UNIVERSITY OF CALIFORNIA,
IRVINE

Delivering Health: In Search of an Appropriate Model for Institutionalized Midwifery in Mexico

DISSERTATION

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

in Anthropology

by

Lydia Zacher Dixon

Dissertation Committee:
Associate Professor Michael Montoya, Chair
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2015

DEDICATION

To

My daughter, Juno Catarina Azuz Zacher

who was there from the beginning

and whose life is entangled in this dissertation as much as my own

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ACKNOWLEDGMENTS

This dissertation has been many years in the making. My relationship with Mexican midwifery began when I was awarded a Human Rights Internship grant as an undergraduate at the University of Chicago in 2002. I travelled to San Miguel de Allende, Mexico, to volunteer with midwives at the CASA midwifery school and clinic, planning to stay for only a few months. The midwives I met there inspired me to instead spend four years traveling across Mexico, working with women's health organizations and learning about the issues facing midwifery today. The relationships I made during that time have grown throughout my doctoral research, and I hope that the issues and analyses I present here can bring attention to the ongoing struggles faced by those strong women.

This dissertation was completed with the generous support of many different funding agencies, including the following fellowships and awards: the Fletcher Jones Foundation Fellowship, the UC Irvine Associate Dean's Fellowship, the Dr. Dard Magnus Rossell Memorial Award, the UC Irvine Graduate Dean's Dissertation Fellowship, the Inter-American Foundation Fellowship, the UC Irvine Center for Organizational Research Fellowship, the UC Irvine Global Health Framework Fellowship, and the UC Mexus Research Grant. Funding for preliminary research was also given by the UC Irvine School of Social Sciences and Department of Anthropology.

I would like to express my deepest appreciation to my committee chair, Michael Montoya, who never stopped pushing me to ask hard questions and go deeper with my analysis. His approach to research and teaching have shaped the way that I think about my work and its applications. Professors Leo Chavez, Kris Peterson and Mei Zhan also provided valuable guidance along the way, reading many drafts and offering advice both practical and theoretical. Professor Tom Boellstorff was particularly influential in helping me clarify my arguments in Chapter Four for publication as an article. The academics in my family – Chris Zacher, Jessica Pandya, and Mihir Pandya – guided me through many difficult steps in the researching and writing of this dissertation. I would like to thank my classmates at UC Irvine for their academic and social support throughout this process: Caitlin Fouratt, Taylor Nelms, Stephen Rea, Ather Zia, Sana Zaidi, Lee Ngo, Michael Hurley, Mark Durocher, Janny Li, Natali Valdez, Cheryl Deutsch, Connie McGuire, and Eudelio Martinez. My husband Peter Dixon made it possible for me to complete the dissertation while living an at times very complicated – but very fun - life far from campus. Finally, I would like to thank all of the midwives and midwifery supporters in Mexico who inspired and shaped this dissertation.

Chapter Four of this dissertation, with some modifications for article formatting, is currently in press with Medical Anthropology Quarterly as an article titled "Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices," and is printed here with the permission of the publisher, John Wiley and Sons Inc.

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ABSTRACT OF THE DISSERTATION

Delivering Health: In Search of an Appropriate Model for Institutionalized Midwifery in Mexico

By

Lydia Zacher Dixon

Doctor of Philosophy in Anthropology

University of California, Irvine, 2015

Associate Professor Michael Montoya, Chair

This dissertation examines the creation of a new model of Mexican midwifery education as a response to national concerns about maternal mortality. Amid these concerns, debates have emerged between midwives and the state about the best way to standardize midwifery education. In this dissertation, based on 17 months of ethnographic research with midwives, students, doctors and politicians, I describe the historical roles that midwives have played in Mexico, situate Mexican midwifery within broader trends in development and the expansion of Western biomedicine, and trace the lived experiences of Mexican midwives and their students to see how such trends impact their daily practices, experiences, and goals. My findings about midwives and their shifting fields of practice illustrate the stakes, challenges, and productive possibilities of large-scale attempts to standardize new models of medical training and care. They also refresh our understandings of what midwives do and know, and reveal how medical innovations from the margins may arise unexpectedly.

By engaging critically with actors at all levels of Mexican midwifery, I reveal how claims to truth, such as in debates over best practices in women's health care, cannot be separated from

the broader socio-political contexts from which they emerge. Specifically, I argue that we must critically examine how medical practices and training develop, especially outside of the global North. My work further engages with discussions about processes of development in Latin America, arguing that we must broaden our conception of what might count as "modern," while not forgetting the historical legacies tied to notions of modernity. Mexico's current investment in midwifery destabilizes assumptions about the roles of indigenous, traditional and biomedical knowledge within the development paradigm. I show how both expertise and marginalized knowledge are strategically levied in light of international standards, national projects of development, and local conceptions of appropriate knowledge forms. Finally, my work contributes to debates around reproductive politics by interrogating the relationship between women's health and national development concerns; international pressures to reduce maternal mortality in Mexico have allowed midwives, who had long been categorized as unsafe, to regain authority in the field of reproduction.

INTRODUCTION

On October 2, 2013, Irma López Aurelio - a pregnant, indigenous woman of Mazateco origins - arrived at the local hospital in Oaxaca to have her baby. As her labor progressed over the next two hours, she tried repeatedly to get help from the staff, but was ignored. Eventually she made her way to the patio of the hospital and gave birth, unassisted, in the grass. It was there that Irma was captured on film in a photograph that soon went viral across Mexican news media sources. In the photograph, Irma bears a frantic expression as she half-kneels on the ground holding the hem of her dress up. Her baby, crying and still connected to her by the umbilical cord, lies on the grass beneath her.

Figure 1

What journalists were quick to point out was that Irma's case was not rare. Public outcry reached all the way to the Mexican National Secretary of Health, and statements were made about the efforts of the Mexican government to increase emergency obstetric

training among its health care workers (*La Prensa* 2013). Irma's story tells one part of a larger narrative about the pervasive inequalities that direct the kinds of reproductive health care women are receiving today in Mexico. But even for those women who have gained access to care during pregnancy and delivery, another realm of injustice still exists - including the use of forced sterilizations and lack of informed consent procedures, the archaic and unnecessary manual removal of placentas[1], the overuse of cesarean sections and episiotomies, and the outright mistreatment of women in labor. And then there are those women who do not even have nearby access to care at all or find that the care they have access to is not what they hope – as in Irma's case.

These elements paint a depressing picture for women's healthcare in Mexico today, especially as the nation's groundbreaking *Seguro Popular* (Popular Health Insurance) program, launched in 2003, claims to have revolutionized free and universal healthcare to all Mexican people. Even with universal care, Mexico is struggling to meet the United Nations' Millennium Development Goal (MDG) of reducing its maternal mortality by 75% between 1990 and 2015; currently it is stuck at around 50 maternal deaths per 100,000 live births and most likely will not reach the goal maternal mortality ratio of 23 (MMEIG). Of all of the concerns covered by the MDGs, maternal mortality marks a particularly significant indicator of development. For example, while infant mortality may be nearly 10 times higher in developing countries than in developed ones, maternal mortality may rise to more than 100 times higher in developing countries (Maine et.al 1997). At stake are not only women's lives, then, but also the developed

[1] A common practice in Mexico is to manually remove the placenta and clean out the uterus after birth to prevent infection. Studies indicate that this is unnecessary and can possibly introduce infection: the placenta is usually delivered naturally without intervention shortly after birth, and if it can be determined to be intact upon delivery the uterus need not be manually cleaned out (Epperly et al. 1989; Alvirde and Rodriguez 2009).

status of the country as a whole – and politicians invested in Mexico's development have taken notice.

It is into this climate of a nation struggling for developed status amid stubbornly poor health outcomes that politicians are reconsidering professionalized midwifery as a strategic intervention. Midwives, from pre-colonial times through the 1950s, had been considered the childbirth experts in Mexico, yet due to the increasing advance of biomedicine into the realm of birth, the practice of midwifery has been marginalized for decades (Carrillo 1999). With the international pressures to reduce maternal mortality and improve women's health more generally, however, Mexican politicians are now working with midwives across Mexico to delineate the best way to incorporate them into the existing healthcare system. A primary focus of this novel collaboration is the training and professionalization of midwives. While midwives and politicians differ in their definitions of the term *partera professional* (professional midwife), they share the belief that, if midwives are to become part of the healthcare system, they should be professionalized through formal education. I use the term professional to mean those midwives who have attended some type of formalized, consistent training program; this is in contrast to traditional midwives, who are most commonly trained through one-on-one apprenticeships[2] and, possibly, occasional short trainings. Central to the process of formalizing midwifery education are questions of what midwives should know and how they should learn. However, debates over midwifery education are also linked to questions about who may claim expertise in matters of medicine and science, and debates over the place of alternative knowledges within the existing healthcare system. In this

2 I use the terms "professional" and "traditional" midwives throughout this dissertation because these are the terms used by the Mexican midwives themselves. In other parts of the world and in some literature, traditional midwives are also referred to as "empirical" midwives.

dissertation, I examine the challenges and productive possibilities that have emerged as midwives seek to work together and with the state to determine the most appropriate parameters for professional midwifery education and practice. What is at stake for midwives and midwifery knowledge? How is midwifery being redefined through debates over best practices, ways of learning, and models for care? What happens when a realm of knowledge and practice that exists explicitly outside of the current biomedical paradigm is reframed as an extension of biomedicine's reach? And how is "traditional" midwifery being redefined amid the professionalization of midwifery more generally?

Actors and Arguments

Despite having been officially marginalized by the state and healthcare system, who systematically pushed midwives out of the healthcare system since the early 20th century (see Chapter 1), Mexican midwives have been organizing at the grass roots level for decades through national groups, conferences, and training facilities. Their goals are multiple, but they all agree that midwifery needs to increase its social and political legitimacy – that is, that Mexican professional midwifery must be rebranded as aligned with international norms for evidence-based practices. Further, they agree that the midwifery model of care has the potential to improve both the quality and the outcomes of women's health. The most prominent midwifery advocacy center has been CASA (*Centro para los Adolescentes de San Miguel de Allende*). Begun in 1996, CASA is Mexico's first professional midwifery school and clinic, which has been praised by international organizations and academics alike as an example of a model of training and health care that "works" in the global fight against maternal mortality (UNFPA 2008;

Davis-Floyd et al. 2009). By "works," they mean that CASA produces students with the right blend of biomedical training and community allegiance to fill in the gaps in the existing healthcare system. Other schools, such as *Nueve Lunas* (Nine Moons) in Oaxaca and *Mujeres Aliadas* (Allied Women) in Michoacán, have also sprung up in recent years and are involved in talks with their state and national governments about how to contribute to a nationally recognized professional midwifery model. My research focuses primarily on these three organizations, both because of their vocal roles in current national debates about Mexican women's healthcare and because of the significant divergences in their approaches to midwifery training. Examining these three perspectives allows me to show both the complexities and contradictions in today's Mexican midwifery and the shared goals and aspirations of the midwives themselves. While each of these organizations agrees that midwifery can address national issues such as access to care in rural areas and the poor quality of women's health care in public hospitals, there is considerable tension over questions of standardization and education: what midwives need to know, how they should learn, and how they will integrate into the existing healthcare system are all topics of contention between midwives and politicians.

While my research was thus primarily focused on those involved directly with midwifery schools in Mexico, the state was an ever-present actor as well. The state became visible in three primary ways throughout my fieldwork: through legislation passed regarding the training and role of midwives within the healthcare system; through speeches in support of midwifery as an intervention into maternal mortality concerns; and through the waxing and waning of state interests regarding the opening of state-run schools modeled after CASA across Mexico. Midwives referred alternatively to the state,

the government, and the politicians - *el estado, el gobierno, los políticos* – as the various forces that constrained their programs or, in some cases, allowed them to imagine more secure futures.

This dissertation tells a story of the state of midwifery in Mexico today as it is being reshaped through increased interactions with the state. In the following chapters I describe the historical roles that midwives have played in Mexico and the diverse kinds of midwifery that exist there today. I situate Mexican midwifery within broader trends in development and the expansion of Western biomedicine (Armada and Muntaner 2004; Isaacs and Solimano 1999; Gomez-Jauregui 2004; Nichter 2008;). I then trace the lived experiences of today's Mexican midwives and their students to see how such trends impact their daily practices, experiences, and goals. The stories of midwives and their shifting fields of practice illustrate the stakes, challenges, and productive possibilities of large-scale attempts to standardize new models of medical training and care. They also refresh our understandings of what midwives do and know, and reveal how medical innovations from the margins may arise unexpectedly.

Midwifery has experienced parallel processes of marginalization and resurgence in countries worldwide, due first to the embracing of biomedicine over traditional medicine and then to the realization that biomedical institutions may not reach all populations; my goal is to show how what is happening to midwifery in Mexico is unique to the nation's particular politics and histories, and also to show how the diversity in models of midwifery worldwide reveal that midwifery may entail inherently "local" properties that keep it from becoming universally defined. In the United States, nurses began to practice as nurse midwives in the 1920s, in response to the needs of the

country's rural poor, and the American College of Nurse Midwives (ACNM) was established in 1955 (Davis-Floyd1998). Lay midwives, or "direct-entry" midwives, became organized in the counter-culture movements of the 1960s and 70s, and formed their own organization, Midwifery Association of North America (MANA) in 1982 (Davis-Floyd 1998). While midwives continue to struggle for access and rights within the US healthcare system, they have had decades to establish their role and are becoming increasingly more mainstream. Throughout my fieldwork I often heard midwives refer to what is going on in Mexican midwifery today as "the same as what happened in the US 20 years ago," yet I would argue that Mexico is unlikely to follow the same trajectory. This is not a case of just "being behind," but rather of a nation coming to professionalized midwifery under very different circumstances. Margaret MacDonald found in her analysis of the professionalization of Canadian midwifery that the depiction of midwifery there as an ancient, traditional craft – one which stands in opposition to biomedicine – has done two different things: on the one hand, such depictions "have been symbolically important and politically strategic for practitioners, users, and advocates of midwifery;" while on the other hand they have "been identified as the source of midwifery's lack of legitimacy by those who oppose it" (2007:7). MacDonald concludes "that midwifery in Canada has not been reclaimed or resurrected from the past so much as it has been reinvented in the present, out of present-day concerns," such that it "is a product of local social and historical specificity, imaginative connections with ideas of universality, and international midwifery networks and knowledge exchange" (2007:7). I am interested in how, in the case of Mexico, midwifery is getting constructed in this present moment through such networks of international knowledge exchanges, and how the local and

global historical trajectories have led to the creation of today's midwives there. For, as Benoit and Davis-Floyd argue, "neither midwives' knowledge base nor their socialization are arbitrary; rather, each is shaped by the larger culture and structure of society that generates it" (2004:183).

Central to my analysis is the finding that the recognition of midwives as an international global health intervention has changed their position within Mexico and expanded their future professional possibilities. I have three primary arguments in this dissertation. First, I show how the same logics of development that led to the marginalization of midwifery have created the conditions by which midwifery is now gaining purchase in Mexico. This paradox has implications for our understandings of development projects more generally, and also gives context to the micro-shifts in midwifery practices and organization on the ground. Sandra Harding (2008) argues that all projects of nation building and development are still founded on underlying concepts of modernization projects. These kinds of projects "typically [treat] the needs and desires of women and of traditional cultures as irrational, incomprehensible, and irrelevant - or even a powerful obstacle to ideals and strategies for social progress" (2008:3). The assumption is that rational, scientific knowledge must be employed to modernize the underdeveloped of the world. I show here, however, that sometimes unexpected solutions arise from the margins; midwives had not been considered part of modernity, yet their global success at addressing health concerns in developing countries has linked them to modernity and development in powerful ways. What is happening is that concerns over indicators of development – primarily maternal mortality – focus both the problem and the solution on the treatment of women's bodies within particular clinical parameters.

When midwives begin to adopt the language of development concerns about maternal mortality, however, they seek to shift the conversation to the underlying structural inequalities that have led to women's poor health outcomes.

Second, I argue that contests over expertise, skills and knowledge are central to the push to standardize midwifery education. Further, I argue that these debates are linked to notions of what modern Mexican midwives are best suited to address. That is, even when midwifery organizations and the state can come to agreements over what midwives need to know to practice within the Mexican healthcare system, tensions remain high around questions of how educational models should be structured. Should midwives be trained by doctors and in clinical environments, or should they learn from local traditional practitioners? Should they be required to have a high school education, or not? Should they be judged by their educational program or by a list of common competencies? Such questions point to broader scholarly concerns about alternative education programs, education as development work, and the ways in which knowledge production is inevitably tied to social and political processes.

Third, I contend that the increased authority and presence of midwives within the healthcare system has allowed for new kinds of critiques to emerge about the quality of women's healthcare more generally in Mexico and beyond. It is because of their historical ostracization and their present contested position that midwives enter into the healthcare system as cautious outsiders; yet it is because of their tenuous acceptance on an international level that they are able to challenge the healthcare system on its own terms. Midwives increasingly experience firsthand the vivid contrast between the government's framing of them as the missionaries of biomedical outreach to rural

populations and their own goals of bringing the midwifery model of care – with its emphasis on "humanized" care – into the biomedical system. I argue that it is because of their new roles within the healthcare system – and their new authority on an international stage – that midwives have developed cogent and timely critiques about hospital-based women's healthcare in Mexico.

The increasing organizing among and between midwives dovetails with the national pressures to reduce maternal mortality in a way that shows surprising potential: midwives have been developing their ability to speak to evidence-based standards in women's reproductive healthcare and are now critiquing the biomedical system on its own terms. Women's health outcomes are poor, they argue, because of the lack of adherence to international norms of best practice in obstetrics. Thus they paint an image of current Mexican obstetrics as not only inhuman and cruel to women (especially to the rural poor and indigenous), but as also failing to adhere to standards. Midwives do not just want to join the healthcare system to help it reach more people; they want to change the way medicine is practiced within the system.

The midwives' critique of hospital obstetrics points to two startling paradoxes. First, safe motherhood is supposed to be about getting women to hospitals, yet midwives are recasting hospitals as unsafe – and possibly violent – spaces. Second, evidence-based practice is assumed to be linked to biomedical practitioners and institutions, yet midwives rework what it means to be a "good" practitioner by arguing that their own practices more closely follow international evidence in obstetrics (for example, that they use less unnecessary medical interventions, such as cesarean sections). Stories like Irma's, above, illustrate the stakes involved if hospitals are indeed unsafe spaces for birth. The

personnel's mistreatment of Irma, and her subsequent unassisted birth on the patio, point to a system in need of change. Midwives argue that we must look beyond the assumed superiority of biomedical practitioners and appreciate the possibilities offered by an investment in midwifery for improving women's health outcomes.

Why midwifery matters

Within anthropology, midwifery in Mexico has been written about for decades, primarily as a comparative model to other women's health interventions worldwide (Davis-Floyd 2001, Jordan 1978) and as a phenomenon that offers insights into alternative modes of practice (Cragin et al. 2007, Davis-Floyd et al. 2009). I am not interested here in merely comparing midwifery models, assessing effectiveness, or examining specific practices of care. Rather, I want to argue that Mexican midwifery today is a phenomenon that can tell us about much more than models of health and their deployment. Today's Mexican midwifery is both a product of international development goals and a form of resistance to them. Midwives are not flashy politicians, nor are they usually published authors. They are perceived to be grandmothers, uneducated, and demure – although as this dissertation will show, this is not an accurate depiction of them – and thus they may be overlooked as actors whose roles and actions have the potential to reflect and to change global conceptions of health and healing.

Mexican midwifery today is a dynamic, intellectual, activist endeavor that is savvy to its political debts and strategic in its increasing calls for systemic change. It embraces its grandmotherly image, but adds to it a Zapatista mask, a stethoscope and a bullhorn. Further, Mexican midwifery is neither homogeneous nor static – it is complex

in its factions and diverse ideologies and is rapidly changing as it carves out new roles for itself in a changing national healthcare system. Today's Mexican midwives want to be relevant.

Midwifery today is a topic of broader interest to scholars of Mexico because of its unique position as a profession that sits at the intersection of national notions of tradition and history and national goals of modernity and cosmopolitanism. The image of the traditional midwife is taken up in romanticized propaganda that beckons tourists and investors alike to a Mexico that is in touch with its pre-colonial past and that respects its history and local traditions. Yet as midwifery becomes a tool for international development – which holds the promise to reduce maternal mortality by increasing trained women's healthcare providers - Mexico's professional midwives are also national symbols of the country's alignment with global goals and progress, and of the country's creative solution to poor health statistics. The relatively new national healthcare system, *Seguro Popular*, has promised to provide free healthcare to all Mexican citizens who sign up; with socialized medicine a topic of international debate and scrutiny, Mexico is scrambling to make their new system work by including midwives as a tool to reach underserved populations.

For the midwives I have worked with, today's Mexican midwifery represents a turning point. Their own national government has come to see its spotty attempts at occasional traditional midwifery training workshops as futile and ultimately ineffective in improving the health of women who do not have access to biomedical reproductive health care. The international sphere has begun to gather evidence in the effort of convincing national governments that professional midwifery training is the way to go

(UNFPA) - a project which requires not only an investment in educational development and implementation, but also a shift in political and professional attitudes towards midwives. As Mexico thus begins to shift its position from one that explicitly marginalized midwives, to one that supports the certification of midwives and employs them in its state clinics, Mexican midwives are taking on new roles. They are coming face to face with hospital obstetrics, participating in policy decisions regarding standards for midwifery training, and working alongside biomedical personnel charged with turning the country's maternal mortality numbers around.

Yet despite the increasing authority of and professional opportunities for midwives in Mexico today, many midwives are being left out. The processes which allow for some midwives to get certified and work in state clinics necessarily distinguishes between those who have certain training and skills and those who do not. For those midwives who do not fit into the new standardized depiction of a professional midwife, other issues arise; what will happen to alternative forms of Mexican midwifery under the increasingly standardized approach to training and care? For both the midwives involved in the system and those who exist outside of it, however, this moment in time represents a chance to draw attention to midwifery as a physical instantiation of critiques against the biomedical system. That midwives are regaining authority in biomedical settings calls attention to the question of what it is midwives know, and how that knowledge that can change the system.

Literature Review

While this topic speaks directly to scholars interested in Mexico and midwifery, it also informs broader anthropological discussions related to knowledge, global health and reproduction. In thinking about midwifery knowledge, I build on theories produced in both medical anthropology and science and technology studies that examine knowledge in terms of its production, its associations with expertise and authority, its standardization, and its circulation. The production of knowledge more generally has been shown to be embedded within larger cultural contexts (Latour 1993; Haraway 1988); here, I am interested in the particular historical and political motivations that shape notions of knowledge in the realms of science and health (Fleck 1935; Jasanoff 2004; Taussig 2009). For example, I am interested in how political and cultural notions of health are naturalized, reinforced and contested through different midwifery education models in Mexico.

Within anthropological studies of medical models, the mapping of authoritative knowledge onto hierarchies of traditional and biomedical care providers has been well explored (Browner and Press 1996; Davis-Floyd and Sargent 1997; Taussig 1980). As previously marginalized midwifery knowledge regains authority in the field of reproduction, this shift forces us to reconsider conventional notions of expertise and authoritative knowledge. My dissertation shows how both expertise and marginalized knowledge are strategically levied in light of international standards, national projects of development, and local conceptions of appropriate knowledge forms. I ask how an emergent recognition of Mexican midwifery's expertise in reproductive health is destabilizing presumed hierarchies, by breaking down dichotomies of local versus global and traditional versus biomedical knowledge.

I am also concerned with the dissemination of knowledge from situated, local beginnings to global aspirations. How do grassroots midwifery schools translate their curricula via international goals and priorities to reimagine midwifery knowledge as a national phenomenon? In thinking about the dissemination of new forms of midwifery knowledge in Mexico, I look first at the training of midwifery students. Scholars who have examined the modes by which midwives learn highlight how tacit knowledge and intuition distinguish midwifery learning from other medical models (Lave and Wenger 1991; Davis-Floyd and Davis 1997). I look specifically at how the ways midwives are learning are informed by various local conceptions about what Mexico needs its midwives to know and do, and at how midwifery training is situated within broader constructions of institutionalized educational systems. I argue, as do the midwives themselves, that *how* midwives learn matters – to the midwives, to the knowledge learned, and to the nation. As a second scale of analysis, I examine the standardization of learning processes through institutionalization, standardization, and international regulation processes (Ong 2005; Pigg 1997; Strathern 2000; Zhan 2010). Finally, I look at implications for health policies, practices and outcomes as new knowledge forms are marketed on a broader level (Anderson 2002; Greenhalgh 2008; Hayden 2003; Mol 2002).

This project engages with current debates in the fields of medical anthropology and global health studies by exploring how local health innovations may be shaped by international trends in health care while simultaneously re-informing those trends. Emergent literature on global health has reframed how scholars think about health practices and outcomes, with recent work suggesting that researchers must scale up from

national borders in order to understand broader connections between global movements and situated health disparities (Farmer 2003; Janes 2004; Nichter 2008; Petryna 2002). Other work specifically interrogates the effects of global or national politics of health on individual bodies, using these individuals to then scale up to a critique of state forces in health (Biehl 2005; Ong 1987). One way that anthropologists have looked at the effects of power on bodies has been by looking at the ways that notions of health and healing are co-constructed with society (Lock and Gordon 1988; Clarke and Olesen 1999), and the ways that social inequalities become embodied (Krieger 2005; Csordas 2002). I am concerned with how women's bodies hold markers of social inequalities in Mexico, and how different medical models regard the manifestations of such markers. For example, how are midwives framing their models of practice in opposition to hospital obstetrics?

Global political changes leading to neoliberal policies have resulted in structural inequalities that directly impact the health of marginalized populations (Chavez 2009; Farmer 2003; Biehl 2005). As this new form of governance grows globally, prompting nations to pull out resources for social services and health care, many scholars are interrogating the role of non-state organizations in health management (Nichter 2008; Adams 1998; Pandolfi 2003). Neoliberal health reforms in Mexico have allowed NGOs to draw on alternative solutions in their attempts to fill the health care gap (Homedes and Ugalde 2005; Isaacs and Solimano 1999; Schneider 2006). While the state's decreased participation in healthcare services is generally cast as dangerous, I suggest that this neoliberal health care gap may have opened up for certain forms of grassroots activism and alternative imaginaries of health paradigms. Mexican midwives are, it turns out, able to navigate this system of neoliberal government and offer an innovative alternative to

biomedical care practices precisely *because of* the state's inability to provide service to everyone. However, even as midwifery is being redefined from outside of the state, there is still a strong presence of national and international oversight. Ultimately, if midwives want to officially circulate their model of care, they will need to work through the state; what does this necessary re-alliance with the state tell us about the state of healthcare in development today?

In drawing from literature on the politics of reproduction, I build on both anthropological and feminist theory in order to examine the non-linear connections between hierarchies of local, state and national power and women's bodies. Many scholars have shown how the meanings and management of female reproduction, and childbirth in particular, have been influenced by changing state power dynamics at both global and local levels (Browner and Sargent 2010; Ginsburg and Rapp 1991, 1995; Greenhalgh 2008; Haraway 1990; Jordan 1992; Martin 1987; Rapp 2001). Women's bodies have been explored as particularly symbolic sites of medicalization, through examinations of the role of biomedicine in all aspects of women's reproductive health management (Riessman 1983; Lock and Kaufert 1998; Dumit and Davis-Floyd 1998). Other scholars have looked more specifically at how women negotiate, resist or actively oppose state impositions on their bodies (Lock and Kaufert 1998; Rapp 2000). Within Mexico, in particular, women have been taking on key roles in the non-governmental health sector due to insufficient state-supported health programs under neoliberal restructuring (Ewig 1999; Jaquette 1994). As I show in this dissertation, however, midwifery groups find that they must work *with* the state if they want to secure legitimacy, authority and a secure living wage for practicing midwives.

I bring together theories of the state's role in reproduction with theories of body politics, framing the craft of midwifery as a form of innovative resistance to a dehumanized approach to women and health. Recent scholarship on reproductive processes has paid much attention to the way that topics related to childbirth in particular illuminate the changing and unstable "interaction of modernity with local forms of meaning-making" (Kaufman and Morgan 2005:322). I build on work that has focused on the practice of midwifery as a lens through which to examine the relationships between the state and individual bodies. Some of the work on midwifery highlights midwives as flexible markers of post-modernity who are consciously adapting to changing political pressures and projects, while others write about midwives as subversive activists who are trying to change the state. Anthropologists studying midwives have shown the efficacy of their practices (Cragin et al 2007; Davis-Floyd 2001), explored different models for midwifery training and their results (Davis-Floyd et al. 2009), and brought attention to the renewed global interest in midwives as important community health providers (MacDonald 2008). I build on these bodies of work as I trace how Mexico's varied midwifery schools are using this renewed academic interest and advocacy to market their models to the state. Yet even as Mexican midwives take advantage of this opportunity to bring midwifery care to more women, they are forging partnerships with a national system that may not share their assumptions about reproductive health care. Further, the practices employed by midwives do not always draw equally from biomedicine or alternative methods. Rather, the decisions midwives make in practice constantly redefine what professional midwifery looks like, as the following chapters will illustrate. Which practices will get standardized, which will go unmentioned, and which will be contested

as national and international pressures push midwives and policymakers alike towards institutionalized midwifery are questions that motivate midwives into action and spur on debates between them.

Field Sites and Research Methods

The research for this dissertation was conducted over a total of 17 months between 2009-2012, including two summers (2009 and 2010) and one continuous year of fieldwork (2011-2012). I was based in the town of San Miguel de Allende, Guanajuato, in colonial central Mexico, and spent the majority of my time at the midwifery clinic and school that is located there called CASA (*Centro para los Adolescentes de San Miguel de Allende*). Unlike the less formal government-run training programs for traditional midwives that had been going on nation-wide since the 1970s, CASA is a structured and institutionalized school. Programs like CASA have gained growing recognition by academics and politicians alike in recent years in large part due to their engagement with discourses of development. CASA's training consists of three years of clinical and classroom education, followed by one year of social service in a public health clinic. Students become proficient in biomedical techniques, but also take coursework in alternative methods and work with traditional midwives. Thus, CASA's program is able to claim ties to distinctly Mexican knowledge and practices, while positioning itself as a leader in Western biomedical knowledge as well. Anthropologists such as Robbie Davis-Floyd (see Davis-Floyd 2001, Davis-Floyd et al. 2009) have written extensively about the power of such a combination of knowledges and practices. CASA's model has also been showcased by the United Nations Population Fund (UNFPA 2008) as an example for

other developing countries to follow. Further, a recent study conducted by the Mexican Institute of Public Health in conjunction with the UC San Francisco Medical School showed that when compared with the curricula of the national medical school and obstetric nursing school, CASA's curriculum covered significantly more competencies and required much more clinical experience (Cragin et al. 2007). CASA has a three-year "professional" (as opposed to "traditional") midwifery training program that combines biomedical and alternative classroom and clinical practices. Students rotate through CASA's own maternity clinic, staffed by midwives, and through the local public hospital. CASA's graduates complete a year of social service in government clinics, then are able to receive a *cedula professional* (professional license) and practice, if they choose, in a government clinic (see Mills and Davis-Floyd 2009 for a more in-depth history of CASA). While some do choose this path, and the potentially more stable salary it offers, others go on to practice out of their homes or freestanding birth centers. CASA has fought for decades to become integrated into both the education and healthcare system, and to get its graduates paying positions in state-run facilities. As I show in this dissertation, however, not all Mexican midwives see CASA's model as the best fit for Mexico's women's health needs today.

I chose CASA as my primary field site both because of its status as an established program that was already entrenched in the state and national healthcare and education systems and because of my own historical connection to it. I had first come to CASA in 2002 as an intern, and between 2002 and 2007 I worked as a volunteer, translator, and workshop teacher there intermittently. My own daughter was born at CASA in 2006 with one of the founding midwives on staff at the time. The relationships that I made during

those early years working with CASA midwives and staff were invaluable when I returned to conduct my research. Because I already had an in-depth knowledge of CASA's programs, I was able to determine that the pressing current concern faced by CASA and its midwives had to do with the future of midwifery education in Mexico and the role of "professional" midwives in the national healthcare system. As Sandra Harding argues, "there are important resources for the production of knowledge to be found in starting off research projects from issues arising in women's lives rather than only from the dominant androcentric conceptual frameworks of the disciplines and the larger social order" (1998: 149). When I returned to the field and re-established contact with my midwife friends, I was asked directly to help them by looking at the bigger historical and geographical picture of midwifery in Mexico today. Further, midwives stressed to me that CASA was struggling to maintain and increase its authority within the healthcare system – and quickly noted that it was no longer the only outspoken midwifery school in the country.

Two other schools, *Mujeres Aliadas* in Pátzcuaro, Michoacán, and *Nueve Lunas* in Oaxaca City, Oaxaca, had both opened in the intervening years and were also struggling to become part of the official education and healthcare system and to gain recognition for their own models of teaching and practice, which differed significantly from CASA. During my time in Mexico before graduate school, I had also lived and worked with midwives in Oaxaca; there, I met the now-founders of *Nueve Lunas,* and so was later able to re-establish contact with them for this research. Throughout my fieldwork I kept in touch with the founding midwives of *Nueve Lunas,* and I was able to visit their school and interview students, teachers and administrators during February 2012. I made contact

with the founders of *Mujeres Aliadas* and was able to visit their school twice, conduct a survey and interviews with their students, and talk many times with their administrators. These two newer schools offered striking alternatives to what CASA had been doing, and made clear to me that, while all of the schools' founders and students shared a common view that midwifery could improve women's health in Mexico, there were sharply divergent notions about how midwives should learn.

Throughout my fieldwork, I examined Mexican midwifery education on multiple levels and in multiple settings through participant observation in: classrooms and student presentations, clinical rotations and home visits, administrative and political meetings, national and international midwifery conferences. During observations, I kept thorough hand-written fieldnotes and typed them up twice a week in order to add reflections and note emergent themes that could later be used in interviews. Only during planned and more formal interviews was a recording device used; I wanted to keep my observations casual, as I felt that bringing a computer or recorder into classes or talks would be obtrusive in settings where most students took hand-written notes. I wanted to see how midwives were learning, and how that training was translating into practice and being debated among midwives, administrators and politicians across Mexico. Because I spent the majority of my time at CASA, I was able to watch the students progress throughout their training and into their early careers. I became close with many students and staff, and our conversations outside of CASA enriched my understanding of their struggles and goals. At *Mujeres Aliadas* and *Nueve Lunas,* I observed and spoke with students during class and break times.

While in classroom settings in each site, I observed regular educational activities and lessons with midwifery students of all years in the programs, and assisted midwifery professors when requested. During class breaks, I talked with students and teachers about their reactions to class materials. I took notes on class lessons, as well as on students' questions, reactions and doubts about materials. Classroom time was also when administrators occasionally gave talks to students about broader concerns facing midwifery in Mexico today, and thus provided me the opportunity to witness students learning about these issues. During my time conducting participant observations at the CASA clinic, I observed routine encounters with midwives, doctors and students. These consisted mostly of prenatal and postnatal exams, family planning visits, and women's health checkups. My attention in these clinical encounters was on the educational process and the relationships between the students, the students and teachers (staff midwives) and the students and patients; I was not studying the patients themselves. However, due to the potentially sensitive nature of many of the clinical encounters, I obtained verbal consent from all patients before entering the room for observations.

While I informally spoke with and observed a total of 65 midwifery students across the three school sites, I conducted more focused, semi-structured interviews with a subset of 20 students, chosen as a representative sample from the three different schools and years into their studies. I conducted semi-structured interviews with 11 practicing midwives (working at the three schools or involved in national debates over standardization), 15 school administrators, and 4 doctors. With the majority of those interviewed, various follow-up interviews occurred throughout the fieldwork period. Additionally, I administered a survey to 38 midwifery students from CASA and *Mujeres*

Aliadas schools, which examined students' career goals and understandings about the current and future roles of midwives in the Mexican healthcare system. This survey also included a section asking students to draw pictures of what birth looked like in the hospitals and what their ideal birth with a midwife would look like. By analyzing these images, survey responses, detailed interview transcripts, and fieldnotes, I was able to understand Mexican midwifery education today from various perspectives and angles. All participants who were interviewed gave verbal consent in accordance with my university's IRB requirements, and all have been given pseudonyms; political figures quoted during public conferences and events, however, retain their real names.

In addition to my three primary school sites, I spent time at *Luna Maya* (Mayan Moon) midwifery clinic and school in San Cristobal de las Casas, Chiapas, as well as the private home clinics of midwives located across Mexico. Those midwives that I contacted who I could not visit (because of distance) I was able to communicate with via email, telephone and Skype. I attended a two week-long training retreat in 2009 for midwives and others interested in birth from around Mexico in Malinalco, a 2010 national midwifery conference in San Cristobal de las Casas, Chiapas, a 2012 forum on humanized birth in Mexico City, the first open meeting for the Association of Mexican Midwifery in 2012, and many smaller, regional conferences, political meetings and public events related to midwifery and women's health in Mexico. At all of these events, I was able to meet and talk with people who had stakes in the future of Mexican midwifery and had opinions about how midwifery education should best be structured.

In combining participant observation, interviews and surveys, I follow Davis-Floyd, et al.'s (2001) assertion that ethnographic accounts of emergent midwifery must "address

temporal imaginaries – pictures of the past, assessments of present conditions, dreams for the future." Further, my methods echo those of Catherine Maternowska (2006), in that my study of reproductive health practices and policies is enriched by my own historical connections to the field sites, through personal relationships and previous work experiences.

In each phase of research, I was concerned with how midwifery models of care are being shaped by broader notions of tradition and modernity in relation to the Mexican historical context. Thus, my project seeks to not only address the specific situation of midwives in Mexico, but also to inform our understanding of how debates of modernity in developing regions contribute to health care practices and, ultimately, health outcomes.

Upon returning from the field, I transcribed all fieldnotes and interviews. These, along with collected textual documents, were coded and recoded, both with Atlas.ti software and by hand, to bring out and organize the major themes. I then created a spreadsheet in which themes were listed on one side and moments of interest coinciding with those themes, by date of fieldnotes, were listed next to them. Next, I reexamined the themes with my original research questions in mind and grouped together themes that related to my questions. My chapter organization reflects these larger groups of coded fieldnotes.

Organization

While my research captures a particular moment in midwifery's history that, I argue, is representative of a pivotal moment for the Mexican healthcare system, I also strive to reveal the multiple histories and stakes of diverse midwifery education groups.

This dissertation is divided into two sections. In Section One (Chapters 1-3), I trace the international, national, and local factors involved in shaping Mexican midwifery today. Section Two (Chapters 4-5) examines both the productive possibilities and potentially harmful consequences that have emerged as certain forms of midwifery gain increased authority and access in the Mexican healthcare system while others do not.

Section One asks why midwives are currently gaining authority in Mexico, and lays out the intersecting visions for what a standardized midwifery education program should look like. Chapter One, *Midwives, Maternal Mortality and Healthcare in Mexico Today*, begins by looking at the ways in which international development concerns about maternal mortality have led to a resurgence of support for Mexican midwifery. In it, I trace the history of Mexican midwives, and show how their current roles are tied to broader national and international trends. Chapter Two, *Posing the Problem, Setting the Standards,* looks more specifically at how the push to standardize midwifery education has prompted diverse and competing framings for the national problems that midwifery is best suited to address. In Chapter Three, *Becoming Mexico's Modern Midwife,* I focus on the experiences of one midwife, Julieta, following her from student to practitioner and teacher. Julieta's story illustrates how the divisions between groups of midwives on a larger scale dissolve at the individual level; as Julieta moves through Mexico and through her career, she draws from diverse models of midwifery and ultimately bridges local, national and global expectations.

Section Two asks what happens as certain kinds of midwives, who had been marginalized in Mexico for decades, regain authority in the healthcare system. Chapter Four, *Obstetrics in a Time of Violence,* argues that the combination of international and

national support for midwifery and an increasing presence in public hospitals has led to a newly articulated critique against biomedicine. By bringing attention to what they call "obstetric violence" in public hospital labor and delivery wards, midwives reposition themselves as the evidence-based, safe practitioners and reposition the obstetric staff as dangerous and violent towards women. Thus, I show in this chapter how the national strategy to use midwives to extend the biomedical reach is at odds with the midwives' strategy to address biomedicine's failures. In Chapter Five, *Rethinking Traditional Midwifery* I show how, even as midwifery experiences a renaissance in Mexico, not all midwives may benefit. Traditional midwives who do not follow a standardized educational path may become further marginalized; I argue that what is at stake in their loss is a way of knowing that is explicitly flexible, local and tied to the communities that these women serve. This chapter thus complicates the notion that increasing authority for midwives is good for Mexican midwifery writ large.

My research has been inevitably shaped and colored by my own historical engagements with Mexican midwives. My introduction to CASA and its midwives set me on the path which has led to my current research interests, and the relationships I made with practitioners there a decade ago continue to inform my understanding of Mexico's women's health system today. I owe much to the midwives I worked with and befriended along the way. This dissertation aims to respect and represent the multiplicity of visions about the current landscape of Mexican midwifery; its role in the healthcare system, its ability to serve as a political platform in movements against obstetric violence, and its potential for future standardization.

My next chapter lays the broad brushstrokes of this landscape. By describing the historical positioning of midwives within the Mexican healthcare system, and their current resurgence as official practitioners in response to national and international maternal mortality concerns, I set the stage for the debates over standardization that follow. It is important to note that the historical and political positionings described in the next chapter are not unknown to the midwives in my study; rather, my informants actively draw on these positionings to justify their goals, argue for increased authority in the healthcare system, and denounce the state for allowing women's health to fall through the cracks. Understanding the contingencies of Mexico's midwifery and healthcare system positions my analysis within anthropological critiques that seek to reveal medicine as an inherently political and cultural system.

CHAPTER 1

Midwives, Maternal Mortality and Healthcare in Mexico Today

"The first state clinic to hire graduates from our school," explained Suzanne, the founder of CASA (*Centro para los Adolescentes de San Miguel de Allende*), Mexico's first professional midwifery school, "was in San Luis Potosi. Deep in the Huasteca region of the state, where maternal mortality had been a big issue. After the CASA midwives began to work there, maternal mortality rates did not just fall – they fell to zero. The thing is, once women heard that the midwives were working at the clinic, they began to actually go there for their births instead of staying away. By bringing the women in to the clinic meant that they could get the care they need, from caring professionals. The professional midwives."

This story and others like it of unequivocal success were repeated throughout my fieldwork, in meetings, to donors, and to new professional midwifery students as they began their studies at CASA. Such stories highlighted the pillars of CASA's goals – to provide quality reproductive healthcare to women by working *within* the healthcare system, and thus to lower maternal mortality. But such stories also brought attention to the layers of history that led to the marginalization of Mexican midwives in the first place, hinted at the problems facing the current national healthcare system, and highlighted the nation's maternal mortality concerns. Today's professional midwives in Mexico are experiencing a resurgence in support from both national and international sources. How this resurgence came about is not a simple story of a longing for a romantic past of midwifery, nor is the integration of midwives into biomedical care

without controversy and a struggle over authenticity and its practices. Moreover, the specific elements of midwifery amenable to inclusion into Mexico's biomedical practice are being debated, as are the implications for the Mexican health care system should midwives become part of the health system's team. The outcome of these debates will determine the future of midwifery in Mexico and has the potential to impact national women's health outcomes, including maternal mortality.

Maternal mortality – *mortalidad materna* – was a topic on the tip of everyone's tongue throughout my fieldwork, though markedly more so by the third year of my research. In this chapter, I examine how the foregrounding of maternal mortality reduction within the Mexican healthcare system has allowed for the reemergence of midwifery as a viable profession because of the promise it offers for improving health outcomes. However, I argue that even as midwives increasingly cite maternal mortality reduction as one of the benefits of an investment in midwifery, they are also critical of the campaign against maternal mortality as a development tactic. The growing emphasis on maternal mortality reduction has, they say, pushed aside other concerns regarding women's health and equality – a set of concerns they seek to address by "humanizing" women's healthcare[3]. Yet it is specifically through an alignment with political campaigns to lower maternal mortality - not to humanize care - that midwives are finding newfound purchase on a national level. Everywhere I went in Mexico, midwives told me the same thing – that maternal mortality was the main issue that politicians are interested in hearing about. Mexico and its midwives are following a shift in the international health community, from a focus on women's health as a human rights issue to a focus only on maternal death as a development issue. But while maternal mortality reduction may have

[3] The midwives referred to "*el parto humanizado* – humanized birth" as one of their primary goals.

become a calling card for the midwives in official circles, in practice and in the classroom, they continued to focus on what they see as the deeper concerns related to their humanization agenda.

The politics of maternal mortality are embedded in a larger politics of Mexico's struggle to emerge from "developing to developed" country status. Midwives have positioned themselves as experts in this highly political field, as key players in reducing maternal mortality to levels in accordance with international goals. They have managed to use their newfound political clout to give voice to underlying issues within the health care system. These critiques come at a time when Mexico's healthcare system is being held up as a model in equal access to care due to its new national healthcare system, *Seguro Popular* (Popular Insurance), which provides free and low-cost care to all citizens who register for the program.

In the following section, I provide a brief overview of the history of midwives in Mexico and a snapshot of the current Mexican healthcare system. Midwives' current position cannot be appreciated without an understanding of their historical roles and of the present options women have for reproductive care. Next, I trace the emergence of the national and international emphasis on maternal mortality reduction as a development strategy, most clearly emphasized through the United Nation's Millennium Development Goals (MDGs). Finally, I examine explanations from midwives and other critics of the current Mexican healthcare system, including doctors, as to why maternal mortality remains high in a country with an expanding national healthcare model with a strong emphasis on technology and medicalization. Midwifery is but one of many proposed strategies for improving maternal mortality, yet its proponents make the case that it is an

appropriate intervention because of its ability to address deeper structural issues behind Mexico's poor women's health outcomes.

The Historical Role of Midwives in Mexico

"We must remember that midwives have always existed, as long as humans have" – Suzanne, founder of CASA.

Midwifery was a long-standing profession in Mexico before the Spanish arrived. In prehispanic times, midwives worked not only with women in birth, but also as community and religious leaders, and as health educators and priestesses (Castaneda Nunez 1988). During the colonial period, midwifery continued as a respected profession. Indigenous, Spanish, black, *mestizo* and *mulata* midwives practiced their trade for centuries, even after Mexico's independence from Spain. Mexican scholar Ana Maria Carrillo (1998) has written one of the only comprehensive accounts of the history of midwives after the arrival of the Spanish. During early colonization in Mexico, women sought out the care of midwives based on their experience in everything from childbirth to fertility concerns, milk production, miscarriages, and postpartum support. In 1750, Spain ordered that all of its colonies would require midwives to be certified – a process which required them to have studied for four years with an approved teacher, show their marriage license or prove their status as a widow, prove that they had been baptized, and pay a fee (Leon 1910: 227).

In the 1830s, after independence from Spain, scientific and European style medical training began in Mexico, and midwifery became part of the educational program. These trained midwives were called "*parteras tituladas"* (licensed midwives) and were meant to replace the traditional midwives. Physicians and medical students

were often reluctant to share educational space and professional authority with women, and laws had to be changed to even allow for them to enter the schools. In 1896, the same year that the city of Toluca was to open its obstetrics school, it also had to pass a law against professional inequality for women in order for midwives to work alongside male doctors (Carrillo 1998:171). Starting in the 1830s, midwifery schools popped up all over Mexico, although they differed based on the resources available and the political climate of the times. Most of these schools focused on the anatomy and physiology of pregnancy, birth and postpartum, and commonly necessary obstetric maneuvers; some schools also included more general training in the healthcare of the mother and child (Carrillo 1998).

One interesting problem for early midwifery training was that there were few maternity hospitals, except in larger cities with established midwifery training programs. In order to be licensed, midwives had to get a year of practical experience either under a physician or an approved midwife, which proved difficult initially, as their schools were purely theory-based. It was not until the mid-1800s that maternity hospitals became common across Mexico, usually associated with medical schools, where midwives and doctors alike were able to conduct their clinical observations. Many women patients complained at the treatment they received from students and doctors there, but the trend was already set in motion to move birth into hospital centers and out of the home (Carrillo 1998). Suzanne, founder of CASA's professional midwifery school, put it more forcefully during an interview, arguing that, "putting licensed midwives in the hospitals was part of the public health system's plan. Women didn't trust hospitals in those days, but they trusted the midwives and so they went, which was how the hospital became a

normal place to go for birth. The midwives were used, they were like '*un gancho que hizo que la gente se acostumbro ir al hospital!'* (a hook that made people get used to going to the hospital)!"

Midwives did not work to "hook" women into going to hospitals solely based on their imagined distinction from biomedical practitioners, however. Benjamin Smith reminds us that we must be careful not to assume or overemphasize an "epistemological chasm between modern doctors and rural villagers with their pre-Cartesian beliefs about the invisibility of body and mind and their instinctive fealty to the local *curanderos,*" or midwives (2012:39). Rather than simply distrusting doctors in favor of their local midwives for epistemological ideas, women were reacting to complex historical legacies: for decades, efforts to bring medical teams into rural areas "arrived as one element in a raft of state assumptions over socio-economic hierarchy, land tenure and political obedience. As a result, the diffusion of rural healthcare closely paralleled the penetration of the Mexican state, creating inequalities in access to healthcare in different areas," such that those areas that had complied with state rules, healthcare was better than in regions where people had resisted (in which case medical teams could take decades to return) (Smith 2012:40).

Once it became normalized for women to birth in hospitals, laws began to emerge discrediting midwives as legitimate professionals. Many midwives had attended the state-supported schools but had never received an official title, and they were the first to be critiqued as illegitimate. However, once the specialty of gynecology was born in medical schools in 1887, even the licensed midwives were discredited. In 1892 the federal government published their intent to officially replace licensed midwives with doctors,

but to continue to use the midwives to "convince patients and their families of the importance of using medical services" (Carrillo 1998:178, *translation mine).* With this shift, midwives' scope of practice was restricted to only normal births without any risk factors. Midwives had to refer any possible complications on to the doctors who now supervised their practices (Carrillo 1998). In the late 1800s, midwives appealed to the state to recognize that they indeed had better training and outcomes than medical students, and that they should be allowed to attend births as they had been trained to do, yet their request was denied by the Secretary of Justice under Porfirio Diaz (Penyak 2003:66). This history continues to haunt the current moment of tenuous new ties between Mexican midwives and the state.

For a time during the late 1800s, programs continued to exist that produced licensed midwives, but the subject matter that students had to learn became increasingly esoteric – including, for example, such seemingly tangential requirements as two years of French lessons. The political battle continued, with physicians pushing the state to designate them as certified primary providers for pregnancy and birth. After successfully achieving that designation, physicians began charging very high prices for their services, beyond what most poor women could afford (Carrillo 1998). The doctors argued that their approach was safer and more scientific, and that the midwives' use of plants, vertical birth positions, and external rotations of the fetus were dangerous and old fashioned[4]. When things went wrong in births attended by midwives, physicians characterized them as ignorant; when things went wrong for the doctors, they blamed it on "a force of nature or the limitations of science" (Carrillo 1998:186).

[4] This seems ironic in hindsight, as the physicians at that time were doing things in birth like: bleeding the pregnant and postpartum women, or using the "Playfair" method (which involved putting his fingers into the woman's anus during labor to speed up birth) (Carrillo 1998).

Despite the politics, there were still a significant number of licensed midwives in Mexico by the beginning of the 20th century (roughly the same amount of licensed midwives as doctors). But in 1911, following the opening of the first national nursing schools, midwives were told that they must have a nursing degree in order to be licensed (Carrillo 1998: 188). Over the following decades, midwives practicing in hospitals faced increasing limitations on the medical procedures they could perform, and hospitals stopped hiring them. After 1960, any midwives still working in hospitals were no longer allowed to attend births (Carrillo 1998).

Carrillo reminds us that throughout this process of exclusion, traditional midwives continued to attend the majority of births outside of hospitals. Whole swaths of the country did not even have access to doctors or hospitals for most of the 20th century (indeed, access to care continues to be an important factor across Mexico); the state of Veracruz still had 20 times the state clinics than states like Guerrero, Oaxaca or Campeche in 1965, and in 1951 there was only one hospital in the state of Chiapas (Smith 2012:41). It took a while after the 1945 formation of the United Nations, with its emphasis on national health outcomes as a measure of development, for Mexico to begin to address access to care issues (Baker Opperman 2012) .Even into the 1980s, more than half of births in Mexico took place outside of hospitals (Coplamar 1983). Brigitte Jordan's seminal 1978 anthropological text, *Birth in Four Cultures*, argues that traditional midwives offered culturally-appropriate support for women, even if they did not have the same technical medical training. But such culturally-appropriate practices could not stem the tide, so that by the mid 1990s traditional midwives attended less than 17% of Mexican births (Davis-Floyd 2001). As scholars have pointed out, across Latin

America – and, indeed, across the world – as midwives are pushed out of regular practice, they are only left to attend only the most life-endangering of births, those that occur in emergency situations, such as twins or a breech baby, or when the patient cannot get to a doctor. (Davis-Floyd et al. 2009:11). The decline in traditional midwives in Mexico is exacerbated by the aging of midwives and the lack of apprentices to pass on their knowledge. Also effecting midwifery's decline are broader Mexican trends in formal education and attitudes about the progressive nature of hospitals over alternative healing practices.

What began to take the place of the licensure programs for midwives were short-term, government led training modules for rural and traditional midwives. These programs continue today, often as two-week training modules (Davis-Floyd 2001), and academics and my informants alike are quick to criticize them as ineffective and, in some cases, dangerous (Pigg 1997). Fernanda, then director of CASA, told me in 2009 that traditional midwifery in Mexico has been irrevocably harmed because of such trainings. "Since 1972," she said, "the government began rounding up midwives and giving them brief workshops. They would just tell them things like 'external rotations are dangerous,' or 'just use oxytocin.' Such advice turned traditional midwifery into something that had very little to do with tradition!" For Fernanda, these trainings were both the wrong kind of information and the wrong method of training – by only telling the traditional midwives to do certain things, but not giving them the background or tools to understand when and why to do them, they were destroying many of the practices and knowledges passed down over centuries.

Mexican Midwifery Education Today

In the past few decades, a model of midwifery education has been developed in Mexico that purports to fill the gap between the fading traditional midwifery model and the hospital-based physician model of care. This new model aims to produce midwives that are most commonly referred to (and which I will refer to throughout the dissertation, despite some debates between groups over the qualifications necessary to hold this title) as *parteras profesionales* - professional midwives. In contrast to the categorization of midwives in Mexico as relics of the nation's past, Davis-Floyd suggests that these new professional midwives are now regaining authority because of their ability to draw smartly from tools of "modernity" while recasting traditional knowledge as valuable and possibly patriotic (Davis-Floyd 2001). These professional midwives, who Davis-Floyd alternatively terms "postmodern midwives" – meaning that they transcend modern, rational medical training to combine it with more traditional, pre-modern knowledges - draw on biomedical training, traditional Mexican midwifery techniques, and other alternative practices from global models of care (2001:3). The image that Davis-Floyd paints of the postmodern midwife suggests an interesting set of divisions: first, the division between the pre-modern midwife - who is associated with the nation's undeveloped past, with poor training and poor settings - and the modern physician, who is associated with development, Westernization, and technical expertise; second, the division between the modern physician - who gets reframed as oppressive and limited by biomedical knowledge – and the postmodern midwife – who emerges as the ideal balance between past and future, biomedicine and its alternatives, women and the health care industry.

In practice, as this research demonstrates, the professional midwife is an evolving concept. Still new to the health care system, not widely known, and struggling to understand her role, the professional midwife is told that she holds promise for a nation of underserved women yet is not entirely clear how she will fulfill it.

Guadalupe was one of those traditional midwives who was interested in getting more training but did not know where to turn, as there were no official schools for midwifery during her early years practicing in the 1980s. She approached Suzanne, an American who had settled in San Miguel de Allende, Mexico, and had recently opened CASA as, at that time, a sort of Planned Parenthood spinoff. Davis-Floyd (2001) describes how Guadalupe asked Suzanne if she could help find her a teacher to continue her education as a midwife. Interestingly, Suzanne reached out to another American – a direct-entry (informally trained) midwife– who trained Guadalupe and a handful of other local traditional midwives. Guadalupe then went on to train yet more traditional midwives, and eventually she cofounded the CASA professional midwifery school with Suzanne. Davis-Floyd describes this collaboration as one in which "the New Age met the traditional midwife, and they clicked" (2001:309).

Suzanne's vision was, perhaps, not so much to bring New Age midwifery to Mexico, but to support the education of Mexican midwives and to get them officially recognized by the state. Suzanne, like many of my informants, noted that the traditional midwives still able to practice were approaching old age, and that their job did not appeal to the next generations anymore. Suzanne envisioned CASA as a school that could teach important obstetric techniques while also respecting and drawing from traditional and alternative knowledges still held by midwives across Mexico.

From the start, Suzanne worked to incorporate the CASA school into the formal state and national education and health care systems so that graduates could eventually get reliable work. It took until 2001 for CASA to graduate its first class of professional midwives – also called "technical midwives (*parteras técnicas)*" because the degree is a "technical" level degree – who were recognized on a state and national level. Yet from the beginning, local physicians and politicians loudly opposed CASA's efforts to train professional midwives. Margot, who graduated in CASA's first generation of professional midwives, described how the doctors in town marched against CASA on the day that it opened[5].

Even now, after graduating CASA's twelfth generation of professional midwives and finally convincing the state of Guerrero to open the first state-run CASA spin-off school, Suzanne recognizes that all of her efforts could still come to nothing if the government does not take up the slack and start opening more schools based on CASA's model. During an interview in 2012, I asked Suzanne what she saw happening with professional midwifery in Mexico's future. She sighed, then said, "I mean, if nothing happens with the CASA school model or other schools… the same thing could happen over the next 20 years that happened in the US and in Canada, where the traditional midwives die, and the younger ones who say they are traditional midwives don't actually provide any services, and there won't be any new midwives. I mean that's probably,

[5] The state where CASA is located, Guanajuato, is still seen nationally as one of the most conservative states, and informants would often refer to the state's "backward" nature, citing influences of the religious right within the state government on policies related to women's health and reproduction. For example, CASA's consistent emphasis on family planning set off alarm bells for the predominantly conservative local officials, who raised issues of birth control and hinted at rumors of illegal abortions. Suzanne complained bitterly during one meeting about how the state government was using state funds to distribute pamphlets in public schools disparaging the use of contraception. During my fieldwork, rumors of illegal abortions connected to CASA were blamed on malevolent government tactics to undermine the midwives' work.

frankly, more than anything, the most… probable scenario." Despite this probability, Suzanne and CASA have continued to push for professional midwives to be accepted in the national health care system, and for individual states to take up the work of opening similar programs and licensing processes.

Not all midwives and midwifery advocates in Mexico see schools based on CASA's model as the ideal path for midwifery, however. While CASA has been struggling to get established and graduate newly minted professional midwives into practicing positions, other groups have formed and are designing educational alternatives to the government-run trainings as well[6].

Two such education sites, *Nueve Lunas* in Oaxaca City, Oaxaca, and *Mujeres Aliadas* in Pátzcuaro, Michoacán, have been particularly vocal in their efforts to impact legislation on midwifery in Mexico. While there are other, smaller, midwifery groups and training programs across Mexico – and while I do refer to them at times in this dissertation – I chose to focus on CASA, *Nueve Lunas*, and *Mujeres Aliadas* for two main reasons: these schools are the largest and most established at this point, and they clearly represent three distinct approaches to midwifery education (which I discuss more in Chapter 3). Each of these three schools consider their graduates "professional" midwives (*parteras profesionales*), even if the term itself gets debated endlessly on the basis of differences in opinions on what constitutes a professional - does a professional need a high school degree? A college degree? Official government recognition? Yet despite such

[6] Often, like with CASA, these groups found leadership in foreigners. What would be the implications for the sustainability of midwife training programs without foreign leadership and the connections to funds and programs that non-Mexican leaders brought with them? An examination of the influence of foreigners in the development of Mexican midwifery education deserves its own project, though it was not my main focus here.

debates, the shared image of a new kind of professional midwife who is able to address Mexico's needs through compassionate, educated and evidence-based approach to women's health links all of these schools.

Mexico's National Health Care System

Each of these professional midwifery schools exists in tenuous proximity to a changing national healthcare system. The very system that, as my informants put it, used the midwives to make women start birthing in hospitals only to later kick out the midwives and degrade the birthing experience, is now a necessary ally. If midwifery schools want to graduate students who can earn a living wage, reach the largest population of women, offer birth certificates, and maintain their authority and autonomy, they will have to engage with the healthcare system.

The Mexican healthcare system was as much an actor in my fieldwork as the individual midwives, students and politicians. It was evoked as something with agency and intentions that ranged from well meaning but badly executed to malevolent and misogynistic. On the surface, the system seemed to be growing in new directions in an attempt to reverse decades of inequality in care for the country's underserved populations – mainly the rural poor and indigenous. My informants are quick to point out the failures of this growing system, however, and to argue that it was perpetuating entrenched national inequalities through the way it extended its services, the kinds of care given, and the requirements for receiving care.

The midwives are not alone in blaming the existing medical system, in part, for women's poor health outcomes; throughout my research I spoke with physicians and

politicians who were also concerned about the current state of medicine in Mexico, although they did not always agree that the midwifery agenda to "humanize" women's health was the most effective platform from which to improve the system. For them, poor health outcomes such as maternal mortality needed to be addressed from within the existing infrastructure (as opposed to by adding midwifery into the mix), by working with doctors, nurses, and hospital administrators. While the Mexican health care system has seen some dramatic improvements in the past few decades, many doctors and politicians were quick to point out continuing problems. In order to understand where these problems stem from, it is helpful to have a brief overview of how the system is organized.

Mexican Healthcare System Overview

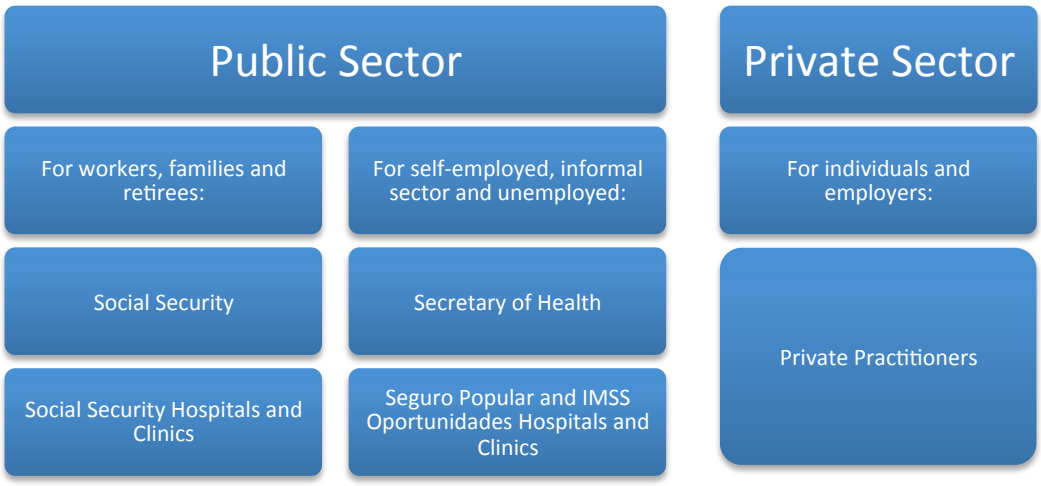

Figure 2 (Graphic adopted from Gómez Dantés et al. 2011:S221)

The national healthcare system is divided into two basic sectors – public and private. The private sector is for individuals who can afford to pay providers out of pocket or for employers who go through private insurance companies for their employees. The public sector is divided further between the *Seguridad Social* (Social Security) and *Secretaria de Salud* (Secretary of Health), and is responsible for the rest of

the population. *Seguridad Social* is responsible for a system of providers and clinics that attend to people who have worked for employers that paid into the program – for example, those who worked for large corporations like PEMEX (the national oil company). As of 2008, 45.3% of the population in Mexico had Social Security (Gómez Dantés et al. 2011:S225).

It is the elements of the health care system that come under the jurisdiction of the Secretary of Health, however, that are most of interest in my work, as they are responsible for people who do not have insurance, are unemployed, or work in the informal sector – descriptions which align primarily with the country's underserved and marginalized populations. Under the Secretary of Health, there are two main programs that are designed to serve these populations - IMSS *Oportunidades* and *Seguro Popular* - and which are funded by the government. Those covered by either of these programs must be seen in a specifically designated *Seguro Popular* or IMSS *Oportunidades* clinic to receive their benefits. *Seguro Popular* is relatively recent (started in 2008, while IMSS *Oportunidades* began in 1979), and by 2008 an impressive quarter of the population had enrolled in the program (Gómez Dantés et al. 2011:S225).

High enrollment rates in the free *Seguro Popular* have achieved many of the goals that were set out for the program. Rosa Nuñez, head of CNEGySR (National Center for Equality of Gender and Reproductive Health) noted at a conference in 2012 that the number of Mexican births to take place in hospitals doubled between 2003 and 2010 because, in large part, of the *Seguro Popular* program. In addition, many more women attended prenatal visits because of the requirements of the IMSS *Oportunidades* program. However, Nuñez noted that while these numbers represented progress on one scale, they

also obscured issues related to the quality of care. "We do not have enough oversight to ensure quality of care!" She argued, citing such issues as a lack of proper medication in the health care centers where people were being sent and a lack of obstetricians on night shifts to attend emergencies.

Between *Seguro Popular* and IMSS *Oportunidades*, Mexico is trying to offer at least basic care to all of its population. A big push was made in particular to get pregnant women to have their prenatal care and their deliveries in hospitals associated with these programs by signing the women up early. To an extent, this was wildly successful – more and more women were birthing in hospitals because of these programs, and they did not have to pay anything for their births. If numbers of births in hospitals was the only indicator, then, Mexico was doing very well – even though midwives argued that the quality of care received there was not acceptable. However, maternal mortality was still not dropping fast enough to meet development goals, despite huge investments in socialized medicine and efforts to bring birth into the hospitals. In the following section, I examine the history of the international focus on maternal mortality as an indicator of development, and point to some of the critiques of this focus in terms of its insufficiency for addressing underlying issues facing women's health.

Women's Bodies in International Development and the Rise of the Maternal Mortality Crisis

"We all have the same goal: reduce maternal mortality" - Juan Luis Mosqueda Gomez, Secretary of Health for Guanajuato, Mexico. Excerpt from speech given on May 5, 2012 in San Miguel de Allende, Guanajuato, Mexico.

Women's reproductive processes have long been the focus of varying international development efforts. Maternal mortality concerns have increasingly come to fuel funding decisions and structure women's health initiatives, in Mexico as across the developing world. How midwives have come to understand this emphasis on maternal mortality reduction, and how they have consequentially allied their profession with this cause, inflects their approaches to the models of midwifery education they present as appropriate interventions for Mexico today. In this section I outline the trajectory of international policies regarding reproductive healthcare, paying particular attention to the growing emphasis on maternal mortality as a crisis of epidemic proportions. What I argue here is that such an emphasis is not a-political, and that it may indeed render less visible other social concerns; yet the international backing of maternal mortality reduction campaigns has also helped to create a space for midwives as professionals within a system that has not been able to reach national targets.

The International Conference on Population and Development in Cairo in 1994 marked the arrival of women's reproductive health as a human rights concern to the international sphere (Mayhew et al, 2006), yet more recent international agendas retain little of the rights-based approach that was heralded as so revolutionary in Cairo. The 1994 conference not only stressed women's reproductive rights as vital to improving women's health outcomes, but also reached consensus that such rights are vital to all other markers of development, from education to nutrition to economic development (Crossette 2005). The Cairo conference and its outcomes must be understood within the context of the conferences that led up to them.

The First World Population Conference, held in Rome in 1954 by the United Nations, called for more accurate demographic information of developing countries in order to understand population concerns. This was followed in 1965 by the Second World Population Conference in Belgrade, where fertility analysis was put on the policy agenda for development planning. The Third World Population Conference, held in 1974 in Bucharest, was where population policies were reframed as interdependent with all other socio-economic development concerns. By the time of the 1994 conference in Cairo, then, population had long been understood in the international sphere to be fully entangled with all other development policies. Cairo highlighted the need to view population issues as part of broader human rights concerns, not as stand-alone development goals (see United Nations 1995)[7]. By the mid-nineties, then, reproductive and sexual health were discussed as rights – rights that were vital to any projects of development.

After the Cairo conference, Mexico created the Program on Reproductive Health and Family Planning in order to realign Mexican health policy with the international women's health movement that the conference had made cohesive and globally recognized. Arachu Castro, in tracing reproductive health care after this program was initiated, concluded that despite Mexico's supposed accordance with the recommendations made in Cairo, the country has as yet been unable to fully disengage from a numbers-based approach to family planning and reproductive health (2004).

7 The majority of countries in attendance at Beijing's Fourth World Conference in Women the following year "agreed that without the most basic rights for women within the family and society – most of all the right to decide, jointly or alone if necessary, on the number of children they were prepared to bear, or that their health could sustain – meaningful and rapid strides in public health, education, the protection of the environment, and economic development would lag at best and be impossible at worst" (Crossette 2005:71).

While Mexico had been one of the first Latin American countries to engage with family planning programs through adopting official policies around the issue in the 1960s, it began by mostly carried out its programs through sterilization and IUD insertion (Castro 2004). These two methods continue to be the most commonly used family planning methods (Castro 2004). Despite direct WHO recommendations to the contrary, Mexican practitioners would carry out these sterilizations and IUD insertions directly after a woman had given birth; rather than obtaining her informed consent prenatally or much later in the postpartum period. During my research, I met many women who have had tubal ligations, IUD insertions, or even hysterectomies immediately following their labor and were either completely unaware that the procedure had been done on them, or were confused about what it meant and why it had been done (see Chapter 4 for a discussion of this phenomenon). Aside from the obvious problems involved in sterilizing populations forcibly, these procedures cause women to incur further complications such as IUDs that are not inserted properly and thus perforate the uterus, or complications from surgery, which are not addressed because of a lack of information.

Non-consensual reproductive interventions echo an earlier model of international health initiatives. Since the 1940s, public health initiatives had been pushed through vertical, top-down interventions that did not necessitate holistic or long-term engagement with patients (for example, through DDT spraying or immunization campaigns) (Justice 1989). By the 1960s, the trend began to change as the notion of primary health care took hold, and with it the notion that health care could be more effective if it was provided long-term and by local providers who could integrate multiple health concerns. At the international level, then, the notion of technical expertise as the only carrier of health

interventions has been reconsidered (Justice 1989). However, at local levels the move from these vertical practices of the past to more integrative health care have not been adopted equally; and while Mexico has officially presented its alignment with a shift towards this new model of health care, in practice it still lags behind.

After the Cairo meeting, Mexico joined other nations in signing on to reduce the focus on population control and instead "promote the integration of reproductive health services, such as counseling and testing for sexually transmitted infections during a woman's visit to a family planning clinic, or providing contraceptives to women after childbirth or an abortion" (Castro 2004:133). Yet as Castro discovers, Mexican practitioners and politicians have not yet been able to get away from demographic targets as social goals, and so reproductive health practices are still shaped by such targets. I suggest that this inability to avoid ongoing concerns with demographic targets – which is not only locally entrenched, but rather connects to networks of donors and international organizations - reflects underlying notions of what Ginsburg and Rapp originally called "stratified reproduction" (1995). That is, concern over who may reproduce and who should not mirrors existing systems of inequality at local, national and international levels. The creation of the Millennium Development Goals (MDGs) dovetailed nicely with the direction in which Mexico was already heading: a numbers-based approach to health care that did not have to account for social inequalities.

The creation of the MDGs could have built off of Cairo's original framework of reproductive and sexual rights; yet instead it delegated women's health to its previous status as an independent variable that did not depend on social and economic indicators. A major force behind this reversal in attitudes towards women's health was the

opposition from the G-77 (the developing nations themselves), which was made up of many conservative members who did not support the language of the Cairo Programme of Action in discussions of reproductive rights (Crossette 2005). The MDGs came out of the Millennium Declaration, a document created by the United Nations, which had no direct reference to reproductive health or rights. When the Goals were crafted, supporters of the Cairo consensus tried to change language about "maternal health" to "reproductive health," but such changes were rejected again by the G-77 – thus maintaining the focus on women's bodies as numerical indicators and not on women as individuals with the right to make decisions about their own lives and bodies (Crossette 2005).

The fifth Millennial Development Goal most clearly echos the Cairo consensus, as it aims to reduce maternal mortality by 75% between 1990 and 2015 and also increase access to reproductive health care. The WHO defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (WHO website). Of all of the concerns covered in the MDGs, maternal mortality makes a particularly significant indicator of development. For example, while infant mortality may be near 10 times higher in developing countries than in developed countries, maternal mortality may rise to more than 100 times higher in developing countries (Maine et.al 1997). Yet such distinctions cannot be solely tied to economic differences; while economic differences *have* been known for years to relate to differences in maternal mortality ratios between populations (McCarthy and Maine 1992), ethnic, racial, and individual characteristics including marital status are also important (Ronsman

and Graham 2006). The two principle causes of maternal death in Mexico – hypertension and hemorrhage – are in most cases preventable if treated correctly; in fact, the majority of maternal mortality cases are considered preventable. Mexican maternal mortality has declined somewhat in recent years – in 1990 there were 61 deaths per 100,000 live births, while in 2010 there were 51.5 deaths per 100,000 live births (Fernández Cantón et al. 2012). However, this number needs to decline further, and faster, if it is to reach the MDG's target. For Mexico, MDG #5 means that the country must lower its maternal mortality ratio to less than 22 deaths per 100,000 live births (Freyermuth and Sesia 2009).

Critics of the MDGs from both the international community and the Mexican midwifery community argue that Mexico will not meet this target maternal mortality ratio unless it addresses underlying social inequalities that are rendered invisible in the language of the development discourse. For example, Crossette (2005) argues that there is "nothing in the Millennial Development Goals about the fundamental physical hurdles women encounter starting within the family, often the extended family, where, in line with cultural practices, the woman may be treated as the property of male relatives or where in-laws may assert control to the point of violence against a young wife brought into the household" (75). My informants stressed that the MDGs also ignored inequalities related to race, ethnicity, and rural/urban divides across Mexico - maternal mortality in the relatively more poor state of Oaxaca, for example, is four times that of the wealthier state of Tlaxcala (Gómez Dantés et al. 2011:S222). Instead, they said, the narrow focus on maternal mortality had led to narrow solutions that rendered invisible such inequalities in favor of a strategy built on medicalization: Mexico had been steadily working towards getting all women to birth in hospitals, not at home or with midwives. As CASA founder

Suzanne told me, the MDGs and this focus on medicalization as the route to better health outcomes only served to "put women right back into the uterus box." By this, she meant that despite positive steps towards policies that focused on integrated women's health and equality, the MDGs had brought the emphasis back to women's bodies - and women's reproductive organs in particular.

A paradox that midwifery advocates across Mexico point out is that maternal mortality has not decreased significantly in recent years, despite the increase in births attended at hospitals. For example, Mexico's cesarean rate is 46 percent (although many argue that it is higher in private hospitals – nearer to 80 or even 90 percent), putting it among the world's highest, yet its maternal mortality rate remains high for its level of development (Alonso and Gerard 2009). Such contrasts prompt them to ask, then, why maternal mortality remains high when birth has become so medically controlled, and when the expansion of free medical services has been so successful nationwide?

Finding Failures in the Mexican Medical System

My informants – midwives, as well as critical physicians and politicians – argue that maternal mortality remains high despite these factors because key underlying issues with the Mexican healthcare system have not been adequately addressed. Their critiques emphasize failures in four areas: medical training, the deployment of rural medicine, overcrowding in public hospitals, and general mistreatment of women – especially women associated with the rural, indigenous poor. Midwives frame their own professional capabilities in ways that specifically address these problems. In such, they

attempt to recast midwifery as a strategy for national development rather than a symbol of Mexico's underdeveloped past.

Problems with how doctors were trained - and with their lack of continuing education - were cited by midwives and doctors alike as contributing to poor health outcomes. Dr. Smith - a boisterous, bi-cultural physician who had divided his life between Mexico and the US since childhood – is the founder of a Mexican NGO that focuses on the issue of medical training, which he sees as an important strategy for maternal mortality reduction. If Mexican healthcare, especially women's healthcare, was to be improved, he told me, "and if we are really serious about that, we have to deal with the fact that there's 150,000 doctors out there – and it's not clear that they know exactly what they are doing or maybe they can do what they do better." An underlying problem, as Dr. Smith explained, is that the vast majority of physicians in Mexico have not done any advanced training. "In the United States," Dr. Smith said, "almost everybody's done a residency – there are very few family doctors. That's not the case in Mexico though, where 85% of the doctors are general practitioners. That means that about 140,000 doctors here are only general practice docs. They haven't had any advanced training!" This means that most women are being attended in pregnancy and birth by general practitioners who have not had more than basic training in obstetric procedures or obstetric emergencies. Dr. Smith was quick to note, "There are some excellent doctors in Mexico, as good as anywhere," but he argued that "the problem is that the worst doctors are still able to practice here – there is nothing to stop them! The regulations are not very tight here, and so the quality control is not good. Perhaps when they enter into an

institution like the health ministry they get more restrictions, but most doctors are not subject to much oversight or continuing education."

Dr. Martinez, a young general practitioner who teaches midwives at CASA and works at a public health clinic in San Miguel de Allende, seconded Dr. Smith's concern about the lack of continuing education. "It is only now beginning to become more mandatory that doctors keep up with medical trainings," he explained. "But really, it's more like an extra thing you can say you did, getting recertified every five years by taking a test or showing continuing education credits. But it is certainly not the norm, and I know lots of doctors who are not up to date on important things." For example, he said that he hears doctors still tell women all the time to have their babies sleep on their stomachs, when current research clearly shoes that babies are safest when they sleep on their backs. "This kind of misinformation is dangerous," he said, "but often times it feels hard to keep up with the most current science." He explained that a primary cause of this difficulty is the predominance of English language in medical journals. "To go into a specialization in medicine here you *have* to speak English – it is the language of science! But even just to keep up to date requires English, and not all of us speak English or receive journals regularly."

For many of my informants, the lack of continuing education was reflected in the lack of evidence-based medicine in obstetric care. During a national meeting on childbirth in May 2012, Dr. Luis Villanueva – obstetrician and vocal supporter of obstetric reform in Mexico – illustrated this argument with a striking example. Villanueva discussed how magnesium sulphate, a cheap medication used to treat pregnant women with preeclampsia, eclampsia or hypertension (the main reasons for maternal mortality), was

not being used in Mexico. “Less than half of the hospitals in Mexico City used it, and in those that did, they did so less than 10% of the times it was indicated!” He explained this phenomenon by arguing that doctors did not want to try new things or had not learned about the medication. Midwives have become increasingly vocal in their assertions that evidence based medicine is not being practiced in public hospitals – the refusal to use magnesium sulphate is just one example of the consequences of this trend.

A second critique of the medical system has to do with the staffing of rural health clinics across Mexico. As I discussed above, healthcare in Mexico has historically been extremely unequally distributed across states, with those states seen as more rural, indigenous and poor receiving less medical services. One way that the gap between rural and urban healthcare services has been addressed in Mexico is through its social service program, in which all medical personnel are placed obligatorily in service positions upon graduation. They are often sent to rural outposts where full-time practitioners do not want to go; this gives them lots of practice, but also means that much of rural and impoverished Mexico is being attended to by newly minted practitioners with little hands-on practice, especially in obstetric emergencies.

CASA founder Suzanne called this process “the best example of racism you can get” in which the nation’s most marginalized and often indigenous population was being used as guinea pigs for doctors to gain experience without consequence. Suzanne often pointed out that CASA’s professional midwives received much more clinical experience than doctors did,[8] and so she argued that the social service was the first time they really

[8] For example: Cragin, L., DeMaria, L.M., Campero, L., Walker, D. M. (2007). Educating Skilled Birth Attendants in Mexico: Do the Curricula Meet International Confederation of Midwives Standards? *Reproductive Health Matters*.

tried out anything they had learned. Dr. Smith found this situation absurd, noting that, "If you ask a typical intern in the US right now if they would be ready to go practice right now, they'd be like, 'No! I'm not ready!'"

The uneven distribution of resources that pervade the national healthcare system was another topic that brought heavy critique from midwives and physicians alike. Poor and more rural states – for example, Guerrero, Oaxaca, and Chiapas – were often highlighted as sites where maternal mortality was highest because of a broader set of health inequalities facing them. This argument put into motion efforts to target these states in particular when addressing maternal mortality. CASA, for example, was pushing hard to open sister schools in Chiapas and Guerrero because of their position on this list of states. The link between socioeconomic status of a state – or, indeed, of an individual – was illustrated through more specific examples, such as when an administrator from *Nueve Lunas* midwifery school in Oaxaca pointed out that hemorrhaging was much more common in the poor.

States or individuals with lower socioeconomic status were not only more likely to have higher maternal mortality rates, but they were also more likely to be indigenous and to live in rural areas. Rural areas presented many possible issues to my informants. One complaint was that providers did not want to staff clinics in some rural areas, while other areas did not have a clinic to begin with. Informants complained to me that in some regions, such as rural Guerrero, half of the physician positions in first level hospitals remained empty because there were no doctors who would go there. This argument has bolstered the professional midwives' position that they are more likely to want to go

work in those communities, especially if young women come from those communities in the first place.

When I asked a CASA graduate who was conducting her year of social service in a rural mountain village in Guerrero what kinds of efforts were being taken to lower maternal mortality, she scoffed. "If they really cared about lowering maternal mortality in these areas, they would give people radios!" Her comment was unexpected to me, but I eventually heard others repeat the same sentiment. Dr. Ortiz, an obstetrician and politician in Mexico City, said that he had been working on trying to get more radios into rural villages and clinics for years in an effort to prevent maternal deaths. "The repeater towers already exist," he said, "but what we need is for people to have a clear chain of communication from the villages to the closest hospital, where doctors or even residents could be on hand to help people when emergency obstetric situations arise." Such an intervention made sense when considering that many of the rural regions across Mexico were located in regions far from hospitals on difficult roads to traverse in emergencies.

The prevailing connection between rural communities and maternal mortality had some informants frustrated, however; they feared that such a correlation took attention away from poor maternal health conditions in urban centers or in states that were not socioeconomically disadvantaged. During a midwifery meeting in Mexico City in 2012, one woman from Jalisco angrily told the group that "people always say that Jalisco is not one of the poorest states in the country, so it must be doing well. But it isn't! It has big problems! There were 35 maternal deaths last year there because of bad care (*maltrato)* in the hospitals." She argued that we needed to focus on the kind of care in all hospital settings, not just in rural areas.

Critiques of infrastructural issues in both rural and urban areas had to do with the physical spaces available for childbirth in hospitals and clinics, the programs offered, and the protocols employed within the system. One reason cited for poor health outcomes despite high attendance at hospitals via programs such as *Seguro Popular* has to do with the resources available within those hospitals. Daniela Francesca Diaz Echeveria, a researcher from *Fundar* research center in Mexico City, presented on this issue during a conference I attended in May of 2012. Mexico, she said, has only .63 beds per 1,000 people who don't have health insurance – which is far below the WHO's recommended one bed per 1,000 people. In "marginalized places," she said, this statistic is even worse – dropping to .1 beds per 1,000 people. Such statistics, she pointed out, made clearer the alarming finding that "in 2009, 33.1% of maternal deaths registered were women who had *Seguro* Popular! And in 2010, of the 992 maternal deaths, 39.2% had it!" For Diaz Echeveria, then, having access to *Seguro Popular* did not mean that women were being seen or attended to especially if there were not even enough beds for patients.

Other doctors reiterated her argument, citing times when they had seen women waiting in long lines outside to be seen at the *Seguro Popular* hospital, even when in active labor. Dr. Angel Quinteno, an obstetrician from Oaxaca who advocated for systemic change to Mexico's maternal health infrastructure, said during the same conference that the country was in a "profound crisis" with regards to low risk births. He meant that under programs like *Seguro Popular*, where women were compelled to go to the big hospitals for birth even if they had no risk signs, those who could have been attended in the local clinics by general practitioners or even professional midwives were clogging up the system for those who did have high risk pregnancies and needed to be

seen in the big hospitals. Renata, an administrator at *Mujeres Aliadas* midwifery school told me that they were appealing to the state to let their professional midwifery graduates attend low risk births instead of making all women go to the *Seguro Popular* second level hospital. "Maternal mortality is *rising* in hospitals!" she said. "It is because of oversaturation. Social programs like *Seguro Popular* grew too quickly, and they couldn't keep up. The can't! How are they going to offer services to the whole population when they don't have the infrastructure?" Renata explained to me that their school was "selling" their model to the state as an intervention into this maternal mortality paradox. She said that linking professional midwives to maternal mortality reduction was much more effective than espousing the benefits of "humanized birth" or other, less politically motivating, elements of midwifery care.

Arguments about the need to humanize birth and address the quality of care received in public hospitals are at the heart of the midwifery movement, even as midwives recognize that they may not be the most influential for policymakers. For Suzanne, Mexico's maternal mortality issue was most directly a reflection of a national devaluation of women. "Excuse my feminist discourse," she told a group of assembled state politicians in May 2012, "but the biggest problem is that Mexico doesn't value women!" Midwives were not the only ones to take this stance; Dr. Villanueva illustrated this sentiment during a conference in 2012 with vivid examples from things he had seen in his time in public hospital delivery wards. During a discussion about the issues with the quality of care in hospital obstetrics, he argued that, "when the doctor says to the woman, 'did you yell like that when he did you?' or, 'is that how you opened your legs?' the woman is going to suffer some tangible consequences!" At these quotes, the audience

gasped, but nodded; such taunting phrases were often reported to me as being commonplace in delivery wards. Dr. Villanueva continued, asking rhetorically, "Do we think this doctor, this idiot, who insults the woman during this vulnerable time really gives a shit about the health of the woman and the baby? Do we really expect maternal health to be improved by doctors who are like that? The first thing he is going to want to do is a cesarean!" Again, the crowd nodded and murmured their agreement. "They make the women naked, then they insult them, then they leave. This is a rape, no?" By the time Dr. Villanueva finished speaking, everyone was riled up, angry and sharing similar stories they had witnessed in hospitals.

Conclusion

While other scholars have interrogated symptoms of state failures in health, such as maternal mortality, as outcomes of inequalities rendered more visible through neoliberal restructuring (Chavez 2009), I take maternal mortality as a focal point here for a different purpose. Rather than ask only why maternal mortality persists in a country with an expanding free health insurance program and increasing emphasis on medicalization of reproductive care, I ask how this particular phenomena has been framed as a concern of development, and how this framing may create space for a new kind of professional midwifery to exist within the system.

Midwives, I have argued here, are savvy to the kinds of issues that motivate politicians to implement change in the healthcare system. At this point in time, by focusing on the structural failures that are leading to Mexico's inability to sufficiently reduce maternal mortality, midwives strategically position themselves to gain authority

within a system that has historically marginalized them. They have managed to align their goals to improve the quality of women's healthcare with the goal of maternal mortality reduction, making the institutionalization of midwifery synonymous with national development. During a midwifery conference I attended in June, 2010, a representative from the Mexican National Institute of Public Health told the midwives that, "90% of women who are going to hospitals are not getting the best care possible. The way for them to get better care, and to also reduce maternal mortality, is to include alternative providers like midwives." This link between including midwives in the system and improving care was linked to an innate ability of midwives to connect culturally to the needs of their patients, to the specific kinds of training midwives received, and to the failings of medical education in obstetrics. Juan Luis Mosqueda Gomez, Secretary of Health for the state of Guanajuato, reiterated that idea during a speech he gave to CASA midwifery students in May of 2012. Midwives, he said, offer something to improve the healthcare system that "goes beyond the technical knowledge, the knowledge of skills they can do – it is emotional accompaniment in pregnancy and birth, and also all the work of sensitization and education about the next pregnancy, family planning, lactation, all of this together is really what favors the reduction of maternal and infant mortality."

In the following chapter I examine more closely three midwifery training programs that are each attempting to address issues of quality of maternal healthcare while providing a route for entry into midwifery as a valued profession in Mexico. Each of these programs has been developed with a distinct philosophy regarding what midwives should know and how they should learn. Each program also does the dual work of addressing the national maternal mortality concerns by imagining how to impact the

structure of the healthcare system and addressing quality of care by reinforcing what midwifery care means and why Mexico needs it now.

CHAPTER 2

Posing the Problem, Setting the Standards

"Midwifery is supposed to be a varied profession, that is why it works" – Catrina, founder of Nueve Lunas midwifery school

"The other schools just don't want to put in the hard work, do the paperwork. They don't want to do things *right"* – Suzanne, founder of CASA midwifery school

As I discussed in the previous chapters, the Mexican government is reconsidering the use of professional midwives as a strategic intervention to lower maternal mortality ratios in regions where there is currently little access to trained care providers. The international community supports the training of midwives in developing countries, and among developed countries worldwide midwifery has seen a resurgence of support in recent years (AbouZahr and Wardlaw 2001; UNFPA 2008). Not all variations of midwifery practice and training, however, are considered equal. CASA (*Centro para los Adolescentes de San Miguel de Allende* – Center for the Adolescents of San Miguel de Allende), Mexico's first officially recognized professional midwifery school, emphasizes biomedical training and the placement of graduates in state health clinics. *Nueve Lunas* (Nine Moons) helps women find apprenticeships in their own communities and supplements their education monthly. *Mujeres Aliadas* (Allied Women) focuses on giving nurses advanced midwifery skills to treat women throughout their lives. As Mexican states begin to seek out ways to standardize midwifery education and open state-run schools nation-wide, these existing schools debate the relevance of their own methods for inclusion in national standards. This process of debating and defining standards for midwifery training thus makes visible the types of training, knowledge and

practices that separate each school. Consequentially, the move to standardize midwifery education entrenches a hierarchy among these schools. This chapter considers the unequal authority held by distinct midwifery training programs across Mexico in the context of a national response to maternal mortality as a development concern.

My argument in this chapter is twofold. First, I argue that the national emphasis on maternal mortality reduction has led to state support of one framing of midwifery education and practice, while further marginalizing others. That is, CASA's model has been legitimated by the state because its goals are in line with the national goals of maternal mortality reduction, and its strategy of placing graduates in state-run clinics in marginalized regions of Mexico serve the national goal. Other programs, like *Mujeres Aliadas* and *Nueve Lunas*, have very different goals for what Mexican midwives should know and do. An important question that arises, then, is this: as these programs are skipped over in favor of a model like CASA's, what will happen to their goals for women's health? My second argument follows from the first: by looking at which goals are granted importance and urgency, and which are not, we see how women's bodies and women's knowledge are only valued by the state to the extent that they add up to better numbers for development.

This chapter examines CASA, *Mujeres Aliadas* and *Nueve Lunas'* models for midwifery training and end goals for Mexican midwifery, revealing what is at stake in the further marginalization of midwifery programs other than CASA. In describing CASA's program, I illustrate the productive possibilities of state collaboration, and highlight some of the ways that CASA is able to further the state's goals while instilling its own agenda in its students as well. CASA's students find ways to learn alternative medical practices,

dream of careers working outside of the healthcare system, and bring discourses of social justice into their training and practice. In describing *Mujeres Aliadas* and *Nueve Lunas*, I reveal how their educational models line up with their own goals for women's health and midwifery in Mexico, which in turn do not correspond as neatly with the state's vision for what midwives need to know and do. Further, these schools' goals reflect a valuation of women's bodies and women's knowledge that are not encompassed in the current state vision for the future of midwifery. Thus in comparing the dominant model with those who still struggle for legitimacy, I bring into relief deeper concerns about how development concerns realign state values around women and health.

In order to contextualize my argument and the relative authorities of these three midwifery schools, I first situate this chapter within literatures that discuss the effects of standardization processes and the impacts of development on women's bodies and women's knowledge.

Situating The Standardization of Mexican Midwifery in the Literature

An overarching argument for this chapter is that the process of developing standards for midwifery training and practice in Mexico sets the stage for debates over what midwives need to know and to what end. A growing body of literature in science and technology studies examines the role of standards and standardization in various contexts, including medicine and education. Scholars have defined standards and outline their shared characteristics (Lampland and Star 2009, Bowker and Star 2000), examined their emergence as a social and political process (Gorur 2012, Timmermans and Epstein 2010), critiqued the ways in which standards reproduce notions of marginal or "other"

knowledges (Lampland and Star 2009, Zhan 2009), and analyzed the ways in which standards translate to actual practice (Bowker and Star 2000, Lampand and Star 2009, Busch 2011, Botzem and Dobusch 2012). My work contributes to scholarship (see, for example, Greenhalgh 2008, Ong 2005, Carroll and Benoit 2004) that examines the specificities involved in early processes of standardization itself. To borrow a term from Geoffrey Bowker (1994) I engage here in a sort of "infrastructural inversion" in which I unpack the histories behind standards, in particular by focusing on the distinctions that they create and reinforce when they are initially debated.

Unlike Bowker, however, I am not working backwards from established standards, but rather am examining their initial conception; like Marilyn Strathern (2004:18), I am interested in how "know-how" gets embedded in standards through processes which will later be rendered invisible. I argue that what becomes a defined arena for standardization is in itself a topic that reveals the diversity of the stakes involved for each midwifery organization; in the case of Mexican midwifery, it is the ways of learning that are up for debate. Bowker and Star urge researches to pay attention to the tensions that arise in processes of standardization, "in order to evaluate the political and ethical implications of the introduction of new classificatory infrastructures" (2000: 227). While the push to standardize Mexican midwifery education is, on the one hand, a sign of renewed support for the authority of midwifery (and thus welcomed by the midwives), it implies a series of decisions that are inevitably political. I ask here what is at stake when certain ways of knowing are rendered commensurate in the name of standardization… and others are not. Further, this chapter builds on work on commensuration as an early step in standardization processes (Espeland and Stevens

1998), by revealing the points of incommensurability and the tensions that ensue. Not all ways of learning and doing midwifery are ultimately commensurate with each other or with the nation's goal to use midwives to reduce maternal mortality in state-run clinics.

The national project to standardize midwifery education in the name of maternal mortality reduction can, I argue, be seen as part of a larger global trend that emphasizes girls' education as a national development project. This is especially evident in the focus on CASA's program, which primarily trains young women who only have a middle school education, with the explicit understanding that their youth and lack of higher education will tether them to their home communities. Girls' education has been increasingly prioritized as a vehicle for achieving seemingly endless development goals. For example, a publication put out by the World Bank in 2008 argues that all conclusive research shows that "education of girls is one of the most cost-effective ways of spurring development," and that such "education creates powerful poverty-reducing synergies and increased economic productivity, more robust labor markets, higher earnings, and improved societal health and well-being" (Phumaphi and Leipziger:xvii).

Further benefits of girls' education indicatives, they argue, is that their impacts can be seen generations later, and that they help nations attain other Millennial Development Goals. Increased education for girls leads to higher wages, faster economic growth, more productive farming, smaller and better-educated families, less HIV rates, and empowerment, argues one review (Herz and Sperling 2004). Such evidence was presented (and later published as the 2008 World Bank presentation) during a symposium for NGOs, the World Bank, and government officials from all over the world on gender, education and development in 2007; by the time midwifery schools across Mexico began

to argue that CASA's program should not be the only official model, the notion of a connection between investing in girls' education and measurable outcomes in development was been firmly entrenched.

The link between girls' education and national projects of development ties into broader relationships that scholars have outlined between women and nation building (Yuval-Davis 1997). While midwifery is seen by many as a feminist project seeking to empower women and change the patriarchal biomedical system, new collaborations between midwives and the state complicate the feminist agenda. Scholars of gender and nationalism have argued that "[w]hen modernity takes shape as feminism… it collaborates with nationalism. In its nationalist guise, it cannot be oppositional. The need to free feminism from nationalist discourses is clear" (Grewal and Kaplan 1994:22). As I illustrate below and in the following chapter, CASA's students experience the dual responsibilities of working within the national healthcare system on the development agenda of reducing maternal mortality and furthering a feminist agenda to change the system itself. This chapter thus complicates the role of midwifery in development contexts. On the one hand, midwives become another example of women as integral to projects of nation-building; yet on the other hand, those midwives who do not fit neatly into the state's vision for what midwives should know and do present a counterargument to development projects as central to nation-building. Rather, they argue that such development projects do not value women's bodies and women's knowledge, but are instead only interested in maternal mortality as a number with which to gain admittance to modernity.

As these diverse midwifery schools and the state debate what midwives need to know and how they should best be taught, I argue that they are also – perhaps most significantly – debating the bigger question of what it is that a standardized, professional Mexican midwifery is meant to address. As I describe below, each school has its own answer to this basic question about the end goal of midwifery, and not all of them align with the state's desire that midwifery be standardized first and foremost to reduce maternal mortality. Others, however, argue that the goal is to improve quality of care and to retain locally specific knowledges and practices. Sandra Harding urges us to pay attention to how such goals, and the social problems they reveal, are defined. In such, we see "that there is no such thing as a problem without a person (or groups of them) who have this problem: a problem is always a problem *for* someone or other." (Harding 1987:6). While all of the midwives agree that maternal mortality is a real concern, its framing as a problem of numbers – not as an issue of the quality of care or the specific needs of diverse women across Mexico – makes possible only certain kinds of solutions.

CASA: Social Change From Inside the System

After the long, hot walk from downtown San Miguel de Allende up the hill to the CASA midwifery school[9], the startlingly cool air and the burst of chattering voices echoing against cement walls hit me simultaneously as I slipped into the classroom. Students from each year of the program already filled the brightly painted wooden chairs that surrounded the central table serving as their communal desk, and many more students lined the edges of the room. I found a sliver of floor space and settled in amid

[9] See Introduction for descriptions of the histories and programs of all of the schools mentioned in this chapter.

my bags, notebooks, and layers of clothing, greeting and smiling at the students around me. I had observed during enough classes to know that the arrival of the teacher did not usually lead to a silencing of the group, but today – despite the amount of students packed into the room – an expectant quiet descended when Suzanne walked in.

Suzanne, founder of CASA and incessant advocate for its model of professional midwifery nationwide, did not often address the students during classroom time. Trained in public health and social work and from New York City, Suzanne had lived and worked in Mexico for more than thirty years, and had seen CASA grow from its modest beginnings into an established NGO. Today's meeting had been planned for Suzanne to give the students an overview of the history of midwifery in Mexico, the history of CASA, and the school's goals for the future. After opening her talk with some casual introductions and checking in with the new students about how they were feeling about the year so far (they were only a couple of months into the semester), Suzanne jumped right in to the main point of her talk.

"The key word here is *movimiento* (movement)," she exclaimed, pausing to let the word sink in. "You are all a part of a movement now. I hope you know that you are not here as students, but as activists. If you don't know that yet, then we at the school have not done our jobs." The students smiled at this, but looked slightly confused. They had indeed not been told that they were here as activists, at least not the new students who had not heard Suzanne talk before. That was not part of the regular recruitment rhetoric. I could see some of the younger and more shy students look uneasily at each other. Seventeen or eighteen year old young women straight off the ranch from Chiapas or Veracruz had not signed on as activists, but rather as novice midwives.

Suzanne's PowerPoint led the students through both a history of midwives in Mexico (which I discuss in Chapter One) and an overview of the status of various women's issues including education, maternal mortality, fertility, and poverty. "No one will respect you if you do not know the statistics," she told them, urging them to memorize the birth rates, maternal mortality rates, and education rates for Mexico in general and for its poorest states in particular. This last point she emphasized as a way to explain her firm stance that CASA – and any future government program based on CASA's model – should directly reflect and respond to education rates for women in Mexico, especially for those in the rural populations and the poorest states that most need midwives. CASA offers a "technical level" degree, which means that the students only need have a middle school education level to enter the program (though they have to be at least 18), and that their pay range will ultimately be determined by this distinction (although some students do come in with higher education levels). Suzanne told them that they must understand the very deliberate choice that CASA made to make the program a technical level school. "You must understand," she said, "that the education levels in Mexico are very low. You need to know these kinds of statistics!" For example, she said, "only 21.1% of women aged fifteen years or more have finished middle school, and that 45.1% of 15-19 year olds are not in school at all." If these levels were higher, CASA could have been – or could become in the future – a university level degree. CASA was designed in direct response to the national education levels, and with the explicit goal of training young women from rural regions of Mexico who have historically not had access to higher education, in the hope that they will return to their communities as professionals who can work *with* the system to make a difference.

Fernanda, then director of CASA, told me in 2009 that offering CASA as a university degree would be risky, as the graduates would have too much status to return home and would naturally want to find better paying work in an urban center. "The CASA model," she told me, "provides a respectable job and a good enough pay, but does not graduate women who then expect to live much higher than the people in their communities. They need to feel compassion for their community members and patients, and not live too high above them." Sara, a CASA graduate and administrator at the school, put it more bluntly when she, only half jokingly, suggested that they only accept students who had not attended high school who she saw as more pliable and better behaved. "What would be the point of them having studied more? To become worse people? (*De que sirve si han estudiado mas? Que se hacen peor personas?)"* she asked, laughing. Sara sounded bitter at the constant challenges of authority headed by the students who did have higher education already, and thought that the school might work better if only the timid and undereducated women could attend. Such conversations hinted at a balance that was being searched for between educating students enough to be efficient care providers and not so much that they would not return home or would challenge the system too much- a balance which, as I discuss below, the other schools approached differently.

As Suzanne moved through her presentation on the state of women's health midwifery in Mexico, she emphasized that CASA had been developed from the start to work alongside the national health and education systems. These intentional partnerships have assured CASA a position of authority and legitimacy, and allowed for its graduates to gain employment in state clinics and earn a living wage.

For Suzanne, changing the system was necessary to achieve a specific purpose: social justice. By making CASA a part of the recognized education and health care system from the beginning, graduates would be able to work in government clinics as government employees. This process was not easy, but it was, for Suzanne, essential. Upon the creation of the CASA professional midwifery school, they had to get it incorporated by the state, by the secretary of education, and incorporated as a profession as well. This last step was vital for the careers of the midwifery graduates; once they were awarded a *título* (degree) from CASA, they could complete their year of social service that all medical professional must do by working in underserved clinics across Mexico. Then, with both *título* and proof of social service in hand, they would be able to go to Mexico City and receive their *cédula profesional* (professional license), but only after the official located them within what Suzanne called his "big book of professions." The first graduates received their *cédula profesional* from the government in 2001. This not only guaranteed them a living wage for the graduates (which was decided on at $12,000 pesos a month – around $1,000 USD - more than average nursing salaries but not as much as doctors), but it also guaranteed that patients would be able to have midwives attend them in clinics that accepted their health insurance.

This has significant implications for women's reproductive health care in Mexico, as it means that women might someday be able to choose a midwife for their care and still be financially covered under the national *Seguro Popular* free health insurance plan. "We know," Suzanne emphasized, "that those who pay the most for health care are the poorest people. We need to change this fact if we really want to help those people!" By creating a profession where the midwives are able to earn a living wage as well as offer

affordable care, Suzanne said that, "we have the ability to empower women *and* reduce maternal mortality." However, despite the empowering documentation of the *título* and the *cédula profesional,* Suzanne warned the students that professional midwifery is still little known and not entirely respected. She suggested that they carry a copy of their *cédula profesional* in their back pocket so that they could prove their position to those in doubt.

CASA exemplifies the growing movement among NGOs to develop standards for practice where the state has yet to tread. Busch (2011) notes that NGOs worldwide are increasingly shifting their strategies from those which sought government support to those which create "their own standards, certifications, and accreditations, in an attempt to advance goals of concern to them" (207). In enacting this shift, NGOs like CASA "have become enmeshed in neoliberal notions of governance" (207). However, as states begin to consider replicating CASA's program nation-wide (starting with the first state-run program in Guerrero, which opened in 2012), we see how certain non-governmental projects may be reabsorbed by the government once they prove useful to broader national goals.

Suzanne's constant push to reinforce ties between CASA and the state point to her understanding that the government would *have* to take up the project of educating professional midwives if they were to make a sustainable difference in the healthcare system. "This particular school, CASA, it cannot sustain itself forever. It is a boutique model," she told her students. She reminded them often of the importance of external representations of CASA in terms of political visibility. A few days before her talk with the students, the national congress had unanimously passed an amendment to the health

laws for the country, which added professional midwifery to the official guidelines[10]. Such support, she noted, would not be offered if it weren't for her consistent engagement with officials. She urged them to foster relationships with government personnel at whatever level they could, saying that such relationships help the profession as a whole as well as the career possibilities for them as individuals. "In fact," she said thoughtfully, "I am going to start inviting a few students to come with me every time I meet with government officials so that you can begin to network with them."

For Suzanne, then, the appropriate model of midwifery training in Mexico would be one which: was developed and tested by CASA, was run eventually by the state, trained young women with educational levels commensurate to their communities, focused on competencies for quality care, and prepared graduates to work within the existing healthcare system, especially with the rural poor. Models that deviated from these goals were not only not appropriate for the current needs of Mexico's health care system, but also just wouldn't work, she argued. Talking with her about the other schools trying to forge a path for a different vision of midwifery education in Mexico made her frustrated. "They just don't want to put in the hard work, do the paperwork. They don't want to do things *right,* "she argued. For her, CASA's model was the right model, the appropriate model, and its curriculum should set the standards for midwifery education nationwide. At stake was not only the improvement of women's healthcare in marginalized areas, but also the opportunity to gain meaningful employment for young women who otherwise might not have access to higher education. CASA's vision thus linked its approach to midwifery training to broader social justice goals. Other schools, however, did not share the same core goals for their graduates.

[10] See, for example, Noticias 2011.

***Nueve Lunas*: Preserving Ancestral Knowledge**

"Midwifery is supposed to be a varied profession, that is why it works," said Catrina, cofounder of *Nueve Lunas* (Nine Moons) midwifery school, located just outside of Oaxaca City, Oaxaca. We were standing outside of the classroom facilities while the students participated in a workshop with a traditional midwife from Cuernavaca. The sun was hot on our shoulders, the adobe walls of the classroom warm against the bright blue sky. Catrina and her business partner, Amanda, were telling me about how they thought the future of midwifery education should look for Mexico. Amanda was from Mexico City, and had become a midwife after training with Catrina, herself trained as a nurse midwife in her native Italy. The two were both highly educated, intelligent, and passionate about midwifery; like Suzanne, they were able to harness international interest because of their own cosmopolitan histories, yet they were also both quick to identify themselves as allies of local women. I had met them both years before, when we all got together to study women's health in small, borrowed spaces in downtown Oaxaca City, back before I went to graduate school and before they opened *Nueve Lunas*, back when we were all trying to figure out how to think about midwifery in Mexico. "Someone told me once that the very problem with midwifery in Mexico today is that it is not a well-defined field," Catrina said. "But I say… that is exactly where our strength lies." Her words were emphatic, but her tone was sad and tired.

Amanda looked at me for a moment before asking, carefully, "You have been working with CASA as well. Do *you* think that their education model will become the only model for Mexico?" I understood that this was a loaded question; on the one hand, it

was a test of my trust and comprehension of the complexities of these competing visions for midwifery education, while on the other hand they really wanted to know what I perceived from my time with different organizations. “I don’t know,” I answered honestly. “I don’t think it makes sense to view this as CASA against all the other midwives in Mexico, just because they have the most established school right now.”

But for Catrina and Amanda, it *did* seem to be about CASA versus the rest of them, a dichotomous relationship that they also expressed in terms of homogenization of midwifery versus variability – or standardization versus multiplicity. For them, CASA’s explicit model of a standardized education program aligned with the state healthcare system went against the tenants of midwifery itself. The first goal of their school was to facilitate the training of women who would carry on the local traditions and practices of the midwives in their own villages. This necessarily implied, then, that even within the school, students would be learning different things depending on the knowledges of the midwives with whom they apprenticed. They came together for one week a month to do workshops and share experiences in Oaxaca City, but the rest of the time they were on their own, apprenticing with traditional midwives. The second goal was to preserve the knowledge and practices of traditional midwives. This was emphasized both through the structure of the apprenticeship model as well as through the teachings provided by visiting traditional midwives who came to the weekly classes to share their knowledge. These teachings were balanced by biomedical trainings that introduced students to tools and concepts they might need to know in order to be flexible practitioners.

For Catrina and Amanda, the kind of midwifery education model that Mexico needed was one that allowed its graduates to be the most flexible. This flexibility would

entail the ability to practice according to the customs and needs of their individual communities, but also to draw on accumulated internationally sanctioned knowledge and practices; in this vision, the two founders mirrored their own backgrounds as internationally savvy but locally focused practitioners. This model thus had students learn primarily from traditional midwives who already had community knowledge; the *Nueve Lunas* program served as a way to add to that knowledge and also to create networks between students. In addition, Catrina noted that it made sense for the students to be accountable to a basic set of skills that all midwives should know, and that *Nueve Lunas* could help them learn these skills. But her concern was that, as CASA made strides with government recognition of professional midwives through official channels, less institutionalized forms of learning would soon become unacceptable to the state. "I worry that if CASA begins to open new schools across Mexico, they will become the only legal form of midwifery education in Mexico," Catrina told me. "For now, midwives still occupy a space outside of legality, for the most part. But anytime one group gets defined as the legal form, others eventually become illegal, by default."

Aside from questions about legality and regulation, Catrina argued that models like CASA just don't work for Mexico and its maternal health care needs. "At CASA, they take students out of their home communities for three years! Studies have shown that if you do that, they won't go back to their communities," she argued. She went on to assert, as if quoting from such studies, that "only one in ten will return to her community," explaining that "three years away makes them too distant from their community, which is why we structured *this* program the way that we did." At *Nueve Lunas*, the students only come to the city for one week a month, and thus maintain

constant ties back home. Amanda jumped in to say that "midwives have always been leaders in their communities, so we want to maintain and support that idea."

"Come," said Catrina, "let's sit down." We climbed the steps back up to the doorway to the classroom and Amanda went inside to get some work done. Inside, the students were practicing techniques that the visiting midwife had taught them, involving the long woven shawls, called *rebozos,* which seem to figure into many traditional midwifery skills. We sat on the top steps, looking back over our shoulders at the students for a few moments. They come from all over – not only from the rural villages, but some are international, some are from nearby cities. They all share enthusiasm at what they are learning, and sounds of laughter and excitement can be heard from across the long classroom as they take turns pretending to be the pregnant woman and the midwife. We turned eventually, sitting beside each other but staring out towards the mountains that surround this valley. Catrina looked tired to me, and worried, when we talked about the future of midwifery in Mexico.

The class inside got louder as the students broke for lunch, and we stood up to join them. "This is really hard," I said to Catrina, looking at the students but referring to her larger project of inserting the goals of *Nueve Lunas* into the goals of midwifery training nationwide. She understood me, and sighed. "Yes," she said, "it is. But we cannot just focus on the idea that we have to solve it all today. We have to focus on the bigger picture." For Catrina and *Nueve Lunas*, this bigger picture is that midwifery should remain a profession of multiple possibilities for entrance and for practice, with as many kinds of midwives as there are kinds of women to become them. For them, this approach to midwifery education was the only one that made sense, the only one that was

appropriate, for Mexico today. It emphasized the value of women's knowledge, of local knowledge, and the heterogeneity of women's needs across Mexico. It eschewed the idea that ties to the healthcare system and formal state recognition were necessary to effectively train students.

And yet the students had other ideas about what would be appropriate for themselves as practitioners – and these ideas mostly had to do with their desire for some kind of certification, which would allow them to find jobs, get paid well, and be respected. *Nueve Lunas* does give graduates a *título,* which basically shows that they completed the curriculum, community service, and their thesis project. Catrina and Amanda told me that the *título* was not the point of the program, but that all the students wanted one. "All of the graduates have it blown up and framed over their desks very proudly," they told me. Later, at a visit to one of the graduate's homes, I indeed noticed her framed *título* immediately upon entering. I asked her about it and she laughed, saying that it was pretty but that it didn't mean anything, legally. What students wanted, more than this *título,* was the unattainable *cédula profesional* that CASA had secured for its graduates – a license which would both legitimize them as practitioners and secure them possible employment. Catrina and Amanda understood why the students wanted this document, but were conflicted about trying to get the school approved on that level. That was not what Nueve Lunas was meant to be about! Furthermore, the route to getting *cédulas* for their graduates was complicated, unclear, and long.

While I was there, the school was considering offering a slightly different kind of health educator license, which would at least give the students some level of authority within the health care system. Even that was proving extremely complicated to achieve,

however. “The secretary of education has to have their medical board approve it,” explained Catrina, “and we need to fill out about 300 detailed pages about why we do every single thing the way we do it here.” That still appeared less complicated than trying for the kind of *cédula profesional* that CASA offered, which required a certain amount of certified clinical experience for its recipients. CASA was able to achieve that experience by having students rotate within the CASA maternity hospital as well as in the obstetrics unit at the general public hospital, but *Nueve Lunas* did not have such access. Their whole model was designed around the idea that students would observe with their community traditional midwives, who would not count in the eyes of the system as far as clinical experience for a *cédula.* “We have no desire to make our students get their clinical experiences in hospitals,” Catrina said, scoffing at the idea. “Because, I mean, what are they going to learn there? Is *that* midwifery?”

For the founders of *Nueve Lunas*, midwifery was necessarily multiple in its definitions, yet these multiplicities had limits. That is, as Catrina alluded, midwifery was *not* to be found in hospitals. The way to teach midwifery in Mexico, then, was to maintain the distinction between it and the biomedical practices that resided in hospitals. To maintain midwifery as a practice that was linked to communities, homes, women and women’s knowledge. This vision necessitated a foundational respect for the knowledge and practices of traditional midwives, who all of my informants agreed were quickly dying out nationwide. An appropriate response to this phenomenon, according to Catrina and Amanda, then, was to train women who had intimate ties to these midwives in a way that ensured their ability to continue on the legacies of community-based midwifery care.

***Mujeres Aliadas*: Filling A Gap In Gynecological Care**

Like CASA, *Mujeres Aliadas* (Allied Women) – located just outside of Pátzcuaro, Michoacán – aimed to produce "professional midwives." Diana is a certified nurse midwife from Chicago whose work with patients originating from Michoacán ultimately inspired her to move there with her husband, Brian, an epidemiologist, where the two co-founded the midwifery school in February 2011[11]. They had begun work in the area some years before, during which time they assessed the needs of the communities surrounding the lake of Pátzcuaro, a region where many indigenous Purépecha people live. They knew from the start that they wanted to open some form of midwifery training center. By the time I visited *Mujeres Aliadas*, they had been in operation for a year and had tailored their vision for the school's goals and future in response to early experiences: it was now more clearly aimed at training rural nurses to become midwives who could work in local clinics or in stand-alone birth centers.

Getting to Pátzcuaro by bus entailed a stunning ride through a region of Mexico that people often told me was of the nation's most beautiful – although when I first went in February 2011, many also warned me that it had become of the most dangerous as well. Stories of hijacked cars and roadside theft were common there, although my own trip was smooth and easy. I arrived in the town of Pátzcuaro in the early afternoon during a torrential downpour, and stood huddling under a small shelter until Brian picked me up. "Look for the South Dakota license plates," he had told me when we arranged this meeting by email. Later he explained that a lot of ex-pats used South Dakota plates,

[11] That all three of the schools I studied had foreigners as their founders points to the bigger ways that midwifery has become a global project, drawing on international norms and on local traditions. As highly educated foreigners, these women had different kinds of access to politicians and could situate their schools' goals within broader global trends.

which you could order online without having to go back to the United States. Brian took me to their home, a lovely adobe-style house with a view of the town and the surrounding hills. Diana greeted us and sat me down with a cup of tea to talk before heading over to the school site, located across Lake Pátzcuaro in the small and lovely town of Erongarícuaro (where, Diana told me later, Frida Kalo and her counter-culture comrades used to hang out back in the day).

Before I could begin to ask my own questions about the school, Diana and Brian both began asking me questions about midwifery in other parts of Mexico. As in my conversations with the administrators at *Nueve Lunas,* I was being seen as someone who might be able to provide a bird's eye perspective on the complicated workings of Mexican midwifery today. I knew that *Mujeres Aliadas* had connections with some of the other schools, but they were eager for my perspective on how things were going in general, for midwifery, and specifically in the other schools that I had been working with. Diana, like the women at *Nueve Lunas* in Oaxaca, was looking for the right path to make her school viable. While CASA had years on these newer schools, and had already forged some of the pathways toward legitimacy, it was always unclear whether CASA's path could be repeated, or whether it would be possible to carve a slightly different path. Diana's vision was similar to Suzanne's in some ways, yet her motivation for and pedagogical design around *Mujeres Aliadas* midwifery school came from a very different place.

"Our main focus here is on gynecology," Diana told me emphatically that first afternoon in her home. I wasn't expecting this, as gynecological training was not very strong at CASA. CASA students were taught to identify and treat basic gynecological

issues, but as a focus of study it was secondary to the issues around primary care in pregnancy and birth. For Diana, this was a huge mistake. “The lack of focus on gynecological issues in other training programs is a big problem,” she argued. For her, midwifery was about caring for women’s health throughout her life, not just during pregnancy and childbirth, and gynecological issues such as bacterial vaginal infections and sexually transmitted diseases were within the scope of practice of midwives. Furthermore, Diana had witnessed the rampant undiagnosed or misdiagnosis of such diseases and infections in this region. “That has been the single biggest health problem that we have encountered in the communities where we work,” she told me. *Mujeres Aliadas* was created in the hopes of offering a new kind of practitioner who could work in the communities and in the clinics, but who could bring renewed attention to gynecological issues faced by many women there. Diana saw the lack of standardized training in gynecological diagnosis and treatment as a huge failing of the existing midwifery training programs.

In order to have access to clinical positions for graduating students – an issue that CASA has solved by securing the *cédula profesionales* for its graduates – *Mujeres Aliadas* has become a school for nurses. That is, all of the students there are already nurses, and thus already have access to work within clinics. Diana’s hope is that they will continue to have such access once they are trained as midwives as well, although the organization is working hard to also secure their own *cédulas* for the graduates. While this arrangement of training nurses may facilitate their acceptance within established medical settings, Diana admits that they hadn’t actually started out with that plan in mind. In fact, their original class had many students in it who were not nurses, but still wanted

to be midwives. Ultimately, Diana realized that those who had not already studied nursing simply couldn't keep up with the materials, and they all had to leave the program.

A class made up completely of trained nurses fit well into Diana's vision for a midwifery practice which took gynecological problems as seriously as pregnancy and birth; nurses already had an understanding of gynecological diseases as well as of procedures for testing and treating these diseases. It was much easier to work with students who already had these skills, Diana told me. She noted that two of her primary staff midwives – who had been, interestingly, hired after they finished their degrees at CASA – proved competent in labor care but had very little understanding of gynecological issues. She argued that if her students already had a background in nursing, they would be able to manage women's health concerns throughout her life cycle. This approach made sense to Diana in large part, I realized, because of her own training and background as a certified nurse midwife from the U.S. While Suzanne at CASA brought with her a background in public health and social work and ultimately focused on broader issues of social justice, Diana brought her nurse midwifery training to her focus on comprehensive patient care.

But Diana's training did not prepare her for all of the kinds of knowledge she and her students would need to have in order to provide such comprehensive care. While I visited her, she was in the midst of trying to learn, along with her students, how to do their own lab tests for patients. This was for Diana another important element of gynecological care – being able to offer reliable, standardized lab results and thus to treat women with the correct intervention. The topic of lab tests and their current lack of

standardization came up on evening as we headed to dinner to talk more about *Mujeres Aliadas*.

As we were driving towards downtown Pátzcuaro, Diana suddenly stopped the car and rolled down her window, motioning to a passing woman to come closer. The woman clearly knew Diana, and smiled as she approached. "Have you gotten your results yet?" Diana asked her. "Not yet – on Wednesday!" the woman said. They said goodbye and we drive off. Because Diana regularly assisted her students in their midwifery clinic outside of town, I assumed that the woman was a regular patient of hers and didn't think much of the exchange.

However, as soon as we had driven a few blocks, Diana began to tell the woman's story, explaining her urgency in wanting to know about her lab results. The woman had come to their clinic and told Diana that she belonged to IMSS *Oportunidades* (see Chapter One for an explanation of *Oportunidades*, Mexico's conditional cash transfer program), and that five years ago she had gotten her pap test done as part of her required yearly *Oportunidades* checkup. Pap tests were just one of the medical routines necessary to receive the cash benefits of the *Oportunidades* program. The test she did then took weeks to be evaluated; she did not get the results of it back until she was already 20 weeks pregnant. When she was finally given the results, they said that she had stage three cervical cancer and sent her to a specialist. The specialist told her that the only choice was to abort the fetus and do a hysterectomy. The woman left the office, chose not to comply with the recommendations, and had her baby. That was five years ago, and she had not been back for another pap test since.

When the woman arrived at *Mujeres Aliadas'* clinic and told Diana her story, Diana immediately sent her pap into a private local lab in order to get the results faster (the state labs are infamous for taking months to return results). The results came back saying that the patient only had vaginitis, a common and non-serious vaginal infection. Diana commented that she had actually never seen a patient's pap result in this area *not* show up positive for vaginitis; it is that common and untreated. Diana's relief was short-lived, however; because of the woman's history, Diana decided to advise her to re-test in 3 months. Again, her test came back from the private lab saying that she had nothing serious. Soon after, however, the woman returned to her *Oportunidades* clinic to get another pap done there, in order to receive her next conditional cash transfer. This pap came back notifying her that she indeed had stage three cervical cancer.

Diana was devastated that her own private lab had given such different, and so conclusively benign, results for her patient. She confronted the lab personnel, who argued that they had the best equipment and most up to date training, and who argued that they could not have made a mistake. The patient was, by this point, obviously upset and confused about the differing diagnosis. She was sent by *Oportunidades* to get a biopsy, the results of which were what Diana was asking her about that day on the street.

Shaken by this experience, Diana decided to conduct an experiment of her own. She had her midwifery students collect two identical samples from a patient during a gynecological exam. They sent the samples to two different labs that they had used in the past. One test was sent back saying that the woman had five different infections; the other came back saying that the woman had zero. Diana's solution has been, so far, to try to teach her students to read lab tests themselves on a microscope in their clinic. "The only

thing I don't know how to teach them is to test for chlamydia," she said, "but I know we can learn." For Diana, being able to teach her students to read their own lab tests had thus become imperative, as she could no longer trust the expertise of the established laboratories.

At *Mujeres Aliadas*, being able to do one's own lab testing was a way to improve upon the biomedical system, empower practitioners, and offer higher quality of care to patients. It also seemed possible only because of Diana's training as a nurse practitioner. CASA's students were directed from the start to rely on specialists to do things like read lab tests, as they were trained from the start to work within the existing healthcare system and as the scope of their own training was not wide enough to encompass laboratory skills. *Nueve Lunas'* students would send their patients out for external lab testing if deemed necessary. For Diana, it was not enough to rely on an uncertain existing infrastructure of biomedicine – her students must be able to act autonomously and rely on themselves and each other to offer the best possible care. This emphasis on self-reliant midwives that could diagnose and treat women for a large range of gynecological and reproductive health issues formed the backbone of *Mujeres Aliadas*' mission. For Diana, midwives needed to care for women throughout their lives, not just in the moment of reproduction. This broader emphasis, however, was not what was motivating the larger political reevaluation of midwives; maternal mortality was still a concept concerned primarily with preventing maternal death in the moment of reproduction, not improving women's health overall.

Conclusion

What model of midwifery education is most suited to Mexico's current needs? As I have illustrated in this chapter, answers to this question vary according to the goals and priorities of the one doing the answering. Davis-Floyd et al.'s 2009 *Birth Models that Work* examined various types of midwifery training across the world, and concluded that, "[f]irst and foremost, models that work do not cause unnecessary harm to mothers and babies" (2009:16). More specifically, such models are woman-centered, midwifery-based, with continuity of care and cultural sensitivity. Technically, they are flexible and include cost-effective mixtures of kinds of skills and technologies, as well as physician back-up for emergencies. The list provided by the authors suggests two general trends in working childbirth models in developing countries: first, that the care provider is sensitive and emotionally attuned to the woman and her community, and second, that the care provider is well trained, able to draw from multiple resources, and well connected to additional sources of expertise (Davis-Floyd et al. 2009). For them, CASA is featured as a prime example of a model that "works."

Each of the three schools discussed here could be seen as fulfilling the above definition of a model that works. Yet what such definitions leave out are the political priorities that fuel decisions over which models ultimately gain legitimacy on a national level. The state's intervention into midwifery education – after decades of allowing midwifery schools to be NGO-run – has set in motion an inevitable reshuffling of authority and access.

I have argued here that the state's involvement in the formalization and standardization of midwifery education in Mexico is both productive and restrictive. It is productive in that it has allowed for CASA's midwives to gain official legitimacy and to

reintroduce midwifery into the healthcare system. Further, as I show in the following chapter, in making room for CASA midwives to fill one kind of role in the system, it allows these midwives the autonomy to bring their own intentions into their practices. On the other hand, the state's involvement is restrictive in that it devalues those educational methods and long term goals for midwifery that do not fall within the narrow parameters CASA has met. There is real concern amid the midwifery community that some ways of learning, as well as some goals of midwifery, are at risk. In particular, I argue that what is at stake are particular valuations of women's bodies and women's knowledge that do not fit into the state's plans and goals: gynecological concerns and traditional Mexican healing techniques are not as easily aligned with goals that emphasize maternal mortality reduction as the main indicator of development in the field of women's health.

CHAPTER 3

Becoming Mexico's Modern Midwife

"Here at CASA, our philosophy is to start treating patients first with the basics: hygiene and diet. If there are problems, we will use traditional things like herbs or homeopathy. Only if none of that works… then we will use allopathic medicines. But always, only, as a last resort*"* – Julieta, professional midwife and CASA[12] graduate.

Julieta's explanation of the choices she makes as a professional midwife trained at and working in CASA's midwifery clinic reveal her underlying logic about the roles of biomedical and alternative medicine. For her, the two exist as distinct models held in a hierarchical relationship, in which alternative methods are privileged above biomedical. Julieta's assessment of these models is not unique, but rather is shared by most of the professional midwives and their students with whom I spoke at CASA. Indeed, I learned quickly that the harshest insult one professional midwife or student could give to another was to call her a "*mini-medica*" – mini-doctor. In contrast, students and practitioners who displayed knowledge of traditional midwifery or other alternative methods were viewed with awe and respect. How did this happen in a school that is so focused on biomedical training in its classrooms (where classes are primarily taught by physicians), where students get the bulk of their clinical education in the public hospital (because CASA itself has such a low patient load), and where graduates are being slated to fill positions in government run, biomedically-driven health centers? What are the implications for the Mexican healthcare system?

[12] The *Centro para los Adolescentes de San Miguel de Allende* (CASA) is Mexico's first government-recognized training program for professional midwives, and is located in San Miguel de Allende, Guanajuato. It's history and educational model are discussed more thoroughly in Chapters One and Two.

In this chapter I look closely at Julieta's experiences as a student and young practitioner in order to understand the factors that lead her and her peers to develop critical views of biomedicine, even as they negotiate for new territories of practice *within* biomedical realms. Building on the previous chapter's assessment of the state's support of CASA as a program that explicitly aims to prepare students for biomedical roles within state clinics, I show how such development projects may have unintended consequences. I ask, more generally, how students like Julieta experience the multiple and conflicting local, national and international framings of what midwives should know, how they should learn, and how they should practice. In the previous chapter I outlined some of these competing framings and showed how they have emerged from particular organizations due to those organizations' views of what Mexico needs its midwives to know. Here, I look here at how an individual midwife navigates seemingly at-odds definitions of midwifery knowledge and practice, ultimately making the profession her own. In showing how she got there, I contribute to broader conversations in anthropology about the ways in which medical knowledges are created, learned and practiced, especially outside of the global North. Further, I question the ease with which notions of idealized integrated healthcare and professional flexibility get imagined as solutions to health disparities in developing contexts.

This chapter has two main arguments. First, I argue that there are two distinct and competing definitions for what counts as a "good midwife" in Mexico today. On the one hand, the development model defines a good midwife as one who is inexpensive to train and who can extend the biomedical reach into areas where doctors cannot or will not go. It makes sense, then, that CASA's educational model has been prioritized by the state (as

I discussed in the previous chapter). However, midwives themselves define the good midwife as one who is actively changing the way that biomedicine is being practiced; the good midwife improves not only women's health outcomes, but – and perhaps more importantly – the *quality* of women's healthcare. As midwives like Julieta are pulled into the state's plans and sent into biomedical settings to do the work that doctors are not doing, they quickly come to critique the way that biomedicine is being practiced in rural Mexico, and to critique the system that has let rural healthcare come to this in the first place. They realize that they are being promoted because the biomedical system has failed: it has pushed traditional midwives out of practice yet has not filled in the gaps in care left in their absence, and indicators such as high maternal mortality, they argue, reflect this. Where biomedicine is present, midwives like Julieta see its lack of ability to fully address women's concerns, and at times see biomedical practitioners as explicitly violent towards female patients. The midwives' own goal emerges as they gain authority in their newfound autonomy: to bring midwifery care – and with it, alternative and traditional medicine – into the biomedical system.

My second argument here is that midwives prioritize alternative medical practices for two deliberate reasons; the first reason has to do with what alternative medicine represents, politically and socially, and the second has to do with how alternative medicine works. For the midwives in this study, alternative medicines – from "traditional" Mexican techniques and herbs to homeopathy to aromatherapy – represent nonconformity with a hegemonic biomedical system. This system historically marginalized midwives and mistreated women's bodies. Resisting that system by resisting its medicines and methods is a political act that the midwives carry out in their

daily practice. Further, the use of alternative medicines represents a connection to ancestral knowledge that is deeply rooted in notions of nationhood. The use of the *rebozo* (traditionally worn woven shawl) to turn a baby, or the use of local herbal medicine, for example, were evoked as examples of ways that midwives could stay connected to their ancestral knowledge and preserve the unique Mexican approach to health. Even as the midwives would employ alternatives that have little to do with Mexican origins – such as homeopathy, which is originally German – they did so under the broader heading of using "traditional" methods. Thus, while I use the term "alternative" to describe practices that fall outside of biomedicine, my informants nearly always used the term "traditional," whether or not the practice or medicine had direct links to national traditions.

And yet the choice to prioritize alternative methods is not always overtly political; midwives also prioritize them because of how they work. Alternative methods are often more tangible and – somewhat paradoxically, at times – less mysterious than biomedical methods. By this, I mean that the explanations behind why particular herbs or homeopathic medicines should work may be more straightforward than the complex explanations behind allopathic medicines. Turning babies using one's hands or a *rebozo* is something that is immediately assessed. Even as midwifery students learn how to employ biomedical practices and tools in their coursework and clinical rotations, the methods and medicines they learn about do not always result in positive outcomes for patients, thus reinforcing the notion that alternative methods are safer and possibly more effective.

Through Julieta's story, I show how various elements of midwifery training in Mexico today contribute to the incommensurability midwives feel with the biomedical

system there. Much work in anthropology has illustrated the ways in which forms of medical training shapes and homogenizes the world views of its students and, eventually, creates ways for practitioners to approach issues related to health and healing (Davis-Floyd 1987; Good and Del Vecchio Good 1993; Mol 2002; Simonds et al. 2006). This understanding builds on broader discussions about the need to unpack assumptions about biomedicine, and to instead consider it within the specific contexts where it is learned and practiced (Taussig 1980). For some scholars, this notion of location refers to the kind of institution where medical knowledge is taught; for example, Simonds et al. illustrate how, when birth is learned in a hospital setting, some students never get the chance to learn how long the placenta normally takes to emerge because they are mandated to extract in manually after a certain time frame (2006). Thus, they argue, the setting in which students learn about bodies and health shapes how students come to understand normal bodies and bodily processes; we must be aware, Simonds et al. argue, that "[d]ifferent bodies of knowledge are produced in different settings" (2006:xx).

Yet other scholars have clarified that we must look beyond distinctions in settings for medical training that occur in the West. Claire Wendland (2010) has suggested that biomedical training outside of the West, as in the African medical school where she conducted research, is irrevocably distinct from biomedical training in the West – however similar the textbooks may be. The specific maladies faced in developing county contexts - which impact medical students and their patients alike - as well as a lack of resources - which make it inherently difficult to conduct certain biomedical procedures - make the African medical school experience different, Wendland argues. Like Wendland, I am interested in the experiences of students learning about biomedicine within a

broader context where development strategies structure educational goals, and where traditional and alternative medicines hold a place of respect for both practitioners and patients alike. Here, though, I consider how failures in biomedicine both large and small (from stubbornly high maternal mortality ratios to ineffectual public health campaigns to technical difficulties), alongside the tangible successes of alternative medicines, interact dynamically to shape how Mexican midwives come to understand their professional roles today. Thus while many scholars have argued that authoritative knowledge in science and medicine originates from the global North, professional midwives are reshuffling hierarchies of authority to reflect their situated experiences with biomedicine and its alternatives.

Ni pies ni cabeza **- Neither feet nor a head**

"This baby has *ni pies ni cabeza* (neither feet nor a head)," exclaims Alejandra, a professional midwife at working and teaching at casa, as her hands gently palpate the patient's expansively pregnant belly. She then turns to glance over her shoulder, remembering that she has two first year midwifery students observing her. Seeing their confused expressions, she holds her hands up in a pose of surrender and quickly adds, "Joke! Joke! You wouldn't really believe that it didn't have feet or a head, right?" The students give forced chuckles, and Alejandra turns back to her patient. She explains that she cannot feel the baby's position clearly because the uterus keeps contracting into a hard ball (in a series of pre-labor contractions called Braxton Hicks), and making it difficult for her to feel anything. She suggests that they head over to the ultrasound room

to get a clearer picture of the position, seeing as the woman is due any day now and she wants to know if the head is in the optimal position for labor.

We all march down the hall to the ultrasound room; along the way, Alejandra quizzes the students on signs of impending labor. When we get to the small exam room, the technician squirts some gel from a repurposed yellow plastic mustard container onto the patient's abdomen and we watch as the baby comes into view on the small, black and white screen. It becomes clear quickly that the baby is sideways, rather than upside down. Its neck also arches strangely backward, which makes the students laugh a little as they try to contort their own necks to mimic this odd position. "Your baby is doing fine, except for this strange position. And it's a girl!" the technician tells the patient with a grin. At this the patient pushes herself up to peer closer at the smudgy image on the screen, saying, "What? My doctor told me it is a boy!" to which the technician backtracks quickly, mumbling something about how she might be wrong, that she may have mistook the anus for the vagina. The woman looks a bit unsettled by this confusing information, but Alejandra jumps in to discuss the issue of the position[13].

"We have to try to get this baby head down before you go into labor," she says. "Do you think your mother knows anyone in your *rancho* (rural community) that can do a *sobada?"* Alejandra asks. The *sobada* is a technique used by traditional midwives to turn babies in utero by massaging the pregnant woman's abdomen and gently pushing the baby into position. The patient shakes her head, and Alejandra begins to lament that the only traditional midwife on staff at CASA is home sick today, when a student suggests that they ask Julieta, another staff midwife. Julieta is not a traditional midwife; indeed, she was one of CASA's first graduating professional midwives and is back working at the

[13] A week later the woman gives birth to a healthy baby boy at CASA, with Alejandra as her midwife.

clinic and teaching the students. However, the students had heard that she knew about *sobadas*, and so we all make our way to Julieta's consult room. Julieta, a 34-year-old woman of short stature with long, dyed-blond hair and a grin that takes up half her face, greets us and listens as Alejandra describes the situation; she would be happy, she says, to do a *sobada*. The patient smiles at her, shyly, and Julieta searches the room for an acceptable place to conduct the procedure.

During Alejandra's initial assessment of the patient during this consult, her inability to feel the baby's position with her hands led her to suggest the ultrasound. During the many consults I observed at CASA, having the patient do an ultrasound just to determine the position was rare; indeed, the midwives were usually quite confident about their ability to feel the baby with their hands. They would grasp the baby's head and gently wiggle it, noting whether it was engaged in the pelvis yet (a sign that labor may be immanent). Alejandra's decision to use the ultrasound was not based on an inability to feel for baby positioning in utero, but because the contractions were making the woman's uterus tight and Alejandra did not want to hurt her by pushing around in there. The ultrasound was, then, a backup plan – not a necessary first step – used here to ensure the patient's comfort. The students, who followed Alejandra throughout this process, noted such informal protocols; when it came time for them to see their own patients, these experiences would influence their own decisions about when to use ultrasound technology.

Once the ultrasound technician brought the baby onto the screen – and confirmed its transverse alignment in the uterus – the students witnessed the conflicting potentials of the technology. On the one hand, the ultrasound was able to quickly illustrate the

transverse position of the baby – a helpful tool that was being used as part of Alejandra's assessment of the patient. On the other hand, the biomedical authority attached to the machine and its technician was put into question when the technician misread the sex of the baby. For the students, this slippage in the authority of a complicated and hard to understand technology was one example of the ways biomedicine becomes seen as the last resort. Students learn that biomedical, technological knowledge is not infallible, and come to the consensus that you cannot depend on it alone. The failure of Alejandra to ascertain the baby's position resulted from her desire not to hurt the patient; the failure of the ultrasound technician resulted from the technology and her reading of it.

Such moments remind us that biomedical technologies are not infallible and impersonal; rather, their use and interpretation depends on the people and institutions that have access to them. As Margaret Lock and Vinh-Kim Nguyen argue, we must pay attention to the ways that "the promise of and the actual effects of biomedical technologies are embedded in the social relations and moral landscapes in which they are applied" (2010:5). By looking closely at the ways CASA's midwifery students learn to approach technology, I answer Lock and Nguyen's call for ethnography that shows how "the views of local actors provide insights into the ways in which the global dissemination of biomedicine and its specific local forms transform not only human bodies, but also people's hopes and aspirations in ways that may well have broader repercussions for society at large" (2010:6). As these student midwives go into the world as practitioners, their understanding and use of biomedical technologies could have significant impacts on the kind of prenatal care women receive.

Back in Julieta's consult room we all find a space to stand. The softest thing in the room is a narrow pink cushion taken from a chiropractor's bench that isn't being used right now. "This will have to do," Julieta says as she arranges it on the floor. Julieta gently helps her pregnant patient lay down on it, making sure that her hips and back are on the cushion and letting her legs relax onto the ground. The midwife lowers herself to one knee, her long braid swings over one shoulder as she leans towards the woman. One hand resting on the patient's belly, she looks up and asks the two students who are eagerly awaiting this – their first – *sobada* if they can fetch her some oil. "What kind of oil?" the students ask, to which Julieta replies casually that, "anything will do – as long as it is not the kind that could induce contractions. So… not *sábila* (aloe), and not *menta* (mint). Better something like *manzanilla* (chamomile). Also, bring hot and cold compresses."

While they wait for the students to return, Julieta gives the patient a capful of homeopathic pills, which they call *chochos,* to dissolve under her tongue. She explains to the patient that the ultrasound had shown that her baby was transverse, instead of head down, and that with so little time until her due date they needed to get the baby positioned correctly. When the students return with a selection of small dropper bottles full of oils, Julieta drips them onto the woman's basketball-size belly. I notice that the skin is so taught that it has slightly bruised in some places. With gentle but confident movements, Julieta begins her massage, starting with broad circular sweeps of her hands around the baby. "The oil makes it easier to massage her," she explains, "and makes it so I don't hurt her skin." The students lean in, hardly blinking. This is not a technique taught

in their regular classes, nor is it one they will get many chances to observe during their clinical rotations; the art of the prenatal *sobada* is being lost, they tell me.

Julieta asks next for her *pinal* (a low-tech instrument to listen to the baby's heart rate which takes years of practice for students to be able to use correctly) to make sure that the massage is not distressing the baby. Instead of the *pinal*, Alejandra hands her an electronic handheld Doppler, which makes the heart rate is audible to all of us from a tiny microphone. The baby sounds fine, she says, and so Julieta continues her massage more rigorously now; she alternates a rocking motion of the entire belly with a pushing, swirling motion of her hands around the baby, encouraging it to shift its position. This goes on for many minutes, as the woman gradually relaxes and the belly begins to visibly change in shape as the baby's position changes. It looks like a giant fish, rolling in her belly, I think to myself. The woman must feel something as it rolls and stretches, as her eyes widen and she smiles up at Julieta.

When Julieta slows her massage, a student returns with hot and cold compresses, which get pressed onto the woman's abdomen; the cold towards the top and the hot towards the pelvis, "to convince this little baby to keep its head down where it is nice and warm – and not to go up to where it is too cold!" says Julieta. She rocks back onto her heels, stretching out her arms and fingers. Then she picks up the Doppler again to check the heart rate now that the baby has been turned. This step is crucial, she later tells me, because sometimes during these external rotations, the baby may get tangled in its umbilical cord or get otherwise distressed. Guessing where the heart should now be located, Julieta presses one end of the Doppler to the woman's skin, but we hear nothing but a low static. She moves it slowly up and down, side to side, and we all stare,

unblinking. Suddenly, the urgent beating blares out at us, and we all breath out and smile. "The heart rate is slightly increased," Julieta tells the woman, "but that it to be expected. Your baby is now head down!"

Alejandra, who is by now kneeling on the ground next to Julieta, jokes with the patient that she will now have to spend the rest of her pregnancy "holding your belly tightly so that the baby cannot turn back down." Julieta laughs, but then says, seriously, that the woman will "still need to keep taking the homeopathic medicine to make sure the baby stays down." Her coworker agrees, telling the patient that, "homeopathic medicine is magic, really – it is the vital spirit!" The students all nod their head; homeopathic remedies are often discussed at CASA as somewhat magical in their mechanisms for healing anything from a headache to a transverse baby. The students have begun to collect their own small selected homeopathic remedies, bought in small brown glass vials or white plastic bottles. They take classes in homeopathy, and are quick to offer up the appropriate remedies during consults, showing what they have learned.

Getting up carefully, the two midwives help the woman to her feet and lead her to the ultrasound room; they want to get concrete proof for the patient– beyond what Julieta felt with her hands and beyond what we all saw as the belly bulged and shifted – that the baby was indeed head down. The students call out to their classmates to come and see this, and the ultrasound room is soon packed with young faces, eager to witness the outcome of this rarely seen intervention. The ultrasound technician gives a little cheer, prompting all in the room to sigh happily, as she displays on her screen the baby's head in the perfect position. "I am going to buy you a chocolate bar!" Alejandra tells Julieta,

who stands by modestly but cannot help grinning. “And I will buy you another one if that head stays down until birth!”

Julieta explains that her work is not done yet, however, and she leads the (now much larger) group of student onlookers back to her consult room, and repositions the patient on the pink cushion. “Now we need to do a *manteada* to make sure the baby stays down.” The *manteada* is a technique in which the midwife rocks the woman back and forth, suspended under her back by a sheet or a *rebozo* (shawl), in order to gently rock the baby downward and into the correct position. “We know that the head is down, but the neck is still too flexed; this movement will help straighten the neck out,” explains Julieta. The students jostle to get a space to watch as Julieta slips a sheet under the woman’s back and rocks her back and forth for a few minutes. She tells the woman that when she goes home, she should practice crawling on her hands and knees as often as she can, which also helps keep the baby in the right position.

Shaking her head, Alejandra tells Julieta that she “never learned to do *sobadas* or *manteadas,* it takes so much wisdom to know when to do it and when not to! The traditional midwives are the ones who know how to do these things.” Julieta explains to her that her mother always told her that babies should be massaged into the correct position. “Ah, I see,” says her coworker. “You have it in your blood, then. The thing is, I am a midwife out of love, not from ancestry!”

The dramatic unfolding of events during the *sobada* – discovering the transverse position, massaging the baby into place, revealing its position on the ultrasound, and performing the *manteada* - create the sensation of witnessing a performance. This sensation is heightened by the accumulation of students who come to see the process, and

by Alejandra's clear enthusiasm for and deference towards Julieta's abilities. With the "success" proven first by Julieta's assessment of the baby with her hands, and second by the ultrasound image, the *sobada* takes on a miraculous quality. Mei Zhan describes the potential for such moments of "miracles" in traditional medicine to impact authoritative structures. Efficacies from the margins create stories of miracles, which then re-inscribe the power of the traditional knowledge itself (Zhan 2010).

Yet the authority held here by Julieta, and by the traditional midwifery knowledge she displays, must be understood within a particular time and place. As Bridgitte Jordan suggests in her work on midwifery models, "for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both" (1997:56). Jordan alludes to the potential for communities where parallel knowledge systems may exist and be viewed as equals, where practitioners are able to seamlessly move between them depending on their needs. I argue that such seamless mobility is rendered impossible due to the very construction of a practitioner who exists outside of both systems, a position which necessitates the making of moral and practical distinctions between the systems. I agree more with Jordan's assertion that it is most frequently the case that one kind of knowledge becomes seen as the more legitimate type, while other knowledges are seen as backwards, not smart, silly, "troublemakers" (1997:56). Jambai and MacCormack's work similarly argues that there may indeed exist multiple authoritative knowledge systems within any one space or region, but that "In any particular frame of observation the dominant system either better

explains the experienced world to the actors, or is associated with a stronger power base" (1996:271). Further, they note that in practice, people may borrow techniques from various knowledge systems strategically, either formally or informally.

Jordan describes the kind of knowledge that is legitimated for a certain community at a certain historical point as "authoritative knowledge," and stresses that this kind of authority is contingent on time, place and community in which it is utilized (1997). By locating authority in communities of practice (a phrase Jordan takes from Lave and Wenger (1991)), Jordan builds off of Bourdieu's idea that the larger structures assign value to forms of knowledges (Bourdieu and Passeron 1977). For example, Bourdieu and Passeron showed how traditional or folk knowledge gets devalued in a class-structured society through the educational system. Once one kind of authority is socially validated as authoritative, that authority gets naturalized and thus hides the power structures behind it; if the power structure itself is invisible, it cannot be challenged or changed (1977:42). How then can we think about educational systems, like CASA, where –despite a heavy emphasis on biomedical training – students and practitioners grant relative authority to traditional knowledge? In the following section I look more closely at how Julieta – and her peers at CASA – experienced their education in integrated midwifery care.

From Ancestry or From Love? Becoming a Student

When Julieta's co-worker noted that Julieta was a midwife "from ancestry," as opposed to "from love," she was inferring that it was something Julieta had inherited as a profession from her mother or grandmother rather than something she had come to on her

own. This was not really the case, however; despite her position as one of few local midwives who could conduct traditional techniques such as the *sobada* or *manteada,* Julieta was not "born into" the profession. Like many of the students at CASA, she had a distant relative that was a midwife (her great grandmother), but she herself had not been exposed to birth until entering the school. Her mother's insistence that *sobadas* be done in pregnancy came from her own exposure to midwifery through her own pregnancies – not because she herself was a midwife. *Sobadas* were just what was routinely done during pregnancy; especially when cesarean sections were not an option for rural women, and having the baby in the correct position was a preventative measure.

"I was the tenth of twelve children, growing up here in San Miguel de Allende," Julieta told me one afternoon as we sat waiting for patients in her consult room. Most of her siblings were boys, and one by one they headed north to the US to make money. She got through middle school and her parents paid for her to go to high school. This was financially hard on them, she realized later, because her mother stayed home and her father worked construction. "He was really good at his job," she said, tearing up, "even though he didn't have much education himself. So then he was angry when I dropped out of high school and was just living off of them." At that point, her family was running out of money and had to sell their home; they ended up moving to a small house near the CASA school. Soon after the move, her father got sick and could not work anymore. Feeling restless and wanting to help her family, Julieta got a job at the CASA daycare for working mothers. "I was paid only six *pesos* an hour (about fifty cents), but I didn't care; I loved working there and I was slowly able to help my family financially. That is where I first heard about the midwifery program."

A German woman, Karen, had come to volunteer at CASA and met Julieta during that time. Karen had became intrigued with the midwifery program herself, and applied to study there; she became the first non-Latin American student to graduate the program, and continues to practice in the area as a professional midwife. Karen saw Julieta's interest grow when she would tell her about the program, and she encouraged her to apply as well. "My father was very angry," said Julieta, "because he thought I would just drop out again, and besides, they had no money to pay for more education for me. But then CASA gave me a scholarship, and I decided to go for it."

Between the scholarship, a small amount of savings she had accrued, and a nominal amount in fees that her brothers sent her from their earnings in the US each month, Julieta was able to get through the program financially. Leaving was not an option, she said, once she had seen her first birth. "It made me cry with joy, I loved it so much! The attending midwife told me not to cry because I might scare the patient, but I couldn't help it," she said, smiling at the memory.

"After that first birth, I was hooked," she recalls. "But then, just a few days later, I was observing a birth and the baby was born stillbirth. It was the opposite feeling – so horrible, I could not imagine ever being in a birth again. I wanted to leave the program. But then the midwife reminded me that we need to be there for women in all phases of life, in all situations, and so… I stayed." Julieta did well in CASA's program, and was selected to accompany staff midwives and administrators to a global midwifery conference in Africa. The point of the conference was to have a sort of cross-cultural exchange of knowledge and ideas between midwives. For Julieta, who did not speak English or French (the two main languages of the conference), her experience was more

about traveling for the first time than about learning anything related to midwifery. After three years, she was up on stage graduating as a professional midwife. “I couldn’t believe it,” she tells me, “that I was the one up there, graduating!”

An extensive amount of fundraising, networking, and political favor-asking goes into securing scholarships for students like Julieta, who come to CASA with limited or no financial resources of their own. Yet Julieta was an ideal type of CASA student, and indeed an ideal type of student to fit into broader development strategies seeking to insert trained providers into underserved areas in the name of maternal mortality reduction. Upon entering CASA, Julieta fit the profile of the average student there: she had not graduated high school, had a vague knowledge about midwifery because of a distant relative, did not have another career, and had little money. Other students at CASA did enter the program with high school degrees (a very few had college degrees or beyond), some had money from their own jobs or family support, and some had worked more closely with midwives in their families or communities. But what these students all had in common was that, by the end of their education at CASA, they developed a logic of care which saw traditional and alternative medicines as inherently better, safer, and more desirable than biomedicine. Yet this occurs against a backdrop of biomedical classes, rotations in the local public hospital, and certification through government agencies. What happens to students during their three years at CASA and in their subsequent careers that creates this particular approach to reproductive healthcare?

Claire Wendland’s work on medical students in Africa argues against notions that biomedical education is an “eminently portable” (2010:7). At CASA, students are pushed through a rigorous schedule of biomedical coursework, taught primarily by physicians.

One on one, students would often tell me that the courses were easy, or that the teachers were not very good; but at nearly every administrative meeting I attended, I was told that most of the students were not doing well in these classes. Simple study habits that a select few students had learned through attending higher education were baffling to those who had only completed middle school. Perhaps a component of the students' mistrust of, and disdain for, biomedical approaches is that many of them had not fully grasped the material their exasperated physician teachers were trying to teach them. This points to a question that begs further inquiry: who, then, is the correct subject for biomedical education?

Robbie Davis-Floyd suggests that the process of going through biomedical education – specifically obstetric training – can be understood as a rite of passage, made up of ritual events that inevitably create certain kinds of practitioners (1987). Her depiction of the three step rite of passage experienced in obstetric training is useful to think about how CASA students become professional midwives: first, students are separated from all they know; second, they come to inhabit a liminal space in which they belong neither to the lay people they once were nor the professional they will one day become; and, third they finally become the professional. At CASA, in contrast to biomedical obstetric settings, however, professionals are shaped through both interactions with and reactions against biomedical systems.

Julieta's situation was rare in that she was not moving far from home to come to CASA, but for most students their first experiences at CASA were of separation from the familiar. The majority of students come from rural villages around Mexico; arriving in bustling, cosmopolitan San Miguel de Allende and to a loud dormitory full of outspoken

women, thrown into clinical settings where birth and death are daily issues, all weigh on these students initially. Eventually, they come to the liminal space, where they begin to assert their vision for what midwifery should be, and what they want to do as midwives, but they are not yet granted the authority to act. Instead, within this liminality, they are forced to observe at the hospital with doctors, study biomedical textbooks, and search out other ways of knowing from friends, midwives, books and conferences. When they finally graduate and become professional midwives, they express the sensation that they have completed a long journey, that even as they hope to go home to their communities to practice, they return as different people.

Within the period of liminality, students learn to make distinctions between models of care that ultimately serve to render these models static. During this time – corresponding roughly to their second year of the three-year program - students are stymied by their own inability to act autonomously; many students act out, rebel against teachers and administrators, cry, or threaten to leave (and some do leave the program at this point). One student, upon missing nearly a week of lectures and clinical rotations, told me that she just needed a break. “The things I was witnessing in the general hospital were just too heavy, to horrible,” she told me. She needed to reassess what she was doing there before she went back to class. It is during this period of their education that students come to witness and define obstetric violence as a failure of the biomedical system. More broadly, they come to see biomedicine as failing women on many levels – in its lack of compassion, its departure from evidence-based practices, its inability to serve the most marginalized populations. In the face of what they see as failures, many students begin to say that they want to leave the program. One teacher was constantly reminding students,

as they passed through this phase, that they needed to stay present above all for the women, the patients, and that they could practice midwifery however they liked once they graduated. This reminder that they were there for the patients struck a chord with many students, who would tell me that they used this advice like a mantra when stuck between practitioners who, they felt, were not making the right choices. In the next Chapter, I look more closely at the growing midwifery-led movement against the violence that midwives are increasingly confronting through their roles in public obstetric wards.

Professional midwives from CASA are produced in large part through these liminal experiences, in which they rebel against biomedical settings and strive for the seemingly gentler, kinder traditional approaches. Biomedicine becomes its own force, as they struggle to understand its textbooks in class and then struggle against what they see as its violences in clinical practice (see Chapter 4 for a discussion of violence in obstetrics). Traditional and alternative medicines, on the other hand, are only loosely addressed in any formal way at CASA, yet their methods become preferable in contrast to what the students are rebelling against at the hospital in the classrooms. Students ask for and seek out additional coursework on homeopathy, flower essences, aromatherapy, massage, herbology, and traditional Mexican methods such as the *sobada* and the *manteada.* Julieta admitted to me later, however, that her knowledge of the *sobada* and *manteada* were not gained while she was at school, nor during her years working before returning to CASA. Rather, she said "I don't really know how I learned to do it, I just feel the woman and have a lot of patience, give a lot of love, and just listen to my internal voice, which is what guides me."

Ultimately, CASA students learn as much (or more) from the things they are not taught directly in their program. That is, they come to define what professional midwives are and should know and do based on what they do not like about biomedicine as it is practiced in the hospitals where they work. This dissatisfaction, and the alternatives sought in what gets labeled as traditional midwifery, grows out of the community of students. I borrow Lave and Wenger's concept of "legitimate peripheral participation" (LPP) as an analytic view on learning, which focuses on social practice and coparticipation. Through LPP, learners gain increasing access to participatory roles in expert performance (1991:17). This analytic recognizes that learning is not about what happens in the minds of individuals, or in a traditional didactic situation (such as in the classrooms or even the clinical rotations), but rather it is something which happens through social interaction, as between the students or between students and their midwife mentors (most of whom are, themselves, CASA graduates). LPP takes place within what Lave and Wenger call learning curriculums; these curriculums constitute a "field of learning resources in everyday practice viewed from the perspective of learners" (1991:97), and are considered situated within a specific community. The kind of real learning that they see in such situated communities can be inhibited in the environments of what they call teaching curriculums (as in classrooms), which are constructed explicitly for instruction of newcomers instead of gradually granting newcomers increasing participatory roles through experience (1991:97).

In the three years that Julieta studied at CASA, she was part of a community through which she learned how to become a professional midwife. She also, as I argue here, learned to distinguish between biomedical and alternative or traditional knowledges,

and to position the two categories hierarchically. Through her training, she came to create a logic that determined what kinds of knowledges and practices were considered biomedical and what kinds were considered traditional. By her graduation, she came to embody what she saw as the professional midwife; a figure who may not have shared the goals and priorities that the school had originally set out for her, but who represented the shared understandings forged through her community of midwifery students. What, then, happened once Julieta left this community and was on her own?

Big Shoes to Fill: Putting Professional Midwifery into Practice

Like all CASA graduates – and, indeed, like all Mexican health professionals who have just graduated from a certifying program – Julieta had to do a year of social service in order to get her *cédula professional* (professional license). Graduates have little choice in where they will be sent for this year, and the stories that filtered back from alumni about their social service year were mixed: for some, this year was full of growth and learning and newfound authority, while for others it was a shocking submersion into a biomedical system that did not know what to do with a midwife. For Julieta's post, she was sent a day's drive north of San Miguel de Allende to a state-run health clinic that had just finished hosting a previous CASA graduate, and was therefor not unfamiliar with the new professional midwives. "I had never left my family before," recalls Julieta, "and when my brother took me up there I was very scared, and very sad." The plan had been to get there while the other CASA graduate was still there, so that she could show her the ropes; they arrived late, however, and missed each other by hours. Julieta told her brother that he had best just leave her there and not stay with her, "otherwise I said that I might

just try to go home with him if I lost my resolve!" She waited alone for hours until the director could talk with her. "He told me I had some big shoes to fill, that the last CASA student had been amazing and so they expected no less of me. In fact, he told me that they expected more!" While the director's words showed a support for midwifery that comforted Julieta, it also left her feeling the pressure of her new position. She was shown around briefly and given a room to share with a female doctor, but told not to take too long to settle in. The director said there was work to be done.

"I barely had time to put my stuff down and find my way to *toco* (the birthing area), when in walked a woman in labor," Julieta remembers. She had to learn the system of that clinic quickly, with nurses and medical interns shouting at her and throwing scrubs and booties at her (items she would not have worn in the CASA clinic). She awkwardly helped the woman onto the bed – a complicated contraption with cold metal stirrups, she said, that she had never used before – and stood by while the others put up a sterile field. "They kept yelling at me, 'don't touch her! You have to be sterile!' and I felt so awkward, " she says. "I was terrified that that baby would just fall right onto the hard floor, because I had never delivered a woman like that, up on a tall delivery bed!" In the end, the birth was straightforward and everything went smoothly enough. Still, Julieta cried that night, and every night for the next two weeks, from the shock of the new place and the sadness of missing her family.

From there, things improved quickly. "There was so much work to do, sometimes ten births in one day!" Julieta exclaims. At this memory, we both look bleakly around the quiet consult room where we sit talking in CASA's clinic. Unlike the busy health center where she had done her year of service, CASA is a private clinic, and has been steadily

losing patients to the free state hospital up the road. Julieta misses the busy pace she had gotten used to during that year. “I basically lived in that clinic,” she says. “I would try to leave sometimes, but if a woman came in, in labor, I would come right back. I never wanted to leave them!” Her dedication and passion earned her the respect of the nurses and doctors at the clinic, who began to call her, endearingly, “*mi partera* – my midwife,*”* or “*nuestra partera* – our midwife,*”* and the nurses would always make sure that she was brought food as she worked through the day and night. A devout Catholic, Julieta recalls feeling as if all of the blessings patients gave her made her incredibly fortunate. “Everyone blessed me!” she says, grinning.

Julieta asserts that such blessings were what allowed her to get through some difficult deliveries during that year. In one case, a woman arrived already pushing. Julieta had never met with her during her pregnancy, and knew nothing about her. “Her belly was gigantic,” remembers Julieta. “But then when the baby finally came out, it was so small, with a strangely flattened face. I paniked and called the doctor, who said it was fine – only a little squashed from the delivery.” However, as Julieta prepared to deliver the placenta, she was surprised to see another baby come shooting out. “Everyone began shouting,” she remembers. “The woman knew all along she was carrying twins, but didn’t want to tell us so that she would not get sent in for a cesarean! That second baby had been pushing on his little brother, which is why his face looked all squished.” Vaginally delivering twins was not something Julieta had been trained to do (that would have been a case to be referred on to the physician), and yet she had done it.

“That was not the only complicated birth I ended up attending,” she tells me. “Once I had a woman come in, already fully dilated and ready to push. When I checked

her, I realized that what I was feeling was too soft – it was the baby's bottom, not its head!" Again, delivery of breech babies was not something that the professional midwives were trained to do – like twin births, this was a case to be referred on. But again, in this case the woman was already pushing and Julieta was put in charge. "I remembered that you cannot touch the baby with your skin, or pull on it as it comes out," Julieta says, "so that it doesn't try to start breathing, or arch its neck and get stuck in the pelvis." Terrified, she guided the baby out gently and slowly with a warm cloth, and mother and baby were both fine.

The nurses and medical interns grew to respect Julieta and her work as a midwife, *because* of her ability to use techniques that they had not learned through their biomedical training. Not completely aware of the impression that she could make within that biomedical setting, Julieta unabashedly employed techniques she had learned at CASA, such as using the *rebozo* (shawl) to help position babies, or prescribing homeopathic medicines to her patients. She came to find out that some of the doctors had used homeopathic medicines with their patients before, but always in secret – they did not want to be seen using such alternative remedies. "But once they realized how much people liked the homeopathic remedies I was using, even the other doctors started asking me for the ones I had to use on their patients, too!"

Julieta's experiences in her year of service gave her the confidence to employ the traditional and alternative midwifery techniques that she was more comfortable using, alongside or instead of the biomedical techniques that had structured her education. She was initially surprised by the acceptance of her use of homeopathy and uterine massage on the part of the medical staff, but came to see that many of the biomedical practitioners

themselves felt comfortable using alternative therapies, due to their own previous exposures to them. As Byron Good and Mary-Jo Delvecchio Good point out, too often anthropological studies of medical practices tend to view them as homogenous entities. Within biomedicine, for example, they point out that practitioners do not all think or practice exactly the same, and that details such as subspecialties or geographic locations dramatically alter the face of biomedicine. Julieta's experiences add to the kind of situated, detailed ethnographic work that the Goods call for, work that does not presume practices or ideologies based on titles such as biomedicine or traditional medicine (1993:83).

When she finished her year of social service, Julieta was scooped up by a researcher from the University of Washington's Department of Global Health to participate in a study that was being conducted with Mexico's National Institute of Public Health. The study was a follow up to earlier studies they had conducted, comparing the curricula, competencies and practices of professional midwives, obstetric nurses, and medical students across Mexico. The overarching emphasis of this collaborative research group was to promote new ways of addressing maternal mortality in Mexico by promoting alternative health providers such as professional midwives in areas where access to care was low.

Julieta was placed in a small health clinic in San Juan Cacahuatepec, a Oaxacan village near the border of the state of Guerrero. Both Oaxaca and Guerrero were being targeted in the study, as they fell under the category of states with significantly higher maternal mortality rates. Positioned there for nearly two years, Julieta was tasked with bringing in more patients for prenatal visits and births in the health clinic, to discourage

them from traveling to larger cities to give birth or from staying at home with traditional midwives. The idea was that community members might trust a professional midwife more than a doctor or medical intern, and thus might decide to go to the local clinic more often. In the study overall, the presence of these professional midwives succeeded significantly at bringing in more women for prenatal exams and births; in Julieta's case, whereas there were only two births at the clinic during the year before she arrived, there were 22 the following year (Walker et al. 2011:70). Compared to the overly saturated clinic where she had done her year of service, however, Julieta found the work in Oaxaca to be slow and boring. Also, she was uncomfortable with the idea of being tasked to lure women away from their local, traditional midwives.

"It seemed as if everyone was already just used to going elsewhere to have their babies," she explains. "They would go to their own midwives, or their private doctors, or just drive to the nearest city." She grew frustrated with her position there and her inability to practice as she wanted to, and eventually left the study. When I asked her what ended up happening with the study, she said that she did not know - she had not heard anything about it. Later in the year, I come to the clinic one day armed with a copy of Walker's study, in which Julieta is cited, to share with her. Julieta is mildly interested, but does not seem to want to read it. She tells me that one thing she did get out of the experience was training in obstetric emergencies, in topics and techniques that she says she had not learned while at CASA.

After leaving Oaxaca, Julieta was ready to come home to her family. Her mother is older now, she notes, and her father is still ill. On top of that, they have mounting legal problems as well as money concerns. She was hired on as a staff midwife at CASA and

moved back into her family's home to help them out. She says that all of her experiences have prompted her to dream of someday traveling again, perhaps working in the far away state of Veracruz, but for now she will stay here. Increasingly, patients have begun to refer friends and family to her care; Julieta is getting a reputation as a caring, kind, midwife who turns first to traditional or alternative approaches. Women who have had negative experiences with the public hospital system, or those looking specifically for a traditional midwife that has the biomedical backup knowledge, seek her out. Slowly, Julieta has been getting used to taking on her role as a resident traditional, professional midwife.

Conclusion

"Being back at CASA is not easy," Julieta tells me. "I am still learning, really, and I am trying to teach students but it is hard. Plus, there are so few births here now, since that they opened up that big public hospital where births are free." Our lengthy conversations during the long lulls between patients on days like this attest to this lack of business for the clinic. Back when Julieta was a student here, the big hospital had yet to be built and births were plentiful. Now, however, the midwives fight over who gets the patients, and there are not quite enough for anyone. Julieta's other difficulty, now that she is back, is working with the students. "I don't like to have to discipline them or correct them," she says, "I was just a student myself!"

While Julieta may indeed have been a student not long ago, she is one of Mexico's very few professional midwives to have been licensed and who now is in the influential position to teach future generations. There are not countless others before her

who have paved the way for the profession she has chosen, and it falls to people like Julieta to represent professional midwifery to the students. Julieta's actions and words inevitably send messages to current students about what professional midwifery is all about. In particular, students look to professional midwives like Julieta to help them navigate the complicated intersection between biomedicine and traditional medicine that they are being primed to inhabit. While some of Julieta's peers echoed and contributed to students' negative portrayals of biomedical practitioners, Julieta tried to present a more nuanced critique.

During a conversation with a student who was complaining about the way the general hospital staff treated the student midwives, Julieta said that, "It is true that the doctors and nurses throw dirt at us (*nos echan tierra)* and that sometimes we throw dirt at them, but in reality they are just doing their job. What makes us different here at CASA is that we believe in humanized birth." Julieta's experiences during her year of service had shown her that not all doctors and nurses were against what midwives represented; she saw the problem more as a lack of communication and understanding. Still, Julieta emphasized to her students and to her patients that she only uses "allopathic medicine as a last resort," thus differentiating her philosophy of care from that of the public hospitals. Yet within this assertion is the reminder that Julieta – and all CASA graduates – have the ability and training to use allopathic biomedicine when they deem it necessary.

Robbie Davis-Floyd has suggested that CASA's professional midwives could be described as "postmodern midwives" because, she argues, they have the ability to draw strategically and smoothly from tools of "modernity" (biomedicine) as well as from traditional midwifery as needed (2001). Simonds, Katz-Rothman and Norman agree that

that the postmodern midwife envisioned by Davis-Floyd draws strength from her ability to be flexible; they paint an image of the postmodern midwife as one who is dexterous and multi-tasking, simultaneously fielding cell phone calls, emails, and educational licensing procedures, while making teas, procuring herbal remedies, and ultimately pulling together whatever each individual patient needs at any given time (Simmonds et al. 2006). Barclay, Aiavao, Fenwick and Papua suggest that such midwives are better understood as "postcolonial" practitioners, who are "moving towards integrating traditional systems and practitioners with the advantages of professional health care" (2005:xix). In both the depiction of the postmodern and of the postcolonial midwives, the notion of a continuum of options – from traditional to biomedical – is evoked, which seems to break with prior notions of bounded models of care. Under this vision, the existence of these emergent practitioners appears to render equal and ultimately compatible biomedical and traditional approaches to women's health care, and to break from troubling categories which rendered such models static.

In suggesting the revolutionary possibilities inherent to the postmodern/ postcolonial midwife, these scholars are highlighting what they see as alternatives to development projects that have merely tried to translate biomedical teachings for traditional healers. Stacy Pigg, for example, has written about attempts to export biomedical training to traditional workers in Nepal (1997). What ends up happening as a result of such programs, she finds, is that the indigenous people learn to talk like their trainers want them to in order to pass as participants in the biomedical model, as legitimate care providers, even if their practices continue to diverge from the training standards. Therefore, despite the trend in international health programs to appreciate

other knowledges, the "training programs continue to serve the 'cosmopolitical' function of establishing medical obstetrics as authoritative" (1997:234). Programs like CASA, scholars have argued, break with this trajectory by doing away with the hegemonic rule of obstetric authority and introducing the "postmodern" approach to care that allows for multiple ways of knowing and doing.

During my work with midwifery students at CASA, like Julieta, I found that, while flexibility between biomedical and traditional or alternative techniques was a central concept in theory, in practice the students do not operate within such a smooth continuum. They do not, in their novel role as professionalized midwives, break down boundaries between historically fraught categories of biomedicine and its "others". Rather, their position as outsider to both biomedical *and* traditional medicines puts them into a triangulated, third position, from which their choices serve to further bound and render static the very models from which they draw their practices. While some scholars have argued that traditional models of healing are created through, rather than in spite of, processes of institutionalization (Zhan 2010; Farquhar 1995; Hsu 2001), I argue that both biomedicine and traditional midwifery become increasingly bounded categories through the creation of hybridities like professional midwives. It is through the intention to integrate the two models that students seek out ways of understanding what counts as biomedicine, just as they define what counts as traditional medicine; often, what "counts" for these students challenges preconceived notions about these models. The tensions between the competing logics of biomedicine and its alternatives play out in Julieta's clinical, educational and practical experiences.

In this chapter, I have argued that student dissatisfaction with biomedicine has shaped the new professional midwives in ways that privilege biomedicine's alternatives. I have shown that students of professional midwifery come to develop a hierarchy regarding biomedicine and traditional midwifery, rather than a flexible continuum. While I find Davis-Floyd's image of the postmodern midwife compelling, I have observed the mass resistance to tools of biomedicine in professional midwifery. What does this mean for Mexico more generally, as it continues to engage in projects of modernization? If professional midwives are the strategy to combat maternal mortality and lift the nation out of its developing status, what happens if the professional midwives come to reject the very biomedicine that they are supposed to deploy? In the next chapter, I look closer at the roots of midwives' growing – and increasingly vocal – dissatisfaction with biomedicine and the public hospital system in Mexico. As students such as Julieta are increasingly allowed access to public hospitals as part of their training and careers, they confront mistreatment of women and misuse of biomedical practices in ways which make lasting impressions and further validate a hierarchical separation between that which is biomedical and that which is traditional midwifery, even within the category of the new "professional" midwives.

CHAPTER 4

Obstetrics in a Time of Violence

The previous chapters have contextualized the resurgence of support for midwives within the Mexican healthcare system, and outlined some of the struggles and opportunities that are reshaping what it means to a midwife there today. In such, I have illustrated many of the issues facing midwives' professional lives as they negotiate for space within the shifting priorities of development initiatives. This chapter examines midwives' reactions to an expanding national healthcare system in relation to their emergent roles within that system. As midwives regain authority in the field of childbirth, many of them have become critical of hospital obstetrics as a site where the medicalization of birth has, they argue, led to the poor health outcomes that the country is struggling with. However, while such critiques echo the sentiments of feminist scholarship denouncing the medicalization of women's bodies, the framework the midwives use differentiates them: the term "*violencia obstétrica"* (obstetric violence) is being used by many Mexican midwives to describe hospital-based obstetric practices. By reframing obstetric practices as violent – as opposed to simply medicalized – these midwives seek to situate their concerns about women's healthcare in Mexico within broader regional discussions about violence, gender and inequality.

While *violencia obstétrica* is an evocative concept, however, its insertion into social and legal systems has proven difficult. This difficulty is a symptom of the nascent and multi-faceted nature of both the *violencia obstétrica* and midwifery movements in Mexico. While the term itself is not new, and the idea of creating legislation to

criminalize acts of obstetric violence has been borrowed, Mexican midwives use the term in part to refer to structural modes of violence that are not always explicitly physical, nor easily codified and regulated. Their goal becomes twofold: to define and regulate specific obstetric practices in terms of overt violence and violation, and to bring attention to deeper patterns of inequality and violence that play out in hospital delivery rooms. These goals distinguish the movement from earlier and ongoing attempts to "humanize birth" that address medicalization as a set of protocols to be changed. However, by attempting to address *violencia obstétrica* both as a set of physically violent practices and as a deeper structural concern, the midwives have come up against a question that anthropologists have also been debating in recent years: how can structural inequality on a broader scale be linked to tangible instances of physical violence? I argue that as midwives reflect on the violences they observe within hospitals and grapple with this question, what they try to articulate is that structural violence *is* physical violence; a common phrase linked to the movement argues that "*violencia obstétrica es violencia de genero*" – obstetric violence *is* gendered violence.

In this chapter, I examine closely the emergence of the movement against *violencia obstétrica* as a socio-political concept. Through their everyday experiences in the Mexican public hospitals where they gain clinical skills, these midwives come to think about medicalization and violence in interesting ways. How do Mexican midwives define incidences of violence in obstetric settings, and what work does this definition do for women's health and for midwifery as a profession that stands in contrast to biomedical obstetrics? My research shows that as midwives come together and do the work of defining and theorizing *violencia obstétrica,* they seek to bring attention to the

topic of medicalized birth in a way that reflects particular constellations of gender, power, history and biomedicine in Mexico today. This approach does work that the humanized birth movement has not been able to do, by tapping into timely concerns about violence in other realms of Mexican society and by shifting the responsibility for medical choices in birth away from patients and onto providers and health care systems.

I contextualize my argument about the *violencia obstétrica* movement within three bodies of scholarship: feminist conversations about the medicalization of women's health, typologies of violence, and violence in Latin America. Feminist anthropologists have traced the effects of medicalization and hypermedicalization – which refers to the overuse or misuse of biomedical intervention – on women's bodies and reproductive health. While I argue here that the *violencia obstétrica* movement attempts to move beyond these critiques of medicalization, its understandings of power and authority in biomedicine are anchored in such feminist critiques. For decades, scholars have been discussing distinctions between physical, symbolic and structural violence (Galtung 1969, 1990; Farmer 1996), yet today debates continue over how these distinctions map onto lived experiences (Goldstein 2007). I show how this academic debate plays out in a parallel fashion within the midwifery community in Mexico, as midwives struggle to make the term *violencia obstétrica* fit as a descriptor for both overt physical violence and deeper structural or symbolic violence against women. Finally, I situate *violencia obstétrica* within conceptions of violence in Latin America and Mexico in particular. Bringing attention to *violencia obstétrica* becomes a way for the midwives to talk about normalized violence related to gender, class and race in Mexico more generally; as Philippe Bourgois argues, such "intimate violence" is increasingly replacing the more

overt political violence across Latin America, and in its path it "has legitimated social inequality and demobilized popular demands for the redistribution of resources" (2010:18). However, within Mexico the recent explicit demonstrations of violence connected to drug cartel tensions have made violence an everyday word. Might the *violencia obstétrica* movement draw on these tensions in its attempt to bring attention to gendered violence that plays out in hospitals nationwide?

Evidence Within Bodies

The manifestations of *violencia obstétrica* are often subtle and hard to see, accounting in part for the difficulty faced by the midwives trying to bring attention to them. In 2011, I was observing with students at CASA's midwifery school and clinic when a patient came in bearing the evidence of such hidden violence within her body. CASA is Mexico's first accredited professional midwifery school, and its students alternate during the three-year program between academic coursework and shifts at the general hospital and the midwifery clinic. It was a slow day in the clinic, and two students were assisting Ana, the staff midwife, during a routine woman's health exam. The patient - a young woman from a nearby *rancho* (rural community) - had come in alone. She spoke quietly, explaining that she was worried something was wrong with her uterus. Cancer, maybe – she didn't know. When Ana asked why she thought that, the patient explained that she had been trying to get pregnant with a second child for a year now, to no avail.

"I was taking birth control pills since my last birth," she explained. "But I stopped them a year ago, and I still haven't gotten pregnant. Something must be wrong." Ana

assured her that this was normal, but told her that she and her students would examine her to ensure that she was healthy. While the patient undressed in the bathroom, the midwife turned to her students to explain that pregnancy can sometimes take many months, and that this is not necessarily cause for alarm. The patient emerged in a blue hospital gown and lay down on the exam table. With Ana guiding her, one of the students explained carefully as she prepared to conduct a pap smear and pelvic exam. She was partway through when she looked up at Ana and exclaimed that the woman had an intrauterine device (IUD). The IUD is a long-term form of birth control that is inserted into the uterus. Ana finished the exam, shaking her head in frustration. It turned out that the doctor at the general hospital had inserted the IUD immediately after her first baby was born, without her consent.[14] This meant that she had been taking birth control pills for years unnecessarily, and explained why she failed to get pregnant even a year after she stopped taking them. The patient was surprised at the news, but also happy to have an explanation for her fertility concerns. She scheduled an appointment to get the IUD removed during her next period. Once she left, the midwife and her students expressed their outrage.

"The problem is not only the lack of consent when doctors put IUDs in immediately postpartum," Ana told her students. "It is also that they shouldn't even put them in that soon – the uterus is not ready for that yet! But when women have their babies at the hospital, the doctor almost always puts one in, whether she wants it or not. Sometimes they tell women, 'you can always get it out later, let me just put it in now.'" The students concurred; while completing their professional midwifery degree at CASA,

1. Arachu Castro's work reveals that alarming patterns of forced sterilization or IUD insertion immediately postpartum in Mexico are linked to doctors' assumptions that women will not return for follow-up contraceptive counseling, and also to attempts on a national level to integrate childbirth and contraceptive services (2004).

they conducted clinical rotations at the local public hospital. While there, they witnessed the coercive use of IUDs on a daily basis and were increasingly frustrated by their inability to stop the practice. "On top of that," exclaimed one student, "the hospitals make it nearly impossible for the women to get the IUDs removed later – they don't want these women having any more babies!" The others nodded their heads, saying that they saw many patients here at CASA who wanted their IUD removed because their doctor at the hospital would not take it out. "This is violence and violation!" exclaimed Ana. For Ana and her students, the violence committed against their patients happened on many registers; it was present in the lack of consent, in the coercive use of the IUD, in the refusal to help women, and in the general attitude towards women's bodies and their fertility. Here, violence was also seen in their patient's unwitting consumption of birth control pills on top of the protection of the IUD that she was not aware she carried in her uterus. Ana and her students used the term *violencia obstétrica* to describe what they see happening at the hospital. Yet this term does more than catalogue individual inhumane practices: it seeks to reframe them as the indicators of pervasive, underlying gendered violence.

Medicalization, Hypermedicalization, and Humanization

When midwives like Ana and her students talk about practices like the coercive use of IUDs as cases of *violencia obstétrica,* they reference two distinct but related sets of conditions. First, they critique the routine technologies and infrastructures that have developed within biomedical settings by calling out their unnecessary or improper usage. Second, they critique the less easily codified, and more insidious, incidences of violence

that occur between providers and patients that they see as indicative of broader trends in social violence towards women. Their first critique echoes ongoing scholarly and activist resistance to the medicalization and hypermedicalization of childbirth and healthcare more generally. In this section, I differentiate between critiques of medicalization and hypermedicalization in order to contextualize *violencia obstétrica* within scholarly and activist movements related to obstetric care.

The arguments made about the mechanisms behind and effects of the medicalization of childbirth echo a large body of feminist scholarship from recent decades (see Jessica Mitford 1992, Suzanne Arms 1975, Emily Martin 1987, Adrienne Rich 1976, Barbara Katz Rothman 1991). Building on Foucault's notion of the "clinical gaze" (1973), such scholars have highlighted specific ways that female bodies come under scrutiny as objects of study, and how reproductive processes from menstruation to menopause (and everything in between) have consequently been pathologized (Riessman 1983). Once reproductive processes are defined solely in terms of medical problems, scholars argue, they must be managed and treated with biomedical interventions (Riessman 1983). As technological intervention into all reproductive processes proliferates, "normal" reproduction becomes classified increasingly as a dangerous throw-back which could detract from women's ability to achieve perfection as feminine bodies and mothers. In fact, what counts as "normal" is itself being redefined; as Davis-Floyd and Dumit point out, for example, technology in childbirth has become so naturalized that now a hospital birth with any number of biomedical interventions is being called "natural," in opposition only to cesarean births (1998:9). As conceptions of

what counts as normal are shifted by technological interventions in childbirth, the potential for new kinds of bodies is created.

While medicalization thus relates to the gradual redefinition of bodily processes as medical domains, scholarship focusing on hypermedicalization explicitly emphasizes the overuse or misuse of medicine and technology in healthcare. Studies pointing toward the negative health impacts of hypermedicalized childbirth, such as its correlation with high cesarean section rates (Simonds et al. 2007) and to its inability to lower maternal mortality rates in developing countries have inspired calls for investigations into the specific manifestations of medicalization in diverse childbirth settings (Boddy 1998). That is, how practitioners approach birth and what women experience must both be understood within broader political and social contexts of specific times and places (Ginsburg and Rapp 1995). In particular, scholars have called for more work on the impacts of the uneven exportation of medicalized childbirth in developing countries as a reflection of unequal distributions of power related to gender, race, class and nationality. By looking at moments of hegemonic imposition of medicalized childbirth techniques within specific contexts of development we may be able to see beyond manifestations of structural violence, to understand the grounded motivations and mechanisms by which childbirth becomes a contested process.

Anthropologists have argued that it is equally important to address moments of resistance to hypermedicalized birth in diverse settings, and to consider who is resisting and how they delineate their concerns. Scholars have looked at midwifery as a site for the promotion of a model of care that stands in opposition to the hypermedicalization of birth (Davis-Floyd 2001, Simonds et al. 2007). The humanized birth movement, which was

popularized for Latin America during the First International Humanization of Birth Conference in Brazil in 2000 (Page 2001), has sought to unite patients, midwives, doctors and activists alike to call for an analysis of the overuse of unnecessary interventions and technologies in birth. In Mexico, midwives have taken up the call to "humanize" birth, a project they say is founded on the notions that birth is a normal event in which women should be in charge, medical interventions should be used only when necessary (Alonso and Gerard 2009). Despite their promotion of the benefits of humanized childbirth, however, increasing pressure by free state health programs has pushed more women than ever into the hypermedicalized system and the very circumstances that midwives are trying to change.

Naming and Framing *Violencia Obstétrica*

In 2011, *Nueve Lunas* (Nine Moons) midwifery school in the Mexican state of Oaxaca sent out a mass email as part of a campaign to change Oaxacan law to include *violencia obstétrica* within other forms of violence against women that the state was responsible for policing. The document – which was sent to policymakers, activists, midwives and academics nation-wide - was titled "The need to generate a scientific and rational debate to categorize *violencia obstétrica* as gendered violence: Pronouncement of organizations from the civil society." It argued that, "*Violencia obstétrica* is a reality that must be legislated! Never again should women have a life with violence!" *Violencia obstétrica* was situated squarely within conversations about both gendered violence against women and national concerns over maternal mortality. *Violencia obstétrica*, it said, is distinct from other kinds of violence that have become more publicly visible in

recent years. "*Violencia obstétrica* has remained hidden and silenced," it read. Yet, "the lack of quality in the attention to pregnancy and birth has been shown to be one of the principal factors responsible for maternal mortality and morbidity, along with discrimination based on gender, ethnicity, race and class." The document went on to blame the violation of sexual and reproductive rights, along with a lack of universal access to health services, for Mexico's continuing problems with maternal health outcomes.

The document linked concerns about *violencia obstétrica* to multiple international scientific sources, while also situating this newly conceptualized violence within Latin America's historical legacies of violence and social movements (Caldeira 2002; Eckstein 2001). Oaxacan midwives were not the first to propose legislative changes based on the term, however; the Mexican state of Veracruz had, three years before, promised women a "life free of violence" – including obstetric violence (Calzada Martinez 2009). One year before that, Venezuela had set the precedent in Latin America by rendering obstetric violence illegal (D'Gregorio 2010). According to Venezuelan law, obstetric violence was defined as: "…the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women" (D'Gregorio 2010: 201). For both Veracruz and Venezuela, markers of *violencia obstétrica* included such infractions as forcing women to give birth lying down, denying women timely emergency obstetric care, and performing cesarean sections when not medically indicated. The Venezuelan law also set the

punishment: practitioners convicted of such acts of violence would be charged a fee, and the practitioner and his/her institution must sign a copy of the given sentence, thus ensuring institutional accountability (D'Gregorio 2010).

The laws passed in Venezuela and Veracruz were and continue to be novel in their attempt to hold health practitioners legally accountable to international norms and recommendations about best practices in obstetrics. However, a year after the law was passed in Veracruz, no lawsuits had arisen – a fact blamed on the lack of general knowledge about the law and even about the concept of *violencia obstétrica* (Calzada Martinez 2009). Similarly, in Venezula, a follow-up article published in 2011 of a study conducted in multiple national hospitals revealed that, while the term "*violencia obstétrica"* was widely known, and many practitioners reported seeing instances of violence inflicted on patients there, paths for recourse and reporting were unknown and so, little could be done for the victims (Faneite 2012). When the Oaxacan midwives sent out their email urging Mexican women to fight for a similar law, their grievances in obstetric care were strikingly similar, perhaps because they were both drawing on international norms and recommendations. In fact, Mexico had already taken up many of these recommendations as its own in the national Official Norms outlined to help reduce maternal mortality. What the midwives were asking for, then, was a way to turn national recommendations into legal accountability; officials did not respond positively, however.

"Our proposal was shut down by the government," explained Marta, one of the administrators at *Nueve Lunas* school, as she gave me a tour of their facilities. "It was all because the doctors were pressuring them." Marta's explanation was echoed by a national journalist covering the issue, who noted that doctors saw the potential law as an effort to

criminalize routine medical practice; doctors had argued that the law should not intervene in doctor-patient relationships (Mino 2012). For Marta and the rest of *Nueve Lunas*, this argument made little sense. Doctors were making it sound as if the midwives were saying that, "any doctor or nurse who participated in a cesarean could go to jail, which is a lie and a manipulation" (Mino 2012 *translation mine*). Despite official rejection, Marta continued, the idea of *violencia obstétrica* had been publicized more widely; she hoped that more women might at least come to realize that they had the right to a birth free of violence.

Something that stands out in both *Nueve Luna's* proposed law and in the Venezuelan legal depiction of obstetric violence is their very banality[15]; that is, the offensive practices listed in them reflect trends in the hypermedicalization of childbirth worldwide. The overuse of cesarean sections and the dependence on the supine position for delivery (that is, making women deliver while on their backs rather than in vertical positions), for example, have been long critiqued within the framework of unnecessary medicalization of childbirth (see Jessica Mitford 1992, Suzanne Arms 1975, Barbara Katz Rothman 1991), yet this current movement reframes these and other such routine practices as indications of violence – not just less-than-ideal practices carried out by unknowing but well-meaning providers. I suggest that this reframing is strategic in that it aims to shift such practices from being merely unnecessary to being dangerous, as well as a direct reflection of practitioner and institutional attitudes to the women they serve.

2. As with Hannah Arendt's 1963 use of the phrase "the banality of evil," I argue here that certain acts of violence become banal in that they are not done with individual, malevolent intentionality, but rather as part of an ingrained, bureaucratic system that justifies and reproduces them.

Getting women and practitioners to question practices that are seen as technologically and biomedically superior has been difficult for the midwives, even as they argue that such practices do not always lead to better outcomes. The exportation of biomedical, Western techniques for birthing practices has often caused more harm than its model would predict. In many cases, the developing world has enthusiastically implemented biomedical modes of birth, such as making women labor on their backs, injecting them with high amounts of the drug Pitocin (a drug used to induce contractions), not allowing them food or drink, etc. Yet these elements of labor were derived in settings where epidurals were being used commonly; in developing countries, epidurals are very often too expensive, and so women are going through more painful labors than if they had been allowed to labor in other ways (Davis-Floyd 2001:xx).

Bringing attention to the misuse or overuse of technological and biomedical interventions in childbirth is an important part of the *violencia obstétrica* movement, then; however, data from conversations with midwives and midwifery students from across Mexico suggests that, in bringing attention to bad practices, many midwives are trying to bring attention to deeper gendered violence that plays out in delivery rooms. It is because of their newfound authority in women's health in Mexico that many midwives are now able to observe and assist in state hospitals; it is this same authority that has given them a platform from which to critique what they see. Implicit in this critique is their argument that midwifery care offers a non-violent – humanized – alternative in care.

Unnecessary Interventions

Students at the CASA midwifery school are learning clinical skills during rotations in public hospitals where they come face to face with multiple manifestations of *violencia obstétrica.* There is a strong ethos of activism within CASA's educational model, and students are told from early on that they are being primed to address not only issues of maternal mortality but also of poor treatment of women. Further, CASA's students belong to larger midwifery networks, such as those behind national efforts to bring attention to *violencia obstétrica*. As they reflect on their encounters with violence in hospitals, they emphasize most clearly an institutionalized pressure on doctors to continue bad practices in obstetrics, and they articulate these practices in terms of their violation of women's bodies, privacy, rights and health. CASA students pointed to the unnecessary but compulsory use of episiotomies and Pitocin on nearly every hospital patient as examples of such violation.[16]

However, the hospital practice that students most frequently discussed in terms of violence and violation was the *revisión manual de cavidad uterina (*manual revision of uterine cavity), which they referred to more often as simply a *revisión de cavidad*. In the *revisión de cavidad,* the doctor manually scrapes out the woman's uterus (after delivery of the baby and placenta) with a gloved hand in order to make sure that no pieces of the placenta remain that could cause infection.[17] The World Health Organization has listed this practice under those which are "Clearly Harmful or Ineffective and Should be Eliminated" (1996:36). During interviews about their experiences in public hospitals,

3. The World Health Organization categorizes the routine use of Pitocin and episiotomies as "Practices which are Frequently Used Inappropriately" (1996:37).

4. While the risk of infection by remaining pieces of placenta is real, studies indicate that such manual revision is unnecessary if the placenta can be determined to be intact upon delivery, a determination that can be made with the naked eye in a few moments (Epperly et al. 1989; Alvirde and Rodriguez 2009).

students and practicing midwives across Mexico described this routine medical procedure as one of the most offensive experiences women had to go through there, both because of the intense pain it can cause (it is done without anesthesia in most cases) and because of its lack of basis in evidence as a preventative measure.

At the public hospital where the some of my midwifery student informants did their rotations, the *revisión de cavidad* was standard for every birth. Despite seeing it performed so many times, the practice still impacted the student midwives deeply and they talked about it often to each other, to their teachers, and to me. It is during such conversations in the time between shifts that students and midwifery teachers collectively articulate the parameters of *violencia obstétrica.* "It is horrible to watch the doctor do the manual revision," shuddered one of the third year students as she described the procedure to some of the younger students while they waited for their teacher to arrive. "You can hear the doctor's fingers, scraping away at the woman. Often, the woman screams louder in that moment than when she was in labor. They do this even if the placenta came out totally intact!" Another student empathized, saying that, "One time it made sense to do the revision, because the placenta did not come out. But that was because the doctor had pulled on the cord so hard it broke, and so then he *had* to go in manually to retrieve the placenta! But other times, the placenta is obviously complete and they still do it. I remember once an obstetric intern was there and saw the placenta come out, intact, and asked me – the midwifery student! - if he should do a manual revision. I said 'why would you, you don't need to,' and so he decided he wasn't going to do it. But then the attending physician came along and made him do it anyway. It is a matter of protocol (*protocolo)*!"

Here, the intern and the midwife were both in a similar position of learning practices through the dominant protocols within which they are stationed. The midwife, however, must balance what she learns in the hospital with what she learns back in CASA's midwifery classes, while the intern will continue to depend on the attending hospital physicians for guidance. While students often referred to such individual physicians who resisted established hospital protocols - and indeed admired many local doctors as teachers, friends, and colleagues – doctors as a category were seen as part of the larger institutional problem. Vania Smith-Oka's work on the misuse of cervical examinations in a Mexican public hospital reminds us to "contextualize, though not excuse" physicians' actions as part of the increasing bureaucratization of childbirth (2013:596). The midwives, despite their increasing presence in the hospital, observe this bureaucracy from the outside.

Elizabeth, a third year midwifery student, grew angry as she described to her classmates her worst experience at the general hospital. "I was observing a birth with a doctor, who told me that I had to do the manual uterine revision on the patient myself," she said. "Her placenta had not come out intact, but that was because he had pulled it out before it was ready! I whispered to the doctor 'no,' that I would not do the revision, but the doctor told me I had to, so I stuck my hand in, but only up to the wrist, and checked the vaginal canal. Because I hadn't done it right, the doctor had to do it too." At this point, Elizabeth stretched out her arm in front of her, pointing to a spot about two inches up her forearm from her wrist to illustrate how far the doctor's arm was inserted. "The doctor went on to manually scrape out the remaining pieces of placenta," she said, shaking her head. In Elizabeth's view, if the doctor had allowed the placenta to emerge

on its own, the patient would not have needed the *revisión de cavidad* in the first place. Yet because the placenta had broken, the doctor's actions were validated and necessary – the pieces of the placenta had to be taken out.

As with most obstetric procedures being critiqued in the *violencia obstétrica* movement (such as cesarean sections, episiotomies or the use of coercive contraceptive techniques), many CASA midwives expressed the view that the technique of manually scraping out the uterus in search of remnants of a torn placenta has its place; as in the above story, where the placenta was not intact, it can be life-saving to prevent infection caused by such remnants. Sara, a CASA midwife, told a group of students one afternoon about how all that observation of manual revision eventually helped her midwifery practice. Her brother had called her up one day to ask her to come help one of her mother's (also a midwife) patients. The woman had delivered the baby two hours prior, and the placenta had yet to emerge. The cervix was already closing, and so Sara decided on the spot that she would have to manually dilate it and bring out the placenta with her hand, which was what she did. However, she was careful to differentiate the manner in which she did the *revisión de cavidad* to the students. By that point, she said, the placenta had become calcified and hard, attaching itself firmly to a spot on the uterine wall. Slowly, with minute and gentle finger movements, she unattached it and delivered it. In doing this, she told me, she possibly saved the woman's life; in her recounting, Sara highlighted not only the importance of having the practical know-how and the knowledge of when to use it, but also of approaching women in a respectful and gentle manner – thus distinguishing her usage of the technique from that of the doctors.

Tensions in the Movement, Tensions in the Concept

There is a tension in the movement against *violencia obstétrica.* The tension revolves around the dual meaning of the violence being discussed; on the one hand, there is a tangible and acute violent act being described, while on the other hand there is a chronic and systemic violence being alluded to. The midwives involved in efforts to legally regulate *violencia obstétrica* struggle with this tension, as do the midwifery students struggling to articulate their reactions to the everyday violences they witness with their patients in the general hospitals. Will the regulation of specific obstetric practices be able to address the deeper gendered violence behind them?

This tension reflects the broader complexities involved in trying to address violence on multiple registers – from overt physical violence, in which there is a clear actor perpetrating an act of violence on a victim, to structural violence, in which there is no clear perpetrator, to cultural violence, which is any violence justified through cultural elements (Galtung 1969; 1990). While in the 1990s, the field of medical anthropology took up the notion of structural violence as a way to approach poverty and inequality from multiple perspectives and to demand political change on a larger scale (see Scheper-Hughes 1992; Farmer 1996, Biehl 2005), in more recent years there has been a backlash to such work. Within anthropology, critiques of the structural violence approach have taken two forms: one body of scholars argues that a focus on structural violence decenters culture from the analysis, in favor of a less specific framing based on political economy; other scholars argue that the political project of the structural violence approach is too entangled with moral assumptions (Goldstein 2007). Can *violencia obstétrica* refer both

to physical violence and to structural violence, without erasing culture as a variable or making moral assumptions?

The *violencia obstétrica* movement positions specific obstetric practices within a broader framework of historical and ongoing patterns of social inequality, especially related to gender, race and class. How women are treated in labor and birth, the midwives argue, mirrors how they are treated in society in general. For many midwives, this means that women are set up from the beginning to be treated poorly in public hospitals – because of their status as lower class and/or indigenous. As one CASA administrator put it, "It's not just that the system lets women die – it's that the system is built in ways that make women more likely to die. They set it up for you to die… then the government comes in to save you with interventions you wouldn't have needed had they just left you alone to start with." From her perspective, the failures of the model of care in hospitals are allowed to perpetuate, then, because they are followed by what she sees as obstetric heroics. What if, asks the *violencia obstétrica* movement, these failures were addressed and women could get better quality care from the start?

Many of the midwives in my study were aware of the historical legacies that underlie the inequalities they witnessed in hospital settings. During a midwifery class taught by two of the students, the topic turned to gender, race, class and inequality in Mexico. One of the teachers, Alicia, told the students to read Octavio Paz's *The Labyrinth of Solitude* (1961) as a text which "explains why we Mexicans are *hijos de la chingada* (children of the raped one): because we are all still the result of the Spanish raping the indigenous." Alicia, like Paz, argued that the legacy of the Spanish conquest of Mexico created inequalities that continued to shape social and political life in Mexico today. In doing

this, she roots current inequalities in a certain ongoing inevitability, yet she also marks the significance of the work they are trying to do as midwives. The midwives' use of violence in their critique references this longer history of violation and abuse, while perhaps gaining a certain purchase in this moment because of more current invocations of violence in Mexican society.

To address *violencia obstétrica* on a national level means addressing the structural violence which perpetuates systems of inequality and abuse and which culminates in specific obstetric practices in public hospitals. While some midwives may be able to advocate for changes to the national norms and protocols, getting doctors to deploy these changes in their existing practices - and getting women to demand them - present a much bigger challenge. For both the doctors and their patients, recognizing current actions as forms of violence in need of redress would necessitate a reevaluation of the power dynamic between doctors and patients which is connected to issues of class, race, gender and poverty. Recent work in anthropology and health has begun to examine more closely the nuances of class, gender, race and ethnicity within acts of violence, and how such acts get inscribed on bodies. Such inscriptions are not necessarily dramatic and obvious – more often they occur in the mundane violence of the every-day (such as in the delivery room of a crowded public hospital) (Rylko-Baer et al 2009). In naming their movement as one that fights against *violencia obstétrica,* the midwives align themselves with a broader movement seen in anthropology which seeks to "recognize violence in the places where it is no longer recognized for what it is," which is often "in social processes that the dominant discourse never articulates in terms of violence" (Fassin 2009:117). And yet the midwives, in this fight, are not only attempting to address issues of quality in

maternal health care, but rather to link quality of care issues to underlying social concerns. In this goal, they put into action an emerging strategy within anthropology as well: through a critical examination of health, scholars hope to find new ways to confront broader global concerns related to inequality and violence (Rylko-Baer 2009).

Violent Times

Even as midwives were crafting legislation and petitions against *violencia obstétrica,* they could not avoid discussions of other permeations of violence in their surroundings. During the time this research was conducted, news related to drug cartels and the violence surrounding them was ever-present, and was impacting many who were unconnected to the cartels. While I was visiting *Nueve Lunas,* a traditional midwife named Barbara had come to lecture to the students on techniques to use while caring for a pregnant woman. During a break, some of the administrators began quietly talking about Barbara, and about how she was not only there to teach the students – but also to scope out the city as a possible new place to practice. Back in her own city up north, she had recently heard that another traditional midwife had been attacked, beaten and robbed in her home because word had gotten out that she had many patients and therefore, possibly, was making good money. Barbara had also begun to receive threatening phone calls, especially because of her own thriving midwifery practice. Violence was not something relegated to those involved in drug cartels; even elderly traditional midwives were becoming victims.

The escalation of drug-related murders and abductions, and the distrust in the government's tactics in a seemingly unbeatable "war" against drugs, contributed to a

sense of pervasive fear and frustration. A background level of violence was becoming the norm, and people continued their daily lives, working around violence with different routes for travel, earlier curfews for their children, and re-directed business ventures. Yet each day new stories of the inventive techniques of the cartels seemed to ratchet the threshold of violent possibilities up a notch. News of the ongoing femicides on the US-Mexico border was still a concern, sparking debate about women's safety more generally. Bus lines had developed separate buses for women only, just as metro services in Mexico City offered women-only cars during peak hours – both moves reacting to fears of increasing violence against women. Everyone was exhausted by such violence, embarrassed by it on a national scale, and angry that nothing seemed to be improving. However, because of the confusion in many stories about who was more at fault – drug cartels or the government – people were wary to speak up or get involved for fear of becoming the next target.

The midwives involved in the campaign against *violencia obstétrica* draw on this national trope of violence in two distinct ways. First, they align themselves with current social concerns about specific kinds of violence that have come under increasing public scrutiny in order to argue for specific changes in obstetric care. Second, they seek to reveal underlying patterns of structural violence which have allowed the persistence of outdated obstetric practices and which shape provider attitudes towards women. In this first endeavor, pressing social concerns around escalating drug violence nationwide, femicides, and high rates of domestic violence are all evoked as a way to harness negative social and political attitudes towards violence in Mexico today. In the second

endeavor, historical legacies of inequality based on gender, race and class are revealed as ongoing concerns with direct impacts on women's bodies and health.

Perhaps the most powerful initiative of the *violencia obstétrica* movement is its attempt to link specific kinds of violence with the broader social structures that allow them to prevail. Obstetric violence, they argue, is not the product of the acts of rogue individual practitioners, but rather of a systemic failure that reinforces outdated practices. Whereas other forms of gendered violence, such as domestic violence – which has gained visibility as a widespread social concern in Mexico in recent years (Castro 2003, Diaz Olavarrieta and Sotelo 1996) – continue to be framed in terms of actions like spousal abuse and intimate relationships, the campaign against *violencia obstétrica* is aligned more with work that frames gendered issues within their historical and political contexts (Finkler 1994) and which must be addressed publicly and regulated by the state. For example, Kaja Finkler argues that broad historical processes, pervasive cultural attitudes towards women, and the daily stresses women face in Mexico result in the patterns of sickness found there today. Further, she argues that once women can "change their existence to allow a restoration of dignity within the society at large and within the confines of their homes," then we will see equal sickness rates between men and women (1994:209). In order to address the tangible inequalities in health seen across gendered divisions, then, we must address these deeper cultural understandings.

This explicit emphasis on underlying structural inequalities - along with the strong language and legal repercussions outlined in the *violencia obstétrica* movement - contrast with the earlier and ongoing humanization of birth movement, which has been more about individual choices and responsibilities. The midwives are making conscious

choices to shift their focus from a grassroots movement to one that calls for accountability from the state at the highest levels. As the midwives from *Nueve Lunas* expressed, they do hope that the public will be moved by the discourse around *violencia obstétrica* and will begin to reframe their negative experiences with the healthcare system in terms of violation and abuse, ultimately pressuring practitioners to change. However, the movement against *violencia obstétrica* offers a more nuanced critique of neoliberal healthcare in Mexico that has put responsibilities for care onto the individual, and its goal focuses on changing norms and regulatory procedures from the top down.

By not framing the *violencia obstétrica* movement as completely a people's movement steeped in grassroots activism, the midwives also reveal, on the one hand, a sensitivity to the possible issues that could arise for women who would be asked to speak out against their care providers - a position that is not taken up easily or without consequence. Women are bound to certain kinds of health providers and clinics due to availability, or, increasingly, by their association with the national conditional cash transfer system, IMSS *Oportunidades*, which pays them if they complete their prenatal and delivery care in a certified clinic. Many have signed on to the relatively new national free health insurance program, *Seguro Popular*, which also obliges them to see certain practitioners and to deliver in the program's hospitals. Further, escalating incidences of private and public forms of gendered violence have reinforced women's roles as victims to authority figures – be they their husbands or their obstetricians. Thus women may be stuck with certain providers and not have the resources or the authority to demand better care – a situation which the midwives are quick to point out stems from unequal racial, classist and gendered relationships.

On the other hand, it is not purely altruistic sensitivity that drives the midwives' campaign against violence. Rather, this movement must be understood as a reflection of their increased presence in state institutions and their increasingly authoritative voice on women's health in Mexico.

Conclusion

Is there a way to talk about structural violence without recourse to metaphor or moral assumptions? Is there a way to talk about direct physical violence without obscuring underlying patterns of inequality? As Mexican midwives discuss *violencia obstétrica,* they attempt to hold structural violence alongside physical violence as equally problematic trends in the healthcare system. In doing this, however, they run the risk of alienating doctors and political allies by defining such violence too broadly.

On the other hand, two contextual processes are making it possible for the midwives' concerns to gain purchase – or at least to get attention. First, international pressures to lower maternal mortality have resulted in Mexico's investment in professional midwifery as a low-cost intervention. Thus, midwives are increasingly present in policy discussions and in public hospitals, where they rotate as students and later work as professionals. Second, national anxieties about widespread social violence have primed the public to react negatively to depictions of violence in spaces that were previously considered safe. The very pairing of the terms "obstetric" and "violence" is unexpected, jarring and provocative. In a time when violence is seeping into people's homes, the notion that it exists in obstetrics may not seem as surprising.

What would it look like to eradicate *violencia obstétrica*? For the midwives in this study, legislating and policing hospital norms of best practices in obstetrics is just the beginning. Even as the midwives struggle to determine the appropriate ways to humanize obstetrics through outlawing certain practices - like manual uterine revisions or the insertion of IUDs immediately postpartum – they confront the impossibility of changing institutional and provider attitudes towards patients. "What was I supposed to do," asked one midwifery student rhetorically when describing a hospital birth she had recently observed, "when the doctor threw his tape measure in the patient's face when she complained in labor? He just hated her, for no reason. I could not do anything to help her."

I do not suggest that all women are treated in this way in Mexican public hospitals; during my research many physicians were backing the movement to combat *violencia obstétrica,* alongside midwives and other activists. Often times, the doctors expressed the violence most articulately, as they found themselves entrenched in systems where inherited protocols dictated how women were treated and what doctors were supposed to do. For the midwives, who are suddenly being thrust into a medical system that had marginalized midwifery for decades, the violence they encounter stands in overt contrast to the humanized model that midwifery champions. Thus, for them it is no longer enough to call for the humanization of childbirth; rather, they must also call for an end to the deeper patterns of inequality in hospital obstetrics that result in the acute manifestations of violence.

In this chapter, I have positioned the critique against obstetric violence as a result of the growing authority of midwives in the Mexican healthcare system. It has been

through increased access to and presence within this system that the midwives have come to articulate their concerns about the treatment of women in birth. Further, it has been through the increased international viability of professionalized midwifery that they have been able to make their concerns heard, and through which they hope to garner support for tangible regulations against obstetric violence. In the following chapter I focus on those midwives whose authority has not grown within the healthcare system: traditional midwives. Even as professional midwives gain support nationwide, the ways of knowing that remain tied to traditional midwives are at risk amid their further marginalization.

CHAPTER 5

Rethinking Traditional Midwifery

I never did find out how the flat cardboard box full of vials of Pitocin had come to fill half a shelf in Doña Chucha's home; it certainly wasn't what I had expected to see after working my way through the chickens that walked in and out of her small adobe home in rural Oaxaca. I only knew that the presence of this drug – used to mimic the body's natural hormone, oxytocin, to force the uterus to contract, either during labor or in case of postpartum hemorrhage – reiterated for me the impossibility of neatly dividing "traditional" from "professional" midwifery knowledge. "What does this say?" the midwife asked me, holding one of the vials up to my face as she squinted at me through eyes that either could no longer read the tiny lettering on the bottle, or perhaps could not read at all. "It's Pitocin," I assured her, although from what I could see the entire flat of vials contained the same thing. Before I had even finished clarifying this for her, she had found a syringe and was drawing the liquid into it. "I always inject my patients postpartum," she explained to me as she made her way to the bedside of a woman whose baby had been born there hours before. "We learned about it in a training, it prevents hemorrhage." Swiftly, Doña Chucha injected the woman in the thigh, and then repeated the whole process with her second patient in an adjoining bed.

Was *this* traditional midwifery? Blindly injecting women with a powerful pharmaceutical as a matter of routine? I stayed for a few days with Doña Chucha, sleeping in the communal bedroom and helping with the patients when they needed food or water. We drank thick hot chocolate each morning, steamed large green squashes for a midday meal, and dipped crusty bread in coffee before bed. During this time around her

old wooden table, I tried to ask the midwife about her work. Although she referred to herself as a "*partera tradicional*" (traditional midwife*)* she was vehement in her position against the kinds of "natural" remedies that I had heard so linked to traditional midwifery, such as teas, tinctures, or steam baths. Doña Chucha must have been near eighty years old, yet it was her much younger neighbor who later told me that she was the one in town that used plants and plant medicine. Women in their village know this, she told me: if you want plant remedies, see the younger midwife, if you want drugs, see the elder.

Each of these midwives has come to know what she knows – her own version of traditional midwifery knowledge – through complex interactions with other midwives, state regulatory bodies, community members, and patients. What makes a midwife "traditional" is not only defined by a set of skills, a way of practicing, or a philosophic approach to reproduction. I met with many self-titled traditional midwives throughout my fieldwork, and their stories and abilities varied significantly. Further, my conversations with midwives, doctors and politicians across Mexico revealed how what traditional midwifery is and does has been defined differently over time and across geographical boundaries. This chapter addresses the notion of traditional midwifery with this historical contingency and professional flexibility in mind.

While the rest of this dissertation has taken on the standardization and professionalization of midwifery as its focus, I look here to those midwives, and those midwifery knowledges and practices, which do not fit neatly into current national standards or international goals. I ask, what is at stake if traditional midwifery (in all its multiplicity) is lost to history? And yet I note that, in looking here at traditional

midwifery – the "other" to the more newly created professional midwifery – I do not seek to merely fill in the other half of the picture. These are not two equal categories, but rather they exist in constant interaction and flux.

Anthropology – and in particular, ethnographic analyses of reproduction (Kaufman and Morgan 2005:322) - has a history of forcing us to rethink our world by deconstructing divisions between categories like nature and culture, developed and undeveloped, or western and nonwestern. Ethnographic analysis reveals that such categories do not maintain sharp distinctions in real life, but rather are created, contested, and reinforced in dynamic and ever-changing ways. I examine such dynamics here through the current tensions around the role of traditional midwifery, in the face of the standardization of professional, biomedically-based midwifery. These tensions have given urgency to a plea to protect and promote traditional midwifery as a viable option. As more women are offered incentives to birth in state clinics, and as the national government works to create standardized, biomedically-based professional midwifery, the consensus among midwives is that traditional midwifery is at risk. I argue here that what is at stake is not so much the content of midwives' knowledge or practices, but rather their *ways* of knowing; traditional midwifery is known through inherited and individualized connections and through situated experiences in communities where biomedicine cannot or will not go.

These ways of knowing in traditional midwifery in Mexico today stand in sharp contrast to the ways of knowing being championed by efforts to standardize professional midwifery. While traditional midwifery knowledge is tied to local and national histories, professional midwifery is international. Where traditional knowledge is ancient and

ancestral, professional knowledge is contemporary and based in Western science and biomedicine. Where traditional knowledge is individualized and adaptive to the needs of specific communities, professional knowledge is conceptualized on a global scale and implemented in an ostensibly homogeneous manner. Of course, within representations of both traditional midwifery and professional midwifery there are unavoidable and constant contradictions – such as when traditional midwives are painted as static vessels of ancient knowledge in one scenario, and then as flexible and adaptive to community change in the next. Such contradictions point back to the underlying impossibility of segregating concepts of tradition and modernity, or the local and the global.

While there are still many holdouts to the official division of traditional and professional midwives (indeed, many informants wistfully imagined the category of "*partería sin apellido*" – midwifery without a last name), the process of standardization and institutionalization seems, at this point, a foregone conclusion. In this process, traditional midwifery is the "other" category, that which does not fit into the standardized format of professional midwifery. As the other, traditional midwifery is at risk – its members are ageing, and are increasingly unable to practice due to the *Seguro Popular* national healthcare system pushing women to deliver in hospitals (see Chapter One for a discussion of this). Efforts to "save" traditional knowledge and practice[18], and to secure a place for traditional midwives in the changing Mexican healthcare system, come in response to standardization. These efforts – made visible in conferences, on social media, and in meetings held nation-wide - reflect a resistance to the hegemonic impositions of biomedical ideals into the realm of women's health in Mexico. In times of rapid social

[18] Traditional midwifery proponents argued for the need to "*guardar*" (protect) its knowledges and practices in the face of biomedical expansion.

change on a national level - when literacy rates are growing rapidly, urbanization is speeding up, and Western science has a broader reach than ever before - these efforts also mark an attempt to preserve and find value in ways of knowing that do not fit neatly into plans for national development. Giving up traditional ways of knowing signifies putting trust into a system that has consistently demonstrated its disinterest in women and the rural poor.

In this chapter I first examine how traditional midwives have been discussed in anthropology, contextualizing today's Mexican traditional midwife within these discussions. My research confirms and builds on anthropological work that situates midwifery as a lens through which to understand modernity, development and the biomedical reach (Bourgeault et al. 2004, Davis-Floyd 2001, Ginsburg and Rapp 1991, Kaufert and O'Neil 1993, Simonds et al. 2007). However, such scholarship has not unpacked the dual identities that make up traditional midwifery as seen in Mexico – that is, its simultaneous ties to ancestry and alleged local flexibility. In order to understand how these two identities are formed, deployed and put into conversation, I examine traditional midwifery's presentation throughout a conference held in Chiapas, Mexico, in 2010. I choose to focus on this conference because it was a place where traditional midwifery was actively being discussed as a dying field of practice in need of support, invigoration, and attention. The messages that emerged throughout this conference reinforced those I heard elsewhere in the field, but were heightened because of the public and performative nature of the conference. Traditional midwifery was repeatedly presented as something that was simultaneously ancient and static and as something that was individualized, flexible and locally specific. In the final section, I discuss both the

productive possibilities of traditional midwifery's message and the possible dangers of these framings in a time of standards and professionalization. A possible danger that has arisen is that the evidence offered in support of traditional midwifery may become the very evidence used to discredit its practitioners. Ultimately, I am interested in this broader question: as biomedical standards increasingly shape ways of knowing and ways of practicing across the world, what happens to knowledges and practices that do not fit into these standards?

Contextualizing Traditional Midwives

Traditional midwives and their practices have been the focus of much anthropological writing, especially since the publication of Brigitte Jordan's seminal ethnography, *Birth in Four Cultures*, in 1978. In the decades following Jordan's book, studies have examined alternatives to biomedical approaches to women's healthcare across global contexts and from varying angles, describing the overlapping categories of traditional midwives, empirical midwives, traditional birth attendants, and indigenous birth attendants[19]. Within these studies, alternative birth practices and their practitioners have been framed in different ways: as connections to local traditional histories, as revolutionary practitioners, as targets of biomedical colonization, and as a form of resistance against hegemonic biomedical institution that seeks to return power to women (Simonds et al. 2006).

Proponents of traditional Mexican midwifery refer consistently to the intimate relationship between traditional midwives and their cultural contexts; within

[19] In this dissertation I refer to "traditional midwives" rather than TBAs or indigenous birth attendants, because that is how my informants referred to themselves and each other.

anthropology, this relationship has also been stressed. Cecilia Benoit and Robbie Davis-Floyd argue that, "neither midwives' knowledge base nor their socialization are arbitrary; rather, each is shaped by the larger culture and structure of society that generates it" (2004:183). This is not to say that traditional practitioners are bounded by their immediate geographical boundaries; rather, that the manifestations of information flows throughout space and across time become evident in practitioners notions of tradition. Similarly, Mei Zhan has illuminated how traditional healing practices in general must be understood as co-created through the multiple entanglements they have with "translocal encounters and from discrepant locations" (2009:1). For Zhan, traditional practices are "made *through*- rather than prior to" these encounters (2009:1).

By situating traditional midwifery within social and political systems, anthropologists have argued that it is important to avoid the romanticization of midwifery as an a-historical phenomenon that stands outside of current manifestations of inequality. Rather, we must consider traditional midwives and their practices as current reflections of modern power and resistance. Midwives in Bijnor, India, for example, are not seen as possessors of special knowledge or skills, but rather as women of equally low status as other women in their social class (Jeffery and Jeffery 1993). Such observations are important because they challenge the trope of the midwife as a revered alternative to colonizing biomedicine, and urge us to contextualize midwives instead within their actual social context. Patricia Kaufert and John O'Neil further argue that we must understand midwifery as belonging to a fluid category that is directly affected by the political economy in which they work. Midwives in the Inuit Canadian northwest, for example, have been devalued as an effect of the government's push to have women give birth in

hospitals (Kaufert and O'Neil 1993). What a midwife stands for in her social and historical context cannot be assumed as stable or universal; I look here then at the specific case of traditional midwives in Mexico in order to both understand and problematize their representation.

Anthropologists have also problematized an assumed division between traditional midwives and their biomedical counterparts, although often their studies begin with this very dichotomy. Faye Ginsburg and Rayna Rapp point out that, "much of the research on indigenous birth attendants originates in evaluations of biomedical interventions" (1991:322). In such work, alternative birthing practices highlight concerns about biomedicine's practices and rapid expansion into developing countries. Nuanced studies of the relationship between biomedical and alternative birthing practices are not one-dimensional, however. Rather, they reveal that "[m]idwives may both appropriate and resist the centralizing, professionalizing tendencies of clinically based birth in their geographic area" (Ginsburg and Rapp 1991:322). It has become more broadly understood within anthropology that traditional medicine does not exist as a separate entity from biomedicine, but rather that the two are complicit and intertwined (Langwick 2011). Mexico's traditional midwives are (as illustrated in this chapter's opening vignette), inevitably entangled with biomedicine's reach, whether they embrace it to some extent or reject it wholeheartedly.

Indeed, it became clear to me quickly during my fieldwork that the term "traditional midwifery" was contested even within the midwifery community, as it had a complicated history of being reimagined by Mexican public health efforts over the years. Fernanda, then director of the CASA professional midwifery program, told me in 2010

that "proponents of 'traditional' midwifery do not realize that many of the things being practiced by these traditional midwives are either dangerous or are not traditional at all!" She went on to explain that many of the actual techniques used by traditional midwives are a result of government interventions since the early nineteen seventies, at which time the government began rounding up the traditional midwives and training them in brief workshops designed to teach them basic obstetrical skills and emergency responses. "They would tell them things like 'external rotations are dangerous' and 'use Pitocin.'" Midwives recalled how they used to sell pre-loaded syringes of Pitocin in Mexican pharmacies, and that traditional midwives were taught in their trainings to use it preemptively during labor, but without much guidance as to dosage or timing. This resulted in midwives injecting women repeatedly until the uterus would get so hard that they could not get the baby out, leading to many maternal and fetal deaths. Eventually, "all this training molded the 'traditional' midwifery of Mexico into something that now has little to do with tradition," exclaimed Fernanda.

And yet, as I found throughout my research, traditional midwives and their supporters continue to depict traditional midwifery as ancient, locally-specific and individualized, despite documented and often problematic interconnections with biomedical trainings. Margaret MacDonald's work on Canadian midwifery reveals that this kind of framing can be a double-edged sword. In Canada, she argues, the depiction of midwifery as an ancient, traditional craft – one which stands in opposition to biomedicine – has done two different things: on the one hand, such depictions "have been symbolically important and politically strategic for practitioners, users, and advocates of midwifery;" while on the other hand they have "been identified as the source of

midwifery's lack of legitimacy by those who oppose it" (2007:7). MacDonald concludes that, "midwifery in Canada has not been reclaimed or resurrected from the past so much as it has been reinvented in the present, out of present-day concerns," such that it "is a product of local social and historical specificity, imaginative connections with ideas of universality, and international midwifery networks and knowledge exchange" (2007:7). Traditional Mexican midwives and their supporters understand and navigate these networks, yet continue to present traditional knowledge as something that exists outside of them. For these midwives, traditional knowledge cannot be separated from traditional ways of knowing, which are, to them, inherently individualized and local.

It is perhaps because of this epistemological differentiation that the midwives I spoke with were interested in how biomedical practitioners knew what they knew, as well. Like many anthropologists studying scientific and biomedical knowledge production, the midwives in my study argued that biomedical practitioners relied on ways of knowing that were not as uniform, universal, and objective as they advertised them to be. Biomedicine and biomedical sciences, like traditional midwifery knowledge, emerge out of specific, situated and local encounters. Michael Montoya demonstrates how such local knowledge, as opposed to supposedly objective scientific knowledge, often "entails oppositional discourses that reveal, rather than occlude, structured inequalities that are embedded in the knowledge" (79). The local knowledges that make up the seeming universals of biomedicine are not seen as objective; yet Montoya, in framing knowledge as partial and situated at every point, reveals the very real work that these local knowledge practices do both for advancing scientific truth claims *and* reinforcing notions of human difference.

The midwives I worked with were quite familiar with the locally specific quirks of biomedical practitioners; indeed, a part of their mission was to expose the ways in which physicians were not attending to evidence-based, internationally-accepted practices. As I discussed in Chapter Four, midwives have become increasingly critical of what they see as obstetric violence in public hospitals, and they see this violence as, in part, a departure from evidence-based practice. However, even as the midwives critique biomedical practitioners for their own subjective interpretation of obstetric care, they argue that local and individual specificity is the very attribute that gives traditional midwifery its value.

Traditional as Personal, Intimate and Individual

In the summer of 2010 I attended an international conference on midwifery in San Cristobal de las Casas, Chiapas, called "*Saber Nacer"* (To Know How to be Born). Organized by the *Luna Maya* (Mayan Moon) midwifery clinic and training site in the same city, it had been advertised as a conference meant to bring together midwives and birth workers from across Mexico – and beyond – to discuss and learn about diverse techniques and issues in women's reproductive health. In attendance at this conference were traditional and professional midwifery students and teachers from across Mexico, Mexican public health investigators, European practitioners, leaders of midwifery organizations and publications from the US and Canada. Most noticeably, there were perhaps fifty traditional midwives that had been bussed in from around Mexico and Guatemala, separated into groups by dialect, region and clothing style. The conference was supposed to be a space for an equal exchange of ideas and techniques between

traditional, professional, and international groups of midwives. More than 450 people showed up, surprising even the organizers and packing the conference grounds. On the first morning, the local traditional midwives led the participants in a ceremony; blessings were said over plants laid out in a circle on the grass, then a procession led everyone over a small bridge and back into the conference room.

"*Saber Nacer* is reminder that women and babies know how to birth. Nature has created elegant system that gives wisdom to women and babies. This knowledge is built in to women and babies, bodies and blood. Midwives are the guardians of this knowledge," began the speaker who opened the conference. She was from the US – the president of a large North American midwifery organization – and spoke in English. She spoke firmly but slowly, and in the dramatic pauses between her statements translations into Spanish and regional dialects could be heard rippling across the large conference space. The words took a while to be translated, but the message was clear – traditional midwifery knowledge was personal and linked to one's connections to nature, bodies, and ancestry. To drive the point home, the speaker brought a few colleagues onto the stage and had them lead a sing-along, chanting in acapella: "We are drownin' out the rhythm on our ancestors' feet…."

The idea that traditional knowledge was personal and passed down through ancestral ties was repeated throughout my fieldwork, and indeed throughout the *Saber Nacer* conference. During lunch that day, I sat next to an older traditional midwife from a nearby mountain community. She was all smiles, with metal caps covering all of her front teeth shining as she recounted stories about some of the nearly 200 births that she had attended over the course of her career. "How did you learn to be a midwife?" I asked her.

She told me about dreams that she began to have when she was younger, in which an old woman would explain to her differences between plants that could be useful for medicinal healing. "She would tell me, 'this plant to prevent hemorrhage, but be sure it has purple flowers, not the white ones.' And then I found it, growing by the river, and we still use that plant!" After she had become known in her community for having knowledge about plants, she was called one day to her first birth. "I had no real training, I just went because everyone thought that the woman and her baby would die. But I received wisdom from God – heat the towels, use *manzanilla* (chamomile) – and in the end, the baby was fine," she recounted. It is possible that this midwife had learned from others in her community about midwifery and plants, yet what interests me is how she herself frames her entrance into midwifery. In her story, training came from a spiritual connection and through the community's decision to call on her as the most authoritative knowledge on plants and healing.

Violeta, another traditional midwife who spoke at the conference, repeated this notion of being called by the community and of inheriting knowledge. "The first time I delivered a baby alone, I was 14 years old," Violeta told one group of assembled midwifery students. "My mother was a midwife, but no one else was home, and a man arrived at my house telling me I had to go with him to help his wife, who was in labor. I went, and everything was going fine, until the woman was about to deliver her placenta. Suddenly, I noticed that it did not look right – it was in fact not the placenta, but another baby. My first birth as a midwife, I was all alone and delivered *twins*! My mother got home later and was angry at me for doing this by myself, but I didn't have a choice!" Violeta described how her own children now accompany her and learn from her, a

process that she says is "like a tradition now." Thus, tradition here takes on the double meaning of referring to a form of knowledge that is differentiated from science and to a way of learning that happens between mothers and their children. This second meaning of tradition is important because it links this category of knowledge to a particular social and historical context. Knowledge that is passed between women is not dependent on formal structures of education. In a country where nearly five percent of the population is illiterate, most of the illiteracy is concentrated in indigenous, rural areas, and more than half of the illiterate are women, the role of having a tradition of handing down knowledge via other routes cannot be overlooked (Narro Robles and Moctezuma Navarro 2012).

Another common way that traditional midwives described how they learned was in terms of a differentiation from science-based education. Violeta was quick to note to the students that, "I have no scientific knowledge; I cannot say that I learned from a book. I learned *traditional* knowledge and that is what I use when I give consultations in my home." This comment served both as a proud marker of Violeta's lineage and as a justification, perhaps, for any gaps in her "scientific" knowledge. Similarly, Doña Guadalupe, one of the founders of CASA's midwifery school who still teaches and sees patients there, consistently introduces herself in conferences and meetings by reminding everyone that "*Yo soy partera tradicional,* no *profesional*" – "I am a traditional midwife, *not* a professional one." By distinguishing herself as traditional, and not professional, Dona Guadalupe marks her way of knowing (and, in her job, teaching) as distinct from professional knowledge.

Traditional midwifery knowledge is not only passed through generations of women, however; there exist both casual flows of knowledge between friends and

colleagues as well as structured moments of teaching in which traditional midwives impart their knowledge through midwife-organized trainings, workshops, or conferences. These latter modes of transmission are becoming increasingly the primary ways that traditional midwifery knowledge does get passed on to others, as traditional midwives are aging and dying out, and younger women in their communities are less interested in learning from them and carrying on the midwifery career. Traditional midwives who continue to practice also use these methods to network with each other, especially if they do not have other local, practicing traditional midwives with whom to discuss techniques or tools. However, many traditional midwives I spoke to agreed that conferences often turned out to be performative spectacles or social occasions. Often, the conferences were put on with much influence of foreigners, or with foreign attendees in mind. One traditional midwife told me that when she had announced to her colleagues that she wanted to get registered with the state as an "official" traditional midwife, "they told me that I had better learn English so that foreigners could come take me to conferences."

Doña Guadalupe, for example, admitted to me at the Saber Nacer conference that she much preferred to learn from individual midwives, rather than through such large conferences. She said that the conference itself was a political and social experience, not a place where you could really pick up new skills. Her method of learning, she said, was to directly ask traditional midwives wherever she travels (and she travels often, due to her position as one of CASA's founders) about what kinds of plants are available in their regions for certain pregnancy or labor concerns. I had seen her prescribe zoapatle (scientific name: *Montanoa tomentosa, Compositeae*) as a natural oxitotic alternative to the drug Pitocin, used to bring on contractions in many patients who had passed their due

dates and needed to be nudged into labor. She kept a plastic grocery bag of the dull green leaves in her desk drawer, such that she could hand out a handful to a patient when necessary, instructing them to brew a strong tea with the leaves and wait to see if labor ensued. When she travelled, she said, she was always interested in what other traditional midwives used to induce labor or speed things along. "Here in this region, we use the zoapatle, but the name varies in different regions. When I was travelling in the south, in Chiapas, I asked them what herb they used there and they told me about a different one, called '*puntitia del nispero*,' which turned out to be the young leaves of the *nispero* (loquat) plant." In these person-to-person interactions, knowledge passes between traditional midwives; it is local knowledge, passed on an individual basis, not through books or databases. In many cases, it is not applicable across geographical boundaries – some plants only grow in some regions, and thus midwives find their own local variations. Books do exist, although it would seem that they are seem to be mostly for professional midwives, researchers, or other interested outsiders – anthropologists, perhaps? - who want to learn about traditional medicine. For example, one book that was being passed around in the midwifery school in Oaxaca had been written by Doña Queta, a traditional midwife from nearby who was known for her knowledge of medicinal plants. The book, entitled "Traditional Medicine: Doña Queta and the Legacy of the Cloud Dwellers," had nice, big, color photographs, and was making the rounds through midwifery conferences around the county. The prohibitively high price tag - $600 pesos, or about $50 dollars – made it clear that this was not meant as a traditional midwives' desk reference, but rather an anthropological collector's item.

In a country where women – especially rural and indigenous women – have historically had less access to formal education, individual apprenticeships and self-reliance make sense. As education rates improve, however, many traditional midwives worry that the next generation will not want to carry on their ways of knowing. Their daughters wanted to move to larger cities, and if they were interested in their mothers' career paths they opted to study nursing or medicine. At stake for the existing traditional midwives is not only the loss of traditional midwifery, but also the loss of a way of knowing that is based on their personal connections to other midwives – primarily female relatives. Further at stake is the loss of ingenuity that is integral to traditional midwifery. That is, what many traditional midwives came to share in the *Saber Nacer* conference were techniques for dealing with complications in labor that they had found ways to resolve because there was no one else to help. The lowest education levels in Mexico map onto the places that most lack access to biomedical care, and thus traditional ways of knowing have filled in the gap to provide the kinds of care necessary for the particular needs of their communities. In the next section, I look more closely at the relationship between knowledge and place, asking: how are traditional ways of knowing in Mexican midwifery linked to the places in which the knowledge is developed?

Traditional Midwifery is Local

On the second afternoon at the *Saber Nacer* conference, I ducked out of a sudden onset of pouring rain and into one of the smaller buildings being used to house some of the traditional midwives who could not afford a hotel. I found a spot to sit on a futon in the corner and nursed my third cup of tea of the day, marveling over the coziness of this

space, the constantly full tea kettle, the tray of chocolates. As I settled in to warm up, I noticed that there was an intense conversation going on just on the next futon. An elder traditional midwife, speaking in the Zapotec dialect and being translated into Spanish by her younger companion, was talking to a group of young midwives who were held in rapt attention. She was telling them how she delivers breech babies (babies who are born in a seated position, instead of head-first). "You hold the butt and pull gently during contractions," she told them, her hands moving in front of her as if holding a baby. "Rotate as you go, back and forth... the head may be stuck for up to fifteen minutes." The students leaned closer – delivering a breech baby is considered dangerous and high risk, the kind of thing that traditional midwives are supposed to refer on to physicians. On their faces, I could see the fear, mixed with awe, as they pictured the baby with its head stuck for a full quarter of an hour. The traditional midwife went on to resolve the tension by saying that if the baby *did* end up coming out "pale and lifeless," you should put the placenta into the fire, or even just in hot water, and this would make the life come back into the baby.

The skills presented in stories like this serve an important purpose, I suggest – which is to highlight other possible ways of knowing and other possible practices, all in contrast to biomedical options. Not only do they serve as a contrast to science, however, but also to the access to modernity and urban resources that have been tied to it. Breech baby? No problem. Lifeless newborn? Just heat up the placenta. These stories serve as an important reminder to midwives - who may be working in rural, isolated areas where they are the only care providers - that there are always things you can do, even if you do not have the latest in technology or medicine. As the traditional midwife, Violeta, pointed

out, “In the communities, everyone knows you won’t be having a cesarean section or anything like that. ¡*O paras... o paras!* (Either you give birth... or you give birth!)” The sharing of birth stories, especially difficult births that get resolved by the midwife’s ingenuity, builds confidence and trust into the community, both in their own abilities and in the birth process itself. The structure of the Mexican healthcare system is such that scientific medical expertise flows from the urban centers outward, yet doesn’t always arrive in rural communities with any force, if it arrives at all. Midwives tell these stories of heroic action in the face of vast deficiencies in healthcare resources, then, to mark the gaps that they find themselves filling. Interestingly, Violeta’s assertion echoed a phrase I had heard used derogatively by physicians opposed to the continued support for midwifery in Mexico: “*El bebé va a salir con la partera, sin la partera, o a pesar de la partera* (The baby will come out with the midwife, without the midwife, or in spite of the midwife).” The connotation there is that midwives don’t do anything to actually help during labor and birth, and that ultimately the baby will be born one way or another. While this phrase demeans midwives’ role as care givers, Violeta’s point about the inevitability of birth was that women in rural areas don’t have the biomedical backup and thus traditional midwives provide the only support.

Figure 3: Traditional Mayan midwife demonstrating uterine massage (photo by author)

Later in the same day at this conference I sat down to observe a session led by a traditional Mayan midwife[20] on Mayan abdominal massage during pregnancy. I had to squeeze into a seat, as the room was packed, full of women taking photographs and notes, as the presentation has already begun. The Mayan midwife was short, square, and somewhere around sixty years old, her long braid hanging like a thick rope down her back. She explained that abdominal massage is a very versatile treatment, which can be used for all kinds of things that allopathic medicine cannot fix – she listed infertility, incontinence, ovarian cysts, pain with sex, endometriosis, lower back pain, and a poorly positioned baby as some of the possible symptoms that this procedure alleviates. She gave us this story to illustrate the use of her massage: "A woman showed up in pain, in

[20] The woman who accompanied her to translate her indigenous language into Spanish introduced her as simply *maya,* without further specification.

labor, but the baby was trying to get out sideways. I began slowly massaging the baby during contractions to get it turned. The woman herself had the intuition to move her hips and sway around, and in the next contraction the baby came... the baby was dark blue and not breathing. But then I took the phlegm out of its mouth and began massaging the whole baby and finally it began to cry. Then I blew on the baby lightly. Now, that baby is grown up." As with the story of the breech baby above, this vignette carried its audience through a quick arc, climaxing in a moment of uncertainty and fear but resolving through the midwife's knowledge and skills.

With an attentive audience, the midwife continued by teaching them more about how Mayan abdominal massage works to help women. When treating a non-pregnant patient, she explained, the massage has to do with the uterus and its position; if the uterus is not properly aligned, the body will not be in equilibrium, causing all sorts of problems. A uterus can fall for many reasons; from a car accident, giving birth, or even wearing high heels, she explained. On pregnant women, the massage is mostly used to reposition the baby so that it is head down and ready for an easier delivery. She pointed to a visibly pregnant woman in the audience and asked if she would volunteer to have her baby turned for the group. The woman happily made her way to the front of the room and lay down on a long wooden table. The midwife felt her abdomen, nodding as she went, then announced that the baby was indeed upside down. The audience leaned forward in their seats.

The midwife began to massage the woman's belly, rocking it back and forth and then slowly but firmly pushing the baby so that it would turn. After a few minutes of this, she felt for the baby's head near the woman's pubic bone. Then, taking a step back, she

proclaimed the baby now head down. Camera flashes fired nonstop as the audience members angled to get better views of this demonstration. After a moment, the woman got up, smiling, and went to take her seat. People had lots of questions, and especially wanted to know why she did that without checking the heart tones at least, to make sure that the baby was not in stress or getting the umbilical cord wrapped around its neck. The midwife said that in her community, this is not a big deal – women get their babies turned through the pregnancy to make sure that the baby is head down when it comes to term. And anyway, she said, she can feel the baby's head and then feel for the cord to see if it is pulsating, or around the baby's neck. That is how she knows that the baby is ok; why would she need to monitor its heart rate with additional technologies? Violeta, who had been sitting in the front row of this demonstration, stood up at this point and reminded everyone that "we must understand the context; again, these are rural midwives living in isolated places far from hospital support." The crown murmured their understanding, heads nodding. Violeta said that mothers want to know that the baby will be head down when labor starts, so as to prevent a trip to the hospital should the baby be in the wrong position, and so the idea of routinely pushing the baby into place throughout pregnancy makes sense to them.

In this context, the idea of pushing the baby into place - called performing external rotation, in biomedical terminology – makes sense to mothers and midwives. When there is no backup emergency care within easy distance from where you live, you want to do everything possible to prevent complications. Yet this is not quite the same as the notion of preventative care under a biomedical model; traditional midwives are not necessarily sending women into town to get lab work done, screening them for

gestational diabetes or even high blood pressure – both normal preventative diagnostics conducted in a biomedical setting. For these midwives, and the women they treat, preventative care revolves not around knowing the body through lab tests and mechanical tools, but rather through listening to the woman and feeling the baby. Repetitive turning of the baby may not make sense as preventative care under a biomedical framework – it is not necessary that the baby be head down throughout the whole pregnancy – but when taken within the context of the kinds of risks these midwives strive to avoid it makes sense. Even as fewer and fewer women have traditional midwives attend their births, they continue to visit them for these uterine massages throughout pregnancy; a phenomenon leading some of the midwives I interviewed to comment that traditional midwives across Mexico are reduced to being seen as "*masajistas* (massage therapists)."

The push to standardize professional midwifery in Mexico is part of a global movement to combat maternal mortality by investing in new strategies that target the most at-risk populations. However, proponents of traditional midwifery argue and demonstrate that traditional midwifery is valuable because of its ability to respond most appropriately to the needs of individual communities – not because of any claims to universality. Standardized, biomedicalized forms of care that import ways of knowing from afar may not understand, respect or approach local concerns to the same extent. The very ways of knowing in traditional midwifery are shaped by local necessity. Anthropologists have long illustrated the ways in which what practitioners know is situated. For example, practitioners who have only seen babies born to anesthetized mothers have a different conception of what newborn muscle tone should be than practitioners attending un-medicated mothers (Simonds et al. 2007). What the traditional

midwives at the *Saber Nacer* conference were demonstrating, then, was the ways that their knowledge about birth is shaped by the social, political, economic and historical structures that inevitably impact women's bodies and their health. When towns are too far from emergency hospital support, having a breech birth can mean serious complications or even death; in these towns, then, routine uterine massage intended to keep babies head down is an appropriate intervention that stems from local necessity and experience.

The Inevitability of Biomedicine

While the uterine massage demonstration above reinforced the locally-specific authority of traditional ways of knowing, such specificity is also what often gets used to discredit traditional midwives. While MacDonald argues that Canadian midwifery was discredited based on its links to antiquity (in the face of modern medicine), I argue that in Mexico, traditional midwives' appeal to local specificity may also delegitimize them. This happens because of biomedicine's supposed universality, its presupposition that Western science does not need to account for the local, and its assumption that variation in ways of knowing undermine efficiency and effectiveness. The divergence between traditional ways of knowing (as local and individualized) and biomedical ways of knowing (as standardized and, ostensibly, universal), and the resulting demonstration of authoritative roles in medicine, became clear during a presentation at the *Saber Nacer* conference.

The afternoon session in which traditional midwives from across the state of Chiapas were going to demonstrate some of their routine practices for prenatal exams and deliveries was packed. It was held in a large plastic tent on the grassy conference

grounds, and when I got there it was already filling up; there were three distinct indigenous groups of traditional midwives in their local attire, and around the periphery stood professional midwifery students, urban Mexican and foreign women waiting with cameras and notebooks in hand. Translators were arranged in each corner for the various languages present. The volunteer in charge of the session banned photographs, to the disappointment of those who had been hurriedly snapping shots of ribboned braids, wrinkled hands, and colorful skirts.

Each regional group of midwives took a turn on the center stage, acting out their responses to typical situations that they deal with in their community practices. The tent was noisy with the buzz of translators – regional dialects into Spanish, then into English, then questions funneled back through the same chain of languages. Spectators quickly realized that this presentation was more performative than educational, as the situations acted out by the midwives were formulaic and lacking in detail; in general, a midwife would perform entering a laboring woman's home, checking her belly, getting her into position for the birth, and "catching" a plastic baby doll that emerged from beneath her skirt. The women acting out these scenes had a hard time keeping a straight face, giggling into the backs of their hands. At times, foreigners would ask questions about why certain positions were being used, or what the midwives would do in case of emergency situations, but the answers seemed lost in translation. It began to get hotter and hotter as the sun hit the plastic tarp above us, and in the middle of one group's presentation, an observer quietly slid to the floor and began seizing.

For a moment, no one did anything – the theatrical setting threw everyone off and reactions were slow. Then, suddenly and in multiple languages, suggestions were thrown

at those closest to the now unconscious woman. “Blow on her head,” “don’t touch her,” “touch her,” “open the tent,” “put water on her,” were some of the suggestions being yelled in different languages at those closest to the woman. But quickly the chant turned from these suggestions to “isn’t there a doctor here? There must be a doctor here. This is a medical conference. Someone go find a doctor!” at which point someone went running through the tent flaps, coming back momentarily with one of the few men in attendance at the conference. The doctor, dressed in a white *guayabera* shirt and white linen pants and a white fedora hat, looked the part. The relief in the tent was palpable when he rushed in, calmly asked some women to make a stretcher out of their *rebozos* (shawls), and carried the woman off.

This performance of traditional midwifery reiterated much more than the techniques and knowledges deployed by various midwives from the region; it displayed the established hierarchy of authority between practitioners. The appeal to the physician by the midwives and attendees alike reflected an inherited assumption of trust in biomedical practitioners. Once the woman had been taken away, no one seemed interested in the demonstration anymore. A pained silence slowly erupted into flustered conversation, and eventually we all filed out of the tent and found our ways to the next session. Later that evening, the news filtered through the group that the woman who had fainted was going to be just fine.

What does it mean for a doctor to be called in during a midwifery conference, by the very midwives that had, moments before, been asserting their experience and authority in the field of health? For me, this situation highlighted again the fact that traditional midwives and biomedical practitioners ways of knowing rely on distinct

premises: for the traditional midwives, knowledge is tied to intimate relationships and known places, whereas for biomedical practitioners, knowledge is universal and removed from the particular and the situated. Of course, as anthropologists have long shown, biomedicine is always inevitably tangled up with locality, individual experiences, and intimate relationships – and of course, traditional midwifery cites its own sets of universals. What I argue here is thus not that the ways of knowing in traditional midwifery and biomedicine are irrevocably distinct in practice, but rather that the loss of an explicit reliance on knowledge as a product of intimate, local entanglements is at stake in the biomedicalization of midwifery in Mexico.

Conclusion

Throughout the *Saber Nacer* conference, references were made to the need to preserve, protect and promote traditional midwifery in the face of a changing healthcare system and a national push towards standardized, professional midwifery training. Such calls were met with vigorous support from the attendees, but in my one-on-one conversations with them outside of the conference setting, most were pessimistic that traditional midwifery, in its current form, would survive the coming changes. People likened the situation in Mexico to that of the US and Canada in the 1950s and 1960s, when the traditional midwives disappeared from the scene (to return later with counter-culture movements). Suzanne, founder of CASA's professional midwifery school, used this parallel to justify the need to standardize professional midwifery training nation-wide, in an effort to preserve at least some remnant of midwifery care in the face of poor obstetric care in hospitals. She optimistically said that Mexico has the opportunity to

include traditional ways of knowing into its professionalized midwifery, although she fears that this opportunity won't last long. "We still have traditional midwives here," she commented, " who are alive, who have skills, and knowledge, and we want to learn from them before they die." Suzanne sighed, then added that, "hopefully it won't happen. Hopefully what will happen is that medical students will get better training on how to better attend women, doctors who are doing births will be trained to be better kinder nicer people, to learn what normal birth is about, obstetrical nurses who have never attended births in their lives will start having clinical rotations and start being able to attend births whether its in the cities or the rural villages, and there will be technical level midwifery schools that make it an open, true option for people who have lesser education who can obviously become good midwives even though they haven't gone to college. I mean that's the 'we'll all live happily ever after' scenario." In this scenario, the individualized, local ways of knowing being championed in the *Saber Nacer* conference are still rendered obsolete in exchange for standardized training opportunities.

What traditional midwives know and how they know it are both symptoms of their historical, political and social situations; what is at stake in the loss of traditional knowledge, then, are linkages to these situations. Yet it is the very situatedness of traditional knowledge that renders it vulnerable, just as it is the standardized and homogeneous nature of biomedicine that gives authority to doctors and professional midwives. When the woman fainted at the conference, this dichotomy became clear: every midwife had a different way of approaching the situation, and this chaos came across as ineptitude in the face of the decisive and authoritative doctor.

In this chapter, I have focused on ways of knowing in traditional midwifery in order to shift the conversation about traditional practitioners away from what they know to how they know it, and to argue that how they know things matters. As Brigitte Jordan reminds us, "when we, as analysts, say that somebody 'has' knowledge, authoritative or otherwise, this constitutes a commitment to try to come to an understanding of how participants in a social setting make that fact visible to each other, ratify it, enforce it, elaborate it, and so on, since we see knowledge not as a substance that is possessed by individuals but as a state that is collaboratively achieved within a community of practice" (1997:58). In this case, then, what traditional midwives know cannot be understood without understanding how they come to know what they do, and what kinds of political, social and historical factors have shaped such ways of knowing. What it is that traditional midwives know is varied, locally-specific, contingent on what they have been exposed to, and non-uniform across time and space. For example, while some traditional midwives know how to perform external rotations of babies in utero, others may know how to prescribe homeopathic medicines (which come from Germany, originally), flower essences, or Chinese herbs. Some may know how to use essential oils for relaxation during labor, while others know how to use their local herbs in *temascales* (sweat lodges) postpartum. In conferences like *Saber Nacer,* these knowledges are demonstrated and appreciated, and yet the take home message is more about the breadth of possible practices and less about learning all of them for one's individual career. It is this variability that lies at the root of concerns about traditional midwifery, and which has in part spurred the government into agreement to standardize a professionalized, biomedically-infused education for midwives.

When traditional midwives demonstrate and discuss their ways of knowing as direct results of their ancestral knowledge and the changing needs of their communities, they do so against the backdrop of encroaching change. As fewer women seek out traditional midwives, fewer young women express the desire to learn traditional midwifery from their mothers or community members, and the government increasingly supports the standardization of biomedically-trained professional midwives, traditional midwifery is literally a dying occupation. Conferences such as *Saber Nacer* are motivated in part by fears of the loss of traditional ways of knowing, and seek to bring attention to its values in the face of its decline.

CONCLUSION

This dissertation has examined the emergence of a new model of professionalized midwifery in Mexico and situated it within the confluence of shifting ideas about what constitutes tradition and what it means to be modern in the context of development. I have argued here that midwifery's current resurgence in Mexico is due to the combined impacts of various grassroots movements to promote a different way of approaching women's health and national concerns about maternal mortality as a development indicator. Further, I have argued that with the resurgence in authority for midwives have come both opportunities and new challenges for those trying to create sustainable models of midwifery education in Mexico. By observing with, interviewing, surveying and getting to know many different kinds of people involved and invested in the current midwifery movement in Mexico, I have described the current standing of midwifery education there today and highlighted the specific lived experiences of those who are learning and living as midwives in this time of changes.

Woven through the ethnographic chapters are three related arguments. First, I argue that shifting development priorities and policies related to women's health in Mexico have produced both new barriers and new opportunities for midwives there. Second, I argue that not only what midwives need to know, but how they should learn and where they should practice are all central to debates over the future role of professionalized midwives in Mexico. My third argument is that the increased authority and presence of midwives in the healthcare system has led to new formulations of

critiques against biomedical care in Mexico. Through these arguments, we can see how specific political, social and historical shifts create the conditions for some ways of learning, knowing and doing in medicine, while precluding others. If we want to understand how health is conceptualized and how healthcare is taught and practiced, we must avoid universals and instead engage with these specifics.

Research was conducted for this dissertation over a period of 17 months, between 2009 and 2012, and included participant observation, surveys, and interviews. I was based primarily at CASA school and clinic of professional midwifery, but also spent time at *Mujeres Aliadas* and *Nueve Lunas* midwifery schools. Further, I visited smaller midwifery training centers, clinics, and individual midwives across Mexico, in addition to attending national conferences and talks related to women's health and midwifery as national concerns. Throughout my research, I worked with midwives, midwifery students, school administrators, activists, politicians and doctors in order to understand midwifery from multiple perspectives. I was interested both in the individuals and institutions behind the push to professionalize midwifery as well as in those self-labeled "traditional" midwives who did not fit into visions of professionalization. Throughout my fieldwork, I maintained a focus on the interactions between midwifery, the existing healthcare system, and broader political trends related to women's health. Of particular importance among these trends was the national response to the United Nation's Millennium Development Goal to reduce maternal mortality by 75% between 1990-2015; this goal, and the policies and programs that it gave rise to, reshaped how professional midwifery was presented and understood in Mexico during the time of this research.

Doing fieldwork on this topic, at this moment in time, proved to entail a series of tense situations. While I had worked with midwives in Mexico since 2002 and knew going into this project that there were considerable differences between how groups of midwives viewed their goals for women's health and midwifery training, I was not entirely prepared for the pervasive tension I encountered during fieldwork. It quickly became apparent that everyone had much at stake: not only was the route to professional midwifery certification being discussed on state and national levels, but contests over midwives' autonomy and the role of the new national midwifery association in making decisions regarding standards for midwifery training and practice was unclear. The three schools where I primarily conducted my research were all struggling to maintain the resources and legitimacy they had, while reaching towards higher goals of official recognition, funding and future security. Individual students were struggling to finance their educations, while balancing the even more stressful conflicting messages they received while in clinical rotations at public hospitals and in their midwifery coursework.

As an anthropologist who had known and worked with many of the midwives, administrators and students for years preceding this doctoral research, I was viewed both as a friend and confidant and as a potential expert about what was going on elsewhere in the country and internationally. When I visited different schools, the administrators wanted to know how the others had forged relationships with politicians and government agencies, such that they might try the same tactics; what became apparent, however, was that what worked in one site might not work in another. State politicians changed frequently, and a pledge of loyalty to the midwifery cause by one politician could be forgotten as soon as she/he left office. Complaints of corruption were the norm, and the

schools were exhausted from dealing with constantly changing representatives. Despite this exhaustion, I was constantly impressed by the tenacity with which the schools and individual midwives and students continued – and continue – to fight to gain legitimacy and official recognition. As this dissertation shows, their fight falls during a time when state interest in midwifery has been heightened because of international development concerns regarding maternal mortality, and the corresponding suggestion that developing countries invest in midwifery education as a strategy to combat it.

A broader goal here has been to maintain a balance between recognition of the temporal, local and individual specificities of Mexican midwifery and of the ongoing and global context within which it is evolving. The first section of the dissertation thus examines the broad landscape of midwifery education in Mexico as it has changed through encounters with state and international agencies. Chapter One introduces some of the stakes involved for midwifery and women's health in Mexico by opening with a discussion of inequality and poor treatment of women in the current Mexican public healthcare system. Even as cesarean section rates skyrocket across private hospitals in Mexico and the free national healthcare system, *Seguro Popular*, broadens its scope, women continue to face barriers to access to care, mistreatment within the healthcare system, and stubbornly high maternal mortality rates. Despite the seemingly antithetical nature of midwifery against a backdrop of technological advance in the field of medicine in Mexico, midwives find purchase in the argument that the over-medicalization of childbirth has not led to significant enough improvements for women's health. However, how midwives learn, what they need to know, and where they will ultimately practice are

questions that must be addressed before midwifery becomes fully integrated into the existing system.

Of course, midwifery in Mexico is nothing new; indeed, its ancestral ties and romanticized imagery alternatingly lends weight to its continued presence and destabilizes it. Chapter One gives more background on the historical roles that midwives have played in Mexico, their educational opportunities over time, and the relationship between growing concerns over maternal mortality and the state's reconsideration of professional midwifery education as a valid development intervention. With the convergence of grassroots efforts to promote midwifery in Mexico as a way to improve the quality of women's healthcare and the United Nations' Millennium Development Goal to reduce maternal mortality by 75% by 2015, midwives have been able to reassert the need for their profession at this moment in time. I argue, however, that the national emphasis on reducing maternal mortality has both enabled new possibilities for midwifery in Mexico and also reframed the way midwives have to sell their profession; discussions of the humanization of birth or the improvement of the quality of women's healthcare experiences may be lost or buried in favor of arguments that midwifery is a useful development strategy for addressing maternal mortality.

Chapter Two discusses three of the primary models for midwifery education in Mexico that exist today, emphasizing how international and national conceptions of development and modernity create both limits and opportunities for midwifery education. I argue here that what is at stake in the standardization of midwifery education is the multiplicity of goals for women's health that are represented in the existing diverse midwifery schools. By looking at these early debates between schools and the state over

what standardized midwifery education should entail, I contribute to discussions about processes of standardization and, more specifically, the production and circulation of knowledge in health and medicine. Models for medical training must be understood within the socio-political contexts in which they were forged and allowed to flourish; here, we see how midwifery education is being given shape by broader trends in development and healthcare in Mexico and beyond.

The three chapters that follow look more closely at some of the consequences of the resurgence in support for midwifery education in Mexico on three levels: for the midwives and their students involved in debates over standardization, for the women they serve, and for those midwives whose scope of practice does not fit into the professionalized model. Chapter Three examines the confluence of ideas around how midwives should learn and practice as they are experienced and lived by individual midwives themselves. I ask why the state's and the midwives' definitions for what counts as a "good midwife" are at odds with each other, and why today's professional midwives may ultimately prioritize alternative methods and medicines above biomedicine, despite their primary training in biomedical techniques. By following one midwife's experiences as a student and practitioner, I am able to show some of the complex and competing influences of biomedical and alternative medicines, development projects, and individual experiences that are shaping midwifery today. Ultimately, I argue that today's professionalized midwifery must balance a dependency on the state that has offered its tenuous support with a commitment to a model of care that explicitly differs from what is offered through biomedical institutions.

The tension between the need to align themselves with development goals to reduce maternal mortality by working with the healthcare system on the one hand, and the resistance to biomedical practices and institutions on the other, manifest most clearly in the emergent midwifery movement against *violencia obstétrica* (obstetric violence). I argue in Chapter Four that this movement has emerged alongside the resurgence in support for midwives, both because midwives are increasingly present to witness injustices within the healthcare system and because midwives have more of a voice politically at this point. However, I describe the difficulties faced by activists in making *violencia obstétrica* a regulated and legislated category of offenses. These difficulties, I argue, emerge from tensions between ways of thinking about obstetric violence as a list of measurable and acute offenses and ways of thinking about it as an underlying, systemic and structural form of violence. In such, the midwives' struggle to define and address obstetric violence mirrors broader social struggles to address violence on multiple registers as it pertains to gender, inequality and society.

As midwives nationwide fight to secure roles for themselves and futures for their students, divisions between self-labeled categories of "traditional" and "professional" midwives grow. Chapter Five focused on those traditional midwives whose training and scope of practice do not fit neatly into development goals for professionalization and standardization by examining the proceedings of a national midwifery conference held in Chiapas in 2010. Rather than reifying their knowledge and practices as static and historical, I argue that what is at stake in the slow disappearance of traditional midwifery is a way of knowing that is situated, both temporally and locally. If traditional midwives are further pushed out of the system in favor of professionalized midwives, ways of

knowing that reflect the needs of specific communities at this moment in time may be lost.

Taken together, these chapters lay bare both the productive possibilities and the challenges to practitioners that are emerging through new interactions between Mexican midwifery organizations and the state. They also aims to inform broader understandings of how grass-roots solutions are able to gain global recognition and how these local solutions then feed back into the global imaginary of what is possible and what works. As women's health issues from maternal mortality ratios to cesarean section rates to homebirths gain international press and scholarly attention, complex layers of solutions are being tested and applied worldwide. However, not all interventions translate equally across borders. This dissertation shows how health care and health education emerge through complex interactions of goals, legacies and knowledge production at local, state, national and international levels.

Since I returned from the field and began writing, many things have already begun to change for Mexican midwives. CASA's first sister school, which had just opening in the state of Guerrero when I left the country, has now been in operation for three years. The National Association of Mexican Midwives, whose first open meeting I attended in 2012, has grown in numbers and is meeting regularly, with a broad agenda for social change and visibility for midwives' issues nationwide. CASA is in the initial stages of beginning an online learning program for those who wish to become professional midwives but cannot move to a school location; preceptors will be found for them locally to allow them to complete clinical rotations near home. With this online option, the entire landscape of midwifery education has the potential to change.

Circumstances have also changed for many of my midwifery informants. Students have graduated and gone on to study other things, work, or complete their year of social service as practicing midwives. Some have been scooped up by development initiatives, such as one put in place by the World Bank in Chiapas to reduce maternal mortality by investing in professional midwives. In my more recent conversations with one of the CASA graduates participating in this Chiapas program, I was suddenly surprised to recall that, despite of her accomplishments and current role in development politics, she was still only 22 years old.

Politically, the movement against *violencia obstétrica*, which was just beginning during my fieldwork, has now gained increasing media attention. The collective voice of the National Association of Mexican Midwives has helped to publicize this movement, in large part through their presence on social media platforms like Facebook. Indeed, the growing participation of midwives, doulas and birth activists on Facebook pages reinforces the sense that midwifery in Mexico is gaining strength. As many midwives nationwide do not have access to peer reviewed journals, or may not be able to attend national meetings or conferences, social media opens up a new channel for communication, sharing of information, and organization. I plan to examine this phenomenon more closely in future research.

While this dissertation has argued for the need to pay attention to the temporal and local specificities of midwifery knowledge, practice and education in Mexico, I also argue that its current reemergence must be understood within the global context of midwifery today. Mexican midwifery is not only going through this resurgence as a response to development strategies to reduce maternal mortality; it is also drawing on the

examples of established systems of midwifery in developing nations such as the US, Canada, and across much of Europe. The depiction of the Mexican midwife as an indigenous, uneducated and unsafe practitioner becomes harder to maintain alongside the growing use of midwives by educated, high-income families in developed countries. What Mexican midwives know, how they know it, and how they frame their knowledge cannot be separated from the social and political contexts in which they practice and defend their authority. As Sandra Harding argues, "[w]omen's knowledge has been and remains crucial to the advance of 'modern' knowledge. Thus, women's knowledge is just one necessarily continuously produced and reproduced element of global systems of (always only local) knowledge" (1998:122). Thus, while midwifery continues to be a term associated with the past, and with traditional midwives, it is also increasingly a global, cosmopolitan and modern profession.

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