grassy area. One structure houses the public biomedical clinic, which offers free or near-free medical care (for example, a consultation with a biomedical physician costs ten pesos, or less than one U.S. dollar). Inside the other structure is the traditional medicine clinic, which offers traditional healing treatments for a charge (a five-minute *limpia*²² costs 50 pesos or approximately four dollars, entrance into the *temascal* is 170 pesos or roughly fourteen dollars, and a belly massage to cure *empacho*²³ is 50 pesos). When I inquired about the degree to which biomedical physicians and traditional medicine healers work as a team to treat patients, I was told that the two types of care providers do not “interfere” with each other’s patients or treatments, with one important exception: biomedical physicians act as gate keepers since they perform a physical examination and provide medical permission before patients may partake in the *temascal* ritual.

I listened to Arturo explain the importance of initiatives like this clinic for recuperating traditional and indigenous medical knowledge. He argued that most of this valuable knowledge has been lost due to traditional healers not passing down their wisdom to future generations.²⁴ The visitors and I were escorted into the laboratory and pharmacy in the traditional medicine clinic. In the laboratory, there were 17 clearly labeled boxes, each indicating to visitors the types of herbs on display. Having already performed substantial research among indigenous healers and midwives²⁵, I noticed that the quantities of herbs in the laboratory were insufficient for

²¹ http://en.wikipedia.org/wiki/Capulálpam_de_M%C3%A9ndez

Alyshia Gálvez includes a photo of the center’s *temascal* in her book 2011 *Patient Citizens, Immigrant Mothers* (see page 62). Capulálpam is a part of the Ixtlán de Juárez region, where Gálvez carried out a portion of her ethnographic research (see page 14).

²² A spiritual cleansing, described in greater detail on the next page.

²³ A ethnomedical term that describes instances where food gets lodged somewhere along the digestive tract with detrimental effects for overall well-being.

²⁴ While I argue that “tradition” undergoes constant transformation and negotiation, my ethnographic encounters suggest that a great deal of “traditional knowledge” *is* passed down from one generation to the next; however, this transmission is not recognized by state officials since it occurs outside of the realm of Foucault’s (1973) “medical gaze.”

²⁵ Later in this chapter I will describe some of my interactions with traditional midwives and healers who were key informants throughout my research. During extended stays in their homes, I learned about their traditional medicine practices through participant-observation. I joined these informants on shopping trips to buy supplies for creating traditional remedies, watched as they prepared teas and gave massages, listened to their methods for making tinctures and balms, read

producing remedies, prompting me to ask myself if their primary purpose in the “traditional laboratory” was to be seen, but not used.

I also noticed that a number of herbs commonly used by indigenous healers were not represented among the specimens laid out on display—*sangregado*, *hierba del sapo*, *ajenjo*, *epazote*, *eucalipto* . . . We were then ushered into the room where limpieas are performed, and two types of herbs were laid out on the ground, but *pirul*, the herb most commonly used for limpieas, was conspicuously absent. Limpieas are rituals that rid individuals of harmful energies—burning incense, rubbing an uncooked egg on the individual’s skin to draw out negativity, spitting *mezcal* in order to cover the afflicted with an antiseptic mist, and sweeping their body with cleansing herbs are regular components of this ritual. As I wondered to myself how traditional healing was carried out without basic herbal ingredients, I had a feeling that I was in a showroom. Were we being interpellated as consumers in a simulacrum of “traditional medicine”? We were then guided into the “pharmacy” where the members of the group began exuberantly purchasing herbal balms and shampoos.



Medicinal plants on display in the laboratory.

their hand-written recipes, went on countryside walks to gather fresh herbs, and was at times the recipient of their expert care.



Herbal balms and shampoos for sale in the pharmacy.

During our visit, there were no patients at the clinic. While the rest of the group admired the installations, I stealthily escaped from the tour. I wondered what members of the community thought about the clinic. I walked to a wooden cabin nearby—the home of an indigenous family that also served as a snack bar (selling gum, sweets, potato chips, and soda) for local villagers. The snack bar attendant, María del Rosario, and a patron were at the cabin when I arrived. I asked them why there were no patients at the clinic. They explained that while there is a doctor and a nurse assigned to the clinic, the doctor is often away in the town of Ixtlán, and the nurse has been gone for several days attending a workshop. I asked María del Rosario if many people visit the clinic. She responded, “*Sí vienen, mucha gente viene. Mucha gente vienen para el turismo.*” (“Yes they come, a lot of people come. A lot of people come for tourism.”)

She went on to say that the traditional medicine clinic built by the Secretary of Health is not necessary because, for many common ailments, villagers possess enough traditional knowledge to heal themselves with herbs in their own homes. “*Cada madre tiene su propia forma de curar sus nenes.*” (“Each mother has her own way of curing her babies.”) While her comments are perfectly aligned with Eduardo L. Menéndez’s observations about *autoatención* (all the health care seeking, decision-making, and healing that take place in multitudinous settings beyond the clinic that often go unnoticed by health officials since they unfold prior to encounters with physicians and medical institutions, and often render would-be encounters unnecessary [Menéndez 1983]), they contradict the Secretary of Health representative’s

assertions that traditional medical knowledge has been lost and must be recuperated and preserved through government interventions which defend Mexico's national heritage. María del Rosario further explained that when her children have an ailment that she is unable to cure herself, she takes them to the *curandera* (the local traditional medicine midwife) who provides three treatments for 100 pesos²⁶.

After leaving María del Rosario's shack, I walked a little farther down the path and ran into a young man, Francisco, whom I asked about his experiences at the clinic. Francisco told me he had inquired about the midwifery services in the traditional medicine clinic before his wife's recent birth, but was told the midwife was only present a few hours on specific mornings. When his wife went into labor, Francisco rushed to the clinic, only to find that neither the physician nor the midwife was present. He made arrangements to transport his wife to the hospital in Ixtlán as swiftly as possible, where she had a biomedicalized birth.

After these brief conversations, I returned to the group at the intercultural clinic. As far as I could tell, my brief absence had gone unnoticed.

Consuming Indigeneity: A High Priced Commodity

In this chapter, I am applying theories of cultural consumption to the object of my ethnographic inquiry: the reinvention and commodification of present-day Mexican midwifery. I am documenting how indigenous midwives are excluded and denied professional status while their "traditional" cultural practices are pirated, lionized, romanticized, and sold for profit by affluent urban Mexicans and by international practitioners in humanized birth^{vi} circles. What humanized birth proponents describe as an international feminist liberation for educated women is based in the exploitation of cultural–intellectual property rights (traditional midwifery) and the reproduction of inequality in Mexico, as the indigenous practitioners of these birthing arts and practices are prevented from practicing them in Mexican hospitals. While I have observed indigenous midwives defy government restrictions, challenge biomedical authority in hospital settings, and attempt to market their traditional knowledge by forming their own association and opening a shared clinical practice, these examples of resistance emerge within a context of power and political economy that, more often than not, capitalizes on images of indigeneity while obscuring the lives, experiences, and opinions of indigenous people. Furthermore, the diverse methods indigenous midwives use to attend births are not equitably included by members of the humanized birth community under the rubric of humanized birth, since they are relegated to the realm of traditional medicine from which humanized birth draws, then improves and develops.

Essentially, I am describing how humanized birth in Mexico is unfolding with a rhetoric of shared humanity while using and commodifying, indeed, dismembering, and reassembling indigenous birthing practices and images for economic profit. Thus, my work uncovers oppositional forces at work during training workshops like the one described in the introduction, and more generally in the humanized birth movement in Mexico: a discursive debate about the humanization of birth which criticizes the biomedicalization of childbirth and celebrates "traditional" birth practices, and the simultaneous commodification of "indigenous medicine" by which nonindigenous individuals consume "indigeneity" while indigenous people are excluded.

²⁶ For more on the experiences of modern-day curanderos in Mexico, see Campos Navarro 1997.

Portraying Indigeneity: Politics of Representation

When writing about the relationship between genetic molecular sequences and key historical events, Tallbear writes, “Native American DNA could not have emerged as an object of scientific research and genealogical desire until individuals and groups emerged as ‘Native American’ in the course of colonial history” (Tallbear 2013:5). That is to say, the pan-racial group defined as “Native American” does not exist except through opposition with “settlers.” Furthermore, the very grouping of humans into “races” is predicated on the notion of purity and the idea of original populations—it therefore “tells a story from the standpoint of those who did the encountering” (Tallbear 2013:5). Importantly, these “scientific” narratives represent a type of knowledge that is made to matter more than others, rescripting what is historically salient, and potentially defining what is politically salient. Thus, Tallbear emphasizes real material consequences: “Native American DNA is material-semiotic” (Tallbear 2013:7). In essence, Tallbear is science and technology studies methodology to argue that natural and social orders are coproduced—in this case, the social and genetic categories of “indigeneity.” She refers to Clifford’s 2001 notion of “articulation” to hold dynamism and transformative elements of cultural practices and identity formation under the same lens as potentially harmful effects of power.

Despite persistent evidence of marginalization of indigenous peoples and examples of profit-seeking around constructed images of indigeneity, I am attentive to Clifford’s point about dynamism (see Clifford 2001 and 2013)—I am careful not to deny indigenous informants and friends of their agency by portraying them *only* as victims. Thus, I am concerned not only with how indigeneity is portrayed by non-indigenous ethnomedicine enthusiasts, but how indigenous individuals portray their own ethnic identities. I suggest that while indigenous people have suffered from centuries-long structural violence, they have also devised strategies for leveraging their indigeneity and, at times, view their indigenous heritage as a source of pride. My perspective does not sanitize the effects of violence and long-standing exclusion, nor does it diminish the agency and dynamism of indigenous individuals; rather, I aim to cast indigenous informants as agentive, proactive people who experience their indigeneity both as a source of marginalization and also as a valuable resource.

In this chapter, I am pointing to “indigeneity” as something that is produced, circulated, and sold. I am not arguing that there is one, singular “indigenous culture” that encapsulates all indigenous people. I recognize there are many ways of being indigenous; simultaneously, I point to how “indigeneity” and “indigenous culture” are constructed as objects of consumption, thus erasing diversity among indigenous peoples. Through ethnographic research, I documented how “indigeneity” becomes a consumer item, especially through “indigenous” medicine. In this dissertation, my use of the terms “indigenous women” and “indigenous people” refers to individuals who self-identify as indigenous, speak indigenous languages, or live in rural, indigenous zones. The indigenous people with whom I worked are from the following ethnic groups: Tlapaneco, Mixteco, Huasteco (Tének), Nahua, Tzotzil, Tzeltal, Maya, and Purépecha.

A primary goal of this chapter is to provide several examples to illustrate the complex politics of representation of indigeneity. In addition to constructed representations of traditional and indigenous medicine that unfolded when I visited the intercultural clinic in Oaxaca, I have, on different occasions throughout my ethnographic research, observed how indigenous individuals perform their “indigeneity” for foreigners and transnationals. At times, it seemed that indigenous informants enjoyed ritualized representations of their indigeneity—that their indigeneity was a source of pride and a resource to be strategically employed to achieve desired

outcomes. Other times, indigeneity seemed to be a liability, and indigenous informants made concerted efforts to portray themselves as “modern” individuals who practice Western techniques. Finally, in some instances, indigenous informants felt used for their indigenous appearance, fetishized as an image of indigeneity, and coerced into acting and speaking according to the interests of non-indigenous others.

* * *

During summer 2011, I volunteered and performed participant observation at Center for the Adolescents of San Miguel de Allende (CASA). In July I was invited by Sagrario Villareal, general director at the time, to participate in field practice in Veracruz—a two-week trip wherein professional midwifery students gave workshops to traditional midwives in government hospitals and subsequently joined them in their homes to continue the “exchange”²⁷ of knowledge.

I accompanied a professional midwifery student, Francisca, to the Nahua village of Zacatochin where we observed Doña Eugenia, a well-respected traditional midwife. This tiny village in the mountains is the farthest I have been from the conveniences of urban life. Zacatochin is perched high above the clouds, leading to a feeling of isolation from the nearest town, located a 45-minute windy drive down the mountain. Water is pumped once a week to a public spout in the center of the village and, on this day, women dressed in traditional blouses and *batas* (heavy, black wool wrapped from women’s bellies to their ankles and tied with colorful silk cloth at the waist) gather to wash laundry. Nahua women and their families travel long distances, as far as from the other side of the Orizaba volcano, to give birth with Doña Eugenia—her use of traditional herbs commingled with biomedical techniques like application of an IV drip appeal to women who want the security of giving birth with someone possessing biomedical knowledge, the comfort of laboring with the support of a woman who has learned generations of traditional healing techniques, and the safety of knowing they will not be discriminated or mistreated while delivering their baby. Doña Eugenia is an example of hybridity—someone who enters and exits modernity with ease (García Canclini 2009)²⁸. Her work throws into question portrayals of “traditionality” and “traditional midwives” as frozen in some prior time, exempt from transformative processes that occur in “the outside world.”

One night, I observed Doña Eugenia attend two simultaneous births. A 20-year-old, María Elena, was giving birth to her first child in the living room of Doña Eugenia’s home-clinic, while a second woman, Juana, was birthing in Doña Eugenia’s bedroom. I witnessed the entire evolution of María Elena’s birth: María Elena’s arrival with a horde of family members in tow, Doña Eugenia direction of the extended family to the patio while only María Elena’s husband accompanied her during the birth, the moment Doña Eugenia examined the shape of María Elena’s belly and predicted a female child, the second when the baby girl emerged from

²⁷ While the purpose of the field practice is to engage in bilateral exchange of knowledge, I observed a mostly unilateral flow of knowledge from “knowing” professional midwifery students (most of whom were only beginning to attend births or were totally lacking in experience) and “unknowing” traditional midwives.

²⁸ In Chapter 5, I deconstruct the “traditionality”–“modernity” binary, thus problematizing the idea of hybrid subjects who move between the two temporal frameworks. Also, I am attentive to the ways in which “hybridity” has been used only to describe “subalterns” and to the concerns some scholars have about this concept being inherently racist. However, for the time being, I am referring to García Canclini 2009 to begin to trouble the idea that “traditional” midwives are antiquated subjects whose practices are necessarily rooted in the past.

her mother's vagina, wailing and filling her strong lungs with oxygen for the first time, the minutes when Doña Eugenia massaged the mother's belly to encourage the placenta to detach from the uterine wall, and the wordless entrusting of the plastic-bagged placenta to María Elena so she can bury it close to her home.

I did not witness Juana's birth as she was uncomfortable with my presence, and I respected her wishes. Since only a curtain covers the passageway to Doña Eugenia's bedroom, I heard the birthing while waiting outside. Later, I asked Doña Eugenia to describe the birth, and she did so with an air of formality, as if presenting a case at medical grand rounds before an attending physician. I wondered to myself as she spoke, did I represent an authority figure in her eyes?

During the night she hardly had any pain, only the mucus plug. It was very slow and I thought they would have to go to the hospital. After, she started to have more pain, and at five in the morning I checked her dilation and she was at two centimeters. I told her it would be better for us to go to the hospital, but she said no—she wanted to wait a little longer. I conceded since they have a truck and I knew we could still go to the hospital later. At eight in the morning she started to have regular contractions, her water broke, and she bled a little—all normal signs her cervix was opening. At 8:50 I performed a vaginal exam, and it was definitive we were going to stay; she was completely dilated. At 9:06 a baby girl was born. I moved the [umbilical cord] a tiny bit, encouraging the placenta to come out, and the placenta came out on its own. The bleeding was normal; she bled a little. I suctioned [the baby's] phlegm immediately. The baby has good coloring, good movements, very active movements. The baby cried. After, I was orienting [the mother], encouraging her and stimulating her to breastfeed. Then, the mother and child stayed together. I dried her vaginal area, changed her sheets, and placed the baby girl with her mother. The mother is content, happy, conversing, and laughing. She is content because she didn't go to the hospital, and since the beginning she said she didn't want to go to the hospital. . . . She is around 34 years old and says this will be her last child.

(Spoken report of Doña Eugenia on July 9, 2011)

The spoken report Doña Eugenia gave is striking because of the performative element that was evident to me even as it was occurring. Juana has quite a few white hairs, and I suspect she is in her forties, but Doña Eugenia told me she is “around 34” since medical guidelines stipulate that births in women 35 and older are high risk and must be referred to the hospital. Furthermore, Doña Eugenia systematically demonstrated she had done everything as instructed in workshops: she monitored Juana's dilation and bleeding, ensured there was viable transport to the hospital, successfully prevented hemorrhage, cleared the baby's airway, checked the baby's well-being, helped the mother with breastfeeding, was careful not to separate mother and child—and all this in a hygienic environment!

Her use of the medical case presentation method is evidence of her experience working in biomedical contexts, thus disrupting definitions of what it means to be “traditional” versus biomedical and humanized. Furthermore, the “objectivity” of the case presentation format serves multiple purposes: by presenting the births in this way, Doña Eugenia frames herself as a medically appropriate birth attendant, while also implying that her intention was to refer the birth to the hospital. In doing so, Doña Eugenia portrayed herself as both capable of independently attending birth and obedient to government mandates. However, what is missing from her report

is just as important as the operative functions of what she chooses to include. At the very end of the report, Doña Eugenia acknowledges that Juana never wanted to go to the hospital, before pausing and briefly reflecting on what to say next. She quickly concludes by saying that Juana is about thirty-four years old. Doña Eugenia (accidentally?) admitted that Juana did not plan to go to the hospital and that Doña Eugenia permitted Juana's will to be fulfilled—against the stipulations placed on mothers by *Oportunidades*. This birth is recorded in the official registers as having occurred in Juana's home, without the help of a birth attendant. Indigenous women in the region must give birth in the government hospital, or else lose their conditional cash transfers. Midwives are ordered not to attend the births of women thirty-five and over since these women are at additional risk for maternal mortality. Doña Eugenia's assertion that Juana is "around 34" is significant since she is again ameliorating the disobedience to government mandates that could be associated with her involvement in Juana's birth. I can only speculate about Juana's exact age given her wisened face and grey hairs, but what interests me more is the context within which women weigh reproductive decisions, sometimes leading them to make choices that are deemed "risky" and "dangerous" by the biomedical system and the Mexican government.

I returned the next summer, and the next. Along with my visits, I began forming a friendship with Doña Eugenia through letters and phone calls. She began to see me as her apprentice, and over time I earned her trust. After many intimate conversations, I asked Doña Eugenia to sit for a formal, video-recorded interview. I explained to her that this footage could potentially be edited into an ethnographic film and used to demonstrate the work of traditional midwives to American anthropology students and conference attendees. She acquiesced, on one condition: that I not start the video camera until she had finished dressing herself in her traditional indigenous attire, put on her best jewelry, and combed her hair. I agreed. Doña Eugenia is among the few women in the village who does not wear indigenous attire on a daily basis. I gazed curiously at her slow and deliberate movements while she searched among several plastic bags, until she finally selected the traditional blouse she wanted to wear while being filmed. She folded the pleats in her *bata* (a large piece of black wool cloth that is worn as a skirt) and straightened out the lace and ribbons on her blouse ever so carefully, in a methodical, almost ritualistic fashion²⁹.

Her purposefulness caused me to reflect on Clifford's assertion that, "media images can lapse into self-stereotyping. And they express a transformative renewal of attachments to culture and place. It is difficult to know, sometimes even for participants, how much of the performance of identity reflects deep belief, how much a tactical presentation of self." (Clifford 2013:16) Why was it so important for Doña Eugenia to be seen by imagined foreigners in indigenous clothing when she wears Western clothing—long sleeve sweaters, button-down shirts, long jean skirts—in her everyday life? Was this ritual production for foreign consumption? On the other hand, considering that many indigenous women in her village *do* wear traditional clothing on a daily basis, what does it mean for Doña Eugenia to wear Western clothing in most situations, and especially when going on shopping trips into town and during interactions with midwifery patients and staff at the village clinic? Moments like these have led me to believe that

²⁹ It struck me that while different informants make concerted efforts to portray themselves in ways that meet disparate goals, the politics of representation at play in this scene are not too far afield from a doctor putting on the emblematic white coat.

“presentations of self in everyday life” (see Goffman 1959; Hendrickson 1995) are based on a syncretic and situational sense of identity/identities.



Doña Eugenia

Leveraging Syncretic Identities

Don Israel self-identifies as a “traditional doctor” and “midhusband” (*médico tradicional y partero*). He is one of the few men that attend birth in the High Mountains of Veracruz, but his gender has not limited his clientele. He is well-regarded for his extensive knowledge of herbal remedies and leads an indigenous organization of traditional doctors. He and other members of the organization have formed a rotation for running the organization’s secluded clinic in the mountains—each participating traditional doctor works at the clinic one day a week.



Center for the Development of Traditional Indigenous Medicine

I first heard about the traditional medicine clinic that Don Israel leads when I was staying with a Doña Agustina during my first visit to Zacatochin. Doña Agustina is an empirically trained traditional midwife who, when compared to Doña Eugenia and Don Israel, has not received many biomedically-oriented trainings and certifications led by government workers in clinical settings. Doña Agustina holds Don Israel in high regard and considers him to be the most knowledgeable traditional doctor in the region. On one misty afternoon, she took me on an excursion to visit his clinic. I sat with her sons in the bed of their old truck while her husband drove, and whenever we encountered a hill, her sons would jump out to push the truck up the incline. At the clinic, I observed that the “laboratory” for preparing herbal remedies was bare, the traditionally-designed *temascal* had fallen into disuse, and while two traditional massage therapists (*sobadoras*) were present, the clinic had no clients. Since Don Israel was absent at the

clinic during our visit, we traveled to his house a few days later, traveling by collective taxi and bus before hitchhiking and walking on foot.



Temascal

When we arrived, Don Israel graciously invited us into his home. The outside structure is comprised of wood boards, but once inside, his family living space surrounds an inner courtyard. At the center of his courtyard is a port-a-potty—a more convenient alternative to the outhouses on stilts that are common in the region³⁰. When I explained to him that I was eager to learn about his practice of traditional medicine, his eyes lit up. He told me about the many trainings and certifications he has received, and his collaborations with the government health sector, researchers at the state university, and chemical supply companies. As he spoke, he showed me certificates, photos of moments when he had been recognized, and book publications for which he had shared his knowledge. During the entire visit, Doña Agustina’s admiration of Don Israel’s talents was apparent. I wanted to know more about Don Israel’s interactions with the different “knowledge-producing” bodies he described, so I made a commitment to return and continue our conversation on a different visit.

³⁰ An example of how traditional medicine practitioners make use of “modern” apparatuses in their everyday lives, thus disrupting notions that representatives of “tradition” make their lives out in a distinct time register from those living in metropolises.



Don Israel

The relationship between Doña Agustina and Doña Eugenia is also characterized by respect, but with an undertone of rivalry, since these two are close neighbors and attend overlapping clientele. On one occasion, Doña Agustina was openly critical to me about Doña Eugenia, saying that the ability to attend a birth is a gift from God that should not be exploited for financial gain. Doña Eugenia charges many times Doña Agustina’s fee for attending a birth—in part because she considers it her responsibility as a midwife to teach couples to value each child they bring into the world, because she feels she should be compensated for her time and work, and because of the high demand for her services. Over time, Doña Eugenia has built a home-clinic out of “expensive” materials (cement and glass-paned windows) with areas for several women to give birth at a time, plus a patio area that functions as a waiting room. Her home-clinic stands alongside the wooden shack where she used to live, where Doña Eugenia still has her kitchen, out house, and bathing area; which in turn is attached to the store where she sells snacks and soda pop. Doña Agustina considers Doña Eugenia to be “enterprising”—her family manages with a more meager budget, derived mostly from her sons’ and husband’s carpentry.



Doña Agustina giving a “sobada” (traditional massage)

I returned to the region where Don Israel and Doña Eugenia live several times over the course of my field work. My relationship with both of them deepened with time despite them both being unable to receive phone calls in their homes. I wrote them both letters which, due to irregular postal service in the Mexican countryside, often took weeks or months to arrive. When they went shopping in the nearest town they would take advantage of the rare opportunity to call me. As soon as I received their phone calls I would return the call to the number from which they were dialing. Both asked me to purchase things for them that they are unable to buy in their area— Doña Eugenia asked me to bring her a pair of gold earrings and Don Israel requested a digital camera. On one occasion, Don Israel and I traveled together to Mexico City to buy materials for making herbal remedies. Over the years, we gave each other many gifts: for

example, Doña Eugenia gave me one of her *batas* and I gave her an embroidered satin blouse from San Miguel. On my trips to Veracruz, I would usually stay the majority of the time with Doña Eugenia and her family in Zacatochin, and upon my departure, she would cry and I comforted her by telling her that I would return soon for another visit.



Having a cup of hot chocolate in the kitchen before bedtime.



After a baptism at which Doña Eugenia was “la madrina” (godmother)

My experiences with Don Israel and Doña Eugenia point to the mutual imbrication of agentive representations of self and commodification of culture. Don Israel was proud of the many certifications and trainings he had received. Furthermore, his having been recognized in governmental, biomedical, and university settings led to him enjoying a higher regard among clients and fellow traditional medicine practitioners and birth attendants.

However, despite his track-record of ongoing recognition, Don Israel has stopped attending birth because he is wary of the consequences that would befall him in the case of a negative birth outcome. He follows the guidelines he has been taught in the trainings, which dictate that he refer birthing mothers to the government hospital. Furthermore, he pondered aloud to me about an apparent increase in ethnomedical tourism. Commenting on poorly designed *temascals* reflecting a lack of understanding about traditional medicine and the therapeutical mechanism that facilitates healing, Don Israel asked why his authentically constructed *temascal* lacked visitors. How could he attract more visitors? He considered putting up a sign on the road directing people to the *temascal* and offering courses on herbalism to the general public in hopes that this would attract more visitors to the clinic.

Although he is no longer attending births and his clinic is under frequented, Don Israel leverages his identity as a regional leader of traditional medicine in a way that is generally satisfying to him. It could be argued that he is an example of someone who uses politics of representation mostly in his favor. However, the opposite argument could also be made: I witnessed moments when Don Israel was treated rudely by nonindigenous individuals. When we went shopping in Mexico City, he asked the clerk for a clarification about the difference in concentration between two types of oils and their appropriate uses. The shop clerk signed loudly and was curt with him and he reacted to her scolding tone by gazing down at the floor, placing his chin in his hand. I wondered about this interaction: had racial discrimination come into play? Throughout the day I noticed how unfamiliar Don Israel was with the metropolitan surroundings. Was the shop clerk's harsh response related to Don Israel being a rural, indigenous, elderly man? When we emerged to sidewalk, I made a remark about the shop clerk's rude behavior. He responded, "People who act like that are just unhappy. We should pray for their happiness."

As time passed and I began asking Don Israel for more details about his interactions with university researchers, chemical supply companies, and the Mexican government, I began asking myself if he was unknowingly being taken advantage of. While his group of traditional doctors shared their knowledge with the Mexican Institute of Social Security from which an extensive herbal manual was published, his name does not appear in the publication nor does he receive royalties for the book. Furthermore, he has shared his knowledge of *sangregado*, *Santa María* and a few other herbs common to traditional medicine with the researchers at the state university who in turn are partnering with a chemical supply company to commercialize the herb and develop balms, tinctures, shampoos, and soaps. When I interviewed him about this project, he explained that the researchers were engaging in legal patent procedures involving the notary public and the Public Ministry³¹.

³¹ I did not have the opportunity to interview the individuals who were patenting herbal remedies based on Don Israel's traditional medicine knowledge. However, one example of a pharmaceutical company that relies on ethnobotany to produce and market new prescription drugs is Shaman Pharmaceuticals, Inc.—a company that was started by Lisa Conte, who at the time was an analyst covering biotechnology companies for a venture capital firm in San Mateo, CA.

A year later, I returned to visit him. In the interim his wife's leg had to be amputated due to advanced diabetes and he had been hospitalized as the result of debilitating leg cramps. The couple was unable to pay mounting debt from hospital bills and were sporadically going hungry. We went to town and after we sat down together to enjoy a meal, I ordered an extra roasted chicken for his family. Don Israel asserted that he only shared his traditional medicine knowledge with university researchers to protect himself from being exploited. As an academic, I know that not everything that is researched in academic settings is solely motivated by "the pursuit of knowledge." While Don Israel derives a positive sense of self-worth when he is consulted and asked to share his knowledge on traditional medicine, I am concerned about biopiracy and wonder about the economic profit that may be resulting for the individuals with whom he shares his knowledge. By simultaneously pointing to the pride that Don Israel derives from sharing his traditional medicine practices, and also the potential exploitation and biopiracy of his ethnomedical knowledge, I am problematizing the binary nature upon which opposing notions of victims and agents are premised. I argue that binary representations are insufficient for the complex reality of how individuals' cultural pride is infused with potential exploitation, and how entrepreneurship unfolds on the edge of uncertainty.

Doña Eugenia's case is perhaps less extreme. She seeks recognition mostly from within her own community and from the staff members at the IMSS clinic in her village. She does not derive a sense of pride from accumulating certificates. In the past she was employed by the local government as a community health worker, but she was underpaid and soon realized that the work limited her from dedicating herself fully to the more rewarding task of midwifery. For similar reasons, Doña Eugenia declined participating in Don Israel's indigenous organization of traditional doctors. She explained to him that with so many pregnant and birthing mothers under her watch, she simply did not have time to travel away from her home. These decisions demonstrate how much Doña Eugenia values her skills as a midwife and how protective she is of her indigenous knowledge. However, Doña Eugenia's relative success depends on a delicate balance: her harmonious relationship with the village physician who turns a blind eye to her midwifery practice, her recognition among local mothers but "invisibility" to government officials, and continued luck with respect to birth outcomes. While Doña Eugenia is a very skillful midwife, all it would take is one negative birth outcome for this delicate balance to come crashing down. She is very aware of the risks she faces and she conscientiously manages how she is perceived (or not perceived) by others, but she is constantly teetering on the edge of uncertainty. How long will it last?

When I asked Doña Eugenia for a formal interview, she exuded a sense of pride as she performed her "indigeneity" for imagined nonindigenous spectators; however, other of my informants have been forced to enact their "indigenous" identity in a way that causes them to feel used and silenced. For example, Mayra, the only indigenous student at the Center for the Adolescents of San Miguel de Allende (CASA) Professional Midwifery School at the time, was asked to join two CASA directors on a trip to Canada for the Midwifery Association of North America annual meeting. Upon returning from Canada, Mayra came to my house for lunch and shared with me her impressions of the trip. As she began speaking, I was surprised by her lack of excitement, as I had assumed that she would be bursting with enthusiasm after her first international travel experience. While I prepared fish and red rice, she described to me how every time someone spoke to her at the conference, the two directors were immediately at her side, demanding to know the details of the interchange. "What did they ask you? What did you say?" She felt like she was being treated as an object of constant surveillance. Sitting on a stool

at my kitchen counter, Mayra pondered aloud about the school administration's choice to take her on the trip out of all the girls in her graduating class. Then it dawned on her that she represented something of value, and that this value lies in her indigeneity. The school directors told her not to say anything to anyone—the person designated to speak was Evelyn, an attractive American woman with blue eyes and auburn hair, a certified midwife, a Brown University graduate, and CASA's clinical director. Mayra explained how her strikingly indigenous physical appearance was what interested the other midwives at the conference—not her perspective or her experiences. She complained that in Canada, she felt like “a poster”—an image at which others are meant to ogle—and living, breathing, fleshy evidence that CASA's model targets indigenous women. Furthermore, as a living image, she was meant to be seen but not heard, and her every word incited fear and anxiety from her school directors, as if at any moment she would commit an error, thus tearing apart the image they were so carefully depicting.

Conclusion

My multi-sited ethnographic fieldwork on the humanized birth movement sought to trace the emergence of a global “cathedral of consumption,” buttressed by the re-enchantment of a transnational community by the most natural of physiological acts: nonmedicalized birth (see Ritzer 2001). In my work, Sidney Mintz' (1985) question of how something that previously did not exist within a population's imaginary is transformed through the engineering of desire into something elemental to the everyday life of the masses comes full circle. How does a bodily practice as foundational to humanity as eating and having sex become alienated from our physiological repertoire, only to then be commodified and reintroduced into society as a fetish that deepens unequal power relations between the “haves” from the “have nots?”

Michael Billig, a social psychologist whose work is foundational to the social identity approach, elaborates on the psychology of consumer capitalism by linking commodity fetishism to repression (see Billig 1999). That is, his work harks back to Marx's assertion that in capitalist life the productive origins of commodities are routinely forgotten; thus, commodities contain an implicit psychology of collective amnesia. Turning to commodity fetishism, Billig argues that the pleasures of consumption would be significantly diminished by an awareness of the productive origins of consumer goods. Billig suggests that the collective forgetfulness embedded in consumerism is, psychologically speaking, a form of social repression.

What ethnographic research on the humanized birth movement offers is a way of thinking about inequality embedded in the consumption of biological and medical goods, and divergent identities that emerge based upon the conspicuousness³² or absence of consumption. I am signaling the collective amnesia that permits inequity to operate within the realm of health care provision. Furthermore, I am drawing attention to the *adverted gaze* that makes the exploitation of others—for example, the ethnomedical piracy described in this chapter—not only possible but also real. What the humanized birth movement unfolding in Mexico affords is an example of how gender-racialized indigenous others can be excluded and dispossessed in the name of humanization, and the subtle processes that allow for this increased marginalization to occur. If individuals were to gaze directly at the fetishized commodity—the origins of images of indigeneity and the effects of ethnomedical piracy on indigenous people—the façade upon which the very life of the fetishized commodity is premised would come crashing down. The questions linger: How much effort is involved in maintaining an adverted gaze? How much intention is

³² Here I am referring to Veblen's notion of “conspicuous consumption.” See Veblen 2006.

embedded in inattention? How much should individuals be held morally accountable for the direct and indirect consequences of gazing elsewhere?

Nancy Scheper-Hughes and Loïc Wacquant's edited volume, *Commodifying Bodies*, explores how bodies increasingly enter into global market exchanges. While Scheper-Hughes and Wacquant are directing attention to the body-turned-merchandise, the concept of bioconsumer citizenship and the example of midwifery in Mexico examine gender-racialized identities-turned-merchandise, with real effects for the bodies of women. In Scheper-Hughes and Wacquant's volume, commodification of the body results in alienation of the self, while in this present chapter, the commodification of others' (imagined) "selves" can lead to their increased exclusion and dispossession. Instead of exploring the political economy of the body under contemporary global capitalism, I have used a transnational context to analyze the political economy of identities vis-à-vis the body.

In the introduction to this dissertation, I used ethnographic observations to illuminate how the humanized birth movement in Mexico is linked to a transnational community of consumption oriented toward "traditional midwifery," and natural, home, and water birth. This chapter has shown that consequently a transnational market for "natural" and "traditional" birth-related products and services emerge around the image of the indigenous woman, while indigenous people are increasingly excluded, marginalized, and dispossessed. "Traditional birth" not only represents the consumption of "indigenous" culture—rather, it is a salient example of ethnomedical piracy and how "indigeneity" is sought through reproduction and health.

In the rest of the dissertation, I will explore how inclusion in consumption-oriented communities is a primary way elites construct identities and how re-enchantment of a transnational community by nonmedicalized birth is deepening unequal power relations between the "haves" and the "have nots." In chapter three, I will use the humanized birth movement to explore how a political moral economy emerges around the particular bodily practices of people who possess cultural capital on a transnational scale. Chapters four and five adds complexity to the story by describing how gender, race, and class intersect and are mutually imbricated: that is, among gendered individuals, race does the work of class *and* class does the work of race. In Chapter six, I turn to the concept of "medical migration" to argue that members of the humanized birth movement participate in New Age practices that conflate "traditionality" with "nature" and "indigeneity." I point to how health (in this case, ethnomedicine) has become a commodity instead of an entitlement in our neoliberal age, thus producing both mobile supranationals and immobile individuals seeking citizenship through public services. I will describe both the physical and social (im)mobilities that emerge to the fore in the realm of (ethno)medical migrations.

HUMANIZED BIRTH: UNFORESEEN POLITICS OF PARENTING

Chapter Three

“Humanized birth” (*parto humanizado*) is usually used in Mexico and elsewhere in Latin America to describe birth that purposefully resists medicalization and technocratic practices (see Davis-Floyd 1992). This movement is preceded by the home and water birth movements in the United States, Canada, and Western Europe. Births are often attended by professional midwives (although some obstetricians have joined the movement) and accompanied by doulas. Generally, proponents of humanized birth criticize power inequality inherent in physician–patient relationships and denounce medicalized practices such as unnecessary cesarean sections, episiotomies, isolation of birthing mothers in hospital labor and delivery areas, labor induction, the use of hormones such as pitocin, and repetitive insertion of medical personnel’s fingers into women’s vaginas to assess dilation.

However, some informants expressed a more nuanced definition of humanized birth, explaining that a highly medicalized birth can be considered “humanized” if the interventions were medically necessary and/or if the interventions were chosen by the birthing mother. Given socioeconomic and race-based disparities across Mexico, I question uncritical notions of “free choice.” In the last chapter, I pointed to the multiple ways humanized birth lapses into (ethno)medical tourism and the commodification of indigenous “others.” While I resisted reducing indigenous medicine practitioners and traditional midwives to helpless victims and highlighted the agentive ways they self-confidently leverage “indigeneity” in their favor, I also attended to the political economy of humanized birth that constrains their equitable inclusion. In this chapter, I take my analysis a step further: I analyze not only the limited agency of indigenous “others” within transnational, consumption-oriented, humanized birth circles, but also how the very definitions of what constitutes a humanized birth limits participants’ choices even whilst celebrating “choice” as a central tenet of humanized birth ideology.

Definitions of “Humanized Birth”

According to a presentation given by Dr. Alejandro Almaguer, Director of Traditional Medicine and Intercultural Development within the Mexican Secretary of Health, the goal of humanized birth is “that women, their children, and their families live the experience as a special and pleasant moment, in conditions of human dignity, in which the woman is the protagonist of her birth”³³. Doctor Almaguer identifies the essential elements of this birth model to be: a vertical birth position, psychoaffective accompaniment throughout labor, massage, skin-to-skin contact between newborn and mother, breast feeding immediately after the birth, demedicalization of the birth to the extent possible, prevention of the abuse and overutilization of technology, and above all, the respect of women and their decision-making.³⁴

³³ While in latter parts of the dissertation I will problematize the assumption that humanized birth is synonymous with “traditional” and “intercultural” practices, within the national offices of the Secretary of Health, humanized birth is a “traditional” and “intercultural” matter.

³⁴ Information in this paragraph was taken from a PowerPoint presentation Dr. Almaguer posted online: “Modelo de Atención Intercultural a las Mujeres en el Embarazo, Parto y Puerperio, con Perspectiva de Género.” <http://cidem-ac.org/maternidad/wp-content/uploads/2012/07/PP.-Dr.-Alejandro-Almaguer-G..pdf>

Similarly, the website of a humanized birth organization in Oaxaca explains, “the humanized attention of birth is rooted in the value placed on the affective-emotional world of the people involved, and in the desires and needs of its protagonists: mother, father, infant daughter or son. It is based in the freedom and right of mothers and of couples to make decisions about where, how, and with whom to give birth, in one of the most important moments of their life.” The principles of humanized birth are respect of human and reproductive rights; respect of culture, rituals, and ancestral knowledge; and a vision of birth as a physiological, transcendent, intimate, and personal occurrence. Humanized birth is directed autonomously and freely by the woman, in an atmosphere of love, respect, and security; and involves no routine interventions into the natural process. Humanized birth ideology prioritizes personalized connection between the couple and the team of professional attendants; respect of her privacy, dignity, and confidentiality; protection of the immediate bonding between mother and newborn child; and vision of the mother as protagonist of her labor and birth. This type of birth is envisioned as a form of culturally compatible care and interculturality,³⁵ which implies respect for her traditions, language, and other cultural factors.

While these are “official” and formalized definitions of “humanized birth,” the most illustrative way to describe how humanized birth is conceived in practice is through the words of its practitioners. I audited a course offered by Doña Isabela, a traditional midwife and clinical director of the CASA Professional Midwifery School. She explained to professional midwifery students that humanized birth involves making the birthing mother as comfortable as possible by orchestrating a harmonious environment for her to give birth in, and liberating her from misinformation about “correct” birthing. Women are socialized to think they must give birth lying on their backs, but it is the professional midwife’s job to encourage her to eat, ambulate, and adopt comfortable positions throughout the labor process. Doña Isabela taught students to use massage, aroma therapy, the music of the woman’s choice, and, depending on the woman’s religious beliefs, prayer and chanting to help the woman feel totally at ease during the birth.

According to a humanized birth obstetrician and doula, guest lecturers at CASA, humanized birth attendants must strive to mediate biomedical hyper-vigilance that often provokes couples to become unwarrantedly anxious about “abnormalities” that are really just normal variation in pregnancy and fetal development. Additionally, humanized birth practitioners help couples connect emotionally with their unborn babies by guiding interaction with the fetus throughout pregnancy. The goal of humanized birth practitioners is to help couples “give birth conscientiously” and to lead them into conscientious parenthood. Another guest lecturer, an obstetrician from Querétaro, taught professional midwifery students to resist “masculine desires” for quickness and medical intervention, to respect the natural physiology of birth, and to view birth as an intimate and unique moment within a woman’s sex life. The goal of the humanized birth practitioner is to make the woman feel supported and empowered, while also preserving the integrity of the phenomenological experience of the child being born.

An obstetric nurse who attends humanized births in Mexico City emphasized the importance of knowing each individual mother personally, using her name when speaking to her, coaching her on breathing techniques during the labor, looking into her eyes, and being present without distractions during her birth. After the birth, obstetric nurses consider it part of their job to help mothers adapt to breast feeding and make sure that the new family is doing well. Likewise, a young obstetrician and apprentice of humanized birth in Guadalajara told me, “The

³⁵ See chapter 3 for a discussion about “interculturality” and its limitations.

key is the relationship we build with patients. They are more like family than patients. We don't even use that term." He expressed that what is "humanized" about humanized birth is the relationship based on love and respect between the couple giving birth and the person who attends their birth.

A humanized birth advocate in San Luis Potosí emphasized the importance of tranquility during birth at a workshop for expectant parents. She explained that the requirements for a tranquil birth are patience, no unnecessary interventions, the privacy of a private hospital, a quiet environment, absolutely no talk of pain from anyone present, constant accompaniment by whomever the woman chooses, freedom of movement, not being connected to monitors, freedom to eat and drink, and only a minimum number of required physical examinations throughout the labor process.

In Monterey I heard a contrasting perspective from a midwifery apprentice at a transnational NGO. While the humanized birth advocate in San Luis described stringent requirements for achieving a humanized birth, the midwifery apprentice explained that the priority is not that the birth take place at home or that the baby be born vaginally; rather, the priority is that the woman's embodied knowledge and the role of the baby as protagonist be prioritized throughout the birth. If the woman becomes too exhausted during the labor and wishes to switch to a medicalized birth or even cesarean, this is still a humanized birth because the woman's decisions were respected. While this midwife identified similar goals for humanized birth as some of the perspectives above (home birth, water birth, the active involvement of partners and doulas, the presence of family members and especially siblings of the baby being born, the absence of excessive pain and screaming, delayed cutting of the umbilical cord by a family member), the primary criteria was that the birth be controlled by the mother and baby.

For a transnational midwife who gives "traditional Mexican midwifery" workshops in Brazil, a humanized birth is the marriage of emotional and physiological, spiritual and corporal, and soul and body. Humanized birth practitioners are advocates of women, life, babies, and families. These advocates lead the movement from many posts around the world, resulting in the globalization of humanized birth. Similarly, a Colombian nurse midwife living and practicing in Guadalajara works to help couples transition from thinking about birth as a physiological act to a transcendental act that will leave a mark on the future of both woman and child. For her, birth is something that effects future generations because the way people are born is predictive of individual's emotional wellbeing and how they will treat others in society. The words and work of both of these midwives signal the transnationalization of the humanized birth movement and the emergence of a globalized rhetoric for describing this type of birth.

When I interviewed the dean of a prestigious private medical school in Mexico City, he emphasized the dearth of scientific literature being produced in Mexico about humanized birth when compared to countries like Brazil. (At the same time, the MacArthur Foundation is working to apply ideas authored in Brazil to the Mexican context through engagement with the Mexican government and advocacy for the reduction of maternal mortality and Millenium Development Goals.³⁶) In his opinion, adopting humanized birth practices is a strategy for bringing Mexico to the table of progress along with other developing countries. The challenge facing obstetricians who wish to attend humanized births in hospital settings is "the struggle

³⁶ Personal communication with Sharon Bissell Sotelo, the Director of the MacArthur Foundation's Mexico Office on September 6, 2013

against the routine of traditional care.” In his perspective, “traditional care” represents medicalized birth and progress is aligned with an ethos of limited interventions bolstered by scientific evidence. Over the course of three decades, he has stopped performing routine episiotomies and no longer has nurses shave women’s pubic hair and place enemas, since “normal birth with interventionism has not demonstrated better maternal and perinatal results than natural birth.”



“Doctor in the public hospital; the same doctor in his private clinic.” (Artist unknown.)

Over the course of my fieldwork, other physicians railed against the terminology of “humanized birth,” arguing that it implicitly suggests that medicalized births are “dehumanized” and “animalistic.” They preferred more neutral terms like “*parto respetado*” (respected birth), “*parto elegido*” (chosen birth), and “*parto natural*” (natural birth), since these terms highlight respect for birthing mothers’ choices, which can be prioritized in both medicalized births and births attended by physicians. Furthermore, physicians agreed again and again that the “interventionism” instituted in public hospitals runs counter to the conditions necessary for humanized birth. For this reason, these physicians echoed that humanized birth belongs to the realm of private practice.

At a private hospital that boasts a cesarean rate that is less than half that of the national average^{vii} and focuses on the integration of natural healing, I inquired about the types of services the hospital is able to offer because of their unique emphasis on holistic medicine, ecological living, and alternative birth methods. Birth-related services offered by the hospital are

psychoprophylactic workshops, art therapy for older siblings of the new baby, homeopathic kits for pregnant mothers, “handprints” and “footprints” of the newborn carved into wood by indigenous artisans³⁷, reading lists of English-language texts on natural and alternative birth³⁸, and doula services. One of the chief officers of the hospital told me that the hospital was designed to look like a top-notch hotel, not a hospital, and all of the food served to guests is organic. The hospital implements 100% lactation (there are no baby bottles in the hospital),³⁹ immediate skin-to-skin bonding between mother and child, and non-horizontal birthing positions. Obstetricians at the hospital do not routinely shave women’s pubic hair, apply rectal enemas, place IVs, ask mothers to fast, perform episiotomies, or use synthetic oxytocin.



The lobby of the private hospital dedicated to the integration of natural and holistic healing.

³⁷ Yet another example of the commodification of indigeneity within the humanized birth movement.

³⁸ Evidence that humanized birth is a transnational movement that traces its origins in the “Global North.”

³⁹ I argue that this all-or-nothing approach sets women up for failure since not all mothers and infants are able to breastfeed immediately after birth.

Marketing “Nature”: The Expense of Humanized Birth

Humanized birth is expensive, despite its proponents’ criticism of the commercialization of biomedicine. In Monterey, I visited a center that offers obstetric care, prenatal yoga, healthy cooking classes and nutrition counseling. The center operates out of a mansion in the most affluent neighborhood of the metropolis. The taxi driver who drove me to the center told me that driving a client to that area of Monterey was a rare experience since it was more likely for its residents to travel by private helicopter than by taxi. This center plays an important role in the humanized birth community in Mexico and transnationally since it has organized and hosted international conferences featuring American and French experts on humanized birth. When I spoke to Elizabeth, the center’s founder and a woman of British heritage who travels constantly between Mexico and the home she has with her husband in California, she spoke at length about how biomedicine is undergirded by the pharmaceutical industry. As a cancer survivor who rejected biomedical interventions and instead adopted a holistic diet, she opines that the wellbeing of patients can often be achieved through organic and holistic methods, but biomedicine fails to explore these possibilities since they are not as lucrative as pharmaceuticals (see Dumit 2012 on how the pharmaceuticalization of everyday life shapes consumer’s understanding of health and prevention).⁴⁰

Later that afternoon, I asked to speak with the obstetrician at the center—a leader of the “health revolution” who uses “best practices for both mother and child.” The obstetrician responded that he could fit me in if I were to book a patient appointment and pay his 800 peso consultation fee (about two and a half weeks of salary at minimum wage). He explained that if he were to grant me an interview, he could have seen a patient during that time, for which he would earn 800 pesos. However, if I were to book a patient appointment, I could use that time to ask him whatever I wanted about his work. I declined his invitation to pay for an interview since doing so would have violated the procedures regarding compensation of informants outlined in my Internal Review Board permissions for research, and moreover, because my most pressing questions about how humanized birth is marketed to patient-consumers at this center had already been answered. My intention behind interviewing this particular obstetrician was not primarily to document yet another practitioner’s definition of humanized birth, but to discern where the center fell on the continuum between a universalizing “humanization” of birth, and marginalizing commercialization of services.

Interestingly, when I interviewed the deans of a prestigious private medical school in Mexico City, the perspective they expressed about humanized birth was ironically parallel to Emma’s remarks about biomedicine. They spoke to me about how “humanized birth” was becoming a buzzword in Mexico, and how obstetricians were beginning to see their lack of involvement as a missed economic opportunity. Instead of allowing “alternative birth attendants” to reap all of the commercial gain, some were beginning to market humanized birth practices based on scientific literature from Brazil, thus securing their participation in the boom.

When I returned home to San Miguel, I sat down for a formal interview with Dr. Tellez, a physician that I had been observing for months at the General Hospital. He described his academic trajectory to me, which includes a degree in homeopathy. While he is a proponent of minimal intervention, he frowned upon the commercialization of humanized birth, saying that the expense of a natural childbirth is fortunate for physicians and unfortunate for patients. He

⁴⁰ In Chapter 5, I discuss in detail how humanized birth is a lucrative source of income and status for professional humanized birth practitioners.

explained that in Mexico, patients often believe that expensive services are the best, so when a bodily practice like humanized birth becomes “trendy,” it also becomes expensive. Shortly after my interview with Dr. Tellez, I spoke with Jaime Breilh, Director of Health Sciences at the Universidad Andina Simon Bolivar in Quito, Ecuador, about my research. He succinctly described what I was observing in my fieldwork: “When ancestral knowledge is commercialized, it becomes a functionalist element and is no longer emancipatory.” Building on my argument in chapter two, I argue that not only does humanized birth fail to fulfill its inclusionary promise relating to the rhetoric of “humanity,” but furthermore, it often fails to truly liberate even those who are able to access its benefits through the pathway of consumption.

Unexpected Politics of Parenting: A New Moral Imperative

My research utilizes the humanized birth movement in Mexico as a lens through which to analyze transnational trends in parenting. I argue that couples from the global professional class (Spivak 2003, 618) often view parenthood as the “last stop” to creating a successful life. That is, upper middle- and upper-class couples aim to follow a life trajectory that includes higher education, professional development, marriage, home ownership, and *parenthood*. The criteria for good parenting is largely defined by parenting trends in a transnational social network originating in the Global North (examples are “humanized birth,” extended lactation, organic/holistic nutrition, Montessori and Waldorf education, extracurricular activities, etc.) As couples increasingly consider parenthood and their ability to produce certain types of future bioconsumers a marker of their overall success, their relationships to their children are changing, often resulting in greater demands on the parents’ time and economic resources.



Social networks: A gathering of families of children who have been born via humanized birth.

The chapter describes how parents and families form social networks oriented around a particular type of birth. While “humanized birth” has so often been described as a pathway to feminist liberation and resistance to (masculine) biomedical hegemony, I problematize uncritical notions of liberation by asking how humanized birth may be the first step within a new regime of pressures and “requirements” presented by modern-day “good parenting.” Through examples of women who struggle or “fail” to give birth naturally (see Crossley 2007), my ethnography signals how humanized birth inadvertently represent another way the burden of correctly producing future bioconsumers falls upon women, even as it aims to liberate them from biomedical hegemony.

The Mexican women who participate in transnational humanized birth social networks share notions of what constitutes good mothering and ideal birthing. Social bonds rest upon mutual understandings of what mothers must do to achieve the best possible birth; at the same time, mothers are bound both by the expectations of their fellow humanized birth proponents, and by the very logic of how a humanized birth should progress. Humanized birth illuminates how the neoliberal meritocracy framing contemporary parenting not only concerns children’s development post-birth, but how moral imperatives related to “proper parenting” pushes back into the womb. As the term “meritocracy” suggests, there is a fine, often vanishing line between elevating standards and provoking competition, shared passion and mutual obligation, defending rights and imposing ideology, challenging power and reinventing limitations.

While humanized birth emerged out of resistance to biomedical hegemony and feminist desire to wrest the power over birth away from (male) doctors and place it back in the hands of birthing women, I point to the irony of humanized birth, and ask how humanized birth social networks may represent “maternalistic biopower.” Humanized birth circles are motivated by mutual concern about biomedicalized birth and desire to improve birth outcomes for mother and child; however, they also incite a sense of obligation within women that can have harmful physical, psychological, and emotional effects. While I eagerly recognize many instances when my informants reported feeling *empoderadas* (empowered), I am also signaling the murky edges of humanized birth experiences and problematic moments in which exchanging biomedicalized birth for humanized birth may be replacing one form of tyranny for another. The ideology of humanized birth leads couples to make significant economic investments⁴¹ towards achieving their ideal birth, and inspires mothers to agentively choose physical pain over anesthesia. These parents meet their socially-influenced obligations to give children the best start in life through consumption and elected suffering.

My work engages in a debate with a great deal of anthropological scholarship on “new midwifery” that revolves around how professional midwives in different countries are helping women reconnect with “nature,” teaching them to trust their bodies, respecting women’s “choices,”⁴² confronting and defying hegemonic biomedical structures, and fighting for women’s

⁴¹ See Chapter 5 and the Conclusion for more detail on the costs of humanized birth.

⁴² I problematize uncritical notions of free choice by drawing attention to how, for most Mexican women, choices are either nonexistent or prestructured. Women (especially indigenous and lower class) do not have options when giving birth in public hospitals. The very idea of “choice” emerges from a middle- and upper-class perspective—“choice” is a privilege of those capable of paying for private medical services. My argument is informed by Bourdieu’s concept of habitus: Class provides the conditions that determine tastes. However, the role of class in determining

right to birth as naturally as possible^{viii}. In these texts, birthing mothers are transformed and “empowered,”⁴³ their lives changed forever by exposure to the midwifery model of birth (see Davis-Floyd 2001 and 2007). While my work employs humanized birth as its analytical object, the subject of this dissertation extends far beyond birth. I argue that parenting is a primary way that individuals accrue cultural capital within a transnational meritocracy, and as a result individuals are incited to demonstrate good parenting before their children are even born. That is, the interpellation of individuals as parents originates *in vitro*, and is perpetuated through social mechanisms that challenge anthropological notions of biopower.

Medical anthropologists have also developed an extensive literature on midwifery, positioning the midwifery model as a pathway to feminist liberation and resistance to (masculine) biomedical hegemony (see Davis-Floyd 1992; Katz Rothman 2007; MacDonald 2008; and Simonds 2007, among others). In contrast, this chapter challenges notions of unrestricted liberation by pointing to how humanized birth may impose a new regime of standards for modern-day “good parents.” While biopower has often been characterized as the control of populations through “paternalistic” institutional and governmental surveillance, humanized birth practices beg the question of how “maternalistic” biopower might operate through social networks.

Furthermore, this chapter aims to add complexity to Jordanova’s (1995) suggestion that anthropologists begin thinking seriously about children as commodities. I provide ethnographic examples that illustrate the complex intertwining of 1) how giving children the best upbringing increasingly entails material consumption among privileged families [commodities are consumed by parents for their children], 2) how children are parents’ stake in a transnational neoliberal meritocracy [children are commodities that are consumed by parents], and 3) both commodities for children and children as commodities are bolstered by love, care, and sacrifice.^{ix} In contrast to cross-cultural ethnographies of child rearing, I am probing a transnational neoliberal meritocracy that superimposes class-infused logic and globalized notions of gender on place-based practices to drive contemporary parenting trends. Thus, my work queries how meritocracy-fueled phenomena—examples are “helicopter moms” and “tiger moms”—unfold in places penetrated by deep disparities^x.

Mommy Wars

The term “mommy wars” began circulating in 1986 when Leslie Morgan Steiner published her book *Mommy Wars: Stay-at-Home and Career Moms Face Off on Their Choices, Their Lives, Their Families*. Since then, the term has come to encompass any controversy that poses one type of parent’s superiority over another. As parenting becomes a key category through which individuals stake claims to moral superiority and accrue cultural capital within their social communities, a flurry of contentious issues emerges to the fore of public debate. One contemporary example is whether to vaccinate your child against measles, with one camp

taste is concealed and the relationship between taste and education is repressed; thus, tastes seem “natural” and are used to legitimate the superiority of the wealthy (see Bourdieu 1984).

⁴³ I am critical of the notion of “empowerment,” asking what it does and for whom. Who does the empowering? For those who are “empowered,” were they truly “disempowered” before? Is hegemony really challenged if people in the Global South are “empowered” by ideas from the Global North? Lastly, I am wary of how neoliberalism and the concept of individualism and choice informs the notion of “empowerment.”

arguing vaccination places children at a higher risk for developing autism, and the other camp arguing non-vaccination places children at a higher risk for infectious diseases and leads to the spread of disease to other children. Other ethical examples include whether sending your unsupervised child to the park to play is negligence; the legality of circumcision and whether parents have the right to circumcise toddlers; and whether leaving your children in a hot car is child abuse. Developmental debates unfold around what types of discipline are violent and damaging to a child's emotional well-being; what teaching methods are best for children's intellectual development, including, but not limited to, the debate over home school versus traditional school; and how much and what kind of academic testing is most appropriate. In the social, moral, religious, and emotional realms, parents ponder how to best teach children about gender and race dynamics; how to best instill moral and religious values in children given their exposure to people and events that counter what is being taught at home; how to adapt a schedule observed by all family members that benefits children, such as family meals; and what types of verbal expressions are emotionally damaging to toddlers. With regards to children's physical wellbeing, topics include the best techniques for getting children to eat and sleep; children's proper nutrition (vegan, organic, and holistic diets, and preventing childhood obesity, etc.); breast milk versus formula, how long to breastfeed babies to optimize their physical well-being, and the challenge this presents to working mothers; whether electronic devices are damaging children's brains; cloth diapering versus disposable diapering; and methods for coping with the challenges of potty training. The list is unending!

Many parents feel an enormous amount of pressure to “get it right”—they feel their children's physical, emotional, psychological, and intellectual development depend on their good parenting, and their deficiencies as parents could have detrimental effects on their children's lives. The results are “guilty mother syndrome”; parents' anxiety that their own emotional troubles, depression, and “brokenness” will negatively affect their child; fathers juggling careers with active parenting and demanding their paternity be taken as seriously as maternity (for example, through paternal leave); and reproductive endocrinology, assisted reproduction, and, at times, “fertility envy” for couples experiencing infertility.

A plethora of self-help books, videos, and web-based materials circulate to aid parents in their quest to become experts in the field of parenting. While past generations learned parenting by doing, present-day parenting is a skill perfected through accrual of expert knowledge, dedication, and correct decision-making. What was once “just life” is now something to blog about—hence the rise of mommy bloggers. The most popular parenting books on the market focus on how to prevent power struggles, raise joyful and resilient children while remaining peaceful and connected, teach children discipline and responsibility without yelling and aggression, “unconditional” and “zen” parenting, how to reason with children using logical explanations, how to strike a balance between nurturing and enabling children, how to have “the happiest baby on the block,” the link between raising children and a deeper understanding of self, how to avoid common parenting “mistakes,” “rules” for “surviving” parenting, strategies for unleashing the potential of children's developing minds, and how to win your child's heart by parenting with purpose.

While these books share the notion that there are better versus inferior ways of parenting for the development and overall well-being of children, and better means nonaggressive discipline, unconditional nurturing, and sustained intellectual engagement; this chapter brings a critical medical anthropology perspective to health-related “mommy wars” circulating in popular media and analyzes how parents use birth to stake claims to moral superiority^{x1}.

Moral Superiority: Birthing Self-Assured Children

On a chilly morning in December 2010, I hiked up the cobblestone road leading to the Center for the Adolescents of San Miguel de Allende (CASA) for the very first time, stopping frequently to ask for directions. While San Miguel de Allende is known for its large population of resident American and Canadian expatriates and is a popular destination for international and national tourists, CASA is perched at the top of the Santa Julia hill in a working-class barrio. I was eager to visit CASA, since among its many programs was the only government-accredited midwifery school in the country and its maternity hospital represents a key site for the unfolding of “humanized birth” in Mexico. CASA’s location suggests that the majority of its maternity patients are working-class Mexicans, but I soon discovered that its clientele was more transnational and from a broader, and more elite, socioeconomic range than I had expected.

When I finally arrived at CASA, I was struck by its charm: the beautiful cathedral-like dome, arched windows, warm yellow and burgundy hues, and pitter-patter of water in the courtyard fountain. As I walked down the hospital corridors, I saw a wooden sign on one of the birthing rooms exclaiming, “It’s a Boy!” in Spanish. A staff member gave me a tour of its newly appointed water birth facility and led me to a plaque proclaiming that, having undergone a workshop with Martha Lipton (“water birth educator, gentle-birth guardian, and celebrity” within humanized birth circles), CASA has earned the designation of internationally certified water birth center. A CASA pamphlet listed prices for different types of births. Significantly, I noted the cost of water birth was nearly twice that of non-water birth.

A few months later, I was accompanying Magdalena, one of the professional midwifery students, during her rotation in the CASA maternity hospital. She explained that the demographic of couples seeking water birth varies starkly from those seeking non-water birth: couples interested in water birth often travel great distances to give birth at CASA, are familiar with the “humanized birth” movement and its European origins, are often transnational, possess a higher level of education, and can afford a more expensive birth.

Two years after Magdalena had graduated from CASA, I visited her and interviewed some of her home birth clients. In contrast to the transnational couples that travel for midwifery services at CASA after reading about their unique model online, Magdalena has amassed her clientele purely by word of mouth. Her clients are professional and entrepreneurial Mexicans who live within the greater Guadalajara area, and a number of them are clustered in the city of Irapuato. Magdalena’s clients connected me with other mothers from the same social circle who are also passionate about humanized birth. The women I interviewed formed friendships with each other by sharing tips and insights about humanized birth while waiting to pick up their children from school.

I sought out Yasmin, Magdalena’s first client in the city of Irapuato. A couple minutes after ringing the large, copper bell hanging above Yasmin’s front gate, Yasmin appeared and led me through the courtyard and into the well-appointed living room of her two-story home. She was more youthful than I had imagined, and I wondered how she and her husband had become so well established at such a young age. Over the course of our conversation, Yasmin explained that she and her husband own a textile manufacturing company specializing in the mass production of cloth diapers. Their respective families are both from Irapuato, and her mother and grandmother live just a few houses away.

Yasmin is 26 years old and the mother of three children. Her first two sons were born via cesarean when she was 22 and 23 years of age, respectively. Defying all odds, she gave birth to her third son in a home water birth.



Yasmin and her third son, born in water at a home birth

During her first pregnancy, Yasmin had wanted to give birth naturally, but as the labor unfolded, her dilation subsided. Yasmin was in the hospital for two days, and despite rhythmic contractions, every time the hospital personnel checked the condition of her cervix, her dilation was at one centimeter. At that time, she had not yet informed herself by reading any “humanized birth” literature or participating in psychoprophylactic birthing classes and relied solely on the obstetrician’s guidance when deciding how to proceed. The obstetrician told her everything was fine, but that at any moment fetal distress could occur. Yasmin explained, “Of course, when any mother hears the words ‘fetal distress,’ she’ll do whatever the doctor recommends so that her child isn’t injured.” Yasmin was afraid of cesarean since she had never undergone surgery, and she recalled the anxiety she felt when the hospital staff shaved her pubic hair and applied an IV and anesthesia. They jostled her, jerking the sliced-open flesh of her belly. When they had extracted her baby boy, they showed Yasmin her newborn, giving her only a few seconds to catch a glimpse of her child before whisking him out of her sight.



Pediatrician suctions newborn's mouth in the first minutes after birth



Newborn tangled in measuring tape after post-birth evaluation by pediatrician

Later, when she was in the recovery area and her baby boy was returned to her, they had already fed him formula. The baby was satisfied and did not seek colostrum from her breasts—Yasmin was a stranger to the biochemical process of birth, and although she desired ever so greatly to nourish the babe with her own milk, breastfeeding was physiologically out of synch with the surgery she has just experienced. She told me, “It wasn’t until two or three days later that I realized I had become a mother and had had a baby. When you give birth [vaginally], you close a cycle. In comparison, cesarean leaves ugly traces [on a mother’s psyche].”

A year and three months later she was pregnant again, and they told her, citing the possibility of uterine rupture, “Once a cesarean, always a cesarean.” Her doctor instructed her, “Go think of a date [for the cesarean].” They scheduled the surgery. Yasmin said her second cesarean was “terrible and frightful.” In the operating room, the surgical team joked around among themselves while she was possessed by fear because the anesthesia had not properly taken effect. She was still moving her feet and feeling sensations in her body when they began cutting. She could hear her heartbeat throbbing loudly, drumming almost out of her chest, and she begged, “Please, don’t open me.” They gave her an inhalational anesthetic, covering her face with a mask and inducing her to sleep. When she awoke, she was still frantic. Her baby was no longer in her womb, and neither her husband nor the doctor was present. What had happened? She was overcome by desperation and physical pain. Her husband later told her their son was born limp and blue, like a dead rabbit. Yasmin believes the inhalational anesthetic had a noxious effect on her baby as well.



Cesarean section in a public hospital

Upon discovering she was pregnant a third time, Yasmin was determined not to have another cesarean. “It is not possible that I cannot give birth vaginally!” she exclaimed. She told her obstetrician she wanted to have a vaginal delivery, but he responded, “Are you crazy? They only do that in the United States! And they are crazy because it cannot be done. The women and doctors who pursue vaginal birth after cesarean are crazy gringos.” Yasmin asked herself, “Only crazy gringos can do it? I don’t think so!” She decided to take psychoprophylactic classes, and the coursework she studied helped her make a definitive decision: yes, she *can* give birth naturally.

Yasmin discussed her desire to give birth vaginally with Celia, a doula invested in “humanized birth” practices. Celia gave Yasmin two options: a pro-birth obstetrician or professional midwives. The obstetrician told her that while Yasmin was at risk for uterine rupture, he was willing to see how the pregnancy progressed before making a decision. Yasmin’s husband was comfortable with the obstetrician’s plan. However, Yasmin wanted to meet with the professional midwives as well, but her husband was skeptical and anxious; his wife not only wanted a vaginal birth, but a vaginal birth at home, attended by midwives! Two weeks before the birth, they journeyed to Guadalajara to meet Lucía and Marisa for the first time. An hour into the interview, her husband was convinced. Both Yasmin and her husband were moved by the careful explanations the two professional midwives provided for each of their questions. They were struck by the difference between the physician’s dismissive statement, “You don’t need to know,” and the midwives’ close attention.

A week before the birth, the obstetrician told the couple that something was amiss with the fetus’ position and prescribed medication that would induce contractions. By the time she left the doctor’s office, Yasmin had already decided she wanted nothing to do with that obstetrician ever again. This time, she was not going to have an induced labor, painful synthetic oxytocin-driven contractions, or cesarean.

Her third son was born after 40 weeks gestation. They placed a blowup birthing pool in their bedroom on the second floor. It was December, but they took the chill off with space heaters. Yasmin was left feeling nothing but joy after her third birth, explaining that the experience transformed the way she and her husband both relate with their youngest son. Her husband was a participant in the water birth, not just a spectator as he had been in the hospital births of their other two sons.

After the birth, Yasmin thought, “Wow! How beautiful! My life has changed!” It is now the couple’s mission to inform other women of their options, and they use their cloth diaper business to facilitate their mission. In the eight months following Yasmin’s water birth experience, four other mothers followed suit, giving birth vaginally after having prior cesarean sections. Yasmin expresses how grateful she is for what she has learned about her body, connecting with her fetus, and breastfeeding. She now knows that her body needs three days of labor to prepare for her delivery. She believes that if she had waited a third day during her first birth, her baby would have been born naturally and safely. “That is just how my body is.” She recognizes, however, that natural birth is about respecting the fetus’ readiness to be born and communicating to the fetus when the right time has arrived. On the third day of her third delivery, while her mother and husband were knotted by anxiety, Yasmin went to bed by herself and whispered to her fetus: “Baby, you have to be born now.” A few minutes later, her water broke. The harmony she experienced during her water birth continued in the ensuing years. Her third son benefited from a year and eight months of breastfeeding, while she only managed to give each of her other two sons six months of breastfeeding. Yasmin asserts that her youngest

son and children born through “humanized birth” are more loving and emotionally secure than other children and form closer connections with their fathers.

For Josefa and Tomás, the differences between their two sons do not end with *how* the boys were born; rather, they are different *because* of the disparate circumstances surrounding their births. Tobías was born via cesarean. He becomes angry, scared, or anxious when he hears a loud noise; for example, the vacuum cleaner, the washing machine, or a slamming door. In contrast, Timoteo, who is still a baby and was born in water, will only turn his head in curiosity to see what has made such a loud noise. Timoteo sleeps even in the noisiest environments, likes to sleep on both his mother and father’s chest, and is soothed by the rhythm of their heartbeats. Timoteo is a tranquil baby, while Tobías seems to be perpetually decentered by his traumatic birth experience. At the time of the interview, Tobías was almost four, and his innocence and inquisitive nature caused him to ask questions that provoked a deep emotional response in his parents: “Why did they snatch me from inside my mother when I was so happy being with her?” As the couple describes, children born via cesarean are haunted by the unnaturalness of their surgical beginnings. In contrast, Josefa and Tomás’ subsequent experience with professional midwives was “the birth of a human being.”

What is remarkable about the many birth stories I heard during my ethnographic research is not only the emphasis on resisting biomedical hegemony to achieve desired births, but also the striking moral dimension embedded in their recounting of events. At times, their retelling seemed akin to religious conversion stories, as if through delivery they themselves had been delivered. Through psychoprophylactic training and familiarization with transnational “humanized birth” literature, these women and couples prepared themselves for arduous labor and learned to place their faith in “nature,” “tradition,” and their innate capacity to give birth naturally over biomedical protocols. They cast cesarean as traumatizing, terrifying, and violating, while depicting “humanized birth” as beautiful and empowering.

Perhaps even more compelling is the way couples described “humanized birth” as the way by which self-assured, well adjusted, happy humans are brought into the world. Even when labor lasts for days on end, couples asserted it is worth going through the pain of natural labor since the result is a healthier and more contented child. Basing their claims on the biochemical process that unfolds during an undisturbed childbirth (most notably, the secretion of oxytocin into the bloodstream, catalyzing the “let down reflex” and facilitating the production of breast milk), these couples affirmed that “humanized birth” practices are correlative with easy, continued breastfeeding, thus strengthening their children’s immune systems and reducing their likelihood of developing numerous diseases later in life. In essence, children born via “humanized birth” are described as the fortunate offspring of conscientious, caring, brave, and intelligent parents; their births link them to children also born in water, at home, and with the help of professional midwives in the United States and elsewhere in the Global North.

My argument is not a rebuttal to these couples’ assertions, nor do I criticize their decisions. I agree wholeheartedly with the reduction of obstetric violence and unnecessary biomedicalization through safe, natural alternatives. However, stopping there would reduce the scope of my research to (albeit valuable) advocacy around a woman’s right to determine the conditions of her birthing. Instead, I am undertaking an analytic project; thus, the novelty of my research lies in the unveiling of multiple ironies embedded in humanized birth. In this chapter, I specifically draw attention to how “humanized birth” ideology represents a new set of expectations to which women strive to conform and sometimes fail to fulfill.



From left to right: Josefa with Timoteo and Tobías, Tomás, and Celia (see her story, below).

The Secret Tyranny of “Humanized Birth”: When Mothers Fail to Meet Expectations

In August 2013, I visited Dr. Horacio García⁴⁴, a perinatologist, hospital administrator, and clinical professor at the National Autonomous University of Mexico, at his private clinic near Estadio Azteca in Mexico City. His clinic is inconspicuously tucked into a small residential street, but once inside, I was struck by a plethora of photographs of healthy newborns intermixed with angel figurines, catholic relics, and *el Niño Jesus* (a Baby Jesus doll).

Dr. García’s clinic features a roomy, light-filled water birth suite on the second floor with a sofa, regular queen-size bed, full bath, Jacuzzi, skylight, marble waterfall with an angel statue, and large windows providing views of the tree- and flower-filled garden. The suite was designed to maximize the comfort of the family and ease of labor. A cord hangs above the Jacuzzi so the mother may suspend her weight and stretch her back while birthing. Wooden bars are fastened to the wall to facilitate prophylactic exercises that relax the pelvis in preparation for birth. Dr. García intentionally rejected a hospital bed in favor of a regular queen-size bed so that his clients would feel at home in the birthing suite, and to promote family bonding after the birth.

⁴⁴ Described in further detail in chapter six.



The “bedroom” portion of the birthing suite at Dr. García’s clinic.

While Dr. García’s attention to detail signals his commitment to humanized birth, or as he prefers, “respected birth,” his training in perinatology gives him a different perspective regarding pain and safety during child birth than many of his doula and professional midwife counterparts. While Dr. García is in favor of birth preparation courses, he emphasizes that if instructors teach pregnant women they can definitely achieve a vaginal birth using a set of relaxation techniques during labor, the results can be detrimental. On one hand, Dr. García has been called to evaluate cases where the mother was in labor for over three days, but when he determined the situation was posing a risk to the child’s health, the mother was intransigent—she was determined to give birth vaginally. On the other hand, Dr. García has had to intervene in cases where the mother is exhausted, in pain, and no longer wishes to continue with her humanized birth plan, but others around her exert pressure on her to not give up.

In one instance, he was asked to consult on a home birth that was already at an advanced stage of labor. The birthing mother was begging for anesthesia, but her husband was insisting she not be given anesthesia since he was concerned about the effects anesthesia would have on his child. The woman’s two doulas were coaching her to push through the pain. When Dr. García arrived, the birthing mother’s cervix was dilated to eight centimeters. She grabbed his arm and exclaimed, “Operate me! I’m so tired! I’ve already had so much pain!” As Dr. García described, in this moment her emotional connection with the two doulas and her husband shattered. She looked into Dr. García’s eyes and pleaded, “Doctor, don’t leave me.” Dr. García reassured her he would not leave her, but he explained that at such an advanced stage of labor, administering

anesthesia was no longer an option. He continued accompanying the woman and forty-five minutes later the baby was born.

Both circumstances—when mothers insist on vaginal birth even when they may be putting their child at risk, and when birth attendants and family members apply pressure to achieve a natural birth despite the mothers' excessive pain and exhaustion—complicate uncritical notions of what humanized birth means for mothers and newborns. In both cases, humanized birth is cast as an accomplishment, while giving into pain and accepting medical interventions is portrayed as failure on the mother's part. Beginning in earlier stages of pregnancy, women who subscribe to humanized birth take courses in meditation, self-hypnosis, breathing, and relaxation techniques in hopes that they will be able to harness their willpower, overcome physical pain, and give their child the best start in life—a birth free of synthetic drugs, hormones, obstetric violence, and traumatic memories that may leave lifelong emotional scars.

Dr. García is hypervigilant of the potential slippage between demedicalized empowerment and dogmatic endangerment. He explained to me that in Mexico, the prevailing cultural notion is that the more a woman suffers during child birth, the more she must love her child.⁴⁵ Dr. García contrasts himself with other obstetricians who practice humanized birth. He is critical of humanized obstetricians who are so resistant to performing medical interventions that they call upon him to intervene instead. In the case of a woman who had been in labor for three days and was fully dilated for over five hours but her contractions had stopped, Dr. García arrived at the request of his colleague and administered intravenous pitocin to restart them. "I then withdrew from the birth as a hero." With his own patients, Dr. García explains that cesarean is a final option—that way, if the birthing conditions are not favorable, he has saved the birthing mother the emotional distress of feeling she has failed.

The way in which natural birth has, for some women, become a marker of good mothering while failure to achieve vaginal delivery without medical intervention is deemed a personal failure was evident in many of my interviews with parents. For example, Celia recounts her reproductive history as a tale of trial and tribulation resulting from her physical inadequacy until she was finally able to overcome her limitations and reach empowerment. Celia has had five pregnancies. Her first was an ectopic pregnancy resulting in the removal of a fallopian tube. Thereafter, she had difficulty becoming and staying pregnant. After several miscarriages, Celia and her husband Javier finally gave up trying. Then Celia became pregnant with their daughter Sandra. These combined events led Celia to think of maternity as a "*don*." A *don* is a talent bestowed upon an individual by God; thus, Celia's difficult reproductive history has led her to believe that the ability to produce a child is a divine gift—some women have been blessed with the knack of producing children while others have not.

Sandra's birth was unexpected. After Celia's water broke, twelve hours passed without a single contraction. Her obstetric team administered oxytocin, but when it did not produce the desired effect, they later administered intravenous prostaglandins in order to induce the birth. When Celia finally began to have contractions, they were strong and painful. Celia demanded anesthesia "*a gritos*" (screaming at the top of her lungs), even though she had planned for a natural birth. The anesthesiologist took "an eternity" to arrive at Celia's bedside, and then took

⁴⁵ Matthew Gutmann (1998) studied the natural, physical and "psychically overwhelming" mutual dependency between Mexican mothers and their children—a relationship that takes precedence over all others and, when combined with modern transformations (for example, mothers working outside the home), can cause children to suffer tremendously.

several more minutes to set up his epidural kit. He placed the epidural with difficulty and “scolded” Celia for being too fat. After that, Celia had regular contractions and Sandra was born an hour later. Even though Celia and Javier had advised the pediatrician before the birth of their wish to keep Sandra with them for skin-to-skin contact and bonding, the medical team whisked Sandra off to evaluate her health as soon as she was born and to observe her in the nursery. Later, when the infant was finally returned to her mother, Celia was unsuccessful at breastfeeding because the nurses had already fed the baby formula.

Twenty months later, Celia became pregnant with Santiago. She describes her prenatal obstetrician as very “pro-cesarean.” He told her she would require a cesarean because she had gained too much weight. Later, he told the couple the baby had a double nuchal chord and the birth must be via cesarean. When they talked to the obstetrician about their birth plan, he insisted that an intravenous drip would be necessary, but agreed to many of the other humanized birth practices they requested. However, when Celia was forty-one weeks pregnant, he told them if the baby were not born in a matter of days, he would have to induce the birth. The couple became very anxious. At 11:00 a.m., at forty-one weeks and two days gestation, Celia began having contractions and had normal bleeding. She took a bath to ease the pain. She heard the daily “Ave María” on the radio signaling twelve noon and transitioned to the bedroom. She could not lie down due to extreme pain in her lower back. Upon arriving at the hospital, her cervix was already eight centimeters dilated. The obstetric team took her to the labor and delivery room on a gurney despite her wish to continue walking. They instructed her to lie down even though the lithotomy position (back flat, legs spread, feet in stirrups) caused her great pain. Later, they allowed her to sit up and the pain subsided.

The attending obstetrician at the time of the birth was a woman. She said to Celia, “If you want a natural birth, you must cooperate.” This prompted Celia to become quiet and introspective and to concentrate her energy. When Santiago was born, they passed him to Celia immediately, but moments later they whisked him away. Unlike her experience after Sandra’s birth, the pediatrician took only five minutes to evaluate Santiago’s health and return Santiago to Celia. While Celia was never able to achieve exclusive breastfeeding with Sandra, she accomplished it easily with Santiago because she had overcome her distrust in her own body.

After the birth, Celia felt like “superwoman” because she had persevered throughout the experience and “everything turned out well.” When she told her closest female friends about her birth experience, they exclaimed, “You are super wild! You are a carnivore!” Celia said, “Everyone had this attitude of ‘Wow!’ when I told them.” Santiago’s birth was the impetus for Celia to study prenatal education, and with Javier’s financial and moral support, she earned her certificate and became a prenatal educator. Celia opines that information about birthing options is empowering since it can attenuate women’s fears, and because obstetricians are unable to unilaterally dictate the terms of the birth to couples that are well informed. “Yes, it is painful, of course. But *I* decided, and *I* chose.”

Celia’s telling of her reproductive history highlights the complexity of humanized birth as it unfolds in the lives of Mexican women. On one hand, Celia’s story is an example of how humanized birth can lead to empowerment and feminist liberation. On the other hand, her account is peppered with comments signaling her own inadequacies prior to her successful birthing without medical interventions. By casting maternity as a “don,” Celia explains her ectopic pregnancy and subsequent miscarriages as resulting from her deficient knack for motherhood. Celia identifies her faulty will power and inability to overcome physical pain when

she describes how she requested anesthesia and abandoned her plan of no interventions during Sandra's birth.

Underscoring the circuitous relationship between how physicians place the mandate of correct motherhood through self-discipline on pregnant women's shoulders and how women internalize these obligations, Celia mentions her excessive weight gain during both pregnancies as the reason for the anesthesiologist's difficulty placing the epidural and for the obstetrician's insistence that Santiago required delivery via cesarean section. Instead of pointing to the synthetic hormones she received during labor or the missed opportunity to initiate lactation immediately after the birth as causes for her difficulty breastfeeding Sandra, Celia situates the problem as resulting from her distrust in her own body—thus, her inability to breastfeed was a physiological shortcoming resulting from psychological misgivings. During her second birth, the solace she found in the Ave María counters celebrations of La Malinche as the original literate mother (see Haraway 1991, Moraga 1983), and instead points to the Madonna-like chosen suffering of “morally superior” mothers who give birth naturally.

While Celia's reproductive history ends with victory and perhaps even the accrual of cultural capital through heightened recognition within her social network, I point to the multiple ways Celia has interpellated herself as an inadequate mother along her path to eventual success. Celia's telling of her reproductive history unveils unforeseen politics of parenting, and, specifically, how the ideology of “humanized birth”—the idea that through conviction and preparation, birthing mothers can overcome the pain of labor to achieve a liberating and empowering natural birth experience that will result in better health outcomes for both mother and child—can inadvertently lead to some women feeling a sense of disappointment and failure. Furthermore, while “humanized birth” is hailed by feminist proponents as an alternative to (masculine) biomedical hegemony, I argue that it places a different, potentially noxious set of pressures on women. While I am not dismissing the benefits of humanized birth for many women, I am using a critical lens to signal that, instead of a wholesale liberation, “humanized birth” once again obliges women to correctly producing future bioconsumers.

Humanized Babies and Cyborg Feminists?

Thinking of reproduction as a discursive field brings up questions of “authorship.” Colonial legacies, racial discrimination, masculine dominance, and scientific ways of knowing are deeply embedded in the production of “truth” about human reproduction—potentially masking women's embodied knowledge. For example, Donna Haraway's work on the social construction of nature asks who are the agents creating representations of birth and reproduction, and to what end (see Haraway 1989)? Who has the power to define women's health?

Humanized birth is envisioned by its participants as inherently feminist since it inverts Sherry Ortner's (1972) identification of women's association with nature as the basis of their devaluation and instead casts “going back to nature” and the life-giving capabilities of female physiology as a source of empowerment and liberation. While for Ortner culturally constructed notions of nature buttress the universality of female subordination and seeps into the underlying logic that assumes the inferiority of women, humanized birth proponents have seized “nature” as a source of power and positive identification. However, my ethnographic work points to an inversion within this very inversion. I argue that this reinvention of nature is still dependent upon unequal power for its maintenance. Elsewhere, I point to how the humanized birth movement in Mexico inadvertently reinforces racialized logics rooted in colonial legacy and contemporary imbrication with the United States, and thus reflects desire for cultural capital

based on “social whitening.” While Donna Haraway (1990) interpellates cyborg feminists to author narrative strategies that rewrite stories in which inequities of race, sex, and class are naturalized in “functioning systems of exploitation;” in this paper, my focus is on the textual politics leading to persisting, unequalizing logics of class, gender, and sexuality, even through a movement that aims to position women as powerful agents by claiming “nature.”

While Haraway deems Michel Foucault’s biopolitics “a flaccid premonition of cyborg politics” (Haraway 1991: 150), I argue that within the humanized birth movement, the masculine biopower that proponents seek to resist has instead been replaced by a maternal form of biopower that similarly restrains women. That is, women have fled the hospital, escaped the “medical gaze,” rejected obstetric violence embedded in patriarchal biomedical systems, and have recast the home as a space not of subordination, but of freedom. And yet, these very women are entangled in a social support system whose fabric is interwoven with definitions of what represents a correct and ideal birth. I challenge uncritical notions of women’s liberation through humanized birth by pointing to how its social networks can lead to the subordination of participants to a new regime of requirements for a glorified, moralized motherhood—an ideal which is only sometimes achieved, and may thus result in feelings of failure and insufficiency. Underneath the battles to resist male-dominant capitalism and women’s sexual appropriation “in a masculinist orgy of war” (Haraway 1990: 154, referring to Sofia 1984) is, still, “the matrix of women’s dominations of each other” (Haraway 1990: 155).

While a movement among Mexican and Latin American women to move beyond the textual politics of science and technology to something even more radical (*el recobrar el poder de las mujeres*, taking back the power of women through ownership of nature, thus “seizing the tools to mark the world that marked them as other” [Haraway 1990: 175]) would seem like a cyborg project of the twenty-first century, humanized birth does not satisfy Haraway’s utopic vision of “a politics rooted in claims about fundamental changes in the nature of class, race, and gender in an emerging system of world order analogous in its novelty and scope to that created by industrial capitalism” (Haraway 1990: 161). The moralized, feminized, “whitening” humanized birth which these feminists of color practice is not what Haraway imagined when she wrote that cyborgs are “suspicious of the reproductive matrix and of most birthing,” (Haraway 1990: 181), but I support Haraway’s suggestion regarding the utility of suspicion. Humanized birth points not only to how science and technology provide fresh sources of power, but how New Age, “traditional,” and “holistic” therapies also require fresh sources of analysis and political action (see Haraway 1990 and Latour 1984).

In conclusion, I point to what the authorship of reproduction as a discursive field *does*, and what tensions it reveals or conceals. Research on reproduction is an important place to begin untangling the politics of representation and uncovering the relationship between gnoseological creativity and social and geopolitical power. I have argued that couples from the global professional class (Spivak 2003: 618) accrue cultural capital through participation in a “whitening” transnational meritocracy that dictates gendered parenting trends. What the term “meritocracy” obscures is the class-logic upon which the criteria for “good parenting” is based. Cultural capital masks economic capital, naturalizing the idea that “good parents” *can* and *do* spend large sums of money on their children. Thus, the very notion of “meritocracy” perpetuates and reinscribes socioeconomic inequality. In the next chapter, I explore the relationship between socioeconomic inequality and the (re)production of socially-defined racial categories.

RACIAL I(NTER)IDENTIFICATION

Chapter Four

A common theme emerged throughout my fieldwork: the “othering” of “them.” Who is “el otro” in Mexico? During in-depth interviews, more affluent informants were sometimes deeply critical of the things “they” do. Over time, I reflected on why criticisms were not offered about “us Mexicans” and the things “we” do. Who were informants referring to? While at times it was clear from the context of the conversation that “they” were indigenous people, at other times, “they” encapsulated marginalized people in Mexico more generally: urban poor, rural farmers, the uneducated, and recipients of government aid or public services (often indigenous women). After several years of living in Mexico, I realized that the disparity between those who form the powerful elite and those who struggle to make ends meet at the margins of Mexican society follows a color gradient.

Upon turning on the television any given evening, viewers can observe the difference between the fair-skinned actors and actresses on the screen and average men and women on the street. If a darker-skinned actor or actress appears in a telenovela, it is likely that he or she is playing the role of a servant. Whiteness continues to be an ideal in Mexico, but unlike some Asian and Middle Eastern countries where skin creams and sun protection are used to physically whiten skin, whiteness in Mexico emphasizes extra-phenotypical factors, almost masking the effort invested into individual portrayals of whiteness, and the sustained role of “race” and racism in everyday life. Education, habitus, socioeconomic status, and cultural and social capital are all variables in the calculus of whiteness. The racial judgments that are made about self and others using complex, interlacing social and physiological criteria are what I call “racial i(nter)dentification.” It is through this construction of self through contrast to others that acid remarks aimed at “them” were rarely explicitly racists. Racial *i(nter)dentification* emphasizes how racial *identification* of self and others is necessarily a syncretic process. In this chapter, I use contrasting ethnographic examples from San Miguel and the Nahua High Mountains of Veracruz to provide texture to the concept of racial i(nter)dentification and thus explore how “racism” operates through processes of differentiation.

The Exclusion of Racialized Locals in “Gringolandia”

After the initial enchantment of San Miguel’s cobble-stoned streets, vibrant-hued buildings, baroque cathedral, mariachis, and officers on horseback subsided, I began thinking more carefully about the unequal politics of transnationalism and identity embedded within my chosen ethnographic “field.” I noticed that in San Miguel, the *rebozo*-cloaked women clutching mud-streaked babies while begging in the street all have indigenous features. Brown-skinned primary school-aged children wander in and out of local businesses during school hours, begging and demanding alms (employing the form of conjugation used for giving an order), their practiced “needy” expressions and aggressive tones elicit feelings of discomfort and guilt, effectively luring coins from the hands of many unaccustomed visitors and foreigners. Meanwhile, on weekends the town center is flooded with tourists and wedding guests from bigger cities—many of who flock to the local Starbucks, converting the international coffee chain into a bustling and noisy hot spot. On Saturdays, the parish on the main square hosts a wedding every half an hour—the beautiful fair-skinned women gather near the *zocalo* to take photos in their elegant beaded gowns.

I spoke to Flor, a CASA midwifery student at the time, and an informant who has evolved into an extraordinary friend. She told me that in San Miguel, there are invisible walls—spaces she cannot access—these are the unspoken rules of inclusion and exclusion for lower-class Mexican women. Having only begun to think about gendered racialization processes, I didn't fully understand her meaning and initially I was incredulous. How could this be if I had never encountered any obstacles moving through numerous spaces in San Miguel?



Panoramic views of San Miguel de Allende



As a brown-skinned woman, I was still thinking of racism in terms of phenotype instead of considering how racial i(nte)ridentification works to make judgments about individuals' positionality in society based on complex criteria that include *and* supersede phenotype. I could not understand how Flor, a woman who is significantly fairer than I, would be discriminated against but not me. Having initiated my ethnographic fieldwork only several months before, I had not yet arrived at that hyper-self-reflexive moment that anthropological work on inequality requires. I still did not understand how my affluence was written on my body—wrapped up in my tone of voice, exuded in my gestures, written in my face-forward gaze, and embedded in my everyday ways of engaging with others. Over time I was able to shed many of these visible markers that had up until then been invisible to me. For now, I still had much to learn.

Flor looked at me in the eyes and said, "Of course you've never been discriminated against! Because you are you, Rosalynn! I could never go into Starbucks." I challenged her. Could she demonstrate to me how this racial i(nte)ridentification was operating at Starbucks? She proposed that we do an experiment: we would go to Starbucks and attempt to use the bathroom. I was to remain silent, submissively by her side. She explained that while young people with fair skin and large pocketbooks are invited to loiter at Starbucks (sometimes without making a purchase), lower-class Mexicans are interrogated and often barred from the premises. We would inevitably be turned away. We approached the Starbucks entrance nonchalantly, hoping to blend in with the constant flow of young iPhone-carrying patrons on this busy weekend and to cross the threshold into the courtyard. (Starbucks is located in a former hacienda that now houses a number of boutiques and art galleries. There is a bathroom in the courtyard for anyone visiting Starbucks or the neighboring stores. In actuality, these bathrooms are considered "public" to anyone who possesses the right amount of cultural capital—but not for everyone, I was about to find out.) The guard stopped us. Where were we going? Flor answered, "We had a coffee here this morning. We'd like to use the bathroom." He asked to see our receipt, stating that we could not come into the building without a sales receipt. She responded, "I threw it away after we left. I'm pregnant and the pressure of the baby on my bladder is causing me a bathroom emergency!" She patted her plump belly to emphasize her words. The guard was unmoved: "If you don't have a receipt you can't come in." Flor retorted, "If you don't let me in, I'm going to pee in my pants!" The guard responded, "Then pee in your pants. You can't come in."

While it may seem that Flor was barred from the premises because of her lower-class standing and not due to being identified as a racialized "Other," throughout this chapter I present race in Mexico as a complex algorithm which orders social hierarchies based on criteria that extends far beyond biology, genetics, and phenotype to also include class, education, national identity, and other forms of cultural capital. I offer racial i(nte)ridentification as a tool for analyzing the multiple variables contributing to the immediate, often unconscious, mental calculus that occurs during quotidian encounters of difference. Racial i(nte)ridentification goes beyond "racial profiling" by discarding U.S. racial politics as the frame of reference, taking transnational encounters as the lens for analysis, examining social interaction in "internal borderlands" like San Miguel where both colonial legacy and contemporary international relations are woven into the fabric of everyday life, and explicitly attending to the amalgam of non-biologic elements that are folded into notions of "race."



Flor and a fellow professional midwifery student, with a baby whose birth she attended.

About a year later, I spoke to my landlady, Pati, about the gendered racialization processes that were occurring around me. Pati had recently broken up with her common-law husband, with whom she had two children, due to his relapse into alcoholism. I lived in a small room above their living quarters and paid about \$120 dollars monthly in rent, utilities included. Over time, we became close friends, and she shared plenty of her heartaches with me. One evening, we were sitting in the kitchen, chatting, when she told me that as a housekeeper it would behoove her to improve her conversation skills in English and thus be able to communicate with her American employers. When I offered to help her, Pati explained to me that she had already attempted to sign up for a language exchange program at the Public Library but was refused. (The Public Library, *Biblioteca Pública*, in San Miguel is actually an NGO funded by donations from foreigners—the Municipal Library, which pales in comparison, is located around the corner and is unknown to the majority of Sanmiguelenses. The Public Library traces its origins to 1954, when Mrs. Helen Ware set out to provide access to educational and reading materials for Mexican children.) The language exchange program pairs American retirees and expatriates with “local Sanmiguelenses” so that both can improve their speaking skills in the others’ native language. Pati went to the Public Library one afternoon after cleaning house and asked to be placed on the wait list. The attendant at the desk gave her the “once over” and decided that she was unsuitable for the program. “I’m sorry—there are no available spots and you cannot be placed on the waiting list.”

Having already pondered the invocation of humanitarianism during training workshops for traditional midwives that inadvertently reinforce racialized hierarchies and commodify indigenous cultures⁴⁶, I wondered about the visual politics of NGO programs that seek exchange with the local community whilst making certain community members appear and others disappear⁴⁷. Program participants that-never-were like Pati are invisible to foreign participants in the language exchange program—language partners learn curated versions of “culture” by conversing with each other about personal experiences—therefore La Biblioteca Pública’s native English-speakers will never know about Pati’s desire to learn, the houses she cleans, or her home and children tucked away in a meter-wide hillside alley⁴⁸.

After listening to her story, I wondered if I could be “racially misidentified”—if I could intentionally “racially darken” myself, and thus experience some of the discrimination my friends were experiencing. It was obvious to me that Flor and Pati’s perceived class had a lot to do with how they were being treated. This was not the question. Rather, I was testing the degree to which perceptions of “race” were also influencing the mental calculus through which individuals decide how to treat other individuals. I had learned that social class is operative during moments of encounter and exclusion, but how is “race” collapsed within social class (and vice versa) as a marker for social categorization? I dressed myself in “indigenous” clothing—an embroidered linen blouse, a long skirt, and sandals—and twisted my long, black, waist-length hair into two braids. I had visited the Public Library on several prior occasions as my American

⁴⁶ See my description in chapter two of the “*encuentro*” in Estación Catorce between traditional midwives and medical personnel.

⁴⁷ I am adapting Haraway’s 1990 approach to “textual politics.”

⁴⁸ I am pointing to the irony of how some forms of inequality are hidden from privileged sojourners while others are revealed and even marketed. For example, compare Pati’s exclusion from the language exchange program to the emergence of “favela safaris” and other forms of touristic voyeurism of poverty and suffering.

self, dressed casually in T-shirts, cotton blouses, and jeans. How would this change in dress/presentation of self alter the cordial treatment I had experienced?

Upon entering the Biblioteca Pública, I chose a table in an area with about a dozen tables and no patrons. I pulled out my copy of Hannah Arendt's book *On Violence* and began underlining and writing in the margins. My objective was to act as I would on any other day, so I carried on with work as usual. I could feel a library employee standing nearby staring at me, wondering what to do, but I feigned ignorance of his conundrum and continued reading. A minute later an older Caucasian woman sat down a couple of tables away. The library employee spared no time approaching her table and asked her, in English, if he could prepare her something to drink from the library's café. She said, "No, not now. I'm fine, thank you." He then approached my table and asked me hesitantly, in Spanish, if he could offer me anything. I responded, also in Spanish, "Not right now. Thank you." (By this stage in my fieldwork, my American accent was virtually undetectable, and I had mastered the art of passing for a woman born and raised in Mexico.) He then responded, "In that case, I'm going to have to ask you to leave. This space is only for our patrons."

At that point, I could have then spoken to him in perfect American English, forced him to acknowledge his racist presumption, and demand he retract his statement. Perhaps this is what I should have done. But I felt the purpose of the experiment had been served. My intention had not been to challenge existing racialized hierarchies, but to conduct "undercover" ethnography to try to comprehend the mechanisms of inclusion/exclusion from which I had thus far been shielded. As my research progressed, a key strategy for my achieving ethnographic acuity was to learn to shed all visual markers of privilege, manage my phenotype, and experience exclusion first-hand. Furthermore, to gain the trust and respect of my lower-class Mexican informants, it was important that I live like them. I limited my spending to approximately 400 USD monthly—an amount that dictated what I was able to buy at the grocery store and caused me to travel by bus and on foot instead of taking taxis. As an ethnographer committed to my craft, it was crucial for me to maintain congruence within my embodied experience of having limited resources.⁴⁹ Throughout my ethnographic research I knew I possessed the cultural capital to stop being excluded at any moment, but it was important to me not to disrupt the experience of rejection and presumed inferiority. So I shuffled off into the street like an "indigenous" woman who understands the unspoken racial code of this transnational town.

While I chose subservience as a response to the library employee's racial identification, the racialization performed by American-led NGOs is not met without resentment from the local Mexican population and Mexican employees at these NGOs. Over the course of my research, I have realized that it is not unusual for American founders at humanized birth NGOs to be accused of extortion. Mexican employees and "beneficiaries" of NGO programs wonder about the apparent disproportion of their salaries and resources when compared to the lifestyles NGO founders lead. Throughout my research, I was often asked by individuals associated with the NGO how founders are able to engage in so much personal travel, leading a transnational life that includes a home in a US metropolis and an extravagant hacienda-style house in Mexico on a sprawling plot of land, among other properties. One NGO founder explained to me how hard he has worked his entire life in the world of Public Health, with sparse

⁴⁹ Over time, this embodiment led to a decline in my physical health. I lost weight, but my cholesterol soared. I was never at risk of serious or chronic illness, but I quickly learned about the pragmatics of limited economic resources and malnutrition.

economic returns. His posture, phrasing, and tone of voice gave me the impression that ongoing criticism has led him to preemptively justify his actions. Upon moving to Mexico, he explained, he had the opportunity to design and build a beautiful home for the very first time.

Unfortunately, the property he has amassed in Mexico has led to suspicion within the NGO he runs, and has resulted in a nasty lawsuit from a spiteful, disgruntled ex-employee. Some of his friends, also leaders of NGOs meant to benefit the local Mexican community, have had similar experiences. When I interviewed him, he was contemplating filming interviews of himself and his friends and putting together a documentary about “the do-gooders,” what moves them, and the challenges they face. During the same trip, I interviewed a few of his current employees, and they spoke to me at length about the personal kindness of the NGO founder and the importance of his advocacy efforts. Shortly thereafter, he and his wife both left Mexico, returning to their hometown in the United States. Since then, he has been supervising the NGO transnationally, and is reinserting himself into the Mexican context. My intention is not to minimize the altruistic intentions of individuals engaged in humanitarian work; rather, I am pointing to tension resulting from inherent inequality embedded within humanitarian encounters (Fassin 2012).

From “Race” to Gendered Racialization Processes and Racial I(nter)dentification

In Mexico, the category of *güero* (which literally translates to “fair-skinned”) can signal a phenotypic category, but often is indicative of a social category using socioeconomic status as a primary criterion for inclusion. For example, the term “*güero*” is used by shop owners to show respect for potential clients, even when the client is not fair-skinned. There is an underlying tone of subservience in this terminology, which can be traced back to Mexico’s colonial past. My work examines what I call “racial i(nter)dentification”: the dialectical, relational, and power-laden process resulting in the construction, negotiation, negation, and (re)production of racialized identities that are operationalized transnationally with political and economic effects. Racial i(nter)dentification can work in both directions—as with examples of “social whitening,” the opposite can also occur. People who are fair-skinned and lacking indigenous heritage can be racialized, “socially darkened,” and treated as inferiors because of their limited education and lower-class standing. While others have written about biologized race and racialized biology⁵⁰, my work is about the construction of social identities that allow for the manipulation of race. What is being racialized is not the biological body or the national body, but the moral body.

Instead of deploying the concepts of “race” and racism, I am pointing to how racial i(nter)dentification unfolds in and through processes of gendered racialization. That is, throughout this dissertation, I resist the reification of “race” and instead use ethnographic observations to critically analyze processes of gendered racialization. In doing so, I am taking an intersectional approach to ongoing conversations about racialized identities to which other anthropologists—for example, Michael Montoya (2011), Marisol de la Cadena (2000), and Elizabeth Roberts (2012)—have greatly contributed.

My approach builds upon a hefty literature on “intersectionality”—the study of how dimensions of inequality co-construct one another, an intersectional way of thinking about the

⁵⁰ See, for example, Kim Tallbear’s *Native American DNA: Tribal Belonging and the False Promise of Genetic Science*; Jenny Reardon’s *Race to the Finish: Identity and Governance in the Age of Genomics*; Marcia Inhorn’s *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai*; and Sahra Gibbon, Mónica Sans, and Ricardo Ventura Santos’ *Racial Identities, Genetic Ancestry, and Health in South America: Argentina, Brazil, Colombia, and Uruguay*.

problem of sameness and difference in relation to power, a foundational logic of interlocking oppressions, and an examination of systemic domination that overlaps sexuality, race, gender, economic class, etc. (Granzka 2014; Cohen 1997). According to Granzka, scholars of “strong intersectionality” (as opposed to “weak intersectionality”) engage in constant self-reflexivity, wielding the concept as an analytic tool that critiques power and privilege, and producing counter hegemonic knowledge about marginalized and subjugated groups.

Kimberle Crenshaw's analogy of the increased likelihood for injury due to crossing traffic at an intersection elucidates how black women sometimes experience gender discrimination in a similar way to white women, other times they experience racial discrimination similarly to black men, and still other times they are discriminated against as black women— not the sum of racism and sexism, but something that supersedes these individual categories and cannot be described as a derivative of white women's or black men's lives. Crenshaw emphasizes gender discrimination against women who are already marginalized by race and or class, and argues that while racialized women face some of the same obstacles that more elite women face, they also encounter obstacles that are unique to them.

In this chapter, I primarily examine the “race” axis of intersectional forms of oppression. That is, I aim to explore the *racialization* aspect of gendered racialization. I am by no means elevating racialization to the most significant criteria for analysis—socioeconomic class, education level, gender, geographic location, etc. are important, intersecting units of analysis. However, I am suggesting that analyzing racialization in this chapter will point our attention to how colonial legacies continue to shape identities.

My research provides many examples of the “class apartheid” to which Gayatri Spivak refers—the class divisions within individual nations that lead people of the same “culture” to live divergent realities, and the elite global professional class that is so often blind to the “Third World subaltern” (Spivak 2003:618). One of the aims of this dissertation is to draw attention to the complex ways class is embedded in gendered racialization processes, and vice versa, to create multivalent social categories. Among gendered individuals, one may ask if “race” is doing the work of class or if class is doing the work of “race.” I will argue, “yes,” and “yes.” Racialization and class, as well as resulting categories like education level and geographic location, are mutually imbricated and compounded in people's lives. That is to say, people cannot experience their positionality in society through only one of these factors; they necessarily structure their identity and their relationships with others through the combination of these intersectional factors.^{xii} By placing emphasis on racialization as an analytical lens, I am questioning how a history of colonialism shapes the contemporary transnational order (see Mignolo 2000).

CASA: Spearheading the Professionalization of Midwifery from the City of San Miguel

The humanized birth movement in Mexico at once references state and national geopolitical boundaries, while referring to ideology, birth practices, policy, and proven results from abroad. The movement points to the effectiveness of midwifery in reducing maternal mortality in Malaysia and Sri Lanka, as well as the sustained low infant mortality rates in Switzerland and Holland, where midwifery holds a privileged status and is widely respected as the best and safest way to give birth. Importantly, CASA's donor network is largely based in the United States, and a significant portion of its members (from co-founders to directors and even students) are transnationals.

CASA is a physical and metaphysical space that forms connections between peoples and social groups that are not based upon propinquity. Urry writes, “There are multiple forms of ‘imagined presence’ occurring through objects, people, information and images traveling, carrying connections across, and into, multiple other social spaces” (Urry 2007:47). CASA forms a network connecting 70,000 foreign donors and thousands of poor Mexican recipients. Furthermore, CASA is tied to many corporations in the United States through financial contributions—over 40 percent of their donations come from American corporations⁵¹. The community CASA forms through multiple forms of connectedness is “real” due to its financial impact, but it is “fictitious” in the sense that donors and recipients do not share a lived reality. This fluid community evidences that, in addition to the corporeal travel of midwifery students and CASA administrators and affiliates, CASA is a site of physical movement of objects (money and other resources), imaginative travel through multiple print and visual media (for example, in pamphlets and solicitations for donations), and communicative travel through person-to-person messages (via email, texts, letters, telephone and fax).⁵² CASA is an “assembly of humans, objects, technologies and scripts that contingently produce[s] durability and stability of mobility” (Urry 2007:48). CASA’s mobility and CASA’s positionality within San Miguel de Allende, a transnational site of circulation and unrelenting movement, make the professional midwifery model of care mobile—so much so that in September 2011, the Ministry of Public Health and Population in Haiti and the Mexican Subministry of Health Prevention and Promotion agreed to send two to four Haitian women to learn professional midwifery at CASA, in order to reproduce CASA’s model in their home country⁵³.

On the subject of mobility, Urry writes, “Individuals thus exist beyond their private bodies, leaving traces of their selves in space ... These changes involve novel, extensive and flickering combinations of presence *and* absence of peoples” (Urry 2007:15-16). The heightened mobility and perpetual travel of CASA employees and volunteers form a network across North America and the world, thus opening up the possibility for the spread of the professional midwifery model across spatial distance. Through these women, CASA has become a node which allows for an emerging ideology about birth and respect for women’s bodies to propagate, spread, and fortify.

Transnational space disregards transnational borders. By pointing to transnational space, I am emphasizing the way the humanized birth movement is informed and shaped by forces originating beyond Mexican borders. These forces have profound effects for the way individual women experience birth at the local level. CASA and its professional midwifery model could not exist without the City of San Miguel de Allende. San Miguel, to put it simply, is a perpetual “contact zone.” However, I would like to depart from this oversimplification to provide a more nuanced explanation of how San Miguel provides a fertile (but not unproblematic) ground for the professional midwifery model of health provisioning.

⁵¹ Personal communication in March 2011 with Sagrario, General Director of CASA at the time.

⁵² While imaginative travel implies that the reader/viewer of print and visual media is imagining themselves in the distant location described or depicted in the media, communicative travel is a way to achieve co-presence in the midst of absence through communicative propinquity (see Larsen, Urry, and Axhausen 2006).

⁵³ Personal correspondence with Sagrario, September 2011. Sagrario was the Advisor for Mexico’s National Center for Gender Equity and Reproductive Health, a sub-bureau of the Ministry of Health, at the time.

San Miguel de Allende is characterized by a large, visible population of semi-permanent resident American or Canadian retirees. (Increasingly, upper-class Mexican families and youth also flock to San Miguel on the weekends for a brief escape from their hometowns.) These senior Americans and Canadians live on a different economic and moral scale than the Mexican locals, and, thus, from the perspective of many Mexican locals, they enjoy the privileges of tourists on an ongoing basis. Urry, referring to Baumann, writes, “The tourists ‘pay for their freedom; the right to disregard native concerns and feelings, the right to spin their own web of meanings ... The world is the tourist’s oyster ... to be lived pleurably and thus given meaning’ (Baumann 1993:241). Both vagabonds and tourists move through other people’s spaces, they involve the separation of physical closeness from any sense of moral proximity and they set standards for happiness” (Baumann 1993:243; Urry 2007:33).

While I confess that Baumann’s assessment is rather harsh, it is true that in San Miguel two distinct worlds exist: the world accessible to most American and Canadian long-term residents, and the world in which many Mexican locals struggle to survive. San Miguel is comprised of two distinct phenomenological landscapes—two disparate realms of possibility—unfolding simultaneously. I argue that stark economic disparities (most long-term foreign residents receive pensions or have savings in U.S. dollars, while a large portion of local Mexicans work in the service sector earning close to the minimum wage in Mexican pesos) have led to two distinct economies, making some experiences (like dining out at one of the “mid-range” restaurants) unreachable for many Mexican locals. Currently, minimum wage in Mexico is 67 pesos per day (approximately 5 USD). Dinner at a “mid-range” restaurant would easily cost 500-600 pesos per couple, or eight to nine days’ wages. Rent for a studio apartment, equipped with American-style conveniences (furnished, with television, microwave, wifi, heating, etc.) costs around 700 USD per month, or what a Mexican local earning minimum wage would earn in 6.5 months. Entire neighborhoods and real estate developments, such as Los Frailes and Las Ventanas, are cost prohibitive to Mexican locals—prices are hundreds of thousands of dollars, and often extend into the millions—more than Mexican locals earning minimum wage will earn in a lifetime. In San Miguel, the percentage of Mexican families depending on near minimum wage earnings is high since the service sector is central to San Miguel’s economy.

On this note, Urry comments, “Such non-places are spaces: where people coexist or cohabit without living together; they ‘create solitary contractuality’” (Urry 2007:156, referring to Augé 1995:94). In this article, I place Urry’s solitary contractuality in conversation with de Genova’s “pluralization of urban space that identifies transnational processes as simultaneously capable of violent disjunctures and creative ferments, both of which are disproportionately felt among the poorest people” (de Genova 2005:123). San Miguel for sojourners is touted as “The Heart of Mexico,” and holds the history of the Mexican Revolution. Furthermore, in October 2013, Condé Nast Traveler Magazine Reader’s Choice Awards identified San Miguel to be the #1 city world-wide, citing “great atmosphere, excellent restaurants, culture and ambiance galore.” However, San Miguel for Mexican locals is sometimes characterized by one word: “Gringolandia.”

Over the course of my research, I have recognize the “reverse discrimination” my native-Sanmiguelense informants described as a result of San Miguel’s fragmentation and the pressure of solitary contractuality (Augé 1995:94). Due to San Miguel’s division into two parallel but mutually exclusive worlds—for many Mexican locals, San Miguel is not always experienced as an authentic place. Urry writes,

“Cities are becoming ... less places of specific dwellingness and more organized in and through diverse mobilities and the regulation of those multiple mobilities... These are the new global order, points of entry into a world of apparent hypermobility, time-space compression *and* distanciation, and the contested placing of people” (Urry 2007:148-149).

In San Miguel, services such as bars, cafés, restaurants, hotels, shopping centers, casinos, and gyms have emerged to impress and entertain visitors and “foreign” residents. San Miguel memorializes movement and circulation, but the idyllic resort town that foreigners enjoy eclipses the difficult reality many Mexican locals face. Often, Mexican locals live in the shadows of American and Canadian proximate strangers, and this experience has profound consequences for their individual psyches. I told Sagrario, “I imagine that always seeing so many services intended for Americans that locals will never be able to afford affects locals’ self-esteem.” Sagrario responded, “And we are so aware of it!” Some argue that San Miguel has become so touristy that it caters almost entirely to foreigners and upper-class Mexican visitors, to the detriment of the Mexican people.

These frustrations are “backstage” while San Miguel is “on performance” on the global stage. Urry writes that notions of certain tourist destinations are “not fixed and given but on the move, traveling the world via the media, the internet and the World-Wide Web, or packed away in suitcases of informal commercial importers, music pirates and drug dealers. There is no given original paradise on these paradise islands” (Urry 2007:58). While San Miguel is not an island, it is considered an enclave—amidst threats of kidnapping and narco trafficking in many regions across the Mexican landscape, San Miguel is touted as a safe place for English-speaking retirees to stay and enjoy themselves for extended periods of time.

From my perspective as someone who has resided in San Miguel for several years, San Miguel is eerily reminiscent of Jamaica Kincaid’s Antigua in *A Small Place*. The beauty of its cobblestoned streets and colorful colonial buildings is undeniable. However, like the Antiguans of *A Small Place*, Mexican Sanmiguelenses experience discrimination and corruption as part of their everyday lives. Kincaid describes the colonial possession of Antigua by Great Britain and how this resulted in the subservience of Antigua to England and English culture. Claudio Lomnitz-Adler (2005), de Zavala (1976), and Suárez-Orozco and Páez (2009) all point to the eclipse of European dominance and the simultaneous ascendancy of the United States to the post of hegemonic world power as key to how Latin American countries experience the United States.

In Mexico, fear of cultural degeneration in the face of ubiquitous U.S. cultural influence is paired with the “sneaking admiration” of U.S.-style modernity. Fitzgerald (2009) points to the plethora of U.S. styles, slogans, and media images that cross into Mexico, and how U.S. styles function as a sort of social capital—a marker of modernity. Not only are U.S. styles imported into Mexico, the United States also influences the way Mexican traditions are celebrated and represented—certain aspects of Mexican culture are stylized for foreign observers. In *Skulls to the Living, Bread to the Dead* (2006), Stanley Brandes discusses how the Day of the Dead has become a kind of cultural capital used to attract tourism, and benefits the economic, political, and social well-being of towns and the national state. In San Miguel, this cultural capital is exercised constantly—a multitude of holidays lead to “traditional” parades, fireworks, and celebrations almost every week.

When Mexican President Felipe Calderón inaugurated Rosewood San Miguel, a landmark resort, in March 2011, the spectacularization of inauguration was for the benefit of

potential tourists to San Miguel. There was the sense that the whole world was watching—and Mexican locals were watching too, but their gaze was not of consequence since they could never hope to step inside the front doors of Rosewood San Miguel (except as receptionists, waiters, and housekeepers). Ironically enough, Rosewood San Miguel’s philosophy is “a sense of place.” For many Mexican locals, entire zones of San Miguel are characterized by a lurking, and not easily ignored, sense of placelessness. In the presence of so many luxuries that locals can never take part of, except from the position of service workers, locals feel *displaced*. While I purposefully resist Urry’s notion of “non-place” and the total lack of agency it implies, I emphasize that San Miguel is simultaneously a site of belonging and dispossession.

Pleasant images of San Miguel can be like one-way reflective glass—sojourners may see diversion and relaxation in their own reflection without seeing the Mexican service workers on the other side of the glass, while Mexican locals watch sojourners’ performance of being “leisured” through the glass without being able to cross to the other side or see themselves in these moments of enjoyment and ease. Urry argues that “the performances of place often cannot be realized or there are contested performances or ‘emotional geographies’ of place” (Urry 2007:261, referring to Bondi, Smith, Davidson 2005).

I suggest that in San Miguel, the emotional geography is a well-kept secret, and is only momentarily revealed when specific violent acts against foreigners catch media attention. For example, San Miguel was abuzz after the murder of three elderly U.S. citizens in late January and early February 2011. According to CBS News, “For decades the city of San Miguel de Allende, nestled along the mountainous region of Central Mexico, has attracted scores of Americans, Canadians and Europeans seeking to retire in the mild climate and tranquil, culturally-rich region. But in just the past three weeks, the safe haven community—known for its low crime rates—has been shattered by the unsolved murders of three Americans.”⁵⁴ More recently, in September 2013, a 72-year-old Canadian woman was bludgeoned to death in her home⁵⁵, causing many foreign women, especially those who live alone, to fear for their safety. It was as Urry said: “To be a tourist is to be on the front line in places of positive affect but places that can transmute within a split second into places of carnage” (Urry 2007:270).

The real San Miguel is fraught with inequality and suffering. As I’ve already mentioned, locals earn in pesos despite the “dollarization” of the local economy. Pointing to the weakened acquisitive power of many Mexican’s wages and increasing poverty, ex-presidential candidate Andrés Manuel López Obrador writes, “Currently, the earnings per person of 70 percent of Mexicans is less than 2,680 pesos monthly” (a mere 175 USD monthly, see López Obrador 2010:95), and explains that as a result, 41 percent of the economically active population do not earn enough to afford good nutrition (López Obrador 2010:97). Many Mexican locals are *displaced* because it is difficult to impossible for them to find an affordable place to live in the pricey center of their own town. I remember once being invited to the home of a well-respected medical professional (an employee at San Miguel’s Seguro Popular clinic by morning and a private clinician by night) in a *colonia* beyond the edges of town. This man was born and raised in San Miguel, and trained at the National Autonomous University of Mexico (UNAM). I had

⁵⁴ Keteyian, Armen. “Mexican Murder Mystery: Three Americans Dead in Last Three Weeks.” *CBS News* 15 February 2011. 2 April 2011 <http://www.cbsnews.com/8301-31727_162-20032001-10391695.html>.

⁵⁵ http://www.thestar.com/news/crime/2013/09/27/mexican_police_suspect_robbery_was_motive_in_brutal_beating_that_killed_canadian_artist.html

passed by a gleaming shopping plaza and several luxury resorts to get to his home, and when I finally found my way, I was standing on a dusty path in front of a 15-foot-wide cinderblock box. A few minutes further away from the town center, a good friend of mine, Frida, a restaurant kitchen worker and pet sitter, lives in a small structure without electricity.

I do not mean to overemphasize the deep social inequalities that separate sojourners from Mexican locals. Also, my intention is not to deny locals their agency. In pointing to the emotional geography of San Miguel, I attempt to demonstrate the disruptive features of foreign and local juxtaposition, while also alluding to the productive possibilities of these encounters. San Miguel, a place where “traditionality” and ultra-modernity intermingle, is fertile ground for the production and revision of ideology, especially with respect to birth and respect for women’s bodies. I argue that San Miguel, as a contact zone, makes the production of emergent health models possible—if only through donations of American and Canadian dollars.

However, I also mean to point to the careful and constant negotiation of CASA’s work in San Miguel, specifically because of the deeply penetrating divide between people of white and brown skin. Sagrario told me that the American founder’s primary role is to fundraise since she is the only one who can. Sagrario commented, “If our founder were not an American, but a Mexican woman, our donors would say, ‘Oh, that’s a nice organization,’ forget about us and never donate a single dollar. We could not exist without [her].” Perhaps her judgement is more black-and-white than reality (or should I say more white-and-brown), but the frustration she expresses points to important lapses in communication between Mexican locals and foreign donors.

The Exclusion of Urban Outsiders in the Nahua High Mountains of Veracruz

While in San Miguel, processes of racialization (and dollarization) distinguish Mexican locals from American and Canadian retirees, in the High Mountains of Veracruz, racialization operates to cast indigenous people as lazy and violent, especially towards women. During my first visit to Zacatochin I conducted an extended formal interview with Fermín, the medical intern at IMSS clinic. As is the case with most rural areas in Mexico, the clinic is staffed by a nurse and a single medical intern who is required to complete a one-year internship as a graduation requirement for medical school. Over the course of the interview, I increasingly felt that Fermín was suffering from social isolation and was eager to speak to someone about his loneliness and anxiety. He explained to me how frustrated and exhausted he felt. While he arrived at Zacatochin full of anticipation and an enthusiastic desire to help and heal, he opined that the “cultural problems and lack of education” have destroyed his hopeful outlook. According to Fermín, the medical knowledge he learned in medical school are worthless when faced with the medical and social problems of rural, indigenous zones. Medical students are taught prevention, but the idea of prevention is useless given the dire living conditions and the poor mentalities of the people.

His interactions with the local villagers are primarily motivated by the fact that virtually all of the villagers are IMSS Oportunidades recipients, and they are required to submit to certain medical screenings in order to receive their Oportunidades stipends. He said that the only reason why villagers come to the clinic is because they are accustomed to state-run cash transfer programs and expect to “receive, receive, receive,” without any effort on their part. As a result of the conditionality of Oportunidades cash transfers, during medical exams, his patients act as if they are there “by force.”



Fermin preparing to perform an ultrasound on an indigenous patient

Fermín was struggling with the solitude of being a man from Mexico City and working in a rural clinic in an indigenous village. Nonetheless, his experience paled in comparison to the violent experiences of his female school mates. One of his classmates suggested to a female patient and her family that she go to the hospital immediately. She filled out the transfer papers, but the family decided not to take the woman to the hospital and returned home instead. The woman died in the night, and her family blamed the doctor for not insisting and accompanying the woman to the hospital. Soon after, the intern woke up during the night when she heard the woman's bereaved husband cutting through her window screen with a machete. She was able to call for help and the man was apprehended without having inflicted any harm on the intern.

Conflicts like these, along with stories of attempted rape, penetrated Fermín's perceptions of the indigenous community surrounding him. While he decided to study medicine because he longed to help people in need, this commitment to altruism was overshadowed by depressing judgments about indigenous villagers shortly after beginning his year-long internship. He told me, "Here there are no values." He felt deflated by the gender inequity, domestic violence, sexually-transmitted disease, infidelity, and alcoholism among the villagers. He criticized Zacatochin villagers for not spending their Oportunidades money on adequate nutrition, but yet they all have cable television!

Towards the end of our interview, Fermín confessed a secret to me. Fermín wears a wedding ring and tells the villagers he is married when this is not the case. According to Fermín's sham, his wife lives in Mexico City, where he went to medical school, and where he spends his weekends. In reality, Fermín lies about being married as a strategy for preventing or at least diminishing accusations of sexual molestation from villagers. If the people in the village knew he is not married, he reasoned, they would say that he only wants to perform pelvic exams because he wants to touch the village women. Fermín's secret points to how men are also gendered subjects who face expectations shaping their habitus and restricting their relations with others.

I wanted to measure the desperate image Fermín painted against descriptions of social problems from people with a different set of engagements with the community. I asked Doña Eugenia for her opinion on the matter. Her primary concerns had to do with how women are treated and related effects on the physical and emotional health. She told me that her own marriage was arranged and while her husband has become a friend with whom she lives in harmony, there has never been a romantic connection between them. In general, the custom of arranged marriages has given way to more "modern" pairings in which couples pick each other. However, this does not mean that women's choices are not restrained in other ways—once married, the women's decisions can be severely restrained by her husband's family. Doña Eugenia gave me an example of a woman "in the next village." (I wonder if the woman actually lived in the next village, or whether Doña Eugenia was attempting to anonymize one of her own fellow villagers.) She told me that after her husband died, her husband's family told her that if she ever remarried, they would take her children from her and prevent her from ever seeing her children again.

In another case, Doña Eugenia provided treatment to a woman who was badly bruised. When she insisted that the woman tell her the source of her bruising, the woman admitted that her husband had been beating her. Angered, she told her patient, "Tell him that if he wants to hit someone, he should come to my house and hit me!" When she encountered her patient's husband in the street, she told him, "I know what you've done, and if I ever find out about you hitting your wife again, prepare yourself, because I will report you to the authorities!"



Doña Eugenia listening to fetal sounds



Doña Eugenia during a postnatal visit with a mother whose birth she attended

The man promised never to hit his wife again, and his wife continues to reassure Doña Eugenia that he has remained true to his word. Doña Eugenia is the descendant of a long line of *curanderas* and *parteras*, so she commands respect within the community, and she uses her authority to demand non-violent treatment of the women in her village.

I also interviewed Padre Filadelfo to assess his opinion of residents of Zacatochin and the surrounding communities. As the priest for twenty-eight chapels in the zone, he has accumulated many experiences with the locals, and is often the keeper of their secrets. He told me that when he arrived to the region, he was fearful since he had never interacted with indigenous people before. Over time what he discovered, however, is that the people in these communities compose a spectrum, and like anywhere else, there are people at either extreme. Before he arrived, he explained, “they described the place to me as being really ugly with respect to the people [who live here]. [The villagers] fight for their rights—for sure—but especially when politicians deceive them to get their votes and when the time comes do not fulfill their promises. It is not violence for the sake of violence.”

According to Padre Filadelfo, the former priest was never able to gain the communities’ trust. The former priest was a *guero* (fair-skinned) and had a French surname. When Padre Filadelfo arrived to the zone, he made a concerted effort to treat the villagers as equals and to prove that he was different than the former priest.

Padre Filadelfo has learned that, in general, the community members are primarily Nahuatl speakers and possess limited fluency in Spanish. They understand the meaning of the messages he delivers from the pulpit but are not familiar with all of the Spanish words. Padre Filadelfo is working on learning more Nahuatl so that he can better communicate with the community he serves. Instead of wishing that villagers become more like non-indigenous people living in cities, he hopes that they preserve their linguistic and cultural traditions, and considers it a “defect” when mothers don’t dress their young daughters in traditional *bata*. While some mothers appreciate the time they save when their young daughters dress themselves in pants instead of having to facilitate wrapping the *bata* and others consider pants to be a more practical, warmer option during the cold winter months, Padre Filadelfo frowns upon this potential loss of cultural heritage.

The padre explained to me that while men often have to go to the cities to find employment, they tend to marry girls from their own villages, and this practice preserves the coherence of the community. That is, men have a perception of city women that is less favorable than village women when it comes to finding a spouse. Once married, marriages tend to last a lifetime. While marriage continues to be endogenous, he argued that gendered relationships are evolving with time. Just in the time that he has been priest in the region, he has noticed a drop in alcoholism, and a related reduction in domestic violence. Padre Filadelfo counsels his young female parishioners to consider possibilities outside of motherhood and marriage; likewise, he urges fathers to send their daughters to school along with their sons. He told me with confidence that in the short time he has preached in this region, the interrelations between the villagers and within families has improved, and this is evidence of the positive effects of the church’s teachings.

While Padre Filadelfo described most of his communication with villagers to be effective, this had not always been the case. The first time he was invited to a baptism, he noticed that the head of the table was set with the most abundant food. Assuming that he was the guest of honor, he sat down at the head of the table, only to be informed that that spot was meant

for the *padrinos* of the baby and was asked to choose another seat. His assumption signals the patriarchal hierarchy of the Catholic church with respect to its parishioners.

While the perspectives of Fermín, Doña Eugenia, and Padre Filadelfo coincide in pointing to gender inequity and violence, they differ in what is presumed to be the origins of social problems. For Fermín, the problem is cultural. He locates the cause of social problems as emerging from the villagers themselves—since their indigenous culture is the source of the social pathologies that plague the community, he is convinced that nothing can be done to improve the situation. For Doña Eugenia, positive change is already underway. She considers herself to be an agent of change and wields her authority to command non-violent treatment of women among her fellow villagers. In her perspective, social problems are not rooted in indigenous culture—rather, they are outdated remnants of the past and antithetical to a “modern” future. Finally, for Padre Filadelfo, indigenous culture is something to be celebrated, and he considers it his job to learn Nahuatl to overcome the language barrier instead of his parishioners obligation to learn Spanish. He also sees a positive change in the community, but the change he identifies is a result of the church’s teachings and not a “modernization” that originates from within the community. His assumption that he was the guest of honor at the baptism points to the potential difference between the role he feels he plays in the community and the role the villagers feel he plays. At times, his perspective takes on a missionary flavor, and he positions himself as the person that “saves the Indians” by enlightening their lives with the teachings of Christ.



Doña Eugenia, godmother and guest of honor at a baptismal banquet

In this chapter, I have juxtaposed locals’ experience of rejection and dispossession resulting from San Miguel’s tourism economy with the struggles of medical professionals and clergy to gain entrance into “closed” indigenous communities in the Nahua High Mountains of Veracruz. In doing so, I reiterate my argument in chapter two that seeks to balance politico-economic power structures with the agentive dynamism of indigenous informants. The pluripolitics of inclusion/exclusion are dependent on spatial contexts—that is, definitions of “race,”

gender, and identity shaping the encounters of difference are themselves nested in places. While gendered and racial hierarchies provide the rhetoric that naturalized the discordant experiences of individuals living in solitary contractuality and limits the realm of possibility; the underlying algorithm includes class, education, the color of one's passport (indeed, whether one possesses a passport at all), and, as I suggested in chapter three, cultural capital accrued from participation in transnational, consumption-oriented networks such as humanized birth.

Why, then, have I not just argued that what is truly at stake is habitus (Bourdieu 1984)? I insist that multiple, overlapping, structural inequalities are unfolding; thus, I offer racial i(nte)ridentification and intersectionality as multivalent conceptual tools because I refuse to disregard the blatant visual discrepancy between servers and patrons in San Miguel, and between institutional representatives and Oportunidades recipients in the High Mountains of Veracruz. "Race," gender, and class in Mexico are intimately imbricated, kaleidoscopic categories. Processes of gendered racialization collapse and incorporate a multitude of social factors, yet reducing these processes to a discussion of habitus would obscure apparent phenotypic gaps readily observed throughout my ethnographic research. In the next chapter, I will deploy my kaleidoscopic notion of inequality in a cartography of "race," gender, and obstetric violence.

A CARTOGRAPHY OF “RACE” AND OBSTETRIC VIOLENCE

Chapter Five

Nowhere is the dynamic of othering more salient than between health providers and the people they are meant to serve. While in San Miguel, I was invited to a directors’ meeting at an NGO focused on community health. The directors considered “ignorance” and lack of responsibility to be primary obstacles to helping community members improve their health: for example, parents who don’t teach their children to eat vegetables and themselves do not eat vegetables, individuals with poor health who do not seek treatment until it is too late, adolescents who forego using contraceptives despite the availability of information about their use and effectivity, and mothers who stay home with their newborn during the first week after birth instead of having their neonates tested for hypothyroidism during the short period when long-term consequences can still be prevented. Whether or not healthy food is available to lower-class families, insufficient infrastructure in hospitals, accessibility of contraceptives given Mexico’s catholic underpinnings, and the benefits and limits of women’s embodied knowledge were left out of the discussion. “Ignorance” is not only used as the explanatory variable for negative health outcomes in boardrooms—elsewhere in San Miguel a woman shared a painful miscarriage experience with me, explaining that the nurse at the public hospital scolded her, saying, “You should have known that you were miscarrying. It is your fault that you didn’t come sooner.”

In Veracruz, health professionals blamed vaginal infections on poor hygiene, while women insisted that “it is not the woman’s fault.” They criticized their patient population for being bad “sanitary subjects” (see Briggs and Mantini-Briggs 2003), placing themselves at risk, not understanding medical advice, and needing to be told things “real slow.” Throughout my fieldwork, I noticed how physicians explained their diagnoses and treatment options in “colloquial” terms, which often meant giving incorrect information. In turn, this was interpreted by patients as lying and breded distrust and avoidance of hospitals all together. Examples are telling indigenous people that an injection contains “vitamins” and that baby must be born quickly or it will die.

In Guerrero, I sat in on a meeting between Secretary of Health officials about incorporating professional midwives into public hospitals and rural clinics. At the conclusion of the meeting, one official summed up the Secretary of Health’s progress in the area of women’s reproductive health by saying that people in villages are “too closed-minded,” making it impossible for them to do their work. I visited a regional hospitals in one of the impoverished, indigenous zones that these officials are responsible for overseeing and spoke to a physician about the difficulties he faces when treating patients. He said, simply, “Their problem is themselves. They are their problem.” Again and again, health professionals told me how difficult it was to work with *indigenas* due to their “distrusting” culture.

In San Luis Potosi I visited a rural hospital in a Huastec zone. The professional midwife working there—herself a person of Huastec heritage and a speaker of the Téenek language—told me that a large number of adolescents are giving birth in that hospital. Some of the birthing mothers she attends, she asserted, do not even know what body part the the baby is coming out of. “The people around here do not know much.” I am interested in the way this professional midwife positioned herself vis-à-vis the community in which she works and in which she herself was raised. Having graduated from a professional midwifery school in another state, she no longer grouped herself with “the people around here.” I suggest that the implicit

contrast embedded in her word choice served to socially whiten her, thus distancing her from her indigenous roots, even as her “indigeneity” and linguistic ability (and, implicitly, her gender) serve as primary criteria for her placement in that hospital (see Matoesian 2000)^{xiii}.



Meeting between Secretary of Health officials about professional midwifery in public hospitals

Elsewhere in San Luis Potosí, I asked two professional midwives what they hypothesized to be the cause behind a curious number of birth complications and congenital abnormalities in the region. They began listing their hypotheses: Women are not educated, have poor diets and don't drink enough water, don't take folic acid, they don't seek regular prenatal care, have poor hygiene leading to vaginal infections, and perform physical labor during pregnancy. One professional midwife said, “The patients are uncultured. They don't come for medical examinations. Also, they lack education. A lot of women don't even know they are pregnant 32 weeks into their pregnancy.” They went on to describe to me how a mother was nursing her newborn in the hospital when a nurse noticed that the baby was purple and not moving and took the baby from the mother. The medical team was able to resuscitate the baby, but if it had not been for the nurse's intervention, the baby would have died in the negligent mother's arms. After they told me this story, I joined them in the OR, where a woman was having the remnants of a miscarriage scraped from her uterus. Doors on both sides of the operating room were propped open, leaving the woman's naked genitals exposed to those passing by in the hospital corridor.



Congenital birth abnormalities are blamed on women being uncultured and uneducated.



Anesthesiologist teaches professional midwife how to apply medication through an IV drip

In Chiapas, I spoke to a health official about maternal deaths. He described recent cases, explaining that the first was a woman whose eclampsia was not identified opportunely because she didn't attend prenatal checkups. In a second case, he was not sure what was the cause of the woman's death, but he knew that the traditional midwife was to blame. In another case, he again was not sure to the actual cause of death, but knew that it was an uneducated woman from a rural area. Lastly, I was told about a maternal death involving a traditional midwife who belonged to a civil association of traditional midwives and had been trained by a local NGO. The traditional midwife attempted to deliver a dystocic baby and broke the baby's neck. I met with many of the traditional midwives in the civil association. They resented being charged with causing maternal mortalities when no investigation is made into the individual cases.

I later spoke to a physician who sees a large number of indigenous female patients. He said, "They lack the economic support to come to the health center and buy medications, but the culture of the people living in the countryside does not allow us to go to them." He identified indigenous peoples' traditions and lack of education as the main reasons why patients and doctors are unable to understand one another. As our conversation broached the overlap between resource scarcity and indigeneity, the doctor reflected aloud on how he chooses whom to attend next from a crowded waiting room. Indigenous patients are less likely to have ready and reliable access to bathing water, and he is more likely to pick someone from the waiting room who has bathed today rather than three days ago; therefore, he tends to pick indigenous patients last, causing them to wait the longest.

In Michoacán, I interviewed a leader of an NGO that advocates for women's health, especially among Purepechan women. He spoke at length about inequality and his words point to how easily indigeneity is collapsed with poverty: "If you ask 'are the Purepecha discriminated against?' some people will say no. But...the majority of Purepecha would say they are routinely discriminated against and looked down upon, or refused service, or delayed service. It's common to have that kind of discrimination. Class is probably, I think, the major issue in Mexico. The disempowerment of poor people."

While I am sensitive to the effects of colonial legacies unfolding in the present day, I resist carrying out a Fanonian or Hegelian analysis of mutual recognition (see Hegel 1977, Fanon 2008 and Villet 2011)—not because I do not consider these analyses valuable, but because I recognize that many others have done illuminating work in this field, and I think it is more productive to use an intersectional approach to address the questions at hand instead of applying the concept of mutual recognition to a Latin American context. In this present analysis, I am positioning myself as a medical anthropologist, and more specifically, as an intersectional scholar of the anthropology of reproduction. Thus, using intersectionality as a lens, I bring ethnographic tools and anthropological theory to bear on racial i(nter)dentification in Mexico. What can stratified reproduction (Colen 1995) tell us about race?

Raza

In his fieldwork on the US-Mexico border, Michael Montoya looks at the human genome as a cultural form that constitutes social and material orders. His book is not an ethnography about Mexicans, but an examination of the people who socially produce individuals as biological Latino/as^{xiv}. While at first glance it seems he is arguing against reductionism, determinism, and geneticization, his work turns out to be even more subversive.

I share with Gravelee the desire to push beyond discussions that reiterate that race is a social construct about which biology can tell us little. While true, this insight closes

rather than opens the conceptual terrain about race and how it relates to biology.... I find it more productive, more faithful to my field encounters, to resist dualistic side-taking of biology versus society in examining the diabetes enterprise. [Montoya 2011:30]

Likewise, my argument is not about deciding whether “race” is essentially biological or primarily a social construct—rather, I am concerned with how a history of colonialism in Mexico has resulted in the lingering concept of “race,” thus opening a space for racialization processes which lead to the consumption of “culture” and the production of differential (“race”-infused) identities^{xv}.

While I resist reducing race to a matter of biology, biological race is used to define the right and wrong types of reproduction, which in turn shapes policy and practice both nationally and transnationally (see Roberts 2012). While medical anthropologists have extensively studied these effects in the realms of international population policy and migration⁵⁶; and have analyzed how nineteenth and twentieth-century battles about slavery, miscegenation, immigration, population control, and eugenics resulted in the categorization of people into fit and unfit reproducers⁵⁷; my work addresses Brubaker and Dillaway’s call to, “conduct comparative research on the subjective experiences of pregnant and birthing women at multiple social locations and multiple contexts, as well the experience and perspectives of midwives and medical providers in order to provide a more critical and meaningful analysis of the complicated intersections of ideology, politics, practice and bodily experience” (Brubaker and Dillaway 2009).

My work holds several of Elizabeth Roberts’ concepts under one lens in order to then engage binational literature on citizenship and interculturality. I employ Robert’s notion of *raza* and provide ethnographic examples of how “reproductive governance” is applied to the supposedly hyper-fertile indigenous women while whitening is sought through private medical care by educated, urban women. In doing so, my work is informed by a binational discourse critiquing public health systems in Latin America⁵⁸.

Roberts writes about how, in Ecuador, middle-class and increasing numbers of working-class women eagerly pay to be scarred (Roberts 2012). Cesarean sections carried out in private clinics serve as a physical mark identifying women as superior to the indignities of devalued public medical services. Thus, women pay to have their bodies cut since this transforms them into more desirable, whiter beings. Women are not seeking citizenship, since in Ecuador, citizenship in the medical realm is denigrated.⁵⁹ Instead, the scar evidences the woman’s ability to stand apart from the governed masses who need to make citizenship claims to state institutions for social services (surveillance Gordon 1988; Foucault 1990). These scars enact a racialized relationship to the nation and effectively whiten women since browner bodies are cast as able to withstand vaginal birth within public maternity care. As an intersectional scholar, my reading of Roberts’ work is that cesarean scars also mark women seeking *privatized* care as *women*. That is,

⁵⁶ See Fraser 1995, Goldade 2007, Morgan and Roberts 2012, and Pashigian 2009.

⁵⁷ See Douglass 2005, Horn 1994, Nouzeilles 2003, and Stepan 1991.

⁵⁸ See Breilh 2003, 2008; Laurell 1997, 2013; Laurell and López Arellano 1996; and Waitzkin’s 2000, 2011.

⁵⁹ On the relationship between the body and political status, especially with regards to neoliberal economic transformations, Roberts references Biehl 2005; Briggs and Mantini-Briggs 2003; Petryna 2002; Rose and Novas 2005.

the cesarean scar serves as an embodied intersection of superior race, higher class, and feminized gender.

Roberts concentrates on the constitution of race, especially whiteness, through the “crucial economic and moral significance of care relations, in which life chances are forged,” (Biehl and Eskerod 2007: 110). Even though the collective goal of *blancamiento* is not often spoken about through the idiom of whitening, it is sought through practices of education, clothing, language, and occupation⁶⁰ and is reinscribed within private gynecological care. By including medical care as another means to mark and transform race, Roberts is calling our attention to the malleability of material reality, and thus provincializes North American tendencies to mark a divide between nature and culture, and assumptions about the universality and fixity of biological processes (Haraway 1991; Latour 1993; Mol 2002; Lock and Nguyen 2010).

While in North America race is understood as inherent to the person, despite scholars’ emphasis on how race is constructed and performed (Hartigan 2010), the materiality of *raza* in the Andes is malleable⁶¹ and can be changed through changes in body and comportment. *Raza* is a “political economy of the body” (Lancaster 1992)—not a ahistorical, unchanging interiority. She writes, “In Ecuador, medical care makes race” (Roberts 2012:217). In this context, public health services were developed to intervene upon poor and indigenous populations, and especially hyperfertile indigenous women⁶². Thus, while *raza* is more pliant, plastic, and cultivatable in the Andes than in North America, it is still used to justify inequality.

Similarly, de la Cadena points to how *raza* is shaped by employment, locale, dress, class, levels of “decencia,” and sexual conduct (Cadena 2000). De la Cadena explains how pervasive racism in Peru is erased, using a rhetoric of cultural difference: “These exculpations of racism are embedded in a definition of *race* rhetorically silenced by the historical subordination of phenotype to *culture* as a marker of difference. In other words, Peruvians think their discriminatory practices are not racist because they do not connote innate biological differences, but cultural ones” (de la Cadena 2000:2). For de la Cadena, cultures are vessels of immanent inequalities, leading to the mystification of racial discrimination and “racism without race.” Culture is achievable, and categories such as Indians and mestizos emerge from interactions and not from evolution. One’s phenotype can be subordinated to one’s intelligence and morality if these have been corrected by “education.” Thus, a brown-skinned individual who is sufficiently educated can become “socially white” (see Bashkow 2006). With respect to the Mexican context, I do not deny associations between phenotype and how people are identified as racialized beings; however, I expressly resist the idea of “race” as phenotype, and signal how “social whitening” is sometimes achieved through the accumulation of cultural capital via commodified birthing practices.

Clark focuses on how educating Indians produced them as national citizens: “By definition Indians were seen as ignorant, because it was assumed that Indians who were educated would automatically become mestizos” (Clark 1998: 230). Roberts writes, “*Raza* entangles what in North America is understood as class relations.... However, disentangling class and *raza* would do damage to an ethnographic understanding of care relations in Ecuador. Identifying the kinds of food ingested or care received as social markers of class, misses the way that *raza* is

⁶⁰ See Pitt-Rivers 1973, Wade 1993, Cadena 1995, and Colloredo-Mansfeld 1998.

⁶¹ See Cadena 2000, Leinaweaver 2009, Orlove 1998, and Smith 1996.

⁶² See Clark 1998 and Ewig 2010.

produced within economic relations. Private gynecological care cultivates female whiteness, which is simultaneously a political, economic, and physiological state” (2012: 230).

Roberts points to how creole elites in Ecuador saw the “Indian Problem” as a roadblock to their civilizing, modernizing, and whitening project (Larson 2004). The solution was to frame people who accept the goals of national culture as white (Stutzman 1981). Roberts argues that the saying “money whitens” is not about misrecognition, but about how accumulating money results in whiter relations of care, such as private medical care. Roberts is pointing to how women become whiter reproducers, not only through education and professional advancement, but through being cared for as whiter women. This care does not cease to be patriarchal since women are cared for by surgeons who cut them tenderly, like a father towards a privileged daughter, instead of public medical patients. Again, while Roberts’ primary focus is “race,” I reiterate that “race” is shot through with class differences among gendered individuals.

As I described in chapter two, citizenship is a fertile terrain for negotiation between indigenous women and the Mexican government. These women are recruited into *Oportunidades* (a conditional cash transfer program that shapes poor indigenous women into obedient mothers and “modern” citizens, see Smith-Oka 2013) and required to give birth in government hospitals. While my observations at times coincided with those of Smith-Oka—some indigenous women eagerly seek biomedical attention while giving birth—I interviewed many others who resist mandates due to prior experiences of racial discrimination. In chapter three and six, I address how citizenship fails to encompass the way privileged women are proactively constructing whiter subjectivities through natural birth in the private sector and participation in the humanized birth transnational network.

These very different engagements with medical care undermine ubiquitous arguments for “interculturality” among Mexican medical anthropologists. Interculturality in Mexico aims to reduce the effects of xenophobia by incorporating indigenous cultural elements into government-provisioned services⁶³. In the following pages I return to how my framing signals the inadequate attention of “interculturality” to gender, racial discrimination, and political economic factors. My concept of racial i(nter)dentification questions the reification of cultures upon which “interculturality” is premised.

Deadly Consequences of Gendered Racialization

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 midwife, Paloma, stood up in the very last row. Paloma 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

⁶³ See my description in chapter two of how “interculturality” unfolds at the clinic in Capulálpam de Méndez, Oaxaca. My primary criticism is that traditional medicine is juxtaposed with biomedicine, without actual integration. Also, biomedical professionals serve as the gatekeepers to traditional medical therapies, which are commodified and sold within the realm of (ethno)medical tourism.

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. Paloma ended the wrenching tale by yelling, “I, too, could put on a white coat!”



Medical personnel teaching workshop in Zongolica, Veracruz

The hospital director asked Paloma 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 Paloma that he would reprimand the community worker. While this seemed to appease Paloma 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, 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.



Traditional midwives in attendance at the workshop

This anecdote, combined with description of “intercultural” health care delivery in Capulálpam de Méndez and discussion of the politics of portraying indigenous identities in chapter two, provide ample grounds for the analysis and critique of 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. My ethnographic observations suggest that indigenous and mestizo cultures unfold and evolve through engagement with one another, and are, thus, co-constitute. Indigenous informants contest and shape how their medical practices are valued, at times leveraging “indigenous” knowledge in entrepreneurial ways. At the same time, social collectivities are differentially nested in geographic places and even “racially” segregated in clinical spaces, signaling how material disparities result from structural inequalities.

The Incoherency of Oportunidades

One particularly elucidative pathway for understanding the relationship between the Mexican government and indigenous groups is through detailed examination of Oportunidades conditional cash transfers. Paloma acquiesced following public dispute with the hospital director in Zongólica. However, throughout my research, I observed many midwives’ disparate behavior in public and private realms. Traditional midwives and indigenous Oportunidades recipients

performed obedience in workshop settings while enacting resistance to government mandates in their daily lives. Program successes “front stage” (like widespread attendance to Oportunidades-mandated workshops) did not easily translate to changes in social behavior “back stage.” Molyneux goes as far as to argue that Oportunidades puts mothers at the service of the “new poverty agenda” and inadvertently exacerbates gender inequality when it holds mothers accountable for their childrens’ well-being, excuses fathers of responsibility toward their offspring, and provokes marital discord (and potentially domestic violence) by putting cash stipends in the hands of women amidst widespread unemployment of male “providers” (see Molyneux 2006).

According to Rodrigo, a physician turned Mayan rights advocate and board member of an indigenous association in Chiapas, training workshops offered by the state are meant to reinforce inequality in existing power structures. While the Oportunidades program has been lauded within the realm of public health⁶⁴, I argue that the conditionality of cash transfers evidences differential valorization of knowledge and medical practices while also serving to extract obedience from Mexico’s racialized “others.” From Rodrigo’s perspective, “Oportunidades is really [an example of] the dominant society practicing coercion over indigenous people.” As an outspoken critic of biopiracy and a proponent of indigenous knowledge, he argues that while traditional midwives’ resistance to biomedical methods is deemed “backwardness” by medical professionals, traditional midwives are not interested in learning new techniques because they are confident about the effectiveness of the techniques they have been using for generations. He explained that while traditional midwives may attend training programs in order to continue receiving cash transfers and other government-provisioned services, they often do so with no intention of changing the methods they employ in their everyday practice of midwifery.

Rodrigo’s assertions are supported by traditional midwives like Yanira who, during an in-depth interview, explained that women’s participation in cash transfer programs has resulted in changes to what she reveals about her practice to authorities, but has not altered the substance of her midwifery. That is, women who receive support from Oportunidades tell her, “Don’t give me a birth certificate. I am going to say that [I couldn’t make it to the hospital in time] and gave birth alone at home. I am going to say that I was not attended by a midwife.”

However, building upon my argument in chapter two, my ethnographic research did not point to wholesale resistance. While indigenous informants often complied with Oportunidades mandates in ways that suggested engagement at the level of form instead of substance, I also observed how Oportunidades mandates structure the rhythm of indigenous womens’ daily lives.

During my first trip to Zacatochin, I joined Francisca as she completed the requirements for her two-week “field practice.” Among the requirements was to deliver a workshop to the villagers, educate them about reproductive health, and document the number of attendees as a measure of her “impact.” Francisca went to the municipal offices to sign up to have her workshop announced throughout the village. Since there are no telecommunicative services in the village (no telephone, internet, etc.), announcements are made via an old Volkswagen Beetle

⁶⁴ See, for example, Neufeld LM. The Oportunidades Program and Child Growth: Mexico Perspectives. In: Preedy VR, ed. *Handbook of Growth and Growth Monitoring in Health and Disease*. Springer New York; 2012:1659-1671. http://link.springer.com/chapter/10.1007/978-1-4419-1795-9_100 (Links to an external site.).

that drives slowly along the winding mountainous pathway, blasting information through a megaphone attached to the roof.

The next day, Francisca and I went to the gathering place where community-wide workshops are held—cement basketball courts covered by corrugated metal, built with government funds to foster “community development.” We waited, and no one arrived. Francisca decided to wait half an hour past the announced start time, and two women arrived. Disappointed in the meager turn out, Francisca half-heartedly delivered the workshop materials she had prepared, and then we walked back to our host’s home.

That night, Francisca reflected on the disinterest in her workshop, and she decided that if villagers were uninterested in learning information that was to their benefit, they would have to be coerced. Furthermore, she refused to return from her “field practice” to report that the impact of her workshop had been the delivery of educational materials to two people. The next day, while I was at the village clinic interviewing Fermín, Francisca returned to the municipal offices to announce another workshop. This time, she identified herself as someone who was coming to the village on behalf of the state-level Secretary of Health and that her workshop was mandated by Oportunidades. The next day, we returned to the basketball courts and prepared for the workshop. This time, over one-hundred and thirty members of the community, mostly women, attended. At the outset of the workshop, Francisca announced that at the end of the workshop she was going to take roll by asking to see each participants’ voting registration card and cataloguing each person’s name. This list, according to what she told participants, was going to be reviewed by the authorities at Oportunidades to determine compliance. In this way, Francisca insured that her audience remain captive until the end of her workshop.

As a professional midwifery student, Francisca was trained in medical terminology, and the intention of this “community engagement” experience was to allow her to develop the skills necessary to practice intercultural midwifery in rural settings. Francisca’s presentation of reproductive health was littered with biomedical terms that were incomprehensible to workshop attendees and she failed to explain underlying physiological properties. The workshop “participants” stared blankly at her during most of the workshop. At the conclusion of the workshop, attendees lined up as Francisca took their identification cards one by one to write down their names.

This anecdote clearly highlights Francisca’s abuse of power, evidencing how women with relatively greater privilege can also act as agents of structural inequality against other women. Moreover, it points to how conditional cash transfer programs like Oportunidades extract obedience from women recipients on the basis of their poverty and dependency on government-provisioned stipends. When the workshop was not a requirement for continued receipt of Oportunidades stipends, community members were almost universally disinterested. Subsequently, threat to Oportunidades stipends elicited compliance from village members. During private conversations, informants have expressed their annoyance at having to their daily routines disrupted and dictated by Oportunidades mandates. One mother reported feeling like “a ball, bouncing from one place to another.” Instead of validating the intended positive effects of obligatory social services, the Oportunidades recipients I interviewed pointed to their frustration with the conditionality of the cash transfers and with forced compliance. I argue that programs like Oportunidades are shaped by notions of “interculturality” that are valuable in theory, but contradictory in practice.



Workshop on sexual and reproductive health, “required” by Oportunidades

Interculturality

In Mexico, “interculturality” had emerged as a buzzword in government offices, academic circles, and a few hybrid clinics to describe respect for cultural differences through the merging of traditional indigenous medicine and biomedical methods. “Interculturality” is explicitly mentioned as a priority in the second article of the Mexican constitution. The article states, “The nation has a pluricultural composition originally sustained by indigenous peoples who are the descendants of those who inhabited the present-day territory of our country at the initiation of colonization and who preserve their own social, economic, cultural, and political institutions. . . . Awareness of their indigenous identity should be a fundamental criteria for determining whom undertakes the ruling over indigenous peoples” (my translation). The article goes on to state that, in an effort to ameliorate the *rezagos* (backwardness) in indigenous communities, authorities are obligated to assure effective access to health services that make the most of traditional medicine, as well as support the nutrition of *indigenas* through food programs, especially for the child population (Article 2, Section B III). Furthermore, authorities are obligated to foster the incorporation of indigenous women into development through support for productive projects, the protection of women’s health, and granting incentives to boost women’s education and participation in decision-making related to community life (Article 2, Section B V).

I argue that notions of “interculturality” are ubiquitous in Mexico, and are thus woven into development programs like Oportunidades even when not explicitly stated. The Mexican government engages with its indigenous population through the (supposedly) benevolent and equitable framework of “interculturality.” However, I examine the textual politics⁶⁵ of “interculturality” to uncover how this concept has been authored from positions of power as an approach to communities that are presumed inferior. The use of the word *rezago* in the Mexican constitution while describing various “intercultural” strategies points to the contradictory way *interculturalidad* in Mexico purports to equitably grant citizenship-based rights to indigenous community members while simultaneously casting indigenous people as “backward.”

To try to understand the concept of “interculturality” better, I shared my observations and compared experiences with Jaime Breilh, Director of the Health Sciences at Universidad Andina Simon Bolivar. He explained to me that in Ecuador, interculturality emerged as an indigenous movement, originating from the indigenous people. It has transformed not only into a political juncture, but an intellectual one as well. The people of Ecuador began applying their critical perspective to a colonial past, and the result was an epistemological and philosophical proposal for the future. In contrast, in Mexico “interculturality” did not originate from indigenous people; rather, it emerged as a theoretical debate in academia and bureaucratic strategy in public health policy and development.

My ethnographic fieldwork suggests that “interculturality” is a powerful force for producing racialized subjects, arranging them hierarchically, and extending the material effects of those hierarchies. I am arguing against a naïve reading of interculturality—a liberal formulation that creates a utopian vision of a world of harmonic difference that exists apart from power. That is, “traditional” medicine and biomedicine do not come together on a level playing field, penetrating each other equally and evenly. The expert knowledge of physicians and traditional medicine doctors are not equally valued, they are not equally remunerated, nor are they equally supported by healthy policy and infrastructure (see Chapter Two). Often, when

⁶⁵ see Haraway 1990.

“interculturality” is celebrated, a series of persistent inequalities are ignored. I am wary of how unequal power dynamics, disparate perceptions of value, and ongoing racial discrimination can potentially be masked by emphasis on “interculturality,” whether it be at the level of academic debate, or public health policy.

When performing fieldwork, I spoke to a variety of people in order to think through how “interculturality” is put into practice. A physician turned NGO leader and traditional medicine advocate spoke to me about different “intercultural” clinics around the country where traditional medicine is “butchered” and decontextualized, deauthenticated techniques are applied in isolated and incoherent ways. For example, in La Riviera Maya, one hospital installed hammocks in the waiting area as a “intercultural” strategy, while nothing was done to make the actual delivery of health care and therapeutics more culturally appropriate.

Meanwhile, efforts to develop more substantive forms of interculturality encounter obstacles when seeking funding. These obstacles stem from the fact that, despite the rhetoric of “interculturality” within policy, the legitimacy of counter-hegemonic models are severely questioned. One midwife, an adjunct professor at the Intercultural University of Quintana Roo, told me “intercultural models are not respected at all.” The university at which she works is part of an emerging university system that attempts to incorporate indigenous knowledge into university-level education and requires students to study the Mayan language and learn about traditional medicine alongside biomedical methods. Nonetheless, the intercultural university model struggles to be acknowledged and valued within Mexican academia.

Obstetric Violence

During a visit to San Luis Potosí, I stayed for a few days with Daniela, a nurse and public health officer whose life work has focused on maternal mortality. She facilitated my participant observation in a large public hospital where professional midwifery is beginning to be incorporated. After hours interviewing expectant mothers in the labor and delivery area, I was invited into the delivery room to participate in a birth. When I arrived, the woman had been in the delivery room for four minutes and the baby was crowning. The young male intern attending the birth was visibly impatient, and a minute later he performed an episiotomy, slicing through the woman’s perineum with a scalpel. During the woman’s next contraction the woman pushed, but the baby did not emerge. As the contraction subsided, the intern ordered the mother to continue pushing, but a nurse interjected that since the contraction had passed, it would be better for the mother to take advantage of those few brief moments to rest until the next contraction. When the obstetric team had been in the delivery room for seven minutes with the birthing mother, the intern hastily performed another episiotomy, this time slicing the woman’s vaginal opening down to her anus. He was not satisfied with the lack of apparent progress and considered using forceps to clamp the baby’s head and yank it from the mother’s womb.

At this point, the attending physician popped his head into the delivery room and asked the intern to report the woman’s progress. The intern suggested using forceps to deliver the baby. The attending asked how long the woman had been in active delivery, and the intern responded “eight minutes.” The attending instructed the intern to wait a while longer before using forceps, since in his view, all the woman needed was a little time.

The attending entered the delivery room and instructed the nurse to each grab one of the woman’s legs and to push them back towards her body. Having audited many professional midwifery courses, I knew that this would shift the woman’s pelvis, thus widening her vaginal canal, and potentially allowing the baby to be delivered with no further intervention during the

woman's next contraction. However, I could not anticipate what happened next. The doctor told the woman, "I am going to help the baby be born." Then, he began performing the Kristeller maneuver by jamming his fists into the woman's uterus, using all his body weight to push down sharply and repetitively. The mother began screaming, "I can't!" Reacting to the pain, she grabbed onto my hand and began squeezing hard. The Kristeller maneuver is an "extinct" practice in the developed world because it is widely recognized to carry the risk of uterine rupture. Even in Mexico, it is considered an option of last resort. I asked the physician why we could not turn the woman over and allow her to give birth on all fours, thus widening her vaginal canal an additional two centimeters. He looked at me as if such an inane comment did not even warrant a response, but then he retorted, "Do you think with this [delivery] table she could turn over?" The woman was lying on a metal table with stirrups for giving birth in lithotomy position. I responded, "No, but if it were not for the table, she could turn over and the baby could emerge more easily." After the baby was born, I congratulated the woman. No one else spoke to the mother, and the baby was whisked off for health assessments.

This experience, among many others, is evidence to me of systematization of obstetric violence in Mexico. While physicians are also aware of systemic violence in public health care, some have shared their feelings of helplessness to change it. I interviewed one humanized birth obstetrician, Maricelda⁶⁶, about her internship experience in a Mexican Institute of Social Security hospital. At the time, her attending told her to place intrauterine devices during pelvic exams with or without the consent of indigenous patients. On one occasion, she reported to him that she had requested an indigenous woman's consent and was refused. The attending ordered Maricelda, "Go get the patient and put it inside her!" Maricelda had to come up with a false reason to perform a pelvic exam and illicitly placed an intrauterine device without the patient's knowledge. She ended her recounting by exclaiming, "That's violence!" I was left reflecting on the potentially double meaning of her assertion—forced contraception is undoubtedly an act of violence against indigenous women, but what about the trauma and years of lingering culpability Maricelda has experienced? At the same time, Maricelda's life does not unfold at the intersection of racial discrimination and gender discrimination—while she suffers from the emotional sequelae of her traumatic experience, as a fair-skinned woman, she would not be the victim of forced sterilization.

The incident Maricelda described is not unique to obstetric internships. Camelia, the daughter of a traditional midwife and a CASA graduate, shared guilty feelings at having to practice episiotomies on women as part of her professional midwifery internship in a government hospital. As a child, Camelia first learned midwifery by watching her mother attend countless episiotomy-free births and lending a helping hand when necessary. From this experience, Camelia knew that episiotomies are, at best, unnecessary procedures, and at worse, mutilations of normal female anatomy. When Camelia confessed to her mother that she was practicing episiotomies as part of her training, her mother began acting "strangely" towards her. Later that day, I traveled to her natal village to spend some time with her mother, Pamela, in her home. At the height of her practice as a traditional midwife, Pamela attended twenty to thirty women a month. These days, Pamela is one of two midwives who have not ceased attending births—the rest have stopped practicing due to the threat of criminal charges were an infant death to occur on their watch. Pamela takes her chances and continues to attend pregnant women who refuse to deliver at the regional hospital where personnel routinely preform episiotomy.

⁶⁶ Described in further detail in chapter six.

Maricelda and Camelia's guilt-ridden intership experiences demonstrate that as violence is unleashed on indigenous women's bodies, it also weighs on health care providers who feel helplessly drawn into its systemic nature. Their complicity in physically violating racialized women points to the powerful reach of racism and discrimination, as well as different women's positionality with respect to systemic, intersectional forms of oppression. Maricelda now considers defending women's rights a part of her job as a private practitioner. Unfortunately, I suggest that her educated, affluent patients are not the individuals who most need their rights defended. In the following chapter, I explore (im)mobility by simultaneously "studying up" and "studying down;" thus questioning the utility of the citizenship concept for capturing the disparate experiences of racialized "others" for whom Mexican citizenship fails to insure even the most basic medical interventions, and global bioconsumers engaged in medical migrations for (ethno)medical tourism.



The area in her home that Pamela uses to attend births

(ETHNO)MEDICAL (IM)MOBILITIES
Chapter Six

In a 2011 special issue of *Body and Society* on Medical Migrations, Elizabeth F. S. Roberts and Nancy Scheper-Hughes describe how “not only people and bodies—surgeons, patients, handlers and body parts—migrate, but also sometimes medical therapies that travel across geographical and political economic terrains are reshaped and modified in surprising ways” (Roberts and Scheper-Hughes 2011:3). In response, I query not only the effects of migration on medical therapies, but how geographical and political economic terrains are themselves reshaped and modified in the process. Furthermore, Adriana Petryna (2009) describes how commercial medical science based in the United States outsources and offshores clinical research trials to countries separated by vast economic and cultural differences. My investigation of Mexican midwifery analyzes how traditional Mexican midwifery is transformed into a series of commodified practices that are then marketed in other countries, and how humanized birth techniques originating in the Global North are combined with “traditional” methods through a New Age logic that confounds Euro-American notions of chronology and progress⁶⁷. That is to say, the humanized birth movement in Mexico provides a salient example of how transnational mobilities foster emergent traditionalities, thereby disrupting reified ontologies of time and reconfiguring how “modernity” is defined and desired.

While others have pointed to the tension and multiple imbrications between “the global” and “the local,”⁶⁸ my observations of Mexican midwifery’s movement across geographic space, border crossing, and deployment led me to contemplate how “the local” (in the form of traditional Mexican midwifery) is usurped by transnational individuals and marketed across the globe for economic profit. My ethnographic observations evidence how “medical migrations are increasingly part of the very fabric of the transnational world order” (see Thompson 2011:205). Simultaneously studying both “up” and “down” led me to ask, “How does ethnomedical culture travel and who is able to perform a simulacrum of traditional culture as culture-in-motion? Conversely, what are the mechanisms that confine others to practice ethnomedicine as culture-in-place?”

Medical Migrations: From San Francisco to San Luís Potosí

In November 2012, while attending the American Anthropological Association (AAA) Annual Meeting at Union Square Hilton in San Francisco, I unexpectedly received an invitation from Martha Lipton, “water birth educator, gentle-birth guardian, and celebrity” within humanized birth circles, to her workshop at Kabuki Hotel in Japantown as part of the Association for Prenatal and Perinatal Psychology and Health (APPPAH) Conference. Over the past five months Martha and I had exchanged several messages and discovered we had traveled to all the same places across Mexico, and, on several occasions, had missed each other by a matter of

⁶⁷ My ethnographic research on the humanized birth movement offers a counter perspective to Jennifer Hirsch’s observations about how “modern” love and marriage is sought by Mexican transnationals “the word ‘modern’ implies a contrast with the traditional, a description of the way things are now in comparison to how they have been in the past.... The prestige of modernity is so omnipresent a feature of our intellectual landscape as to be invisible; it has become one of our unexamined habits of thought” (Hirsch 2003:13).

⁶⁸ For two distinct examples, see Walter Mignolo (2000) and Anna Tsing (2005).

days. Finally, our presence coincided in San Francisco! Not letting this opportunity pass, I briskly footed to the APPPAH Conference. At the hotel, I wandered past various vendors' tables, replete with educational books and videos, and birth-related artesian jewelry, bookmarks, postcards, etcetera, and located the workshop hall.

Moments later, Martha Lipton, earrings dangling and flowered shawl streaming, burst in with a bevy of followers. Among them was David Chamberlain, renowned author of *The Mind of Your Newborn Baby*—which has sold worldwide and is available in 13 languages. Martha immediately began her talk, “Birth and Bonding: How First Hour Programming Will Shape Your Baby’s Life.” Her presentation was peppered with personal anecdotes, including a few specific experiences in Mexico.

Drawing from her recent travels, Martha described a workshop in Monterrey, Nuevo Leon where she probed eager parents in her audience, “If I could guarantee a self-regulating, talented, intelligent, precocious child, . . . I’m currently accepting clients.” Judging from their reactions, Martha said, “These parents would pay any price.” She explained to the parents they were too late, as some of this programming already happened at birth. She also spoke of a married couple, both obstetricians, who were attending gentle birth in Puerto Vallarta. “What a wonderful place for a destination birth!” she exclaimed. “You could give birth and swim with the dolphins, all on the same trip!”

Martha then described ways she uses her “celebrity status” to leverage power when instructing directors of private hospitals in Mexico on how to properly attend births and preserve the connection between mother and newborn. She recounted her recent experience at a hospital she inaugurated as a water birth center. When she saw newborns isolated in a nursery, separated from their mothers, thus losing valuable opportunities for first-hour “programming,” she authoritatively demanded of the director, “You must stop this immediately! You must take these babies to their mothers right now! I’ll wait right here!”

When her three-hour lecture concluded, Martha and I retreated to a quiet hallway where she granted me a two-hour interview, describing in rich detail how she became a humanized birth advocate. Her journey began with a search in France for Frédéric Leboyer and Michel Odent. After a successful water birth sans physician in her own home, Martha’s prenatal care OB/GYN called Child Protective Services, denouncing what he considered to be child endangerment. When police arrived at her four-bedroom home with two Mercedes Benz out front, it was obvious to them this was not the typical home where abuse happens—“the total opposite of what you look for when you’re looking for abuse.” Next, Martha apprenticed with spiritual midwives and certified nurse midwives from around the globe. People began arriving from England, France, Sweden, and Norway to give birth in the Jacuzzi installed in her living room.

After a trip to Russia where the Russian Orthodox Patriarch anointed her, Martha had a dream while dozing in the park with her baby. “In that dream state I folded time and I saw the future.” She envisioned a vibrational birth: A woman walks into a pyramid and descends into a pool of water, where she “let the baby out.” Then, the woman “picks up the baby into the ‘habitat’” (skin to skin), walks out of the pool, and is cloaked by singing observers. When Martha awoke, she thought, “I have to start a nonprofit organization and spread the word about water birth.” She hired an attorney, wrote the bylaws, and paid the fees, putting at least two million dollars of her own money into the project, which was fine, she explained, because she was married to a millionaire when the nonprofit was created. “From that day until this one, I haven’t stopped.” She has since spread the word in 49 countries, spoken with health ministers

and presidents (for example, of Russia and Costa Rica), and developed projects in Germany, Denmark, and Norway.

Martha suggested I meet with Larissa and Jose Felix, founders of the Mexican water birth organization Tranquilo, and entrepreneurs of Port-a-Pool. After returning to Mexico, I traveled to San Luis Potosí to interview them at their home. Arriving early with no one home, I waited, admiring the ornately carved sun on their heavy wood door. Minutes later, Larissa returned in a minivan with their five-year-old daughter from Montessori school. Their little girl popped out of the van, a picture of perfection—red ribbons in her hair and pretty white shoes with beading on her feet. Then I met Jose Felix—together, he and Larissa made a handsome, fair-skinned couple that could pass for Anglo.

The grandeur of their enormous home was impressive—wood and tile floors, marble countertops, luscious couches, and fine furniture oozed luxury. The family ate only organic, vegetarian food, and offered me chocolate-covered amaranth, nuts, and fresh fruit. Their dining room table held a wooden box with an assortment of teas and a silver hot water thermos. A Michael Kors shopping bag was perched on a couch armrest in their living room. There were children's toys scattered around the house and a jungle gym in the backyard; yet their baby was more interested in playing with Jose Felix's iPhone, promptly dropping it on the floor. Jose Felix did not flinch.

When Larissa and Jose Felix met in New York, he was working at a stock brokerage firm and she was studying international relations at Barclay College. Both come from entrepreneurial families—her family owns numerous beachfront hotels, while his owns funeral homes and crematoriums. They recounted how they were drawn to humanized birth five years ago while attending a conference in Monterrey, Nuevo Leon. Barbara Harper, Michel Odent, and David Chamberlain were in attendance—“the humanized birth leaders of the world.” So far, Larissa and Jose Felix have coached 30 couples in the City of San Luis Potosí over the past two years. They teach relaxation and self-hypnosis strategies, and help women trust their bodies and stop fearing labor pains. While their Port-a-Pool business required a significant initial investment, it generates insufficient revenue to support their lifestyle. For them it represents a hobby that, in Larissa's words, “inspires me, and I have come to see it as a social responsibility. I not only feel that I *have* to and *want* to do it, but I *like* doing it” (my translation). Jose Felix enthuses that water birth education fascinates him, and hopes to grasp important opportunities to present their courses to large companies and influential people.

Couples taking their course began arriving. They are all educated, English-reading, and working professionals in the fields of real estate, mortgage assessment, law, graphic design, and human resources. When I asked what drew them to water birth, the human resource manager joked that his conjugal family's religion is water birth and Montessori school; for those who wish to marry into this family, it does not matter what else they believe, as long as their children are born by water birth and attend Montessori school. Larissa began her workshop by describing characteristics of “tranquil birth”: no unnecessary interventions or manipulations, privacy, silence, accompaniment, freedom of movement, and freedom to eat and drink during the birthing process.

Larissa and Jose Felix's three home births were attended by Dr. Maricelda Hernández Tellez, an obstetrician who “converted” to gentle birthing after witnessing Larissa give birth with

zero intervention, and now attends water births at Hospital Lomas, a private hospital nearby⁶⁹. Hoping to tour the facilities, I walked to Hospital Lomas and explained my research to the head nurse. She told me all the birthing suites were occupied and could not be viewed, but ceded to a general tour. I was quickly flanked by two nurses assigned to guide me. I perceived from her tone of voice and gestures that she was signaling to them to guard me and ensure I did not pry.

As luck would have it, both nurses enjoyed boasting about their top-notch facilities. “This hospital is 100% private, so it’s targeting a certain clientele, which is the upper-middle and upper class. It is a very exclusive hospital.” As we toured the labor and delivery area, I complimented them on their hospital’s amenities, which, truth be told, were quite impressive. This fueled them to show me the birthing suites: a regular suite, a junior suite, and a master suite—complete with flat screen TVs, sofa beds, closets, full bathrooms, living rooms, second bedrooms, large balconies, refrigerators, and minibars. Bottled water was placed in pyramid formation on dressers, Kleenex was fashioned into shapes of fans, and ends of toilet paper rolls were folded in triangles.

During my next visit to San Luis Potosí a year later, I was finally able to interview Dr. Maricelda. Her office building appeared to be a private practice where a group of physicians work. Seeing only Dr. Maricelda’s name in enormous metallic letters across a marble wall in the reception area, I realized the entire space—which includes a multimedia room, a multipurpose classroom, a play room and jungle gym for patients’ children, an exam room, and several offices—was solely hers. Dr. Maricelda’s receptionist led me to her “main” office.



Dr. Maricelda with photos of the children whose births she has attended.

⁶⁹ Throughout the course of my fieldwork, the analogy of religious conversion reoccurred in interviews with informants.

In describing her patients, Dr. Maricelda explained that since hers is a private practice, her patients are middle class and above. Their average educational level is university. Generally, the women are in their late twenties or older, communicate via email (a distinguishing factor in Mexico), first-time mothers, and most have only one child. She tends to deliver children for couples in stable marriages, and rarely sees single mothers.

My interview with Dr. Maricelda spurred me to seek out other humanized birth obstetricians and inquire about their clientele. In Guadalajara, I entertained myself while waiting for an audience with a renowned humanized birth obstetrician by counting the number of iPhones being used by patrons in the reception area: five. As I waited a little longer, I could hear different couples speaking English and French, as one of each pair was a foreigner. When I asked the obstetrician about the sociodemographics of his clientele, he explained that while his clients all have a high “cultural level,” he does not consider many of them to be wealthy. “My patients are more cultured than rich.” His patients have at least a bachelor’s degree, while others speak five languages and have multiple postgraduate degrees. (Even a bachelor’s degree is a distinguishing factor when compared to the general population in Mexico.) Commenting on the truly rich, he said, “All of those who go to really expensive places [to give birth], it is because they have a lot of money to pay, but not enough brains to ask questions.”

In Mexico City, I asked another humanized birth obstetrician to describe his clientele and he responded that they are middle-upper and upper class. About fifty percent pay a portion of the cost of birth with health insurance, while the other fifty percent pay the entire price out of pocket. Nearly all of his patients have university studies, while many have earned postgraduate degrees. Most of his clients are bilingual and articulately express as a unified couple exactly what they are seeking from his humanized birth practice. Like his clientele, he himself is a transnational, holding dual US/Mexican citizenship, and is married to a Spanish woman who earned a master’s degree at Duke before working for the World Wide Fund in Washington D.C. His daughter was born in water.

I interviewed several humanized birth obstetricians whose lives also included transnational experiences, including a tall, blue-eyed obstetrician/entrepreneur who studied English at UC Berkeley, medicine at UC Irvine, and genetics in Switzerland before opening a private hospital for patients seeking “natural” medical alternatives. My interactions with humanized birth obstetricians, Martha Lipton, Larissa, and Jose Felix highlight how their social class and economic capital have allowed them to open nonprofit organizations and for-profit businesses through which they meet their “social responsibility” to promote humanized birth. While I do not deny the authenticity of these individuals’ desire to improve the way children are born and the noble intentions behind their work, I recognize that a definitive tendency toward consumerism (and, at times, “conspicuous consumption” [see Veblen 2006, also Ritzer 2001])—the idea that parent-clients would pay any price for a certain type of child; that couples might plan a “destination birth”; the fact that hospital suites where humanized births take place resemble those of a five-star hotel; and that all the merchandise relate to humanized birth—acts as a filter, in addition to a couple’s level of education and exposure to birth in other countries, resulting in couples with a certain profile becoming members in the transnational movement for humanized birth while others are excluded.

Eventually, I ended up across the desk from Dr. García, a Universidad Nacional Autónoma de México (UNAM)-trained OB/GYN and perinatal expert whose private medical practice near Estadio Azteca includes a birthing suite with a queen-sized bed, bathroom, Jacuzzi,

skylight, and fountain with the statue of an angel.⁷⁰ He spoke to me about his desire to “give back”—as someone who received a stellar public education, he now teaches UNAM medical students for virtually no pay. (His comments led to a sense of solidarity during the interview since at the time, I was also teaching UNAM medical students—an invaluable and rewarding experience with little economic benefit.)



Dr. Pérez' garden-view birthing suite with Jacuzzi, skylight, and fountain

When I asked him to describe the women he attends, he looked into my eyes and said, “women like you.” He went on to say that his patients are women who hold advanced degrees in the humanities and sciences (as opposed to technical fields), are foreign or transnational, bilingual or multilingual, and who place more emphasis on values than aesthetics. A year later, when I had an occasion to make a gynecological appointment, I thought back to all the obstetricians I had interviewed over the course of my ethnographic research and the one that sprung into my mind was Dr. Pérez. What this says about my own subjectivity is for the reader to decide. At the very least it signals that as much as I am committed to uncovering social mechanisms that marginalize and disenfranchise, when it comes to my own health matters, I sometimes revert to my own transnational identity, education, and privilege. Throughout the

⁷⁰ I was struck by how reasonable his prices were when compared to everyone else I had interviewed (8,000 pesos for a water birth, including postnatal care). The services he offers at his private practice are still inaccessible to lower-class Mexicans (across Mexico, minimum wage ranges from 61.38 to 64.76 pesos daily; 8,000 pesos represents about six-months salary) but is approximately a quarter as expensive Paula’s midwifery services (see chapter one).

course of my fieldwork and during the process of writing, I was careful to recognize, confront, and explore the implications of my “complicity” (see Kapoor 2004).

Bioconsumption and the Limits of Citizenship

Martha Lipton is the quintessential medical traveler: her combined geographic and social mobility buttress her authority as a leader in the transnational humanized birth movement. CASA has emerged as a special site in the transnational network for humanized birth—it has earned a great deal of recognition and attracts volunteers and visitors from around the world. Some of CASA’s credibility rests on the fact that it has been certified by Martha Lipton as a water birth center—her name appears on a plaque prominently displayed in CASA’s main hallway. Thus, CASA deploys the social capital of its association with someone whose privilege has allowed her to become a humanized birth “celebrity” and a representative of expert knowledge from the Global North.

Martha’s influence in the humanized birth movement unfolds across the Mexican landscape. Through followers like Larissa and Jose Felix, her teachings are spread among affluent, professional couples who, through reading English and French-language texts about birth practices originating in the United States and Europe, seek inclusion in a transnational community of bioconsumption. Not only couples, but humanized obstetricians and birth attendants, position themselves as transnational subjects. Couples and birth attendants encounter each other as resources for enhanced mobility within a social network that emerges outside of the realm of citizenship. Through the bioconsumption of bodily practices that associate them with consumers who are giving birth elsewhere, participants in the humanized birth movement lead privatized lives that render citizenship irrelevant.

Throughout my research, I was struck by socioeconomic and georacial patterns distinguishing participants in the humanized birth movement from those the movement references but does not include. I argue that the concept of (im)mobility allows us to think about how some people are able to position themselves as consumers within transnational networks, while others continue to make their lives out within the citizenship modality. Considering the intersections between (im)mobility and neoliberal consumption helps test the limits of citizenship, thus highlighting when it is an appropriate analytic, and when it ceases to describe people’s behaviors and motivations.

Petryna’s (2002) concept of biological citizen^{xvi} is premised on the responsibility of the nation–state to care for its citizens, and that basic health care is a citizenship-based right. I am specifically pushing against biological citizenship by conceiving health (in this case, ethnomedicine) as a commodity instead of an entitlement. My focus on (ethno)medical migrations brings into view a transnational political order in which biological and medical practices produce both mobile “supranationals” and comparatively immobile counterparts who are socially situated in ways that encourage them to seek citizenship through government provisioned services.⁷¹ Thus, I argue that the very presupposition of equality embedded within citizenship as a concept must be reexamined in our neoliberal age.

Rose and Novas’ (2008) reinterpret biological citizenship when they emphasize the transnational nature of emerging citizenship projects and the partial delinking of citizenship and

⁷¹ In the case of traditional midwives, being “undocumented,” or “without papers” is an interesting metaphor to consider, given that they are denied entrance into the guild created by the Mexican Midwifery Association for professional midwives.

nation. While I find their proposal to be provocative, I am committed to matching the transnational content of my ethnography with transnational content in my theory. Thus, I bring Latin American (and especially Mexican) scholarship to bear on the concept of biological citizenship, thereby drawing attention to the roles consumerism, socioeconomic class, and representations originating in the Global North play in the construction of global, biological, consumption-oriented communities.

In *Consumers and Citizens: Globalization and Multicultural Conflicts*, Nestor García Canclini (2001)⁷² argues that while citizenship used to signify equality of abstract rights and collective participation in public democratic spaces, nowadays questions of belonging, information, and representation are answered in the realm of private consumption and mass media—effectively rendering citizens of the 18th century into consumers of the 20th (or 21st) century⁷³. Signaling the decline of nations as meaningful unit of social analysis, García Canclini notes how people’s sense of belonging and identity is increasingly defined by participation in transnational or deterritorialized communities of consumption. Identity is now configured by consumption—how much one possesses and is capable of appropriating. Thus, García Canclini argues that the neoliberal conception of globalization reserves the right of being a citizen for elites.

Following Charles Hale (2005), I consider neoliberalism to be a mode of global governance that has led to consumption as a primary way the “haves” construct identities, leading to a regime of inclusion–exclusion that, in the case of Mexican midwifery, feeds off of the “have nots” in a symbolically cannibalistic or vampiric way (see Weismantel 2001, Scheper-Hughes and Wacquant 2006, and Anagnost 2006) and (re)produces uncritical notions of “indigeneity,” thus reinscribing inequality and disparity. In chapter two, I described how fetishized “indigenous” medical practices are consumed and claimed by elites, while simultaneously being surveilled, controlled, disciplined, and denied to indigenous people (see Billig 1999).

In this chapter, I argue that while “biological citizenship” and “consumer citizenship” are useful analytical tools for some contexts, they are insufficient for assessing the mobilities and immobilities that emerged among informants during my ethnographic research. Furthermore, (im)mobilities are not just geographic, but also reference *upward* mobilities. I am signaling the operative relationship between social geographies and citizenship projects. The parenthetical composition of (im)mobility is a permanent sign post for the complexity of mobilities afforded by immobility, and vice versa.

Mobile Humanized Birth Practitioners and Participants, Immobile Mexican Midwives and Families

After a few phone and email conversations with Sagrario Villareal to arrange institutional access for research performed at Center for the Adolescents of San Miguel de Allende (CASA), I traveled to San Miguel de Allende for the first time in December 2010. Sagrario later told me

⁷² Argentine-born anthropologist at Universidad Autónoma Metropolitana in Mexico City and director of its program of studies in urban culture.

⁷³ In a time when political campaigns are broadcasted on television in a way that resembles marketing, García Canclini argues that individuals feel summoned as consumers, even as they are interpellated as citizens.

that as general director of CASA, she received an endless stream of solicitations from *gringa* researchers and volunteers wanting to involve themselves in CASA's work. Her answer is always the same—a cordial but uninvested “yes.” She has found that while many foreigners express their desire to collaborate, their help is often ineffectual or fleeting, and may at times even be detrimental.

Over time I began to understand the elements shaping Sagrario's perspective. Unbeknownst to me, I surpassed her expectations when I followed through with my offer to spend four months over summer 2011 volunteering at CASA, faithfully arriving every day to perform video editing and translation as well as liaising with the country sales manager for Laerdal International, thereby obtaining didactic materials for the midwifery students. In exchange, Sagrario allowed me to audit CASA's professional midwifery classes, sit in on administrative meetings, and interview all the students. By the end of summer I had performed at least one in-depth interview with nearly every student. Shortly before returning to Berkeley to commence the academic year, Sagrario granted me an in-depth interview (the first of many, deeply personal conversations we shared over the next several years) and told me how pleasantly surprised she was to see my sustained commitment to volunteering and carrying out research at CASA—she has had experience with many eager foreigners over the years, but these experiences had not resulted in mutual collaboration and ongoing partnership⁷⁴.

Her experience with other volunteers has not been as positive: she shared how resentful she felt when American student volunteers came to CASA, believing that they can touch and manipulate Mexican women's bodies, knowing very well that they are not trained to do so and would not be able to perform these activities in their home country. However, her fraught relationship with foreigners does not stop with entitled volunteers, but extends to donors as well. Sagrario expressed her frustration and exhaustion—she is tired of perpetually conforming to the desires of Americans, and pleasing Americans at fundraising events. Why don't Americans living in Mexico try to adapt to Mexican standards of living?

This tension also unfolds in her daily life, outside the confines of her work post. She talked to me about the injustices she has personally suffered as a Mexican woman living in San Miguel. She explained that if she hails a taxi on any street in San Miguel and a white person is also hailing a taxi half a block ahead, the taxi will bypass her and pick up the white client. In that moment, Sagrario's social and symbolic capital as general director of a renowned NGO disappears as the taxi driver makes a racialized judgment based on a centuries-long history of imperialism leading to present day socioeconomic differences between Mexico and the United States. This same phenomenon was readily admitted to me by a taxi driver—he will often pass up Mexican passengers to pick up “gringo” passengers instead. While he recognized that he is engaging in “reverse-discrimination,” for him the determining factor is who is more likely to pay a larger fare.

Subsequently, Sagrario resigned from her position at CASA and accepted a contract as an adviser at the Center for Gender Equity and Reproductive Health in Mexico City. Soon after she left CASA, the clinical and academic directorships were filled by American women. She scoffed, saying that when she was general director, she was careful not to hire foreigners for key administrative posts as, in her opinion, such an organization should be run by Mexican women

⁷⁴ Sagrario emerged as a key informant throughout my fieldwork; thus, my commitment to volunteering reflects both the importance my involvement at CASA played in accessing the transnational humanized birth network, and the deep friendship that we developed.

for Mexican women. This theme of bowing down to foreigners had followed her to her new job. Recently some “gringo people” came to visit the Center for Gender Equity and Reproductive Health. She prepared a presentation for their visit but had no luck explaining any of the current programs to them since they didn’t speak any Spanish whatsoever. They wanted to see statistics on reproductive health in the State of Puebla, so Sagrario assumes they are considering investing development funds in Puebla. In spite of the language barrier, Sagrario perceived that their intention was to show Mexicans “the right way” of doing things—she was very critical of this, stating that America’s lacking health system produces poor health outcomes when compared to its neighboring country, Canada.

While Sagrario was working in Mexico City, she returned to San Miguel often to visit her teenage and adult children. Whenever she returned to town, she invited me to her home. On one such visit, she expressed her frustration at being a “second class citizen” in midwifery circles when compared to foreign midwives who are not licensed to practice midwifery in Mexico. Several times she asked me the same rhetorical question: “Why, why, WHY do foreign midwives come to Mexico to practice midwifery? She commented extensively on the privilege these midwives enjoy, which she argued is based entirely on their cultural capital and not actual training or skill.

She offered the following anecdote to illustrate her point: Recently Sagrario attended a birth with two midwives from Europe. Although the first-time mother had been in labor for quite some time, the European midwives did not want to check her dilation. Finally, at Sagrario’s urging, they discovered that the mother was fully dilated but that the baby was not emerging due to a nuchal cord (a tangle in the umbilical cord). Sagrario suggested that they administer low-dose oxytocin, but the European midwives resisted for the next several hours. The birth had to be transferred to the hospital. Upon arrival, Sagrario asked the physician if she could administer low-dose oxytocin at four drops per minute and the doctor agreed.

Even though Sagrario considers that many foreign midwives are not as well trained as she is, she observes their elevated status in Mexican midwifery circles. For example, foreign midwives offer courses and workshops at high rates—hundreds of pesos if the course or workshop lasts several hours, and thousands of pesos if it lasts a few days. Sagrario asserted that a Mexican midwife would never be able to charge as much—she could not charge as much—no one would come. Furthermore, Sagrario had recently attended one of the first Mexican Midwifery Association organizational meetings, discovering that despite the Association’s name, the Association is comprised almost entirely of foreign midwives, and that the majority of the women on the directive panel are from the US and Europe. Even more offensive from Sagrario’s perspective was that a panel member from Spain began her midwifery training under Sagrario’s tutelage. Nonetheless, within the organizational structure of the Association, it is as if this unlicensed Spaniard is more knowledgeable about midwifery than Sagrario—a possibility Sagrario deemed ludicrous. At the meeting she confronted the issue, asking why she had not been invited to participate on the directive panel. Her question went unanswered, and years later she is still not a participant in the directive panel. Hypothesizing to me and to herself, she said that the Mexican midwives in the organization idolize their foreign counterparts, believing that they are more knowledgeable and better trained, just because of their US and European origins. In her opinion, what was happening within the Mexican Midwifery Association was an example of *neocolonialismo* (neocolonialism, her term) occurring in the name of humanized birth and professional midwifery. Indignant, Sagrario told me that she was intent on fighting against this ongoing phenomena of doors opening for foreign women living in Mexico and slamming shut in

the faces of Mexican women. I asked her if I was included among the foreign women she was maligning, to which she responded that I am an exception—an “amiga”—someone who is an ally and a supporter, but who does not attempt to usurp positions of power based on my “expert knowledge.”

Traditional Midwifery Popular Tourism?

My thoughts continued to circle around how certain women are able to construct lucrative, transnational identities as professional midwives within humanized birth networks, while others are not able. I realized that the middle- and upper-class lifestyles of transnational midwives had not only called the attention of Mexican counterparts like Sagrario, but also resulted in these midwives being the targets of blackmail and kidnapping threats.

Three years before, while performing preliminary research in La Costa Grande region of Guerrero, I too had been the target of kidnapping threats. As a young anthropologist doing ethnography in Mexico for the first time, I did not yet understand, nor was I able to anticipate, the sentiments my transnational, multilingual, multiracial identity provoked among the rural farmers whom I was attempting to study. After repeated phone calls demanding \$40,000 and chilling remarks by the anonymous caller about my whereabouts and activities the day before, I decided to abandon La Costa Grande as a potential field site. I never returned. After being targeted, I began to see kidnapping and anonymous threats as symptoms of deep socioeconomic inequality, and I reflected on steps to prevent this same problem from recurring in other impoverished sites. Over the next several years, I conscientiously adapted myself to the socioeconomic level of my informants; this meant changing my habitus, the clothing I wore, and the very food I ate.

One well-known professional midwife, Adeli, fled to Brazil from Veracruz after her children’s private school became a target for kidnappings. When I heard about Adeli suddenly uprooting her family and relocating to Brazil, I wondered what factors contributed to her being identified as a target. Many of the individuals I interviewed mentioned Adeli—she has discursively emerged as an important figure in the Mexican humanized birth movement, even in her physical absence.

I decided to seek her out in Florianópolis, the capital city of Santa Catarina, Brazil, known for its high quality of life, unparalleled Human Development Index score among Brazilian capitals, nightlife, tourism, and dynamism. Florianópolis is a second home destination for many Argentines, North Americans, Europeans, and people from São Paulo; as a result it is perhaps the “whitest” city in Brazil (see Bashkow 2006). After spending a week with Adeli in her home and around Florianópolis as a participant in a workshop she held on “Traditional Mexican Midwifery,” I had a better understanding of the decision-making process that led her to move to Brazil and forge a new life with the three children she has with her ex-husband, a Japanese artist.

Adeli is of mixed Jewish and Mexican heritage and was reared in the United States and Mexico. Her parents are writers and intellectuals. She has tight brown curls, piercing blue eyes, and the warmest of smiles. She exudes positive energy with her every word and gesture—the way she carries herself signals her training in dance at UC Santa Cruz and in the Congo. Like other successful professional midwives in Mexico, she studied midwifery in Texas. I was excited to meet her, but as the workshop unfolded, I was equally intrigued by the other participants in the workshop, most of who had specifically traveled to Brazil from other Latin American countries to learn from Adeli. I was surprised at how fair the group was—I was among the darker women

in the room, and although we were in Brazil, there were very few women of African descent. As we went around the room introducing ourselves on the first morning of the workshop, Adeli commented to the group that I was the only Mexican in this workshop on “Traditional Mexican Midwifery.” I quickly explained to the group that perhaps I, a person of mixed ethnic heritage reared in the United States, am not the most adequate representative of Mexico.



Participants at the workshop on “Traditional Mexican Midwifery.” I am second from the right.

For most of the week, the group sat in a circle on the beach or in boats, listening to Adeli’s anecdotes of births she attended and her personal reproductive experiences. Adeli is a remarkable storyteller—her anecdotes highlight the spiritual and emotional elements of birthing, and are infused with symbolism and imagery. However, as the workshop transpired, I realized that very little of what was being taught is traditional Mexican midwifery. That is to say, the techniques that Adeli discussed represent her own style of midwifery, and most are not the traditional techniques of indigenous midwives in Mexico. For example, her workshop included New Age explanations of homeopathy and how to make tinctures from placentas and placenta art.



Participants on a boat to a beach restaurant where the workshop was held that day



Using rebozos to manipulate the shape of the birth canal by applying pressure to the pelvis.

Throughout the week, I increasingly wondered if what I was observing can be more aptly described as traditional midwifery popular tourism: middle- and upper-class women from across Latin America who are not midwives but are interested enough in New Age notions of traditional midwifery, indigeneity, and going back to nature to travel internationally and spend a week on Brazilian beaches with someone who offers herself as a representative of traditional midwifery knowledge.⁷⁵



Participants watching, filming, and photographing Adeli prepare herbal cosmetic balms.

My curiosity of whether the workshop was an example of traditional midwifery popular tourism became more persistent after we went as a group to a spa and participated in a nighttime *temascal* ritual. Compared to the *temascales* prepared by indigenous people in Mexico for healing purposes, this *temascal* was decidedly mild. The temperature was not as extreme as the traditional version, the door was opened quite often to let participants cool off and breathe fresh air, and no flogging with fragrant herbs was involved. While I sat in the *temascal* dressed in a bathing suit, some of the women around me began stripping off their clothing. Ana, a young

⁷⁵ The fact that professional midwives go unquestioned when they stake claims to traditional knowledge, while traditional midwives are excluded from a national guild for professional midwives unless they undergo a formal course of study, speaks to the unequal power relations operating within Mexican midwifery. I will return to this topic in the conclusion.

woman with dyed flaming red hair and a deep voice, laid her naked body across my lap and began touching herself, occasionally touching my arm and side. I was not certain what to do but I felt uncomfortable being fondled, so after a few minutes I repositioned myself, lying down on the floor in a corner. Moments later I heard her moans in the pitch black as she reached orgasm.

I disappeared for a while in the darkness, listening to the sounds the others were making, and remaining inaudible to them until Adeli called out my name and asked, “Will you sing ‘Amazing Grace’?” I did, lying down, my lungs filling with hot rosemary-infused air, and my voice was stronger and throatier than ever, filling the small space with a palpable vibration. In this moment, my years of singing in church as a child lent a sense of closure to what, I would soon discover, represented an emotional journey for the other women. After the ritual was over, the women emerged, hugging and kissing each other, and crying. By the end of the night I was covered with the sweat and tears of two dozen women. I felt awkward with each embrace—the feeling of other women’s naked breasts pressing against my body was strange and unnerving to me. The next day, as we sat on the beach and shared our experiences, most of the women recounted how being in the *temascal* had forced them to deal with old emotional traumas, and by the end of the ritual, many had let go of the fear and pain which they had been harboring.

What was striking to me about this experience was how the *temascal* ritual had been extracted from its original geographic and sociocultural contexts; usurped, transported, and manipulated for profit within Florianópolis’ tourism industry; and infused with New Age meanings, which led to experiences of sexual liberation, emotional cleansing, and psychological healing among the participants that were wholly distinct from the way my indigenous informants experience the *temascal*. Furthermore, my own interpellation to perform “Amazing Grace” made me wonder about the intermingling of traditional and indigenous practices with Anglo-Christian elements. How does the New Age notion of healing allow for the mixing of concrete practices originating from disparate contexts and rooted in divergent ideologies? What are the unintended consequences of this ostensibly clean extraction of healing practices from the social milieu for which they were created?

After returning to Mexico, I looked over my accounts to think ethnographically about what the sum of money I had spent represented for the majority of Latin American women. In addition to the cost of international air travel and hotel accommodations, the base price for the workshop was \$795. The participants also had to pay for passage on two boats, a fee for the *temascal*, and food. Also, during the course, participants eagerly purchased birth-related jewelry, birth manuals, music, and *rebozos* from Veracruz (the iconic shawl worn by “indigenous Mexican midwives” and a “tool of their trade”).⁷⁶

⁷⁶ Rebozos are used by indigenous women in Mexico for many different activities—carrying children, transporting firewood, protection from the beating sun, warmth during cool evenings—it is like a backpack, handbag, coat, and umbrella wrapped into one. While wrapping a pregnant woman in a rebozo and forcefully jerking the material can be used to jolt a misplaced fetus back into proper position (this technique is called *la manteada*), during field work I observed that traditional midwives are more inclined to use controlled hand movements to manipulate the fetus’ position (a type of massage called *sobada*). Since *la manteada* is not the most prevalent technique I observed among traditional midwives, I am curious about the rebozo’s “cult status” among humanized birth practitioners. Upon typing “rebozo parto” in an internet search (*parto* is the Spanish word for “birth”), Adeli’s name appears several times on the first page, along with a doula from Mexico City who trains doulas internationally (in the United States, Canada,

After the workshop had ended and the other participants dispersed, I spent an extra day on the beach with Adeli and her boyfriend. I enjoyed getting to know them both outside of the workshop setting. Adeli shared with me her deeply held desire to improve women's birthing experiences, and I observed during my week-long stay how she combines this passion with entrepreneurial spirit. Through the workshops she offers and ongoing speaking engagements, Adeli is able to provide her children with a comfortable upbringing and enjoy an affluent Florianópolis lifestyle. However, as we spoke, her hesitance about how Mexican ethnomedicine is enacted in Florianópolis and participants' reactions arose. She identified the differences between a traditional *temascal* in Mexico and the less therapeutic, more touristic version we experienced during the workshop. For participants to truly experience a level of meditative consciousness resulting in healing from psychoemotional traumas, the *temascal* has to be very hot, pushing participants towards their physical limits. Nonetheless, participants expressed deep transformative experiences during the *temascal*. Adeli wondered aloud of this had more to do with the social dynamic of the group than body-mind-spirit effects of the *temascal*.

* * *

Almost exactly two years after my first in-depth interview with Sagrario, I joined her on a supervisory trip of CASA graduates working in public clinics in the State of Guerrero. While the CASA model envisions training indigenous women from rural communities in professional midwifery so that they may return to their places of origin, practice professional midwifery among a "vulnerable" and "at risk" population, and, thus, reduce maternal mortality, I have observed that this is rarely the case.

The gap between what CASA aims to do (train indigenous women to reduce maternal mortality among indigenous women) and what actually manifests led to the inception of a pilot program in Guerrero, for which Sagrario was partly in charge, as a CASA graduate, an adviser at the Center for Gender Equity and Reproductive Health, and an expert on midwifery at the federal level. The program was developed to curb the trend of CASA graduates either abandoning the practice of midwifery after graduation, or solely attending births of nonindigenous women in the private sector.

CASA graduates who do actively practice midwifery have generally avoided working in rural zones for lifestyle reasons—after four years of intense study and clinical training, they generally settle in urban zones where they receive higher remuneration for their services and their children can get a better education. Furthermore, the distance from urban conveniences (hot water, cell phone signal, internet, food other than beans and tortillas, etc.); the feeling of isolation produced by separation from friends and family; and the slow wearing down of the soul from routinely witnessing deep social pathologies such as widespread alcoholism and normalized domestic violence have deterred CASA graduates, many of whom studied professional midwifery in hopes for "a better life" after graduation.

Through the public employment of CASA graduates at rural clinics in indigenous zones across the State of Guerrero, the Mexican government aimed to outweigh detractors to rural living with economic balances (i.e., a salary of 12,000 pesos per month, to be raised to 14,000 pesos in the second year of the program). While the salary the Secretary of Health offered pales in comparison to the sums foreign and transnational midwives like Paula and Montserrat earn per

Argentina, Chile, Uruguay, Puerto Rico, Belfast, and England), and a Chilean midwife who was a fellow participant in Adeli's workshop.

birth, it rivals the salary of other publicly-employed medical personnel, and is more than many Mexican midwives, professional or “traditional,” expect to earn.

María del Carmen and Ignacio

Sagrario and I spent two weeks together traveling across Guerrero, visiting and assessing CASA graduates as they provided prenatal care to indigenous women from their rural posts. On one sunny afternoon, we were lurching up a windy mountain road with our driver, a Secretary of Health worker for the State of Guerrero. Sagrario and I crammed into the passenger seat of the truck since neither of us wanted to get motion sickness while sitting in the truck bed. My eyes were glued to the pavement, snaking back and forth along the mountainside. Suddenly, Sagrario saw something off to the side of the road, and our driver halted the truck to a screeching stop. Emerging from the truck, we saw a short-statured, indigenous man—bewilderment and desperation in his eyes—holding the limp body of his unconscious wife. Sagrario ordered the driver to help her load the woman into the back of the truck, and she quickly grabbed a bag of IV saline solution from her purse. With the calmness and efficiency of someone with extensive clinical experience, Sagrario inserted the IV needle into the woman’s arm as our driver jolted down the mountainside. (I later asked her why she carries IV saline solution in her purse and she told me that she is always prepared for the possibility of someday intervening in a life-threatening situation.)

When Sagrario arrived with the patient, María del Carmen, and her husband, Ignacio, at the closest semi-urban clinic in San Luís Acatlán, she was informed that while the clinic has an operating room, it does not have a surgical team to perform the procedure María del Carmen needed to stop her potentially fatal hemorrhage. During the ride to San Luís Acatlán, Sagrario had diagnosed the cause of María del Carmen’s hemorrhage as miscarriage of an unknown pregnancy. Unable to access the necessary treatment in San Luís Acatlán, Sagrario decided to take María del Carmen and Ignacio to the closest urban hospital in Ometepec. Three hours after seeing the couple on the side of the road, Sagrario finally left them with hospital personnel, who were already initiating surgical management of María del Carmen’s acute uterine bleeding. During the long car ride from the winding road we found the couple to San Luís Acatlán and then on to Ometepec, Sagrario asked María del Carmen if she wanted to have any more children. María del Carmen answered no, and Sagrario sought her consent for tubal ligation, explaining that this would prevent any similar complication from happening in the future. María del Carmen consented, and Sagrario passed this information along to hospital staff, asking that they perform the ligation in addition to the surgical management of María del Carmen’s hemorrhage.

Sagrario and I then took Ignacio to the Health Jurisdiction Offices in Ometepec to meet with the head administrator and discuss the case with him. I watched the encounter with the administrator unfold, as Sagrario insisted that the administrator personally look after María del Carmen’s case, and as Ignacio slouched and stared sheepishly at the floor. Instead of locating the origin of the problem in María del Carmen’s biology or in inadequate health resources and infrastructure in rural indigenous zones, the administrator complained about how difficult it is to provide health care to “*gente indígena por su cultura*” (indigenous people because of their culture). The administrator made harsh and discriminatory comments as if Ignacio were not present in the room—as if Ignacio did not even exist. Ignacio’s facial expression never changed; he continued to stare at the floor until Sagrario and I signaled to him that it was time to leave.

The next day, we returned to check on María del Carmen, who was already being prepared for discharge. She had not received a tubal ligation. One staff member said that the

operating room was not suitable for such a surgery due to a recent earthquake (the earthquake occurred two and a half months before), while another staff member indicated that the problem was actually blood. If they performed the tubal ligation, María del Carmen would have to be administered at least one pack of blood, but the blood bank's policy is to refuse blood to any patient whose family cannot replace the same amount of blood on the patient's behalf. Since Ignacio was assumed to be anemic like the majority of indigenous people in the region, he was not a candidate for blood donation, thus precluding María del Carmen from receiving blood or a tubal ligation.



From left to right: Sagrario, María del Carmen and Ignacio

Sagrario's blood began to boil. She was visibly angered by this news, and she stormed down the hospital corridors until she found the chief of staff and demanded that María del Carmen be given a tubal ligation immediately. She insisted, telling him that he knew perfectly well that if they missed the opportunity to ligate, the patient would not return and would likely have more children, in addition to potentially suffering another hemorrhage in the future. The chief acquiesced, and we left the hospital...for that day.

* * *

The next day, we drove to a small village tucked deeply into the Guerrero countryside. To get there, we had to ford four streams and small rivers, holding our breath while hoping that the water would not rush into the cabin of the truck or damage the truck's engine. Then came the biggest challenge: driving along a faint mountainside path that withered away until we found

ourselves on a narrow ledge. The truck crept forward, cautiously, slowly...and then it happened. One of the wheels had slipped over the edge cliff, and for a second we were suspended, balancing in the air, throwing our weight toward the side of the mountain. The driver put his foot on the gas and the wheels spun until the truck climbed back to safety.

When we finally arrived to the tiny hidden village, we were famished. Perhaps our brush with death had unconsciously motivated us to fill our stomachs with whatever sustenance we could find. Arriving at a villager's house, we were welcomed into her kitchen (the area in her cabin around the fire she uses to cook) and promptly served *chipilis* (a weed that grows abundantly in the area, and a source of free food) in clear broth (I suspect that the broth was made from water and salt instead of meat or bones). Unboiled water is undrinkable in the area, so we all accepted Coca Cola.

After satisfying our bellies, we paid the woman for the food and began a long trudge up the hill to visit a first-time pregnant woman. When we arrived to an adobe house at the top of the hill, we asked for Verónica, but Verónica's father-in-law emerged. He asked us to explain our business with Verónica, and when Sagrario explained that she wanted to perform a follow-up prenatal exam since Verónica had been totally absent from the San Luís Acatlán clinic, the father-in-law cocked his head to the side, considering Sagrario's proposition, before heading over to a cell phone sitting in a cut-off plastic water bottle, taped to the top of a wooden post. He dialed his son's cell phone number and his son answered from the taxi he drives in Mexico City. They spoke in Mixtec, conferring about what to do. A couple minutes later, the husband in Mexico City asked to speak to Verónica, to inform her that she should submit to the prenatal exam. Verónica came to the post, heard her husband's instructions, and hung up the phone.



Verónica's father-in-law talking to his son through the cell phone on the end of the wooden post

Verónica led us to a woven-straw bed, similar in construction to a trampoline, in the patio of the family’s adobe home. Sagrario performed the prenatal exam and determined that everything was fine. She inquired why Verónica was no longer seeking prenatal care at the clinic in San Luís Acatlan. Verónica explained that on her last visit, she was told the baby was undergoing “fetal distress,” displayed cardiac rhythm abnormalities, and had a nuchal chord. Verónica demonstrated a steely, unshakable confidence in her capacities to sense the well-being of her fetus and give birth to a healthy child (in contrast to David-Floyd’s 1992 assessment of the American paradigm which mires women in fear). Relying solely on mother’s intuition, she determined that her baby was perfectly fine and that the medical personnel were manipulating her in order to lure her onto the operating table. We asked her what she planned to do: how would she, a 19-year-old first-time mother, give birth in a small village with no midwife? Her answer was simple and matter-of-fact: “By myself.”



Victoria receives a prenatal exam from Sagrario and another professional midwife

* * *

After similar visits in other villages, we returned to the place where we found María del Carmen and Ignacio on the side of the road. From there, we beat our way through thick brush and foliage until we found a small one-room cabin tucked among the trees. María del Carmen’s sister-in-law, Valeria, was in tears as she translated the story of the couple’s journey home from the hospital, late at night, with no money, no medicines, and no place to stay. To get home, the couple had to *engañar* (deceive) the taxi driver, only admitting they had no money to pay him

once he had driven them home. It was the only way. Ignacio's mother also cried, saying that it felt so good to be treated well by *gente*⁷⁷ and that she was touched that "*doctoras*" would come all the way to their home to offer help.



Searching for María del Carmen and Ignacio's cabin in the woods

After hearing about María del Carmen and Ignacio's tribulations during their return home, Sagrario was again on the rampage. We drove three hours to Ometepec, Sagrario fuming every kilometer of the way and planning a tongue lashing for the Health Jurisdiction Administrator. Our driver, anxious about what was in store, said, "I will take you wherever you want to go, but do not face me with those monsters." He explained that the administrator is a close friend of the governor, has support of the union, and his sister is the municipal president. As someone within the circle of power, he is accustomed to abusing the local population. Once we arrived, Sagrario reminded the administrator that he had personally assured her he would provide María del Carmen and Ignacio with transportation home. She told him that he broke his promise and is not trustworthy, and threatened, "I am not leaving here without a solution." After some squirming on his part during Sagrario's tirade, the administrator was left speechless. He

⁷⁷ *Gente* can literally be translated to mean "people." However, this term is often used to contrast "decent folk" from "the dregs of society" and evidences her presupposition that Ignacio and the rest of his family are somehow lesser people than Sagrario and myself.

pulled out two 500 peso notes (approximately eighty dollars) from his billfold and handed them to Sagrario as reimbursement for María del Carmen and Ignacio's travel expenses and had a nurse bring the postoperative analgesics and antibiotics María del Carmen required from the health center. Then he sent us to a restaurant in the town center, telling us to eat to our heart's content, "The bill is on me."



Tranquilino helps María del Carmen sit up in the bedroom portion of the cabin



The inside of María del Carmen and Ignacio's cabin; their children and family members

Supranationalism: The Limits of Citizenship

While marginalized individuals like María del Carmen and Ignacio seek minimal government-provisioned medical services and are deeply moved by rare experiences of kind treatment by *gente*, their affluent counterparts are oblivious to the trials of state-issued health care. Due to limited economic resources and ongoing racial discrimination, María del Carmen and Ignacio can only hope that their dire health needs will be met through the trope of citizenship. Since they are not positioned to leverage scientific knowledge and the performative medicalization of their suffering bodies as Petryna describes, biological citizenship is always just out of reach. For mother's like Verónica, being denied agency within government hospital settings fosters agentive disinterest in pursuing ever-alooft biological citizenship and willful determination to go it alone. In contrast, Larissa and Jose Felix' privatized lifestyles⁷⁸ unfold entirely outside of the realm of citizenship. For them, citizenship is neither unattainable nor alooft—it is simply inconsequential. Instead, their identities are linked to a transnational meritocracy around parenting and birthing that allows cultural capital to stealthily stand in for economic capital.

Furthermore, I have provided examples in this chapter that contrast the relative physical and social mobilities of a humanized birth practitioner, a Mexican midwife, and impoverished

⁷⁸ See chapter three.

indigenous patients and their families.⁷⁹ The landscape I am describing is fraught with conflicting interests, and as mobilities collide into immobilities, social tensions surge. Each example offered highlights a different aspect of this complexity. I dispute Appadurai's 1996 notion of "flow" and instead build upon Ong's 1999 portrayal of how power works in globalized contexts since my work not only describes (ethno)medically mobile travelers on the one hand and socially situated individuals on the other; but rather, highlights the tensions that emerge from physical propinquity and divergent access to transnational consumption and national citizenship.

Sagrario comes in contact with foreigners who she perceives as more privileged but less skillful than her. Their mobility and her relative immobility, along with associated cultural and economic capital inequality, caused her to express frustration and resentment. Adeli is an example of someone who has leveraged a transnational identity to accumulate both cultural and economic capital—she is a U.S.-trained Jewish Mexican American whose livelihood depends on successfully portraying herself as a "traditional Mexican midwife."

Adeli's experiences again show that both physical and social mobility are premised on one's ability to position oneself in a transnational community of consumption vis-à-vis traditional and professional categories. Her "border crossing" was met with resistance in her community, leading her to flee Brazil. The contrasting ethnographic examples of Sagrario's exclusion from the Mexican Midwifery Association advisory panel and threats to the safety of Adeli's children demonstrate that while some informants enjoy heightened mobility and others are constrained by immobility, the social categories that separate the two groups can sometimes be equally binding in emotionally challenging ways. In this chapter, I have highlighted moments that add complexity to the concept of medical migration in order to describe how people from disparate socioeconomic and georacial spectrums experience (im)mobility.

Conclusion

In Mexico, neoliberal economic restructuring has led to the dismantling and defunding of social safety nets. Cash transfer programs like *Oportunidades* situate poor indigenous women at the crossroads of multiple forms of oppression and require them to alternate between performances of need and performances of capacity (see Gálvez 2011 and Smith-Oka 2013). While Maldonado suggests that the government's "cultural approaches" to national health problems hold individuals responsible for self-care (see Maldonado 2010), Gutmann describes working-class Mexicans as having "a widespread belief that formal government institutions and officials could not be trusted to provide them with the necessities of life, and a general feeling that self-reliance was both the cross and the honor they would bear in life" (Gutmann 2002:2). The ethnographic examples in this chapter collectively suggest that neoliberal governance is not only premised on self-care, but is resulting in the restructuring of the very meaning of citizenship.

Gálvez links neoliberal models of self-reliance to Foucault's "technologies of self" (Foucault 1988) and Ong's dual technologies for the formation of neoliberal subject: "technologies of subjectivity" and "technologies of subjection" (Ong 2006:6). In contrast, I am pointing to the limits of governmentality. My observations from the field do not support the argument that self-government and internalized discipline reinforce power structures and further regulate populations. While scholars are increasingly pointing to how neoliberalism is resulting

⁷⁹ Other examples include Doña Eugenia, Doña Agustina, and Don Israel in chapter two; Paloma and Pamela in chapter five.

in the simultaneous expansion and delimitation of citizenship⁸⁰, my work aims to decenter citizenship and explore other forms of subject-making. I am not discarding citizenship; rather, I am emphasizing moments in which citizenship is either not attainable or simply not the object of desire. Thus, I agree with scholars who critique the exceedingly narrow and racialized sphere of citizenship, but I depart from these critiques by asking what is unfolding beyond.

My rethinking of citizenship resists uncritical assumptions about how health as a human right unfolds in our neoliberal age. While countries like Mexico and Brazil are investing in nascent universal health systems, supranationalism and medical migrations point to the transnational nature of health care in the contemporary world and the delinking of nation and health provision. Recognizing the disjuncture between national health systems and legal citizens—that is, attending to how some individuals seek “citizenship” that is always just out of reach while others secure inclusion in transnational health-related communities through consumption—throws into question the very premise upon which universal health systems are based. Can health as a universal *good* (both as a moral value and as concrete medical services) exist in an epoch that, ideologically speaking, combines neoliberal notions of choice with capitalistic realities of deep socioeconomic inequality?

The gap between state provisioned health services and market driven health acquisition is inscribed in individuals’ identities, granting of greater or inferior value to those individuals as moral subjects. While many have researched how inequalities (socioeconomic, race, gender, etc.) become embodied through unequal health care provisioning, my research goes in the other direction: I attend to how unequal access to biological services reinscribe inequalities which are then incorporated into identities.

⁸⁰ See Galv3ez 2011; Chavez 2008; Coutin 2003; D3vila 2008; and De Genova 2005.

CONCLUSION

The humanized birth movement provides a telling example of how “traditional” practices are usurped and reinvented using a New Age logic that commodifies indigeneity through claims to “ancestral” knowledge while failing to include the very people it celebrates. The humanization of birth in Mexico demonstrates how New Age practices are buttressed by transnational markets that restrict some and privilege others. In this dissertation, I have provided ethnographic examples detailing how New Age interpretations and practices travel around the globe and unfold within specific places. That is to say, while medical migration is global, its effects are nested in the lived realities of my informants. By studying both “up” and “down” simultaneously, I have queried how transnational communities of consumption provide the conditions through which different forms of inequality converge and are reinforced. Throughout the dissertation, I have resisted binary questions like, “Is it race, gender or class?” because this framing is inadequate for describing the messiness I observed in the field and potentially hides more than it reveals. Affluent participants achieve “social whitening” and access global “white” communities through bioconsumption and commodification of indigeneity and feminized, moralized mothering practices. Thus, this dissertation signals how on the one hand, economic capital facilitates access to female-centered social networks through which cultural capital is accumulated, and on the other hand, “whiteness” and “indigeneity” are coproduced and co-constituted.

The transnational humanized birth movement points to the syncretic meanings and outcomes of New Age practices. I offer the New Age as a series of consequential contradictions—that is, The New Age is not just a philosophy, a way of life, or the passive intersection of an ecumenical global spirituality and “traditional” cultural forms—The New Age *does something*: the dual production of new “traditional” identities, and the “traditionalization” of new movements.

Latin American social scientists have critiqued European and American sociological approaches for advancing a globalizing argument which privileges the perspectives of cosmopolitan spirituality seekers (see De la Torre et. al 2013)^{xvii}. In contrast, they attend to both the circulation of teachers, symbols, rituals, knowledges, and concepts on the one hand; and process of resignification, reinscription of what it means to be “ethnic,” and reappropriation of the New Age by the masses on the other hand. By signaling that New Age is characterized by practitioners as a countercultural form of spirituality, an alternative to materialism and consumption, and a symbol of postmodernity and cosmopolitanism⁸¹, these scholars argue that the New Age engenders the dynamization of existing syncretisms into new hybrid cultures, and simultaneously, the essentialization of ethnic identities.

My concept of racial i(nter)dentification injects intersectional inequalities of race, class, and gender into De la Torre et al.’s emphasis on how multicultural, New Age encounters result in novel syncretisms that redefine social identities.⁸² My ethnography pushes back against De la Torre’s (2013) reading of the emergence of New Age practices in developed capitalist countries as an alternative to capitalist modernity among middle-class actors with access to art, science, and cosmopolitan culture. In the case of humanized birth, participation by middle-class actors in

⁸¹ See Melton 1990, Heelas 1996, Hanegraaff 2001, and Champion 1995.

⁸² For examples of the effects of New Age practices on the contemporary construction of identities, see Galinier 2008, Sarrazin 2008, and De la Peña 2002.

transnational communities of consumption leads to the accrual of cultural capital. Moreover, privatization of (ethno)medical services results in the decentering of citizenship as the most appropriate category for analysis. While De la Torre argues that the encounter between middle-class actors and indigenous and “popular” cosmovisions has resulted in cultural exchanges (in contrast to a globalized homogenization or the creation of a world-wide culture), my ethnographic fieldwork highlights the inequity inherent in these “exchanges.” At the same time, however, my critique is a kaleidoscopic departure from Molinié’s (2013) denunciation of the hybridization of New Age practices as nothing more than a reshuffling of colonial forms of exploitation.⁸³

The subtlety of my argument lies in my sensitivity to the effects of intersecting forms of social inequality. I take a moderate approach that combines both systemic power with the dynamism and agency of marginalized populations. In doing so, I problematize the assumption that New Age practices are adopted evenly among “the masses.” My ethnographic examples add complexity to the interaction between New Age practices and contemporary construction of identities by pointing to the important effects of processes of gendered racialization and socioeconomic class. Thus, my work highlights the variability of social positions (and associated restrictions) from which individuals negotiate and portray their identities.

The humanized birth movement in Mexico is a valuable example for rethinking the arguments presented in the literature on New Age practices. I argue that tourism and transnational consumption of ethnomedicine exploits the image of indigeneity when it usurps “traditional” medical practices and refashions them into hyper-mobile commodities. Furthermore, my research on humanized birth in Mexico clarifies the apparent contradiction between Molinié and Aguilar Ros’ (2013) arguments and conceptualizations of the New Age as a postmodern, cosmopolitan, and countercultural alternative to materialism and consumption. As I have argued in the introduction to the dissertation, the great irony of the humanized birth movement in Mexico lies in parents’ perspective of themselves as critics of late capitalism; all the while, their very rejection of consumerism bolsters ongoing commodification of culture, reinscription of racial hierarchies, and (false) appropriation of indigenous notions of racial “hierarchy.”⁸⁴

New Age Ideologies and Ethnomedicine

According to Michael York, the New Age Movement is an open availability process that converts various spiritual traditions into public property. The sacred is commodified, allowing it to be bought or sold, and thus consumed in a free-market. York points to the irony of the New Age rationale: spiritual commercialization often clashes with the traditions from which it appropriates^{xviii,xix}.

In this dissertation, I have argued that what humanized birth proponents describe as an international feminist liberation for educated women is based in the exploitation of cultural–intellectual property rights of traditional midwives and the reproduction of

⁸³ In a similar vein, Aguilar Ros 2008 suggests that tourism exploits native spirituality.

⁸⁴ See example in the introduction about how specialized baby carriers made of cloth serve as non-commodity commodities among women who enact a feminized, moralized, “purified” motherhood. These women place cloth carriers in opposition to prams and baby carriages, which they critique for being commodities. Also, see section in Chapter 2 about the expense of having a humanized birth.

inequality in Mexico (see Chapter 2). Thus, my work not only uncovers the clash between commodified New Age forms and traditional practices, but also highlights how intersecting forms of social inequality are actually reinforced and reinscribed by New Age ideologies that are purportedly value inclusiveness and “humanity.”^{xx}

In the context of traditional midwifery in Mexico, traditional midwives are excluded from practicing in hospitals. While some regions offer certification for traditional midwives, the exam-based evaluations pose a virtually impossible obstacle for traditional midwives with limited formal schooling. As Gálvez describes (see Gálvez 2011:75), traditional midwives face legal problems if they practice without certification, and as a result, many have been forced to cease practicing. What I am arguing differs from Kudlu (2013) in that he signals a paradigmatic shift from “pharmaceuticals” to “services” and describes how the ayurvedic doctor is kept within the loop^{xxi}. In contrast, I argue that while traditional midwives are largely excluded as participants in the commodity chain, their image is usurped, commodified, overlain on “traditional” services and goods, and sold. My argument is not about the “large-scaling” of traditional midwifery and concomitant “deskilling” of practitioners—rather, I am diagnosing the (false) appropriation of traditional midwifery, the commodification of indigeneity, and the exclusion of traditional indigenous midwives. Furthermore, while Nazrul Islam is concerned with how Eastern medicine is desired by the West and how this desire has transformed Ayurveda into wellness therapy (a process he calls “ideological contamination”); I am concerned with how desire among the “global professional class” (see Spivak 2003) for “going back to nature” and “traditional ways of birthing” reinforces socioeconomic stratification and processes of racialization in the name of humanization, places the burden of correctly producing future bioconsumers on women’s shoulders using the rhetoric of feminist liberation, and commodifies culture under the guise of rejecting consumption.

Remaking “Anew” of Tradition

In Mexico, tradition is remade “anew” through New Age iterations of humanized birth. Furthermore, as humanized birth practitioners and traditional birth attendants come into contact during training workshops, conferences, and fairs, a reordering of “tradition” and “progress” is challenging Euro-American ontologies of time. While this has led to a change in how indigeneity is imagined and desired by non-indigenous individuals, it has translated into material differences for only a few specific indigenous participants, and has failed to disrupt undergirding racial hierarchies rooted in colonial legacies.

Examples of this complex relationship between emerging traditionalities and the commodification of indigeneity under the New Age paradigm are many. In Guerrero, Dr. Gilberto, a health official within the state-level Secretary of Health, told me that his office aspired to be the “pioneers” of vertical birth positions in Mexico. For him, going back to birth postures regularly assumed by women before the biomedical naturalization of the lithotomy position (lying on one’s back, feet in stirrups) was a strategic way for the state of Guerrero, a state among the poorest nation-wide with respect to health indicators, to identify itself as a leader towards modernity and progress through corporal techniques that have been “scientifically proven in the First World.” In the context of demedicalization, modernity is aligned with “ancestral knowledge.”

Meanwhile, for Doña Eugenia’s indigenous clients, modernity is sought through medicalization and pharmaceuticalization. While they avoid interacting with hospital staff due to previous experiences of racial discrimination, they seek out Doña Eugenia’s services over other

local traditional midwives because of her skillful placement of an IV drip during the labor process, administration of intravenous vitamin solution during the recovery period, and extensive in-home pharmacy of pills promising quicker results than traditional herbal remedies (see Friedlander 1975).

Doña Eugenia also offers herbal treatments, but even these services are sufficiently “modern” since she does not rely solely on traditional knowledge passed down through the generations; rather, she studies texts produced by the University of Chapingo which catalogue the effectiveness of herbs based on clinical and laboratory studies. In doing so, Doña Eugenia is drawing from academic expertise produced at an institution that groups traditional and alternative medicines in New Age fashion: herbalism, the therapeutic uses of temascal, and healing massage are taught alongside African traditional medicine, Chinese medicine and acupuncture, Ayurvedic medicine, biomagnetism, and homoeopathy. Thus, for Doña Eugenia’s clients, modernity is achieved through being cared for as modern beings.



Doña Eugenia preparing an IV to administer postnatal vitamin solution

The complex and, at times, contradictory perspectives of Dr. Gilberto and Doña Eugenia’s clients are not unique by any means. A prominent humanized obstetrician in Guadalajara and a handful of his clients are featured in a French documentary on birth practices around the world. For him, humanized birth is part of a greater movement towards natural and ecological living. He not only wants to help women become more in tune with their bodies, but

to himself become more in tune with the earth through sustainable farming and raising livestock. Nearby, a Colombian nurse turned midwife uses “traditional” Mexican rituals, temazcal, dance circles, and herbs with her transnational clients. In Cuernavaca, Yanira⁸⁵ combines acupuncture with the traditional midwifery techniques that piqued the interest of American filmmakers. A transnational organization in Monterey, Nuevo Leon offers transcendental yoga, chiropractic treatments, and humanized birth services alongside “ancestral” baking classes. In a private Mexico City hospital dedicated to “natural” healing and minimal intervention, the highest technology from around the world is combined with a dedication to organic living.

My perspective on the rupture and reordering of existing Euro-American ontologies of time responds to phenomena similar to those observed by Robbie Davis-Floyd in her discussion of “postmodern” midwifery, but my interpretation bares stark contrast. For David-Floyd, “postmodern” midwifery is a productive combination of elements from traditional midwifery and modern-day obstetrics (see Davis-Floyd 2007). That is, the “postmodern midwife” merges techniques from past and present in a way that benefits birthing mothers. While in Davis-Floyd’s view the interpenetration of traditionality and modernity have a positive impact on women’s births, my dissertation reframes the question entirely. I am less concerned with making value judgements about humanized birth as a potential paradigm shift in obstetrics and more concerned with the racialization, politics of portrayal, and socioeconomic inequalities that it often buttresses and masks. I am not disputing that the humanization of birth and reduction of obstetric violence are valuable projects, but I ask, in practice, who have these projects been good for?

While the humanized birth movement has facilitated access to demedicalized birth in the private sector for the global professional class, traditional midwives face government-sanctioned limitations on their work. The current nation-wide health policy dictates that all births take place in hospital settings; however, I discovered a great deal of regional variability between policy and practice. In some places, indigenous midwives and mothers use subversive strategies to seek the midwife-attended births they desire. In other places (see Van Hollen 2003 and Smith-Oka 2013), indigenous women seek “modernity” through biomedical births and are actively turning away from traditional midwifery. In still other places, traditional midwives have transitioned to the role of contraception advocates in order to escape blame for maternal mortality, but nonetheless continue to be scapegoats for negative birth outcomes. In other zones, traditional midwifery is framed by NGO workers and members of the community as a response to inadequate health infrastructure in the state. Elsewhere, midwives have ceded births to hospital staff, but regularly provide prenatal care and provide mother’s with guidance that often takes precedence when making reproductive decisions.

In Veracruz, midwives contend that the distance to the nearest hospital from their rural communities combined with irregular transportation make it impossible for many births to be attended in hospitals, resulting in their moral obligation to attend births when they are already unfolding. However, their argument is met with further, unwritten measures attempting to curtail the practice of traditional midwifery. At a training workshop, I listened as traditional midwives complained to the regional hospital director about difficulties obtaining birth certificates for the babies they had delivered. Some were even being charged a fee by corrupt hospital administrators for birth certificates that are officially free of charge.

Despite attempted censure of traditional midwifery, in some municipalities across Veracruz midwives are interpellated by government officials to perform unpaid duties as

⁸⁵ Introduced later in this chapter.

community health workers and contraception advocates (see Pigg 1997, 2001). One traditional midwife maintains a positive relationship with the medical intern in her village by submitting to his “supervision.” While he is still a student and she has attended thousands of births, she turns in a weekly report tallying the number of home visits she has performed, how many hospital references she has made, and how many women she has convinced to use contraceptive methods. I witnessed noticeable absences in her report—that is, she prepares herbal remedies and attends births for her fellow villagers, but these midwifery activities not included in the report. Nonetheless, it is worthwhile for her to continue to deliver her weekly report to the medical intern because, in exchange for her submission to his “supervision,” he turns a blind eye to her practice of midwifery. At the same time, her ongoing provisioning of midwifery minimizes his need to intervene in obstetric and gynecological cases, freeing him from potential accusations of molesting the village women and violent backlash were he to incur a negative birth outcome. Thus, while their performative relationship seems characterized by submission to biomedical authority, the midwife and the intern are complicit partners—he silently supports her as she fulfills her role in the community, and she alleviates him from his anxiety-provoking obligation to intervene.

The official story is that the women in this community are giving birth “alone” in their homes because their indigenous physiology and broader hips lead to speedy births that make it impossible for them to arrive on time^{xxiii}. This type of community-wide secrecy is not unique to Veracruz. I interviewed traditional midwives and indigenous mothers in the mountains of Guerrero and while traditional midwives tell officials they are not attending births in that region, it is not uncommon for women to give birth “alone.” One mother told me that she gave birth “alone” to eleven children, and each time, the birth was so swift that she could not make it to the hospital.

In Oaxaca, the threat of financial loss has not been sufficient for making sure women attend all of their prenatal visits, so the Secretary of Health instituted a “Obstetric Godmothers Program” (*Programa de Madrinas Obstétricas*), thus adding a financial incentive for female members of the community to assure that their pregnant neighbors attend all required prenatal consults. After her contract ended at the Center for Gender Equity and Reproductive Health, Sagrario accepted a position within the Guerrero Secretary of Health. From her post, she proposed that instead of paying stipends to lay women for assuring that pregnant women comply with biomedical mandates like in the neighboring state of Oaxaca, traditional midwives in Guerrero who pass a certification process should be paid monthly stipends for their midwifery work. Shortly thereafter, Sagrario began focusing her energies on the freshly inaugurated professional midwifery school in Tlapa, Guerrero, leading her away from advocacy for the practice of traditional midwifery.

In Chiapas, traditional midwives spoke openly to me about their practice of midwifery, and mothers were forthcoming about choosing to have a traditional midwife attend their births instead of trekking to a distant hospital that is often overcrowded, understaffed, and lacking medical supplies. One mother told me that while the Oportunidades program requires her to go to prenatal consults, this has no effect on the prenatal care she receives from the midwife she trusts. While she relies on the knowledge of the midwife to make decisions about her pregnancy, physicians at the government clinic remain totally unaware that she is receiving ongoing midwifery care. Concurrent prenatal care with traditional midwives is a common omission in clinical settings. In this region, traditional midwives do not act as hospital referralists at the service of the state; however, their active role is not often officially acknowledged. The

ambivalent relationship between traditional midwives and clinical care providers is mediated by Global Pediatric Alliance, an NGO based in San Francisco, California. Global Pediatric Alliance's binational team negotiates with government leaders on behalf of traditional midwives.

In Quintana Roo, virtually all births take place in hospital settings, very few traditional midwives continue to attend births, and the population adheres to the national policy. Traditional midwives in Quintana Roo are frequent recipients of workshops, credentials, and certificates, but one midwife complained to me that the result all of this "training" has been their conversion into contraception *promotoras*. She commented, "We are the social workers outside of the hospital. There are no rights for *indígenas*." She complained that despite generalized compliance with government mandates and attendance at relentless social worker-led trainings, traditional midwives are still the scapegoats for maternal mortality in the state. In the process, multiple measures of inequality and related risk factors for maternal mortality are obscured.

Throughout my ethnographic fieldwork, I noticed that the regional variability of restrictions placed upon traditional midwifery practice stem from content differences among the training workshops that traditional midwives receive. While in states like Veracruz, Guerrero, and Quintana Roo traditional midwives are instructed to refer birthing mothers to the nearest hospital, in the Huasteca region of San Luis Potosi state, traditional midwives are "medicalized," instructed not to use herbal remedies, and taught to perform an episiotomy during all of the births they attend.

Transnationalism in the Humanized Birth Movement

Humanized birth in Mexico is the result of transnational flow of ideas, people, and practices; but to what degree are comparisons of professional midwifery and alternative birth in Mexico and in the developed world meaningful and informative? Given that such comparisons can be made, what are they informative about? In Chiapas, I interviewed Andrea, the local director of Global Pediatric Alliance. In her opinion, when people use Chilean professional midwives as an example of how professional midwifery can be transformative for women's health through marked reduction in maternal and infant health, their argument does not take into account the political, economic, and social realities of Mexico. According to Andrea, it is impossible to compare the unfolding of professional midwifery in Chile with that of Mexico because of their distinct contexts.

I agree with Andrea in that strategies for ameliorating negative health outcomes in one nation will not bear the same effects in another nation if they are applied in exactly the same way—for professional midwifery to result in a similar reduction in maternal mortality in Mexico, a number of adaptations accounting for georacial and socioeconomic differences must be made to the Chilean model; however, I am more concerned with the question of why these comparisons are being made. I argue that such comparisons are born of lingering and consequential aspirations of modernity and "whiteness," and a desire to be aligned with whiter, more developed countries.

During that same trip, I visited an organization of traditional indigenous medicine doctors and midwives, where I interviewed the director and several members of the staff. At the time of my visit, some traditional midwives from the association were on a trip to Germany, where they had been invited by a group of obstetricians and professional midwives to appear at a conference. The organization has very limited funding, and its members' lives are marked by poverty. In this dissertation, I have explored how the image of indigeneity is fetishized in international forums and have argued that in many cases, this celebration of "ancestral knowledge" and

“humanization” is ironically and, at times, unwittingly rooted in notions of racial hierarchy that in effect reify and reinscribe race-based inequality. Through ethnographic examples, I have suggested that this decontextualization and appropriation of indigenous peoples’ images is articulated in multiple and complex ways: while some indigenous individuals feel objectified; others engage with transnational politics of representation, using their indigeneity as a resource through which to achieve various sorts of recognition that are meaningful to them, despite continued economic scarcity; and still others leverage their identities with lucrative results, leading to violent backlash from their communities.

Consumption and “Social Whitening” on a Global Stage

Issues of “social whitening,” consumerism, and transnationalism intersect in the humanized birth movement. More specifically, parents and families form groups oriented around a particular type of birth; their participation in these groups, which often times reiterate discourse originating in the Global North and connect them to a transnational movement, is an expression of how patterns of consumption and “social whitening” operate in tandem.

My perspective draws from and simultaneously resists both Rose and Novas’ interpretation of Petryna’s biological citizenship^{xxiii} and García Canclini’s consumer citizenship. Nikolas Rose and Carlos Novas broaden Petryna’s notion of biological citizenship by pointing to new forms of identity and morality created along with novel transnational citizenship projects. Similarly, I point to the transnational moral communities to which parents in the Global South seek membership, inclusion, and belonging. In the same vein as Rose and Novas, I assert what is at stake is not necessarily material, economic, or medical resources, but, rather, claims to cultural capital through production of new identities and novel moral scales. Individuals who identify with the humanized birth movement and practice natural, home and/or water birth, skin-to-skin contact with the newborn, and extended breastfeeding consider themselves better parents, and affirm their children are more emotionally balanced, self-assured, and intelligent. However, I resist Rose and Novas’ suggestions regarding the partial delinking of citizenship and nation since I argue that broadening the notion of citizenship to include transnational social networks runs the risk of stripping citizenship of its essential meaning and depleting its analytical usefulness.

By bringing Latin American (and especially Mexican) scholarship to bear on the concept of biological citizenship, I draw attention to the roles consumerism, socioeconomic class, and representations originating in the Global North play in the construction of global, biological, consumption-oriented communities. Nestor García Canclini argues that while citizenship used to signify equality of abstract rights and collective participation in public democratic spaces, nowadays questions of belonging, information, and representation are answered in the realm of private consumption and mass media—effectively rendering citizens of the 18th century into consumers of the 20th (or 21st) century. Identity is now configured by consumption—how much one possesses and is capable of appropriating. Thus, according to García Canclini, the neoliberal conception of globalization reserves the right of being a citizen for elites^{xxiv}.

From my perspective, the fact that so much of contemporary social life is ordered by neoliberal patterns of consumption problematizes citizenship as an adequate explanatory concept for how individuals negotiate both transnational and locally situated inequalities in their everyday lives. During ethnographic research, I observed how bioconsumers citizens seek *inclusion* in global biological and consumerism-oriented communities rather than rights and resources from a particular nation or state. Thus, my dissertation explores processes of inclusion/exclusion and patterns of bioconsumption that produce both “supracitizens” and

“noncitizens,” and critiques tendencies to apply the concept of citizenship too broadly.⁸⁶ What is truly at stake for the bioconsumers I observed are presentations of self (see Goffman 1959) and the accrual of cultural capital, not government-provisioned services.

Nonetheless, a simple switch from the citizenship modality to the consumer modality would be too reductive. What I observed were neoliberal parenting in action, and the many ways neoliberal ideology reproduces classism, gender inequality, and mother-blaming even as it casts parents as expert consumers with many options from which to choose. Thus, in this dissertation, I resist viewing children only as commodities since I observed the deep love with which parents raise their children and the thoughtfulness and carefulness that guide decisions regarding their children’s wellbeing. However, I do argue that children represent parents’ stake in our contemporary meritocracy—a system that naturalizes extreme inequality by allowing us to believe in democratic structures and the idea that education and proper preparation will open doors for children to a brilliant future. Furthermore, I suggest that the pressure of meritocracy pushes back into the womb. That is, the difference between a privatized and public childhood begins *in vitro* with prenatal care.⁸⁷

The great irony lies in the fact that these parents view themselves as actively resisting materialism, but their very refusal of the corruption they diagnose in consumerism, nationalism, and late capitalism leads to the commodification of culture, heightened moralization and gradation of motherhood, reinscription of racial hierarchies, and (false) appropriation of indigenous notions of spirituality. The humanized birth movement explicitly avoids direct references to consumption. That is to say, these mothers reject the most expensive baby carriages, nannying services, and similar markers of commodified or elite motherhood. Instead, they seek cloth wraps with which to bind their children to their bodies and promote mother-child bonding. Their cloth wraps, however, are not the woven shawls that indigenous women use; they are sold by specialized companies that use the internet to market humanized birth products as non-commodity commodities. These women’s project—to enact a feminized, moralized, “purified” motherhood—is a critique of García Canclini’s description of consumption since it unfolds around a *moral* fluorescence and through *moral* spaces that allow ideologies to flow “freely.” The goal of these mothers is not to have the most, but to be the best. It is not that the pathway to citizenship in neoliberal societies is through consumption (as García Canclini 2001 argues); rather, cultural capital is earned by parents who set themselves apart as morally superior in neoliberal meritocracies.

⁸⁶ Scheper-Hughes 2000 also problematizes contemporary anthropological notion of citizenship by pointing to “super-citizens” and “sub-citizens.” Her terminology suggests a hierarchical scaling of citizens in which some individuals have access to more citizenship rights than others. While I do not disagree with Scheper-Hughes, I use the terms “supracitizen” and “noncitizen” to describe individuals whose lives unfold outside of the realm of citizenship—marginalized individuals for whom citizenship is always just out of reach and transnational elites whose privatized lives render citizenship simply irrelevant.

⁸⁷ On the privatization of childhood and neoliberal parenting, see Lareau’s *Unequal Childhoods: Class, Race, and Family Life*; Charis Thompson’s “Three Times a Woman” and *Making Parents: The Ontological Choreography of Reproductive Technologies*; Folbre’s *Greed, Lust and Gender: A History of Economic Ideas*.

REFERENCES

ⁱ It is worth mentioning that “urban hippies” and “rural Christians” are two very distinct groups in the United States that, despite their shared enthusiasm for humanized birth, do not map onto each other at all. Furthermore, while some humanized birth proponents in Mexico would not take offense at being described as “urban hippies” and even use “hippy” as a term to describe themselves, it is important to point out that these categories originating in the United States do not map directly onto humanized birth in Mexico. That is to say, Christian practices and what it means to be “hippy” have different roots in the U.S. than in Mexico.

ⁱⁱ In the context of my ethnographic research, “parto respetado” unfolded as a multivalent descriptor that signals birth that is respected, respectful, and that evidences the respectability of its practitioners. For a discussion of “respectability,” see Cooper’s lecture, “The End of Respectability: Black Feminism and Ratchet Politics,” delivered at the University of Wisconsin, Madison on March 10, 2015 (available online at: <https://vimeo.com/121847236>).

ⁱⁱⁱ While others at the *encuentro* labeled these participants “hippies,” I am sensitive to discriminatory processes of racialization that unfold despite white privilege, and am therefore careful to avoid terms that have in some contexts been employed as racial epithets against white people. My purpose for describing the demographic at this event is to signal how humanized birth proponents may engage in lifestyle choices that actively critique capitalization while also participating in the fetishization of indigeneity.

^{iv} For Fassin, humanitarian government is the governance of those who are victims of precariousness. The vocabulary of suffering, compassion, and assistance qualifies the issues involved and shapes the choices made in our contemporary political life. Fassin argues humanitarianism fugaciously bridges the fundamentally unequal human condition, making the intolerability of injustice somewhat bearable. (His argument resonates with the life work of Eduardo Menéndez on hegemony and subalternity.)

^v Clifford places his work in conversation with seminal literature on postmodernity (“Postmodernism” [1984] by Jameson and *The Condition of Postmodernity* [1990] by Harvey) and more recent work on ethnicity (Chow’s *The Protestant Ethnic and the Spirit of Capitalism* [2002] and Comaroff’s *Ethnicity, Inc.* [2009]). These authors argue capitalist globalization encourages differences so long as these differences do not upset the dominant political–economic order.

^{vi} “Humanized birth” (*parto humanizado*) is usually used in Mexico and elsewhere in Latin America to describe birth that purposefully resists medicalization and technocratic practices (see Davis-Floyd 1992). This movement is analogous to the home and water birth movements in the United States, Canada, and Western Europe. Births are often attended by professional midwives (although some obstetricians have joined the movement) and accompanied by doulas. In general, proponents of humanized birth criticize power inequality inherent in physician–patient relationships and denounce medicalized practices such as unnecessary cesarean sections, episiotomies, isolation of birthing mothers in hospital labor and delivery areas, labor induction (including the use of hormones such as pitocin), and the repetitive insertion of medical personnel’s fingers into women’s vaginas to assess dilation. However, some informants expressed a more nuanced definition of humanized birth, explaining that a highly medicalized birth can be considered “humanized” if the interventions were medically necessary and/or if the interventions were chosen by the birthing mother. Also, some Mexican physicians have railed against the terminology of “humanized birth,” asking if the birth they attend is, by default,

“animalistic.” Thus, some prefer the term “respected birth,” since it highlights respect for birthing mothers’ choices, which can be prioritized in both medicalized births and births attended by physicians. Given socioeconomic and race-based disparities across Mexico, I question uncritical notions of “free choice.”

^{vii} While at the time of my participant-observation this hospital reported an approximate cesarean section rate of 20 percent (more than the World Health Organization’s recommended 10 to 15 percent), this figure is less than half of the national averages in both public and private sectors. Cesarean section represents 45.8 percent of births in public Mexican Institute of Social Security hospitals (see the IMSS website [imss.gob.mx] and their publication, “Guía de Práctica Clínica: Vigilancia y manejo de parto. Evidencias y Recomendaciones. Catalogo Maestro de Guías de Práctica Clínica: IMSS-052-08) and approximately 70 percent of births in private hospitals (see Sánchez, Cinthya. “En México, uno de cada dos niños hoy nace por cesárea.” Eluniversal.mx. July 18, 2010. Web. Accessed September 21, 2014.)

^{viii} See, for example, Davis-Floyd and Sargent 1996; Davis-Floyd, Pigg, and Cosminsky 2001; Katz Rothman 2007; Simonds 2007; MacDonald 2008; Davis-Floyd, Barclay, Tritten, and Daviss 2009.

^{ix} A number of anthropologists have focused on the relationship between reproduction, modern industrial capitalism, and the intensification of global inequity with regards to material resources (Anagnost 1995; Martin 2001; Ginsburg and Rapp, 1995; Colen, 1995; Whittaker, 2010). Some have analyzed the shift from children whose productive labor contributes to the household economy to children whose unproductive existence drives consumption of household resources (Layne 1999; Taylor et al. 2004; Zelizer 1994). These accounts posit that while raising children had once been a strategy for sustaining the domestic unit as parents age, in the present day children are born to be loved and educated to the highest extent possible.

^x While Ludy S. DeLoache and Alma Gottlieb published *A World of Babies: Imagined Childcare Guides for Seven Societies* in 2000—a cross-cultural comparison of how people raise their babies and an anthropological, psychological, and historical account of the nature versus nurture dilemma—this approach does not offer a political economic critique of privilege and inclusion/exclusion in globalized markets.

^{xi} Several books have emerged to stir the parenting pot. Jennifer Senior’s 2014 book *All Joy and No Fun: The Paradox of Modern Parenthood* points to the perils of placing children at the top of the family hierarchy and giving them minimal responsibilities. While this strategy is meant to make children happy, Senior argues it makes children, and their parents, very unhappy. Parents end up overextended, overscheduled, and overstressed—a recipe that often takes a toll on their romantic relationship. Senior’s perspective is an outlier among parenting books, and it represents a non-anthropological approach that develops in a similar direction as my present argument. Also see *Bringing Up Bébé: One American Mother Discovers the Wisdom of French Parenting* (2012) by Pamela Druckerman.

^{xii} See Roberts 1997, Glenn 2002, Crenshaw 2014, Granzka 2014, and Haraway 2014.

^{xiii} Within the context of trial discourse, Greg Maltoesian points to how intertextuality generates inconsistency. Specifically, he analyzes the metapragmatic negotiation framing both the authority and the reception of reported speech. The strength of Maltoesian’s work lies in his attention to the performance of legal knowledge, the naturalization of discursive power, and the production of intertextual transparency.

^{xiv} Montoya first points out that for 70 years anthropologists, following after Boas, have considered race to be a social construct and fundamentally an ideology about human differences;

and how decades of research shows that most variation exists within so-called racial groups, rather than between them. Specifically, he studies type 2 diabetes and asks how, given this previous notion, race could be biologically meaningful. Montoya indicates drug companies and epidemiologists simply view diabetes as a biochemical error or a population-based syndrome, without paying attention to the living conditions for Mexicanas/os along the US-Mexico border. He writes, “Placing DNA acquisition within the sociohistorical context of the US-Mexico border, the processes and products of genetic epidemiological research can be understood as founded upon long-standing racialized social and economic inequalities” (Montoya 2011:13). He argues that population labels, in fact, reference the biological effects of a particular population’s social history. When researchers and scientists use the notion of racial groups, they confound the fallacy of race by using it as a freestanding independent variable. Thus, Montoya points to the co-construction of cultural meanings and political economies of diabetes.

^{xv} Using the lens of genetic research on asthma in Barbados, Whitmarsh (2008) offers an analysis of how plurality of ethnic identities and illness meanings are transformed into a science of race. Through ethnographic observations of genetic researchers, government officials, medical professionals, and families, Whitmarsh documents how the bundling together of disease populations and biological race is contested by practices around nation, race, and family. For further perspectives on the relevance of race as a social, legal, and medical category (as opposed to nothing more than a social construct), see Whitmarsh and Jones 2010.

^{xvi} Adriana Petryna (2002) first developed the concept of biological citizenship in *Life Exposed: Biological Citizens after Chernobyl*. (Others have theorized related concepts that merge corporeal practices and civic status; notably, “sanitary citizenship” [Briggs and Mantini-Briggs 2003] and “biomedical citizenship” [Anderson 2006].) In the aftermath of the Chernobyl disaster, the Ukrainian state rejected the World Bank and U.S. cost-effective model of disaster remediation, taking a paternalistic role as the giver and taker of social resources and creating a new role for the individual impacted by the Chernobyl disaster: that of biological citizen. Individuals navigated their citizenship, rights, and social identities through the leveraging of scientific knowledge, the performative medicalization of their suffering bodies, and bureaucratic influences. Others have theorized related concepts that merge corporeal practices and civic status; notably, “sanitary citizenship” (Briggs and Mantini-Briggs 2003) and “biomedical citizenship” (Anderson 2006).

^{xvii} The syncretic nature of New Age phenomena is discussed at length in De la Torre, Gutiérrez Zúñiga, and Juárez Huet’s edited volume *Variaciones y Apropiaciones Latinoamericanas del New Age*. They argue that “New Age” is the intersection of an ecumenical global spirituality and “traditional and ancestral” cultural forms. Thus, for them, New Age practices are the result of a dual process: the production of new “traditional” identities, and the “traditionalization” of new movements.

^{xviii} York the New Age Movement as a response to the decline of “traditional religion” in the West. Citing Bryan Wilson, York argues that the New Age Movement conforms to the spiritual pluralism that results from secularization.

^{xix} Property-oriented approaches have been adapted to the globalization of Ayurveda. Masato Kasezawa performed research in Kerala, India to examine the cultural politics determining intellectual ownership of Ayurveda. Kasezawa observed the redefinition of Ayurveda as national intellectual property, and therefore an object of state control.

For an example of a similar analysis on yoga, see Allison Fish's 2006 "The Commodification and Exchange of Knowledge in the Case of Transnational Commercial Yoga in the International Journal of Cultural Property, Volume 13, Issue 2, pages 189-206.

^{xx} This aspect of my work can be compared and contrasted to the work of Chithrabha Kudlu, who, in his Washington University in St. Louis dissertation, "Brand Kerala: Commodification of Open Source Ayurveda," points to the recent emergence of global ayurvedic tourism. Instead of conceptualizing the effects of commodification in terms of intellectual property rights, he focuses on the "social lives" of ayurvedic pharmaceuticals and how the livelihoods of actors in the ayurvedic commodity chain are transformed. Like York, Kudlu describes classical medicines as "open-source commodities," and specifies that their commercial viability is rooted in the continuity of a cultural practice. He signals a dual, contradictory process: while tourists flock to Kerala, where Ayurveda is a mass commodity (as opposed to its elitist status elsewhere), industrialization and institutionalization (and resulting homogenization and scientization) threaten the traditional role of knowledge-intensive actors: ayurvedic doctors, consumers, raw drug shops, and medicinal plant collectors. He argues that "economic stakes" are at odds with "cultural stakes," leading to the "deskilling" of ayurvedic practitioners.

^{xxi} My work is more closely aligned with Nazrul Islam's 2011 research on the branding of Ayurveda, the creation of "New Age orientalist desire," and what he calls, "wellness and spa culture." Similar to the ethnographic observations I have made in this dissertation, Islam underlines the role of Euro-American tourists and Indian middle-class professionals and affluent entrepreneurs in the commodification of Ayurveda. Furthermore, Islam examines how a global demand for herbal drugs, supplements and beauty products and the commodification of Ayurveda has led large pharmaceutical companies to redefine ayurvedic drug production for profit maximization (see Islam 2010).

^{xxii} See O'Neil and Leyland-Kaufert 1995 on the racialization of Inuit women's physiology and their births.

^{xxiii} A related concept of that of "sanitary citizen." Charles Briggs and Clara Mantini-Briggs coined the term "sanitary citizenship" in their 2004 book *Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare* to describe a key mechanism for deciding who is granted substantive access to the civil and social rights of citizenship. Those who are perceived to possess modern medical understandings of the body, health, hygiene, and illness are sanitary citizens. In contrast, Briggs and Mantini-Briggs show how race, class, and gender figure into medical profiling; construing certain individuals as incapable of modern medical relationships to the body, hygiene, illness, and healing; thus rendering them unsanitary subjects. .) Sanitary citizenship is supported by binaries such as modern/traditional, global/local, and biomedicine/ethnomedicine. To be rural and poor means to only have access to local knowledge, to be traditional and rely erroneously on ethnomedicine. Briggs and Mantini-Briggs suggest that, due to their relegation to the category of unsanitary subject, the poor and rural population's struggle for adequate health care and human rights equal to their wealthy, urban counterparts is rendered invisible.

^{xxiv} García Canclini strongly implicates the United States in the global conversion to consumer citizenship. He suggests international uniformity, imposed by neoliberal planning "far away" (often originating in North America), has led to individuals feeling the only things accessible to them are goods and messages arriving to their homes, to use "as they see fit." The tastes and consumption patterns of audiences are often scripted in the United States—so much that García Canclini calls identities "multimedia spectacles," and suggests Latin America and Europe are

“suburbs” of Hollywood. In contrast to García Canclini’s perspective on the United States’ presence in Latin America, I point to the multiple imbrications of the so-called First World and global “whites” in shaping what is considered progressive and desirable in Mexico.

BIBLIOGRAPHY
Organized by Chapter

Introduction

Anagnost, Ann

1995 A Surfeit of Bodies: Population and the Rationality of the State in Post-Mao China. *In* *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

Appadurai, Arjun

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

Augé, Marc

1995 *Non-places: Introduction to an Anthropology of Supermodernity*. London: Verso.

Bamford, Sandra C.

2007 *biology Unmoored: Melanesian Reflections of Life and Biotechnology*. Berkeley: University of California Press.

Bashkow, Ira. 2006. *The Meaning of Whitemen: Race and Modernity in the Orokaiva Cultural World*. Chicago: University of Chicago Press.

Bauman, Richard and Charles L. Briggs

2003 *Voices of Modernity: Language Ideologies and the Politics of Inequality*. Cambridge: Cambridge University Press.

Bauman, Zygmunt

1993 *Postmodern Ethics*. Oxford, UK: Blackwell Publishers.

Berry, Nicole S.

2013 [2010] *Unsafe Motherhood: Mayan Maternal Mortality and Subjectivity in Post-War Guatemala*. New York: Berghahn Books.

Bondi, Liz, M. Smith, and Joyce Davidson

2005 *Emotional Geographies*. Aldershot, UK: Ashgate.

Barroso, Carmen and Sônia Corrêa

1995 *Public Servants, Professionals, and Feminists: The Politics of Contraceptive Research in Brazil*. *In* *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

Bourdieu, Pierre

1984 *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, Massachusetts: Harvard University Press.

Breihl, Jaime

1998 La sociedad, el debate de la modernidad y la nueva epidemiología. *Revista Brasileira de Epidemiologia* 1(3):207–233.

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

2008a Latin American Critical ('Social') Epidemiology: New Settings for an Old Dream. *International Journal of Epidemiology* 37:745–750.

2008b Una perspectiva emancipadora de la investigación e incidencia basada en la determinación social de la salud. *In* Taller Latinoamericano sobre Determinantes Sociales de la Salud: documento para la discusión. México, D.F.: ALAMES.

Briggs, Charles

1986 *Learning How to Ask: A Sociolinguistic Appraisal of the Role of the Interview in Social Science Research*. Cambridge, UK: Cambridge University Press.

Brubaker, Sarah J. and Heather E. Dillaway

2009 Medicalization, Natural Childbirth and Birthing Experiences. *Sociology Compass* 3(1): 31-48.

Cabral Soto, Javier, with Ángel Flores Alvarado, María del Carmen Baltazar Rivas, Fabiola García Vargas, María Concepción Orozco Meinecke, and Carlos Brambila Paz

2000 *Salud sexual y reproductiva en jóvenes indígenas de las principales etnias de México*. México, D.F.: Instituto Mexicano de Seguro Social.

Calhoun, Craig

2010 A Cosmopolitanism of Connections. *In* *The Cosmopolitan Idea*. Hillary Ballon, ed. New York: New York University Abu Dhabi.

Carillo, Ana

2002 Physicians "Who Know" and Midwives "Who Need to Learn". *In* *Midwives in Mexico: Continuity, Controversy and Change*. Robbie Davis-Floyd, Marcia Good-Maust, and Miguel Güemez Piñeda, eds. Austin: University of Texas Press.

Casper, Monica J.

1998 *The Making of the Unborn Patient: A Social Anatomy of Fetal Surgery*. New Brunswick, NJ: Rutgers University Press.

Chow, Rey

2002 *The Protestant Ethnic and the Spirit of Capitalism*. New York: Columbia University Press.

Colen, Shellee

1995 Like a Mother to Them: Stratified Reproduction and West Indian Childcare Workers and Employers in New York. *In* *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

-
- Comaroff, John L., and Jean Comaroff
2009 *Ethnicity, Inc.* Chicago: The University of Chicago Press.
- Crenshaw, Kimberlé Williams
2014 The Structural and Political Dimensions of Intersectional Oppression. *In* Intersectionality: A Foundations and Frontiers Reader. Patrick R. Granzka, ed. Boulder, CO: Westview Press.
- Crossley, Michele L.
2007 Childbirth, Complications, and the Illusion of “Choice”: A Case Study. *Feminism Psychology* 17(4):543-563.
- Dávila, Arlene
2012 [2001] *Latinos, Inc.: The Marketing and Making of a People*. Berkeley: University of California Press.
- Davis-Floyd, Robbie
1992 *Birth as an American Rite of Passage*. Berkeley, CA: University of California Press.
2007. “Daughter of Time: The Postmodern Midwife.” *Revista da Escola de Enfermagem da Universidade de São Paulo* 41, no. 4:705–710.
- Davis-Floyd, Robbie, with Leslie Barclay, Jan Tritten, and Betty-Anne Daviss
2009 *Birth Models that Work*. Berkeley: University of California Press.
- De la Cadena, Marisol
2000 *Indigenous Mestizos: The Politics of Race and Culture in Cuzco, Peru, 1919–1991*. Durham, NC: Duke University Press.
2015 *Earth Beings: Ecologies of Practice Across Andean Worlds*. Durham, NC: Duke University Press.
- DeGenova, Nicholas
2005 *Working the Boundaries: Race, Space, and “Illegality” in Mexican Chicago*. Durham, NC: Duke University Press.
- Douglass, Carrie B.
2005 *Barren States: The Population “Implosion” in Europe*. Oxford, UK: Berg Publishers.
- Dumit, Joseph
2012 *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham, NC: Duke University Press.
- Edu, Ugo
2015 *I Only Want Two!': Aesthetics, Race, and Sterilization in Brazil* (Unpublished doctoral dissertation). University of California, San Francisco.

Erikson, Susan

2001 Maternity Care Policies and Maternity Care Practices: A Tale of Two Germanys. *In Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe.* DeVries, R., Benoit, C., Van, E., Tejilingen, S.W., eds. New York: Routledge.

Fassin, Didier

2010 Inequality of Life. *In In the Name of Humanity.* Miriam Ticktin and Ilana Feldman, eds. Durham: Duke University Press.

2012 Humanitarian Reason: A Moral History of the Present. Berkeley: University of California Press.

Folbre, Nancy

2010 Greed, Lust, and Gender: A History of Economic Ideas. Oxford: Oxford University Press.

Foucault, Michel

1990 [1978] *The History of Sexuality.* United Kingdom: Vintage.

Franklin, Sarah

1995 Science as Culture, Cultures of Science. *Annual Review of Anthropology* 24:163-184.

1997 *Embodied Progress: A Cultural Account of Assisted Conception.* New York: Routledge.

2006 The Cyborg Embryo: Our Parth to Transbiology. *Theory, Culture and Society* 23(7-8):167-187.

Fraser, Gertrude J.

1995 Modern Bodies, Modern Minds: Midwifery and Reproductive CHangein an Anfrican Community. *In Conceiving the New World Order: The Global Politics of Reproduction.* Faye D. Ginsburg and Rayna Rapp, eds. Pp. 42—58. Berkeley: University of California Press.

García Canclini, Néstor

2001 [1995] *Consumidores y ciudadanos: Conflictos multiculturales de la globalización.* México, D. F.: Grijalbo.

2009 [1990] *Culturas híbridas: Estrategias para entrar y salir de la modernidad.* México, D. F.: Grijalbo.

Gibbon, Sahra, with Mónica Sans and Ricardo Ventura-Santos, eds.

2011 *Racial Identities, Genetic Ancestry, and Health in South America: Argentina, Brazil, Colombia, and Uruguay.* New York: Palgrave Macmillan.

Ginsburg, Faye D.

1998 *Contested Lives: The Abortion Debate in an American Community.* Berkeley: University of California Press.

Ginsburg, Faye D., and Rayna Rapp

1995 *Conceiving the New World Order: The Global Politics of Reproduction.* Berkeley: University of California Press.

Glenn, Evelyn Nakano

2002 *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor*. Boston, MA: Harvard University Press.

Goldade, Kate

2007 *Reproducción transnacional: la salud reproductiva, las limitaciones y las contradicciones para las migrantes laborales nicaragüenses en Costa Rica*. In *El mito roto: Inmigración y emigración en Costa Rica*. García, C.S., ed. San José: UCR Press.

Granzka, Patrick R.

2014 *Intersectionality: A Foundations and Frontiers Reader*. Boulder, CO: Westview Press.

Greenhalgh, Susan

2008 *Just One Child: Science and Policy in Deng's China*. Berkeley: University of California Press.

Hannerz, Ulf

1996 *Transnational Connections*. New York: Routledge.

Haraway, Donna

1997 *Modest Witness@Second Millennium. Female Man Meets Oncomouse: Feminist and Technoscience*. Routledge, New York.

2014 *Situated Knowledges and the Persistence of Vision*. In *Intersectionality: A Foundations and Frontiers Reader*. Patrick R. Granzka, ed. Boulder, CO: Westview Press.

Haraway, Donna and Thyrza Nichols Goodeve

2000 *How Life a Leaf: An Interview with Thyrza Nichols Goodeve*. Routledge, New York.

Horn, David

1994 *Social Bodies: Science, Reproduction, and Italian Modernity*. Princeton, NJ: Princeton University Press.

Howes-Mischel, Rebecca

2009 *Regimes of Responsible Pregnancy Management: Creating Reproductive Subjects in Oaxaca, Mexico*. *Anthropology News*, February 2009:16–17.

Inhorn, Marcia Claire

2003 *Local Babies, Global Science: Gender, Religion, and In Vitro Fertilization in Egypt*. New York: Routledge.

2015 *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai*. Durham, NC: Duke University Press.

Jordanova, Ludmilla

1995 *Interrogating the Concept of Reproduction in the Eighteenth Century*. In *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna Rapp, eds. Pp. 369—386. Berkeley: University of California Press.

Kahn, Susan

2000 *Reproducing Jews: A Cultural Account of Assisted Conception in Israel*. Durham, NJ: Duke University Press.

Kapoor, Ilan

2004 Hyper-Self-Reflexive Development? Spivak on Representing the Third World "Other." *Third World Quarterly* 4:627-647.

Katz Rothman, Barbara

2007 *Origin Stories*. In *Laboring On: Birth in Transition in the United States*. Wendy Simonds, Barbara Katz Rothman, and Bari Meltzer Norman, eds. New York: Routledge.

Kearney, Michael

1996 *Reconceptualizing the Peasantry: Anthropology in Global Perspective*. Boulder: Westview Press.

Kligman, Gail

1995 *Political Demography: The Banning of Abortion in Ceausescu's Romania*. In *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

Lakoff, Andrew

2005 *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry*. Cambridge, UK: Cambridge University Press.

Landecker, Jannay

2003 *On Beginning and Ending with Apoptosis: Cell Death and Biomedicine*. In *Remaking Life and Death: Toward an Anthropology of the Biosciences*. Franklin S., Lock, M., eds. Santa Fe: School of American Research Press.

Langer, Ana and Kathryn Tolbert

1996 *Mujer: Sexualidad y salud reproductiva en México*. México, D.F.: EDAMEX, S.A. de C.V. y The Population Council, Inc.

Laurell, Asa Cristina

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

2013 *Impacto del Seguro Popular en el sistema de salud*. Buenos Aires: CLACSO.

Laurell, Asa Cristina, and O. L. Arellano

1996 *Market Commodities and Poor Relief: The World Bank Proposal for Health*. *International Journal of Health Services* 26(1):1-18.

Layne, Linda L.

1999 *Transformative Motherhood: On Giving and Getting in a Consumer Culture*. New York: New York University Press.

Low, Setha M., and Denise Lawrence-Zúñiga

2002 *The Anthropology of Space and Place: A Reader*. Oxford: Blackwell Publishers.

MacDonald, Margaret

2008 *At Work in the Field of Birth: Midwifery Narratives of Nature, Tradition, and Home*. Nashville: Vanderbilt University Press.

Malkki, Liisa

1996 Speechless Emissaries: Refugee, Munitarianism, and Dehistoricization. *Cultural Anthropology* 11(3):377–404.

2010 Children, Humanity, and the Infantilization of Peace. *In* *In the Name of Humanity*. Miriam Ticktin and Ilana Feldman, eds. Durham: Duke University Press.

Mamo, Laura and Jennifer Fishman

2001 Potency in All the Right Places: Viagra as a Tehcnology of the Gendered Body. *Body and Society* 7(4): 13-35.

Marcus, George E.

1995 Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology* 24(1):95–117.

Martin, Emily

2001 *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston: Beacon Press.

Mazzarella, William

2003 *Shoveling Smoke: Advertising and Globalization in Contemporary India*. Durham: Duke University Press.

Mbembe, Achille

2003 Necropolitics. Libby Meintjes, trans. *Public Culture* 15 (1):11—40.

Melhuus, Marit

2003 Exchange Matters: Issues of Law and the Flow of Human Substances. *In* “Globalization” *Studies in Anthropology*. Eriksen, T.H., ed. Sterling, VA: Pluto Press.

Mendoza González, Zuanilda

2010-2011 “Parir en la casa o en el hospital.” Saberes acerca del parto de mujeres triquis migrantes a la Ciudad de México. *In* *La Antropología médica en México* (Rivista della Società Italiana di Antropologia Medica). Rosa María Osorio Carranza, ed. Perugia: Fondazione Angelo Celli per una Cultura della Salute. 29-32:59-81.

Menéndez, Eduardo L.

1990 *Morir de alcohol: Saber y hegemonía médica*. México, D. F.: Alianza Editorial Mexicana.

1996 *De algunos alcoholismos y algunos saberes: Atención primaria y proceso de alcoholización*. México, D. F.: CIESAS.

2009 De sujetos, saberes y estructuras: Introducción al enfoque relacional en el estudio de la salud colectiva. Buenos Aires: Lugar Editorial.

2010 [2002] La parte negada de la cultura: Relativismo, diferencias y racismo. Argentina: Prohistoria Ediciones.

Menéndez, Eduardo and Renée Di Pardo

2010-2011 Sector Salud y organizaciones no-gubernamentales: convergencias y articulaciones en torno a la salud reproductiva. *In* La Antropología médica en México (Rivista della Società Italiana di Antropologia Medica). Rosa María Osorio Carranza, ed. Perugia: Fondazione Angelo Celli per una Cultura della Salute. 29-32:215-251.

Mignolo, Walter D.

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

Molina, Natalia

2006 Fit to Be Citizens? Public Health and Race in Los Angeles, 1879–1939. Berkeley: University of California Press.

2013 How Race is Made in America: Immigration, Citizenship, and the Historical Power of Racial Scripts. Berkeley: University of California Press.

Montoya, Michael

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

Morgan, Lynn

2009 Icons of Life: A Cultural History of Human Embryos. Berkeley: University of California Press.

Morgan, Lynn and Elizabeth F.S. Roberts

2012 Reproductive Governance in Latin America. *Anthropology and Medicine* 19(2):241-254.

Morsy, Soheir A.

1995 Deadly Reproduction among Egyptian Women: Maternal Mortality and the Medicalization of Population Control. *In* Conceiving the New World Order: The Global Politics of Reproduction. Faye D. Ginsburg and Rayna Rapp, eds. Pp. 162—176. Berkeley: University of California Press.

Munn, Nancy

1996 Excluded Spaces: The Figure in the Australian Aboriginal Landscape. *Critical Inquiry* 22: 446-465.

Murphy, Michelle

2011 Distributed Reproduction. *In* *Corpus: An Interdisciplinary Reader on Bodies and Knowledge*. Casper, M.J., Currah, P., eds. Pp. 21—39. New York: Pelgrave Macmillan.

Nader, Laura

1972 *Up the Anthropologist: Perspectives Gained from Studying Up*. In *Reinventing Anthropology*. Dell H. Hymes, ed. New York: Pantheon Books.

Nestel, Sheryl

2006 *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery*. Vancouver, BC: University of British Columbia Press.

Nouzeilles, Gabriela

2003 *Hysteria in Turn-of-the-Century Buenos Aires. Disease in the History of Modern Latin America: From Malaria to AIDS*. Armus, D., ed. Pp. 51—75. Durham, NJ: Duke University Press.

O'Neil, John and Patricia Leyland Kaufert

1995 *Irniktakpynga! : Sex Determination and the Inuit Struggle for Birthing Rights in Northern Canada*. In *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

Ong, Aihwa

1999 *Flexible Citizenship: the Cultural Logics of Transnationality*. Durham: Duke University Press.

2003 *Buddha Is Hiding: Refugees, Citizenship, the New America*. Berkeley: University of California.

Pashigian, Melissa

2009 *Inappropriate Relations: The Ban on Surrogacy with In Vitro Fertilization and the Limits of State Renovation in Contemporary Vietnam*. In *Assisting Reproduction, Testing Genes: Global Encounters with New Biotechnologies*. Birenbaum-Carmeli, D., Inhorn, M.C., eds. Pp. 164—188. New York: Berghahn Books.

Pearce, Tola Olu

1995 *Women's Reproductive Practices and Biomedicine: Cultural Conflicts and Transformations in Nigeria*. In *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

Pigg, Stacy Leigh

1997 *Finding, Knowing, Naming, and Training "Traditional Birth Attendants" in Nepal*. In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Robbie Davis-Floyd and Carolyn F. Sargent, eds. Berkeley: University of California Press.

2001 *Languages of Sex and AIDS in Nepal: Notes on the Social Production of Commensurability*. *Cultural Anthropology* 16.4:481-541.

Rabinow, Paul

1996 *Essays on the Anthropology of Reason*. Princeton, HJ: Princeton University Press.

Rapp, Rayna

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

Reardon, Jenny

2004 *Race to the Finish: Identity and Governance in an Age of Genomics*. Princeton, NJ: Princeton University Press.

Richardson, Miles

1982 Being-in-the-Plaza versus Being-in-the-Market: Material Culture and the Construction of Social Reality. *American Ethnologist* 9:421-436.

Ritzer, George

2001 *Explorations in the Sociology of Consumption: Fast Food, Credit Cards, and Casinos*. London: Sage Publications.

Roberts, Dorothy

1997 *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Vintage Books.

Roberts, Elizabeth F.S.

2006 God's Laboratory: Religious Rationalities and Modernity in Ecuadorian In Vito Fertilization. *Cultural Medicine and Psychiatry* 30:507-536.

2007 Extra Embryos: The Ethics of Cryopreservation in Ecuador and Elsewhere. *American Ethnologist* 34.1:181-99.

2012 *God's Laboratory: Assisted Reproduction in the Andes*. Berkeley, California: University of California, Press.

2012b "Scars of Nation: Surgical Penetration and the State in Ecuador" *Journal of Latin American and Caribbean Anthropology*. 17.2:215-237.

2015 *Reproduction and Cultural Anthropology*. *International Encyclopedia of the Social & Behavioral Sciences*. James D. Wright, ed. Second edition, Volume 20:450-456. Oxford: Elsevier.

Roberts, Elizabeth F. S. and Nancy Scheper-Hughes

2011 Introduction: Medical Migrations. *Body & Society* 17:1-30.

Rosaldo, Renato

1989 Imperialist Nostalgia. *Representations*, Special Issue: Memory and Counter-Memory 26:107-122.

Rotman Zelizer, Viviana A.

1994 *Pricing the Priceless Child: The Changing Social Value of Children*. Princeton, NJ: Princeton University Press.

Scheper-Hughes, Nancy and Loic Wacquant

2006 *Commodifying Bodies*. London: Sage.

Sesia, Paola M.

2007 Reproductive Health and Reproductive Rights after the Cairo Consensus: Accomplishments and Shortcomings in the Establishment of Innovative Public Policies in Oaxaca. *Sexuality Research and Social Policy: Journal of NSRC* 4.3:34-49.

Simonds, Wendy

2007 A Lifetime's Labor: Women and Power in the Birthplace. *In Laboring On: Birth in Transition in the United States*. Wendy Simonds, Barbara Katz Rothman, and Bari Meltzer Norman, eds. New York: Routledge.

Smith-Oka, Vania. 2013. *Shaping the Motherhood of Indigenous Mexico*. Nashville, Tennessee: Vanderbilt University Press.

Spivak, Gayatri

1988a Can the Subaltern Speak? *In Marxism and Interpretation of Culture*. Cary Nelson and Lawrence Grossberg, eds. Pp. 271-313. Chicago: University of Illinois Press.

1988b *In Other Worlds: Essays in Cultural Politics*. New York: Routledge.

1999 *A Critique of Postcolonial Reason: Toward a Critique of the Vanishing Present*. Cambridge, MA: Harvard University Press.

2003 A Conversation with Gayatri Chakravorty Spivak: Politics and the Imagination, interview by Jenny Sharpe. *Journal of Women in Culture and Society* 28(2):609-624.

Spivak, Gayatri and Sarah Harasym

1990 *The Post-Colonial Critic: Interviews, Strategies, Dialogues*. New York: Routledge.

Stepan, Nancy

1991 *The Hour of Eugenics: Race, Gender, and Nation in Latin America*. Ithaca: Cornell University Press.

Strathern, Marilyn

1992 *Reproducing the Future: Essays on Anthropology, Kinship, and New Reproductive Technologies*. New York: Routledge.

2005 *Kinship, Law, and the Unexpected: Relatives are Always a Surprise*. New York: Cambridge University Press.

Tallbear, Kim

2013 *Native American DNA: Tribal Belonging and the False Promise of Genetic Sciences*. Minneapolis, MN: University of Minnesota Press.

Tarlo, Emma

2003 *Unsettling Memories: Narratives of the Emergency in Delhi*. Berkeley: University of California Press.

Taylor, Janelle S., Linda L. Layne and Danielle F. Wozniak

2004 *Consuming Motherhood*. New Brunswick, NJ: Rutgers University Press.

Thompson, Charis

2005 *Making Parents: The Ontological Choreography of Reproductive Technologies*.

Cambridge, MA: MIT Press.

2006 *Race Science. Theory, Culture & Society* (Special Issue on Problematizing Global Knowledge) 23(2-3): 547-549.

2012 "Three Times a Woman: A Gendered Economy of Stem Cell Innovation," *UCLA Center for the Study of Women Blog*, <http://uclacsw.blogspot.com/2012/11/charis-thompson-three-times-woman.html>

2013 *Good Science: The Ethical Choreography of Stem Cell Research*. Cambridge, MA: MIT Press.

Tsing, Anna Lowenhaupt

2000 *The Global Situation*. *Cultural Anthropology* 15(3):327-370.

2005 *Friction: An Ethnography of Global Connection*. Princeton, NJ: Princeton University Press.

2015 *The Mushroom at the End of the World: On the Possibility of Life in Capitalist Ruins*. Princeton, NJ: Princeton University Press.

Tuan, Yi-Fu

2001 *Space and Place: The Perspective of Experience*. Minneapolis: University of Minnesota Press.

Unnithan-Kumar, Maya

2004 *Reproductive Agency, Medicine and the State: Cultural Transformations in Childbearing*. New York: Bergahn Books.

Urry, John

2007 *Mobilities*. Cambridge [u.a.]: Polity Press.

Van Hollen, Cecilia

2003 *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley: University of California Press.

Van Loon, Joost

2005 *Epidemic Space*. *Critical Public Health* 15 (1): 39-52.

Veblen, Thorstein

2006 [1902] *Conspicuous Consumption*. New York: Penguin.

Weismantel, Mary

2001 *Cholas and Pishtacos: Stories of Race and Sex in the Andes*. Chicago: Chicago University Press.

Waitzkin, Howard, and Celia Iriart

2000 *How the United States Exports Managed Care to Third-World Countries*. *Monthly Review*: 1-15.

2011 *Medicine and Public Health at the End of Empire*. Boulder, CO: Paradigm Publishers.

Whittaker, Andrea

2010 "Cyclinc Overseas": Care, Commodification, and Stratification in Cross-Border Reproductive Travel. *Medical Anthropology* 29(4):363-383.

Wilson, Ara

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

Chapter Two

Billig, Michael

1999 *Commodity Fetishism and Repression: Reflections on Marx, Freud and the Psychology of Consumer Capitalism*. *Theory Psychology* 9(3):313–29.

Campos Navarro, Roberto

1997 *Nosotros los curanderos : experiencias de una curandera tradicional en el México de hoy*. México, D.F.: Nueva Imagen.

Chow, Rey

2002 *The Protestant Ethnic and the Spirit of Capitalism*. New York: Columbia University Press.

Clifford, James

2001 "Indigenous Articulations." *Contemporary Pacific* 13(2):468-90.

Clifford, James

2013 *Returns: Becoming Indigenous in the Twenty-First Century*. Boston: Harvard University Press.

Comaroff, John L., and Jean Comaroff

2009 *Ethnicity, Inc*. Chicago: University of Chicago Press.

Coombe, Rosemary J.

1998 *The Cultural Life of Intellectual Properties: Authorship, Appropriation, and the Law*. Durham: Duke University Press.

Davis-Floyd, Robbie

1992 *Birth as an American Rite of Passage*. Berkeley, CA: University of California Press.

De Certeau, Michel

1984 *The Practice of Everyday Life*. Berkeley: University of California Press.

Fassin, Didier

2012 *Humanitarian Reason: A Moral History of the Present*. Berkeley: University of California Press.

Foucault, Michel

1973 *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Pantheon.

García Canclini, Néstor

2009 [1990] *Culturas híbridas: Estrategias para entrar y salir de la modernidad*. México, D. F.: Grijalbo.

Gálvez, Alyshia

2011 *Patient Citizens, Immigrant Mothers: Mexican Women, Public Prenatal Care, and the Birth-Weight Paradox*. New Brunswick: Rutgers University Press.

Goffman, Erving

1959 *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday.

Harvey, David

1990 *The Condition of Postmodernity*. Oxford: Blackwell.

Hayden, Cori

2003 *When Nature Goes Public: The Making and Unmaking of Bioprospecting in Mexico*. Princeton, New Jersey: Princeton University Press.

Hendrickson, Carol Elaine

1995 *Weaving Identities: Construction of Dress and Self in a Highland Guatemala Town*. Austin: University of Texas Press.

Jameson, Frederic

1984 Postmodernism, or the Cultural Logic of Late Capitalism. *New Left Review* 146:53–97.

hooks, bell

1990 *Yearning: Race, Gender, and Cultural Politics*. Boston, MA: South End Press.

Menéndez, Eduardo L.

1983 *Hacia una práctica médica alternativa. Hegemonía y autoatención (gestión) en salud*, vol. 86: Cuadernos de la Casa Chata. México, DF: Centro de Investigaciones y Estudios Superiores en Antropología Social.

Mintz, Sidney W.

1985 *Sweetness and Power: The Place of Sugar in Modern History*. New York: Penguin.

Molina, Natalia

2006 *Fit to Be Citizens? Public Health and Race in Los Angeles, 1879–1939*. Berkeley: University of California Press.

Ritzer, George

2001 *Explorations in the Sociology of Consumption: Fast Food, Credit Cards, and Casinos*. London: Sage Publications.

Rosaldo, Renato

1989 Imperialist Nostalgia. *Representations*, Special Issue: Memory and Counter-Memory 26:107-122.

Scheper-Hughes, Nancy and Loic Wacquant

2006 *Commodifying Bodies*. London: Sage.

Tallbear, Kim

2013 *Native American DNA: Tribal Belonging and the False Promise of Genetic Science*. Minneapolis, Minnesota: University of Minnesota Press.

Veblen, Thorstein

2006 [1902] *Conspicuous Consumption*. New York: Penguin.

Chapter Three

Anagnost, Ann

1995. "A Surfeit of Bodies: Population and the Rationality of the State in Post-Mao China." *In* *Conceiving the New World Order: The Global Politics of Reproduction*, edited by Faye D. Ginsburg and Rayna R. Rapp. Berkeley: University of California Press.

Crossley, Michele L.

2007 Childbirth, Complications, and the Illusion of "Choice": A Case Study. *Feminism Psychology* 17(4):543-563.

Davis-Floyd, Robbie

2001. "La Partera Profesional: Articulating Identity and Cultural Space for a New Kind of Midwife in Mexico." *Medical Anthropology* 20(2-3):185-243.

2004 [1992] *Birth as an American Rite of Passage*. Berkeley: University of California Press.

2007 "Daughter of Time: The Postmodern Midwife." *Revista da Escola de Enfermagem da Universidade de São Paulo* 41, no. 4:705-710.

Davis-Floyd, Robbie, with Leslie Barclay, Jan Tritten, and Betty-Anne Daviss

2009 *Birth Models that Work*. Berkeley: University of California Press.

Davis-Floyd, Robbie, with Stacy Leigh Pigg and Sheila Cosminsky

2001 "Daughters of Time: The Shifting Identities of Contemporary Midwives." *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 20(2-3):105-139.

-
- Davis-Floyd, Robbie, and Carolyn F. Sargent
1996 *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Berkeley: University of California.
- DeLoache, Judy S., and Alma Gottlieb
2000 *A World of Babies: Imagined Childcare Guides for Seven Societies*. Cambridge: Cambridge University Press.
- Dumit, Joseph
2012 *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham, NC: Duke University Press.
- Ginsburg, Faye D., and Rayna Rapp
1995 *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press.
- Gutmann, Matthew C.
1998 "Mamitis and the Traumas of Development in a Colonia Popular of Mexico City." *In Small Wars: The Cultural Politics of Childhood*, edited by Nancy Scheper-Hughes and Carolyn Sargent. Berkeley: University of California Press.
- Haraway, Donna
1989 *Primate Visions: Gender, Race, and Nature in the World of Modern Science*. New York: Routledge.
1990 *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York: Routledge.
- Katz Rothman, Barbara
2007 "Origin Stories." *In Laboring On: Birth in Transition in the United States*, edited by Wendy Simonds, Barbara Katz Rothman, and Bari Meltzer Norman. New York: Routledge.
- MacDonald, Margaret
2008 *At Work in the Field of Birth: Midwifery Narratives of Nature, Tradition, and Home*. Nashville: Vanderbilt University Press.
- Moraga, Cherrie L.
1983 *Loving in the War Years: lo que nunca pasó por sus labios*. Boston: South End.
- Ortner, Sherry
1972 *Is Female to Male as Nature is to Culture?* *Feminist Studies* 1(2):5—31.
- Senior, Jennifer
2014 *All Joy and No Fun: The Paradox of Modern Parenthood*. New York: Ecco.

Simonds, Wendy

2007 "A Lifetime's Labor: Women and Power in the Birthplace." In *Laboring On: Birth in Transition in the United States*, edited by Wendy Simonds, Barbara Katz Rothman, and Bari Meltzer Norman. New York: Routledge.

Sofia, Zoë

2004 Exterminating fetuses: abortion, disbarment, and the sexo-semiotics of extra-terrestrialism. *Diacritics* 14(2):47—59.

Spivak, Gayatri Chakravorty

2003 "A Conversation with Gayatri Chakravorty Spivak: Politics and the Imagination." By Jenny Sharpe. *Journal of Women in Culture and Society* 28(2):609–624.

Chapter Four

Augé, Marc

1995 *Non-places: introduction to an anthropology of supermodernity*. London: Verso.

Bauman, Zygmunt

1993 *Postmodern ethics*. Oxford, UK: Blackwell Publishers.

Bondi, Liz, Mick Smith and Joyce Davidson

2005 *Emotional geographies*. Aldershot, UK: Ashgate.

Bourdieu, Pierre

1984 *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, Massachusetts: Harvard University Press.

Brandes, Stanley H.

2006 *Skulls to the Living, Bread to the Dead: The Day of the Dead in Mexico and Beyond*. Malden, MA: Blackwell Publishers.

Cohen, Cathy J.

1997 Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics. *GLQ* 3: 437-465.

Crenshaw, Kimberlé Williams

2014 *The Structural and Political Dimensions of Intersectional Oppression*. In *Intersectionality: A Foundations and Frontiers Reader*. Patrick R. Granzka, ed. Boulder, CO: Westview Press.

De Genova, Nicholas

2005 *Working the Boundaries: Race, Space, and "Illegality" in Mexican Chicago*. Durham, NC: Duke University Press.

De la Cadena, Marisol

2000 *Indigenous Mestizos: The Politics of Race and Culture in Cuzco, Peru, 1919–1991*. Durham, NC: Duke University Press.

De Zavala, L.

1976 *Obras: Viaje a los Estados Unidos del Norte de America*. México: Editorial Porrura.

Fassin, Didier

2012 *Humanitarian Reason: A Moral History of the Present*. Berkeley: University of California Press.

Fitzgerald, D.

2009 *A nation of emigrants: how mexico manages its migration*. Berkeley: University of California Press.

Glenn, Evelyn Nakano

2002 *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor*. Boston, MA: Harvard University Press.

Granzka, Patrick R.

2014 *Intersectionality: A Foundations and Frontiers Reader*. Boulder, CO: Westview Press.

Haraway, Donna

1990 *Simians, Cyborgs, and Women: The Reinvention of Nature*. London: Free Association.

2014 *Situated Knowledges and the Persistence of Vision*. In *Intersectionality: A Foundations and Frontiers Reader*. Patrick R. Granzka, ed. Boulder, CO: Westview Press.

Kincaid, Jamaica

2000. *A Small Place*. New York: Farrar, Straus and Giroux.

Lancaster, Roger N.

1992 *Life is Hard: Machismo, Danger, and the Intimacy of Power in Nicaragua*. Berkeley: University of California Press.

Lomnitz Adler, C.

2005 *Death and the idea of Mexico*. Brooklyn: Zone Press.

López Obrador, Andrés Manuel

2010 *La mafia que se adueñó de México...y el 2012*. México: Grijalbo Mondadori S.A.

Montoya, Michael

2011 *Marking the Mexican Diabetic: Race, Science, and the Genetics of Inequality*. Berkeley: University of California Press.

Roberts, Dorothy

1997 *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York, NY: Vintage Books.

Roberts, Elizabeth F.S.

2012 "Scars of Nation: Surgical Penetration and the State in Ecuador" *Journal of Latin American and Caribbean Anthropology*. 17.2:215-237.

Stutzman, Ronald

1981 *El Mestizaje: An all Inclusive Ideology*. In *Cultural Transformations and Ethnicity in Modern Ecuador*. N. Whitten, ed. Pp. 45—94. Urbana: University of Illinois.

Suárez-Orozco, M. and Mariela Paéz

2009 *Latinos: remaking America*. Berkeley: University of California Press.

Urry, John

2007 *Mobilities*. Cambridge, UK: Polity Press.

Chapter Five

Bashkow, Ira

2006. *The Meaning of Whitemen: Race and Modernity in the Orokaiva Cultural World*. Chicago: University of Chicago Press.

Biehl, João Guilherme

2005 *Vita: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

Biehl, João and Torben Eskerod

2007 *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.

Breilh, Jaime

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

2008 *Una perspectiva emancipadora de la investigación e incidencia basada en la determinación social de la salud*. In *Taller Latinoamericano sobre Determinantes Sociales de la Salud: documento para la discusión*. México, D.F.: ALAMES.

Briggs, Charles and Clara Mantini-Briggs

2004 *Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare*. Berkeley: University of California Press.

Brubaker, Sarah J. and Heather E. Dillaway

2009 *Medicalization, Natural Childbirth and Birthing Experiences*. *Sociology Compass* 3(1): 31-48.

Clark, Kim A.

1998 Race, "Culture," and Mestizaje: The Statistical Construction of the Ecuadorian Nation, 1930-1950. *Journal of Historical Sociology* 11(2):185-211.

Colen, Shellee

1995 Like a Mother to Them: Stratified Reproduction and West Indian Childcare Workers and Employers in New York. *In* *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna R. Rapp, eds. Berkeley: University of California Press.

Colloredo-Mansfeld, Rudi

1998 "Dirty Indians": Radical Indigenas and the Political Economy of Social Difference in Modern Ecuador. *Bulletin of Latin American Research* 17(2):185—205.

De la Cadena, Marisol

1995 "Women Are More Indian:" Ethnicity and Gender in a Community Near Cuzco. *In* *Ethnicity, Markets, and Migration in the Andes: At the Crossroads of History and Anthropology*. Brooke Larson, Olivia Harris, and Enrique Tandeter, eds. Pp. 329—348. Durham: Duke University Press.

2000 *Indigenous Mestizos: The Politics of Race and Culture in Cuzco, Peru, 1919–1991*. Durham, NC: Duke University Press.

Douglass, Carrie B.

2005 *Barren States: The Population "Implosion" in Europe*. Oxford, UK: Berg Publishers.

Ewig, Christina

2010 *Second-Wave Neoliberalism: Gender, Race, and Health Sector Reform in Peru*. University Park: Pennsylvania State University Press.

Fanon, Frantz

2008 [1952] *Black Skin, White Masks*. New York: Grove Press.

Foucault, Michel

1990 [1978] *The History of Sexuality*. United Kingdom: Vintage.

Fraser, Gertrude J.

1995 *Modern Bodies, Modern Minds: Midwifery and Reproductive CHangein an Anfrican Community*. *In* *Conceiving the New World Order: The Global Politics of Reproduction*. Faye D. Ginsburg and Rayna Rapp, eds. Pp. 42—58. Berkeley: University of California Press.

Goldade, Kate

2007 *Reprodución transnacional: la salud reproductiva, las limitaciones y las contradicciones para las migrantes laborales nicaragüenses en Costa Rica*. *In* *El mito roto: Inmigración y emigración en Costa Rica*. García, C.S., ed. San José: UCR Press.

Gordon, Deborah

1988 Tenacious Assumption in Western Medicine. *In* *Biomedicine Examined: Culture, Illness, and Healing*. Margaret Lock and Deborah Gordon, eds. Pp. 19—56. Dordrecht: Kluwer Academic.

Haraway, Donna

1991 *Simians, Cyborgs, and Women: The Reinvention of Nature*. London: Free Association.

Hartigan, John

2010 *What Can You Say: America's National Conversation on Race*. Stanford: Stanford University Press.

Hegel, G.W.F.

1977 *Phenomenology of Spirit*. A.V. Miller, trans. Oxford, UK: Oxford University Press.

Lancaster, Roger N.

1992 *Life is Hard: Machismo, Danger, and the Intimacy of Power in Nicaragua*. Berkeley: University of California Press.

Larson, Brooke

2004 *Trials of Nation Making: Liberalism, Race, and Ethnicity in the Andes, 1810-1910*. Cambridge, UK: Cambridge University Press.

Latour, Bruno

1993 *We Have Never Been Modern*. New York: Harvester Wheatsheaf.

Laurell, Asa Cristina

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

2013 *Impacto del Seguro Popular en el sistema de salud*. Buenos Aires: CLACSO.

Laurell, Asa Cristina, and O. L. Arellano

1996 Market Commodities and Poor Relief: The World Bank Proposal for Health. *International Journal of Health Services* 26(1):1–18.

Leinaweaver, Jessaca B.

2008 *The Circulation of Children: Kinship, Adoption, and Morality in Andean Peru*. Durham: Duke University Press.

Lock, Margaret and Vinh-Kim Nguyen

2010 *An Anthropology of Biomedicine*. Oxford: Wiley Blackwell.

Mol, Annemarie

2002 *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.

Molyneux, Maxine

2006 Mothers at the Service of the New Poverty Agenda: Progres/Oportunidades, Mexico's Conditional Transfer Programme. *Social Policy & Administration* 40(4): 425-449.

Montoya, Michael

2011 Marking the Mexican Diabetic: Race, Science, and the Genetics of Inequality. Berkeley: University of California Press.

Morgan, Lynn and Elizabeth F.S. Roberts

2012 Reproductive Governance in Latin America. *Anthropology and Medicine* 19(2):241-254.

Orlove, Benjamin

1998 Down to Earth: Race and Substance in the Andes. *Bulletin of Latin American Research* 17(2):207—222.

Pashigian, Melissa

2009 Inappropriate Relations: The Ban on Surrogacy with In Vitro Fertilization and the Limits of State Renovation in Contemporary Vietnam. *In Assisting Reproduction, Testing Genes: Global Encounters with New Biotechnologies*. Birenbaum-Carmeli, D., Inhorn, M.C., eds. Pp. 164—188. New York: Berghahn Books.

Petryna, Adriana

2002 *Life Exposed: Biological Citizens After Chernobyl*. Princeton: Princeton University Press.

Pitt-Rivers, Julian

1973 Race in Latin America: The Concept of Raza. *Archives Europeennes de Sociologie* xiv(1):3—31.

Roberts, Elizabeth F.S.

2012 “Scars of Nation: Surgical Penetration and the State in Ecuador” *Journal of Latin American and Caribbean Anthropology*. 17.2:215-237.

2015 *Reproduction and Cultural Anthropology*. *International Encyclopedia of the Social & Behavioral Sciences*. James D. Wright, ed. 2nd edition, Volume 20. Oxford: Elsevier, pp. 450-456.

Rose, Nikolas, and Carlos Novas

2008 [2005] Biological Citizenship. *In Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Aihwa Ong and Stephen J. Collier, eds. Pp. 439—463. Malden, MA: Blackwell Publishing Ltd.

Stutzman, Ronald

1981 El Mestizaje: An all Inclusive Ideology. *In Cultural Transformations and Ethnicity in Modern Ecuador*. N. Whitten, ed. Pp. 45—94. Urbana: University of Illinois.

Smith, Carol A.

1996 Myths, Intellectuals, and Race/Class/Gender Distinctions in the Formation of Latin American Nations. *Journal of Latin American Anthropology* 2(1):148—169.

Smith-Oka, Vania. 2013. *Shaping the Motherhood of Indigenous Mexico*. Nashville, Tennessee: Vanderbilt University Press.

Wade, Peter

1993 Race, Nature and Culture. *Man* 28(1):17—34.

Waitzkin, Howard, and Celia Iriart

2000 How the United States Exports Managed Care to Third-World Countries. *Monthly Review*: 1-15.

2011 *Medicine and Public Health at the End of Empire*. Boulder, CO: Paradigm Publishers.

Whitmarsh, Ian

2008 *Biomedical Ambiguity: Race, Asthma, and the Contested Meaning of Genetic Research in the Carribean*. Ithaca, NY: Cornell University Press.

Whitmarsh, Ian and David Jones

2010 *What is the Use of Race?: Modern Governance and the Biology of Difference*. Cambridge, MA: MIT Press.

Villet, Charles

2011 Hegel and Fanon on the Question of Mutual Recognition: A Comparative Analysis. *The Journal of Pan African Studies* 4(7):39—51.

Chapter Six

Appadurai, Arjun

1996 *Modernity at Large: Cultural Dimensions of Globalization*, vol. 1: *Public Worlds*. Minneapolis, MN: University of Minnesota Press.

Anagnost, Ann

2011 *Strange Circulations*. In *Beyond Biopolitics: Essays on the Governance of Life and Death*. Patricia Ticineto Clough and Craig Willse, eds. Pp. 213–237. Durham: Duke University Press.

Anderson, Warwick

2006 *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines*. Durham: Duke University Press.

Bashkow, Ira

2006 *The Meaning of Whitemen: Race and Modernity in the Orokaiva Cultural World*. Chicago: University of Chicago Press.

Billig, Michael

1999 Commodity Fetishism and Repression: Reflections on Marx, Freud and the Psychology of Consumer Capitalism. *Theory Psychology* 9(3):313–29.

Briggs, Charles L., and Clara Mantini-Briggs

2003. *Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare*. Berkeley: University of California Press.

Chavez, Leo R.

2008 *The Latino Threat: Constructing Immigrants, Citizens, and the Nation*. Palo Alto, CA: Stanford University Press.

Coutin, Susan Bibler

2003 “Suspension of deportation hearings and measures of ‘Americanness.’” *Journal of Latin American Anthropology* 8(2):58-95.

Dávila, Arlene

2008 *Latino Spin: Public Image and the Whitewashing of Race*. New York: New York University Press.

De Genova, Nicholas

2005 *Working the Boundaries: Race, Space, and “Illegality” in Mexican Chicago*. Durham, NC: Duke University Press.

Foucault, Michel

1988 “Technologies of the self.” *In Technologies of the Self: A Seminar with Michel Foucault*, edited by L.H. Martin, 16-49. London: Tavistock.

Gálvez, Alyshia

2011 *Patient Citizens, Immigrant Mothers: Mexican Women, Public Prenatal Care, and the Birth-Weight Paradox*. New Brunswick: New Jersey: Rutgers University Press.

García Canclini, Néstor

2001[1995] *Consumidores y ciudadanos: Conflictos multiculturales de la globalización*. México, D. F.: Grijalbo.

Gutmann, Matthew

2002 *The Romance of Democracy: Compliant Defiance in Contemporary México*. Berkeley: University of California Press.

Hale, Charles

2005 *Neoliberal Multiculturalism: The Remaking of Cultural Rights and Racial Dominance in Central America*. *Political and Legal Anthropology Review* 28:1–28.

Hirsch, Jennifer

2003 *A Courtship after Marriage: Sexuality and Love in Mexican Transnational Families*. Berkeley: University of California Press.

Kapoor, Ilan

2004 Hyper-Self-Reflexive Development? Spivak on Representing the Third World "Other." *Third World Quarterly* 4:627-647.

Mignolo, Walter D.

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

Maldonado, Andrea

2010 "Culture: The new drug of choice in Mexico City." PhD dissertation research proposal, Department of Anthropology, Brown University.

Ong, Aihwa

2006 *Neoliberalism as Exception: Mutations of Citizenship and Sovereignty*. Durham, NC: Duke University Press.

Petryna, Adriana.

2002 *Life Exposed: Biological Citizens After Chernobyl*. Princeton: Princeton University Press.
2009. *When Experiments Travel: Clinical Trials and the Global Search for Human Subjects*. Princeton: Princeton University Press.

Ritzer, George.

2001 *Explorations in the Sociology of Consumption: Fast Food, Credit Cards, and Casinos*. London: Sage Publications.

Roberts, Elizabeth F. S., and Nancy Scheper-Hughes

2011 Introduction to Medical Migrations. *Body & Society* 17(2-3):1-30. London: Sage Publications.

Rose, Nikolas, and Carlos Novas

2008[2005] Biological Citizenship. *In Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Aihwa Ong and Stephen J. Collier, eds. Pp. 439-463. Malden, MA: Blackwell Publishing Ltd.

Scheper-Hughes, Nancy, and Loic Wacquant

2006 *Commodifying Bodies*. London: Sage Publications.

Smith-Oka, Vania

2013 *Shaping the Motherhood of Indigenous Mexico*. Nashville, Tennessee: Vanderbilt University Press.

Thompson, Charis

2011 Medical Migrations Afterword: Science as a Vacation? *Body and Society* 17(2-3): 205-213.

Tsing, Anna L.

2004 *Friction: An Ethnography of Global Connection*. Princeton: Princeton University Press.

Veblen, Thorstein.

2006[1902] *Conspicuous Consumption*. New York: Penguin.

Weismantel, Mary

2001 *Cholas and Pishtacos: Stories of Race and Sex in the Andes*. Chicago: Chicago University Press.

Conclusion

Augé, Marc

1995 *Non-places: introduction to an anthropology of supermodernity*. London: Verso.

Aguilar Ros, Alejandra

2008 Danzando a Apaxuki: La Semana Santa en San Andrés Cohamiata desde los mestizos visitantes. *In Raíces en movimiento. Prácticas religiosas tradicionales en contextos translocales*. Kali Argyriadis, René de la Torre, Cristina Gutiérrez Zúñiga, and Alejandra Aguilar Ros, eds. Pp. 159-192. Guadalajara, México: El Colegio de Jalisco/CEMCA/CIESAS/IRD/ITESO.

Briggs, Charles and Clara Mantini-Briggs

2004 *Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare*. Berkeley: University of California Press.

Champion, François

1995 Persona religiosa fluctuante, electricismos y sincretismos. *In El hecho religioso. Enciclopedia de las grandes religiones*. Jean Delumeau, ed. Pp. 705-737. Madrid: Alianza Editorial.

DasGupta, Sayantani and Shamita Das Dasgupta

2014 *Shifting Sands: Transnational Surrogacy, E-Motherhood, and Nation Building*. *In Globalization and Transnational Surrogacy in India: Outsourcing Life*. Lanham, MA: Lexington Books.

Davis-Floyd, Robbie

2007. "Daughter of Time: The Postmodern Midwife." *Revista da Escola de Enfermagem da Universidade de São Paulo* 41, no. 4:705–710.

De la Peña, Francisco

2002 *Los hijos del sexto sol*. Mexico City: Instituto Nacional de Antropología e Historia.

De la Torre, Renée, Cristina Gutiérrez Zúñiga, and Nahayeilli Juárez Huet

2013 *Variaciones y apropiaciones latinoamericanas del New Age*. Mexico City: Publicaciones de Casa Chata.

Folbre, Nancy

2010 *Greed, Lust, and Gender: A History of Economic Ideas*. Oxford: Oxford University Press.

Friedlander, Judith

1975 *Being Indian in Hueyapan: A Study of Forced Identity in Contemporary Mexico*. New York: St. Martin's.

Galinier, Jacques

2008 *Indio de estado versus indio nacional en la Mesoamérica moderna*. In *Raíces en movimiento. Prácticas religiosas tradicionales en contextos translocales*. Kali Argyriadis, René de la Torre, Cristina Gutiérrez Zúñiga, and Alejandra Aguilar Ros, eds. Pp. 45-72. Guadalajara, México: El Colegio de Jalisco/CEMCA/CIESAS/IRD/ITESO.

García Canclini, Néstor

2001 [1995] *Consumidores y ciudadanos: Conflictos multiculturales de la globalización*. México, D. F.: Grijalbo.

Goffman, Erving

1959 *The Presentation of Self in Everyday Life*. Garden City, NY: Doubleday.

Hanegraaff, Wouter

2001 *Prospects for the Globalization of New Age: Spiritual Imperialism versus Cultural Diversity*. In *New Age Religion and Globalization*. M. Rothstein, ed. Pp. 15-30. Aarhus: Aarhus University Press.

Haraway, Donna

1990 *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York: Routledge.

Heelas, Paul

1996 *The New Age Movement: The Celebration of the Self and the Sacralization of Modernity*. Oxford: Blackwell Publishers.

Islam, Nazrul

2010 *Indigenous Medicine as Commodity: Local Reach of Ayurveda in Modern India*. *Current Sociology* 58: 777-798.

2011 *New age orientalism: Ayurvedia 'wellness and spa culture.'* *Health Sociology Review* 21(2):220-231.

Kasezawa, Masato

2004 Ayurveda in the Age of Globalization: 'Traditional' Medicine, Intellectual Property and the State. *Journal of the Japanese Association for South Asian Studies* 16: 85-110.

Kudlu, Chithrabha

2013 Brand Kerala: Commodification of Open Source Ayurveda. PhD dissertation, Washington University. St Louis: <http://openscholarship.wustl.edu/etd/1142/>

Lareau, Annette

2003 *Unequal Childhoods: Class, Race, and Family Life*. Berkeley: University of California Press.

Melton, Gordon J. et al.

1990 *New Age Encyclopedia*. Detroit: Gale Research.

Molinié, Antoinette

2013 La invención del new age andino. *In Variaciones y apropiaciones latinoamericanas del New Age*. Renée De la Torre, Cristina Gutiérrez Zúñiga, and Nahayeilli Juárez Huet, eds. Pp. 285-308. Mexico City: Publicaciones de Casa Chata.

Nestel, Sheryl

2006 *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery*. Vancouver, BC: University of British Columbia Press.

Petryna, Adriana

2002 *Life Exposed: Biological Citizens After Chernobyl*. Princeton: Princeton University Press.

Rose, Nikolas, and Carlos Novas

2008 [2005] *Biological Citizenship*. *In Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Aihwa Ong and Stephen J. Collier, eds. Pp. 439–463. Malden, MA: Blackwell Publishing Ltd.

Sarrazin, Jean-Paul

2008 El Chamanismo es un camino. Las culturas indígenas como Fuentes de sabiduría espiritual en Bogotá. *In Raíces en movimiento. Prácticas religiosas tradicionales en contextos translocales*. Kali Argyriadis, René de la Torre, Cristina Gutiérrez Zúñiga, and Alejandra Aguilar Ros, eds. Guadalajara, México: El Colegio de Jalisco/CEMCA/CIESAS/IRD/ITESO.

Scheper-Hughes, Nancy

2000 The Global Traffic in Human Organs. *Current Anthropology* 41(2): 191-224.

Spivak, Gayatri

2003 A Conversation with Gayatri Chakravorty Spivak: Politics and the Imagination, interview by Jenny Sharpe. *Journal of Women in Culture and Society* 28(2):609-624.

Urry, John

2007 *Mobilities*. Cambridge, UK: Polity Press.

Thompson, Charis

2005 *Making Parents: The Ontological Choreography of Reproductive Technologies*.
Cambridge, MA: MIT Press.

2012 "Three Times a Woman: A Gendered Economy of Stem Cell Innovation," UCLA Center
for the Study of Women Blog, [http://uclacsw.blogspot.com/2012/11/charis-thompson
threetimes-woman.html](http://uclacsw.blogspot.com/2012/11/charis-thompson-threetimes-woman.html)

York, Michael

2001 New Age Commodification and Appropriation of Spirituality. *Journal of
Contemporary Religion* 16(3): 361-372.