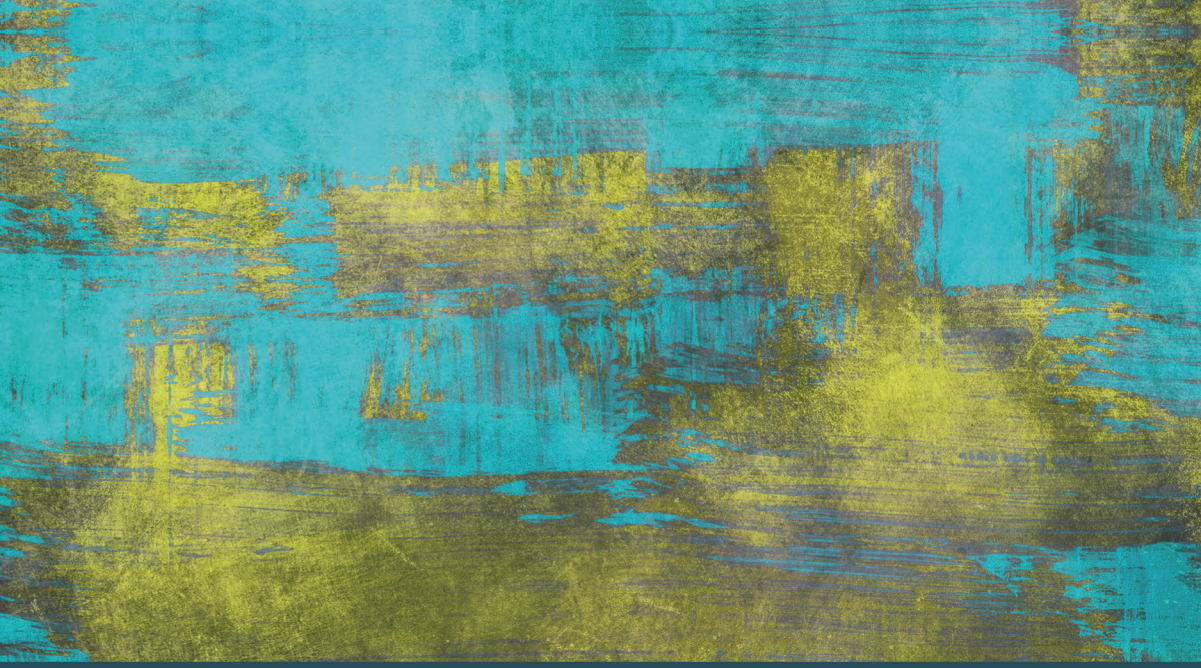
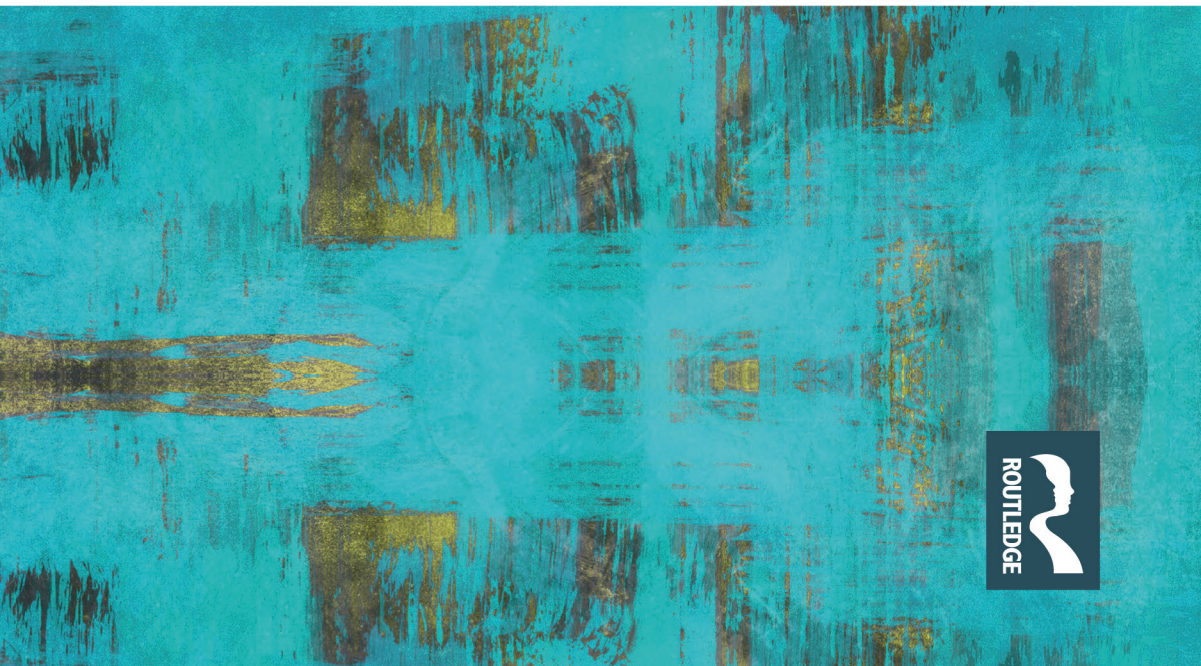


Social Science Perspectives on Childbirth and Reproduction

MIDWIVES IN MEXICO

SITUATED POLITICS, POLITICALLY SITUATED

Hanna Laako and Georgina Sánchez-Ramírez



Midwives in Mexico

This book presents the contemporary history and dynamics of Mexican midwifery—professional, (post)modern or autonomous, traditional and Indigenous—as profoundly political and embedded in differing societal stratifications.

By *situated politics*, the authors refer to various networks, spaces and territories, which are also constructed by the midwives. By *politically situated*, the authors refer to various intersections, unsettled relations and contexts in which Mexican midwives are positioned. Examining Mexican midwiferies in depth, the volume sharpens the focus on the worlds in which midwives are profoundly immersed as agents in generating and participating in movements, alliances, health professions, communities, homes, territories and knowledges. The chapters provide a complex panorama of midwives in Mexico with an array of insights into their professional and political autonomy, (post) coloniality, body-territoriality, the challenges of defining midwifery and, above all, into the ways in which contemporary Mexican midwiferies relate to a complex set of human rights.

The book will be of interest to a range of scholars from anthropology, sociology, politics, global health, gender studies, development studies and Latin American studies, as well as to midwives and other professionals involved in childbirth policy and practice.

Hanna Laako is an associate researcher at El Colegio de la Frontera Sur (ECOSUR) and the University of Eastern Finland (UEF). She is also a member of the Mexican National System of Researchers (CONACYT).

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Midwives in Mexico

Situated Politics, Politically Situated

Hanna Laako and
Georgina Sánchez-Ramírez

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This book is dedicated to Mexican midwives, whom we hope will always thrive.

And to our children, Aurora, Lumi and Andrés, whom we also hope will always thrive in their lives.

Contents

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Foreword

> *We show that, while the crucial differences and uncomfortable tensions among midwives and the differentiated realities they revisit exist, the perspective of situatedness enables us to demonstrate as well the unifying and universal movements, alliances and struggles for human rights in childbirth that emerge from within the contemporary midwiferies of Mexico… [O]ur broader objective and desire are that this book … might help catalyze the growth of conversations among scholarships in different regions and in support of the development of midwifery studies in Latin America.*
>
> (Laako and Sánchez-Ramírez, Introduction to this volume)

This critically written, thought-provoking volume addresses Mexico's multiple midwiferies in all their fascinating, shape-shifting forms. I am proud to claim it as part of the Routledge Book Series addressing *Social Science Perspectives on Childbirth and Reproduction,* for which I serve as lead editor.

As my (now deceased) friend and mentor Brigitte Jordan (1993) so famously noted, "birth is everywhere culturally marked and shaped"—and I note here that *midwifery too is culturally marked and shaped*. As the authors of this excellent book show, there is no universal, standardized "midwifery." Instead, within Mexico and around the world, there exist multiple "midwiferies," each grounded in its particular geographic, demographic, genealogical and political contexts. For Mexico, Hanna Laako and Georgina Sánchez-Ramírez have identified all of these Mexican midwiferies—traditional, Indigenous, *mestiza*, professional, technical, nursing-oriented, postmodern/autonomous, hybrid and "midwives in the tradition"—illustrating their similarities and differences and the implications of these for the tenuous future of Mexican midwifery as a whole. As the authors point out, all midwifery knowledges are "situated" within their contexts, and studying this situatedness allows us to hear the voices of both the subaltern and the dominant, the silenced and the vocal.

For the past 30 years of my academic research and in my personal life, midwives have been much on my mind. Like the authors of this volume, I have lived, breathed, studied and participated in ways both large and small in the advancement of midwifery in my own country—the USA—and in Mexico, Brazil, New Zealand and the Netherlands, immersing myself in their worlds

just as the authors of this volume have immersed themselves in the multiple midwifery worlds of Mexico. And I have a vision for the future of midwifery. Having examined the outcomes of midwifery care in many countries, I, like many others, have come to the inevitable conclusion that *midwives should be the primary, autonomous caregivers for at least 80% of all mothers,* while obstetricians, with their focus on the pathological and the high-risk, should be confined to attending only around 20% of pregnant and birthing women—those who are truly high-risk and who actually need their interventionist care. This is the case in New Zealand, which to my mind boasts the best midwifery system in the world. In this system, midwives are present at 100% of births, even scheduled cesareans, and are chosen as primary caregivers by over 90% of pregnant women. And indeed, midwives *should* be the first line of care, referring women to obstetricians only when necessary or when that is the woman's choice.

Does my vision include traditional midwives, such as those written about in this book? Of course, as they remain the primary caregivers for many women around the world, most especially for those in low-to-middle-income countries (LMICs). As this book shows for Mexico, these traditional midwives are coded by international agencies as "traditional birth attendants" (TBAs) because they do not meet the international definition of a "midwife," delineated in various chapters of this book. Part of my vision includes an expansion of that international definition, to include not only those who have graduated from a government-recognized program but also *those who are recognized by their community as midwives*. I have lived with and observed (self-named) Mexican *parteras tradicionales* attending births. As I witnessed their tender, loving and often evidence-informed care (yes, many do continuously read and enroll themselves in multiple training workshops to learn and to progress in their craft, and long for an official national certification to achieve), I cried inside knowing that such midwives are vanishing from the face of the earth, being phased out of practice by their governments, reduced to bringing women to hospitals to birth and/or simply dying off with no apprentices to replace them. I consider their ongoing disappearance to be a global tragedy.

As Laako and Sánchez-Ramírez point out, the World Health Organization (WHO), the International Confederation of Midwives (ICM), and other agencies have issued a call for 350,000 more "skilled birth attendants," needed immediately. Such organizations *want* traditional midwives to just disappear, along with their skills and their often-ancestral knowledge, to be replaced with professional midwives who do meet the international definition. Yet I wonder, along with others and as also inquired in this book, how many of those professional midwives will choose to live in the rural hinterlands where community-based "TBAs" have long served their communities?

Nevertheless, all developmental signs point to the ongoing elimination of those "TBAs." So, in looking to the future of midwifery, I look not to the traditional midwives (though I wish I could), nor to the thousands of medically trained midwives who practice within the technocratic model of birth,

adding their compassionate, humanistic touches. Rather, I look to the autonomous midwives who constitute a major focus of this book. They liaise with and learn from the traditional midwives in their regions, supporting them as best they can and carrying forward their knowledges—of herbs, of massage, of upright or all-fours physiologic positions for labor and birth. This is not a form of knowledge appropriation: the traditional midwives are freely sharing their knowledges with their professional or professionalizing colleagues. In my vision, traditional and professional midwives work together, supporting each other for as long as the "TBAs" continue to exist.

Thus I consider this book to be of extreme importance, because its authors have deeply studied the autonomous midwives of Mexico, who to me constitute role models for all other midwives. These *parteras autónomas*, as defined by Hanna Laako, may not actually be autonomous in their practices—though some of them are—yet in their hearts and minds they *are* autonomous—fully independent practitioners free to use their own informed judgments about how best to accompany women as they labor and give birth. Hanna Laako's descriptions of these midwives and their "herstories" are rich and detailed. As she notes in her chapters, the autonomous midwives on which she primarily focuses are politically savvy and engaged in the fight for official recognition—legalization, licensure and regulation—according to standards they themselves set, which they have yet to achieve in Mexico. But they are trying. Laako also analyzes the relations between autonomous midwives and Indigenous midwives in "postcolonial" perspective, meaning that interior colonialisms and Indigeneity in midwiferies are importantly addressed.

These *politically situated* midwives, who are engaged in *situated politics*, have goals that are intimately related to those of women's movements, Indigenous movements and the achievement of the honoring of human rights in childbirth. They consider themselves participants in the Latin American movement for the humanization of birth and against obstetric violence. Their political activism, knowledge of midwifery history and the *informed relativism* with which they practice—picking and choosing among different knowledge systems what works best in a given situation—make them postmodern midwives in my definition of such, which the authors fully acknowledge in these pages, fundamentally equating the "autonomous" with the "postmodern" midwife as I have long defined her (see Laako's chapters herein). Because these midwives engage in this kind of relativistic praxis, the knowledge of their traditional counterparts will not be lost as those counterparts disappear, but will be carried forward into what I view as a hopeful future for midwifery, primarily because such midwives exist, both in Mexico and in many other countries. Though they are often marginalized and sometimes actively persecuted for their radical critiques of technocratic obstetrics, still they carry on because they believe so deeply in the evidence-based efficacy of their praxis. They present such critiques both in their writings and in their care provision—simply practicing holistically under the midwifery model of care

(see below) constitutes a radical critique of the hegemonic techno-medical model and serves as a way forward for others.

One of the major problems these postmodern/autonomous midwives face is that most of them do not meet the international definition. With that definition, as is usual in this heavily colonized world, the midwives of the Global North, such as those who founded ICM and those who wrote the international definition (intentionally leaving out traditional midwives) have set the standards by which the midwives of the Global South, and Indigenous midwives everywhere, must abide and be judged if they are to be considered "real" midwives and legalized, licensed and regulated as such. Perhaps some day those midwives will create their own global organization and fight to preserve "glocal" traditional midwifery in its varied forms, writing their own definition and setting their own standards and practice protocols. If only that could happen before they all disappear! Yet at present it seems highly unlikely—how would one get the rural midwives of Uganda or Bolivia connected via the internet when they don't even have access to computers?

Yet in my experience, many traditional midwives do have such access, in libraries or on their own personal computers. Over the years during which I carried out fieldwork and spoke at multiple midwifery conferences in Mexico, I watched them become tech-savvy to the point where, after my PowerPoint presentations, they would show up in numbers with flash drives in their hands asking for copies. So much for stereotyping them as illiterate, premodern vestiges of a past that needs to be left behind in the modern world. In Guatemala, one local organization established by traditional midwives developed a close relationship with their regional Minister of Health, who supported them in their autonomous practice, yet was later fired, possibly in part for providing that support. One step forward, two steps back.

On midwife-led birth centers, Georgina Sánchez-Ramírez shows that, even though international organizations promote "skilled or professional" midwifery globally to reduce maternal mortality, they do not really address midwives as autonomous practitioners. Rather, they address even the "skilled" midwives only as "helpers" of doctors or facilities led by doctors. Yet midwifery autonomy is key to them being able to fully practice "the midwifery model of care," which in my definition bridges what I have long called the technocratic, humanistic and holistic models of birth. Midwives bring technological skills with them to births in all settings, while remaining primarily ideologically focused on the relationship-centered care of humanism and the integral, energy- and intuition-based approach of holism.

Georgina Sánchez-Ramírez also stresses the useful theoretical concept of "body-territoriality," which she is the first to apply to the context of births, highlighting the ways in which midwives can empower and heal the bodily experiences of birthing women who have previously suffered from the obstetric violence that is, unfortunately, so pervasive in Mexican hospitals. She shows that this kind of midwifery can contribute to enhancing the sense

of autonomy of the bodily territory of Latin American women, pointing to bodily enhancement as a strength of midwifery and as a source of peace.

The traditional midwives with whom I worked in Morelos and Oaxaca were keenly aware that they often constituted the only alternative to obstetric violence and the excessive use of cesarean section in their regions—the cesarean section rate of the major Oaxacan maternity hospital was 80% when I gave a talk there in the early 2000s. Almost all of this hospital's obstetricians and obstetric residents attended; all were completely shocked and stunned by the beautiful photos of normal physiologic birth I showed them, as they had literally never seen anything of the kind. When they asked me where they could observe such births, I pointed to Doña Queta (Enriqueta Contreras), a well-respected traditional midwife sitting in the audience, and asked her to stand and say a few words. She gave a moving testimony to the value of facilitating *parto normal*, and issued an open invitation to those doctors to come to births in her (beautiful, colonial-style) birth center—built with funds she received from her multiple speaking tours of the USA, during which she often held two- or three-day workshops for Latin American US citizens who wanted to learn how to "get back to their roots" and "reclaim their heritage." She received a hearty round of applause, but no one actually responded to her invitation. To them, she was a moving and beautiful vestige of a premodern past they honored yet had long ago left behind. In my terms, they lacked the "postmodern consciousness" that would enable them to re-value and adopt at least some elements of traditional midwifery practice. And if any had actually attempted to do so, most likely they would have been roundly condemned, criticized and bullied by their modern, technocratic colleagues, as many of the few postmodern and holistic obstetricians of the world often are.

On a different, important note, Georgina Sánchez-Ramírez and Geicel Llamileth Benítez Fuentes address the majorly understudied issue of midwives and abortion provision. Although abortion is often treated in women's rights and social science literature, and elsewhere, there are few studies that address this "hot potato" issue in midwifery. As these authors note, it is very difficult to even research this topic in a context in which abortion is illegal. They show that the midwives they studied who do perform safe abortions save many women from the dangers of unsafe, "back alley" abortions. In so doing, they generate a great deal of appreciation and "human capital" in their communities by carrying out safe "pregnancy interruptions" according to WHO guidelines. Far from being the hapless victims of state and national reproductive policies, these midwives are active agents flouting the Mexican state laws against abortion by creating safe spaces and providing skilled care to women in need.

In their Conclusions, the authors mention the climate crisis and the coronavirus pandemic, noting that midwives will be even more needed under situations of disasters, pandemics and wars. In *Sustainable Birth in Disruptive Times*, edited by Kim Gutschow, myself and Betty-Anne Daviss and published in 2021 by Springer Nature, my chapter on sustainable and effective maternity

care in disaster zones (co-authored with internationally practicing midwives Robin Lim and Vicki Penwell, and with Israeli anthropologist Tsipy Ivry) clearly shows that the maternity care most needed in the immediate and long-term aftermaths of disasters is skilled, low-tech and high-touch, with minimal equipment—exactly the kind of care provided by autonomous midwives such as those described herein. As in that chapter, here also I stress that in order to prepare for the coming disasters ensured by the oncoming climate catastrophe, including increasing numbers of wildfires and superstorms, rising sea levels and the ensuing displacement of billions of people, *birth care should be decentralized everywhere*. It is the flexible, community-based, independent midwives—both traditional and professional—who will be most needed when hospitals are damaged or destroyed, are inaccessible or become massive sites of contagion, as they did during the COVID-19 pandemic. My latest research has shown that, during this pandemic in the USA, demands for care at home births and freestanding birth centers rose rapidly due to fear of hospital contagion, and to the fact that hospitals were forcing women to bring only one support person, making them choose either their doula or their partner and thereby causing these women great psychological distress. Yet these independent practitioners were unable to fully meet those demands because their numbers were too few. I imagine that this has been the case in Mexico as well. Clearly, we need many thousands more of the autonomous midwives so carefully addressed in these pages.

If this book can help in any way to garner more international support for midwives of all types, and greater national support for Mexican midwives of all sorts, then it will have fulfilled a practical purpose. If not, nevertheless its outstanding scholarship will serve as an exemplar for others engaged in related work. I laud the authors for their success in laying out the varied, multi-colored landscape of contemporary Mexican midwiferies, and for describing midwives' "immersion" in their attempts to build knowledges and trainings, nations and worlds. I applaud the authors for telling midwives' *her*stories in print, thereby preserving them so that others can know that such strong, knowledgeable, dedicated and brave midwives exist in this confusing and disruptive world where techno-medicine (still) prevails. And because such midwives so visibly and publicly exist—even insisting on having their own names used in this book—they can serve as role models for those wishing to follow in their footsteps as they blaze a trail toward their own, necessary vision as stated herein: "a midwife for every mother."

Robbie Davis-Floyd
Austin, Texas
July 15, 2020

Acknowledgments

This book is a result of years of research and "immersion" in Mexican midwiferies. It also brings together our two social scientific trajectories in terms of Mexican midwives. It is a great honor, pleasure and responsibility for us to write this book precisely during the 2020 Year of the Midwife.

Midwives and midwiferies have been our utmost sources of inspiration, knowledges and driving energies both in our scholarly and personal paths, and in the pages of this book. Therefore, we first and foremost wish to thank all the midwives we have had the opportunity to engage with during the past decade and who have profoundly nourished our academic thinking. This book obviously would not exist without you. We sincerely thank you for your confidence in us and for the opportunity to immerse ourselves in your making of midwifery worlds, and in the different personal and political paths you have shared with us while immersed in this craft. *Gracias con todo nuestro corazón por existir. No se rindan, no están solas.*

In addition, Hanna Laako would like to thank the Postdoctoral Scholarship Program of the Mexican National Autonomous University UNAM, which permitted her to carry out most of the research that corresponds to this book, and particularly Jaime Page for his support in this trajectory. I also thank El Colegio de la Frontera Sur (ECOSUR) as my current institution but also as the institution where various parts of this research were carried out. I sincerely thank Georgina Sánchez-Ramírez, who greatly supported my research at ECOSUR, and with whom I have now collaborated in terms of various midwifery books. I extend my gratitude also to various seminars, academic encounters and midwifery forums in which this research, or related issues, were discussed, and which deepened my understanding of the complexity of the topic. Thank you also to those editorials, journals and reviewers who have been involved in my research in terms of the previous publications that sustain my parts of this book.

Georgina Sánchez-Ramírez would like to thank all the women who have formed part of her research for sharing their *herstories* as midwives and mothers, but also as women, who are ensuring in their daily resistance that midwifery does not disappear from this country; that birthing can be a loving and respected act; and that our body-territory will be ours, and only ours, in

all its strength, autonomy, delight and freedom. I also extend my gratitude to my research institute ECOSUR, because this institute has always supported my research initiatives and work in general in terms of the issues that are fundamental to women's health in Mexico. And thank you, Hanna Laako, for having invited me to this adventure, for being so rigorous and serious in the path that we shared; I learned a great deal.

Together we would like to extend our gratitude to Jemima Repo, Anders Widfeldt, Tiina Seppälä and Rosalba Icaza for their support in terms of this book initiative. We are indebted to our reviewers and the Routledge series into which this book was accepted. In particular, we wish to extend our sincere thanks to Robbie Davis-Floyd and James Allan Smith, both of whom took on the tremendous task of revising our long chapters and polishing them linguistically.

We are hugely grateful to Robbie Davis-Floyd for believing in our work, for having been so dedicated to making sure this book would be published, for being there for us in terms of our doubts at any hour, for making great suggestions, for her always excellent editing work and for sharing our passion for Mexican midwifery.

Finally, we want to thank our families, friends and close academic communities for support, friendship, space to write, inspiring dialogues and daily companionship, which is fundamental for carrying out this sort of research and writing processes. To all of you: thank you, *gracias* and *kiitos.*

Abbreviations

ACNM	American College of Nurse-Midwives
AMP	*Asociación Mexicana de Partería*: Mexican Midwifery Association
BC	birth centers
CASA	Center for Adolescents of San Miguel de Allende (Professional Midwifery School)
CEDAW	Committee on the Elimination of Discrimination Against Women
CNM	certified nurse-midwives
COMPITCH	*Consejo de Organizaciones de Médicos y Parteras Indígenas Tradicionales del Estado de Chiapas*; Council of Indigenous Doctors and Midwives in Chiapas
CONAMED	*Comisión Nacional de Arbitraje Médico*; Mexican National Commission for Medical Arbitration
CONACYT	Consejo Nacional de Ciencia y Tecnología (National Council of Science and Technology)
CONAMIT	*Consejo Nacional de Médicos Tradicionales*; National Council of Traditional Doctors
CPM	certified professional midwife
C-section	cesarean section
ECOSUR	El Colegio de la Frontera Sur
EMA	endouterine manual aspiration
GIRE	*el Grupo de Información en Reproducción Elegida*; Information Group on Chosen Reproduction in Mexico
HRiC	Human Rights in Childbirth
ICM	International Confederation of Midwives
IMSS	*Instituto Mexicano del Seguro Social*; Mexican Social Security Institute
INEGI	*Instituto Nacional de Estadística y Geografía*; Mexican National Institute for Statistics and Geography

INI	*Instituto Nacional Indigenista*; National Indigenist Institute in Mexico
IUD	intrauterine device
LEO	*licenciada en enfermería y obstetricia*; obstetric nurse/nurse-midwife
LMIC	low-to-middle-income country
MANA	Midwives Alliance of North America
NACM	National Aboriginal Council of Midwives in Canada
NARM	North American Registry of Midwives
Ob-Gyn	obstetricians and gynecologists; obstetric-gynecology
ODETT	*Organización de Terapeutas Indígenas Tzeltales*; Organization of Indigenous, Tzeltal Therapists
OMIECH	*Organización de Médicos Indígenas del Estado de Chiapas*; Organization of Indigenous Doctors in Chiapas
ReHuNa	Network for the Humanization of Birth
RELACAHUPAN	*Red Latinoaméricana y del Caribe para la Humanización del Parto y el Nacimiento*; Latin American and Caribbean Network for the Humanization of Birth
RM	registered midwife
SBA	skilled birth attendant
TBA	traditional birth attendant
UEF	University of Eastern Finland
UN	United Nations
UNAM	*Universidad Nacional Autónoma de México;* National Autonomous University of Mexico
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRA	White Ribbon Alliance

Introduction

Navigating the midwifery waters in Mexico

Hanna Laako and Georgina Sánchez-Ramírez

This book, *Midwives in Mexico: Situated Politics, Politically Situated*, stems from our long-standing and deep interest in exploring and discussing the multi-layered knowledges, struggles and *herstories* of women who are midwives. We have continuously inquired about what happens to the midwifery craft and to the midwives themselves throughout time and space, particularly in the case of Mexico. Our pursuits in these fields have been both academic and personal. We are Mexican and Finnish scholars from middle-class, urban backgrounds who reside in the southern Mexico state of Chiapas. We are also mothers previously attended by midwives. We have dedicated years to researching how midwives navigate and exercise their vocation in Mexico. In this book, we intend to discuss those issues, pending inquiries and our research results.

What we share as scholars in this line of midwifery research is the consideration of *situatedness*: that is, the ways in which midwives, midwifery and we ourselves are embedded in complex, intersectional contexts that are particularly related to geopolitics, gender, health, professions, ethnicity, class, different spaces, movements, networks and territoriality. This situatedness also forms the undertone and perspective that run throughout the chapters of this book, although each chapter is an individual unit with a particular theoretical frame, immersed as we are in different intellectual traditions of social sciences. From our own personal research trajectories and perspectives (such as gender and health, and postcoloniality), we also critically examine social sciences while navigating the complex waters of midwiferies.

We decided to give this book on contemporary Mexican midwiferies the subtitle *Situated Politics, Politically Situated* because herein we examine how contemporary Mexican midwives—professional, (post)modern, autonomous, traditional and Indigenous—move among and relate to different kinds of societal stratifications as they position themselves in complex intersections in terms of gender, class, ethnicity and coloniality. Although the book addresses the challenges confronted by midwiferies in the context of Mexico, we also extend the discussion, when possible, to broader multiscale settings related to the Global South, the Western, and the Indigenous.

By *political,* we refer to those issues that are at stake in the state of affairs, or even politicized, in terms of midwiferies. By *politics*, again we refer to collective action, networks, spaces and collaborations constructed by the midwives themselves. Thus, *Midwives in Mexico: Situated Politics, Politically Situated* explores midwives and midwiferies as immersed in different political settings and contexts. It also examines both the state and the stakes of affairs in differing, intersectional and multiscale perspectives.

Our book builds on the scholarship that has sought to capture the intersectional, multiscale, historical panorama of contemporary midwifery struggles (such as Jordan 1993; Davis-Floyd and Sargent 1997; Marland and Rafferty 1997; Laako 2017a; Sánchez-Ramírez and Laako 2018). We show that, while the crucial differences and uncomfortable tensions among midwives and the differentiated realities they revisit exist, the perspective of situatedness enables us to demonstrate as well the unifying and universal movements, alliances and struggles for human rights in childbirth that emerge from within the contemporary midwiferies of Mexico.

By doing this, we seek to bridge critical social sciences (which so far have been less interested in the case of midwifery) and midwifery studies (in which such critical social science approaches are less familiar). We also seek to engage with midwifery scholarships emerging from different locations, and in this way to contribute to *comparative* social scientific midwifery studies. This is important because, as we will show in the forthcoming chapters, midwifery as a profession practiced by many kinds of women and attending to all kinds of women reveals various societal stratifications and structures, while simultaneously challenging comfortable binary divisions sometimes provoked by the situated theories.

Creating bridges between critical social science approaches and midwifery studies is also important because, as noted by Jordan (1993), childbirth, birth systems and midwifery always have to do with societal relations, culture, power and politics. Thus, they are key issues for social scientific analysis. In addition, social scientific research on midwifery inevitably obliges us to rethink (women's) professions and work across time and space. It could also be argued that the social scientific study of midwifery is important for understanding women's history in general, as midwives are (almost all) women with professional identities who, nevertheless, do not fit into exclusive categories of oppression, domestic labor or bourgeois power status (Vainio-Korhonen 2012). Instead, midwives are something beyond and in between.

"Situated knowledges" as a theoretical perspective emerged from criticisms of scientific androcentricity made by Western feminist and gender studies scholars, but are currently broadly linked to intersections of gender, subaltern, Indigenous and postcolonial studies. The latter have emphasized the importance of analyzing the *intersections* of women by taking into account their situatedness in terms of geopolitics, class, gender and ethnicity (for example, Haraway 1988; Mignolo 2000; Mohanty 2004; Ortiz 2006; Leyva Solano et al. 2015). Theorists of situated knowledges have argued that, for

too long, women's movements and gender studies have spoken universally for all women without acknowledging fundamental differences among women and their positionings in societies (Haraway 1988; Razack and Fellows 1998; Mohanty 2004).

This theoretical framework also gives an important place to different *knowledges* emerging from the interstices of class, gender and ethnicity. It also emphasizes the ways in which all knowledges are partial, and therefore, that a sufficient degree of objectivity can be gained only by first acknowledging our own situatedness and the lenses through which we analyze our research (Haraway 1988). Situated knowledges have contributed importantly to making visible the differences among voices, knowledges and positionings of so-called "subaltern" women: women from the Global South, Indigenous women, women of color and women of varying gender identities often previously silenced by Western White and heterosexual women. Intersectional theory has deconstructed this previously stereotyped "universal nature" of women's struggles—a stereotyping that has provoked great antagonism among stereotyped women (e.g. Mohanty 2004).

If there is any group of women that has been particularly subject to harsh historical stereotyping, with long-term consequences, that group would be the midwives. Indeed, a great deal of midwifery history has been a constant battle for and against particular imaginaries and/or stereotypes, which may have been either favorable or detrimental, or both, to midwives, who have been variously romanticized and vilified.

Currently, according the International Confederation of Midwives (ICM, 2011) and as endorsed internationally by the World Health Organization (WHO), a midwife is defined on the basis of formal professionalization, and thus is legally licensed in the country in which she works:

> A midwife is a person who, having been regularly admitted to a midwifery educational program that is duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> (ICM 2011)

As we shall see in this book, and has been outlined by other scholars, this contemporary definition is considered very exclusive: since midwifery as a profession was eliminated in many countries, or simply was not professionalized or licensed as an autonomous profession, there are many full-time midwives who do not fit this definition. Particularly in the world's rural regions, such midwives tend to be the only form of maternity care accessible to women. Internationally, these kinds of midwives are usually referred to as "traditional," "empirical," or "technical assistant." They are coded as "traditional birth attendants" (TBAs) by ICM, WHO and other maternity-related international organizations. These definitional challenges related to midwives

globally have been the subject of discussions among academics, and indeed among midwives themselves (such as Davis-Floyd and Sargent 1997; Díaz 2006; Wagner 2007; Sarelin 2014; UNFPA 2014; UNFPA-México 2014; Laako 2017a).

This is also the case in Mexico, where professional midwifery was eliminated by the 1960s (Carrillo 1999). Currently, professional midwifery is vaguely recognized in Mexico (López-Arellano et al. 2019). It is not properly acknowledged as a legitimate health profession at the federal level, and only a handful of individual states recognize it as such (López-Arellano et al. 2019). The few schools that are officially recognized as providers of midwifery training have limited capacities. These are the CASA School for Professional Midwives in Guanajuato, the *Escuela de Mujeres Aliadas* in Michoacán, the *Escuela de Partería* in Tlapa, Guerrero, and the *Escuela de Iniciación a la Partería Luna Llena* in Oaxaca. The CASA School was created in 1996, and the others thereafter during the past decade. Obstetric nursing (nurse-midwifery) careers are offered by the National School of Nursing and Midwifery. In addition, some apprenticeship-based training and tutorings are offered by different institutions or midwives: the Mexican Red Cross, midwifery centers (for example, *Luna Maya* and *Osa Mayor*) and individual traditional or professional midwives in various locations. However, there is no uniform midwifery education model in the country, and the latter do not provide formal midwifery licenses.

Moreover, the midwives who graduate and obtain licenses often have difficulty finding employment because, again, the official health system does not really have open vacancies for them. Some might be employed by municipalities or states to help with birthing women in rural communities or "maternities" annexed to hospitals. Others might have private practices or attend women at home, although the first option is particularly heavily regulated. Midwife-led birth centers do not have a properly recognized official status for the same reasons (Sánchez-Ramírez 2016). As a result, few midwives qualify as professional midwives according to the international definition. In this sense, it could be argued that, strictly speaking, there are "no (professional) midwives" in the country. This (in)definitional challenge has formed one of the cornerstones of current midwifery research in Mexico. (See, for example, Argüello and Mateo 2014; Laako 2017a; 2017b.)

Thus, in this context, it is difficult to ascertain the exact number of midwives (and of different types of midwives) in the country, because there is no governmental institution that would keep such a record. In other words, because Mexico does not really recognize the concept of midwife as a profession, there is a lack of information about the number of midwives in Mexico. In 2002, one report indicated that "each year 22,000 midwives attend around 270,000 women, heal families, and give advice about family planning in places where no doctor arrives" (Ruíz 2002). In 2018, the Mexican National Institute of Statistics and Geography (INEGI 2018) showed that 89% of the 2,162,535 registered births in the country took place in a hospitalized space, versus the

4% attended by midwives. The latter percentage is lower than for the year 2002. These contradictions and the lack of adequate information confirm our findings about the multiple challenges related to midwifery research in Mexico.

The above is important because, despite the lack of official statistics, we are safe in saying that there are thousands of midwives in Mexico (see also Comité Promotor por una Maternidad Segura en México (the Mexican Committee of Safe Motherhood) 2014 and UNFPA-México 2014). First of all, traditional midwives have always existed in Mexico. Indeed, the word for "midwife" (*partera*) has usually been understood as the traditional midwife, who is the "wise woman" of the communities (as described in Carrillo 1999; RELACAHUPAN 2007; Araya 2011; Villanueva and Freyermuth 2018). She is often empirically trained in the generations-old family traditions of midwives, who inherit broad cultural, herbal, physio-emotional, social and therapeutic knowledges for attending childbirths and giving neonatal and gynecological care. She may also have obtained her skills or calling in dreams, visions and/or "from God."

Today, the category of *parteras tradicionales,* which is a commonly used term in Mexico, comprises a diversified group of midwives. It is increasingly difficult to specify who the "traditional midwives" are. Given that some states in Mexico (such as Veracruz) have initiated the certification of traditional midwives with differing requirements, a traditional midwife might (at present) have any one of a great variety of profiles and realities, ranging from the older-generation midwife with Indigenous heritage to the younger generation of women with Indigenous roots who are allopathically trained, but are nevertheless midwives. The "traditional midwife" category also includes rural non-Indigenous midwives and urban semi-trained, lower-middle-class midwives, as well as "midwives in tradition," who can also be highly educated, urban-origin, middle-class midwives with an interest in tradition.

In other words, what the term "traditional midwife" is intended to communicate in contemporary Mexico is difficult to define, categorize and label. This difficulty should be kept in mind. When we talk about the traditional midwife in Mexico, we are not talking about a stereotype frozen in time, but about a complex web of different kinds of midwives, most of whom are located in rural regions, but not exclusively.

Again, there are also those midwives who consider themselves professional, although they do not have a formal Mexican license (and thus do not fit the international definition) because those licenses, as explained above, can only be obtained in some particular schools or locations (see for examples Davis-Floyd 2001; Sánchez-Ramírez 2016; Laako 2017a; López-Arellano, Sánchez-Ramírez et. al. 2019). Many of these midwives have been trained and licensed abroad, or have been apprentices of trained midwives in Mexico. Some may have other degrees, such as in nursing or obstetrics and gynecology (Ob-Gyn); others are even doctors who have shifted their practice toward midwifery and have unofficially taken some amount of midwifery training. In Mexico, there

are currently broad, regional midwifery networks and several professional midwives who receive apprentices and have graduated apprentices from their own, informal systems. This can be understood as more of an underground apprenticeship midwifery-training system that does not have formal, legal status in Mexico.

Nevertheless, midwives—just like anyone else—may assist homebirths when requested. Often these midwives, who consider themselves professional, are educated women from middle-class, urban backgrounds. Yet some of them consider the word "professional" politically charged (or not really existent in contemporary Mexico). Therefore, they prefer to call themselves (for example) "autonomous" (Laako 2016; 2017a). In other words, while the concept of professional midwives in Mexico is often related more to urban contexts, there is no single category or easily defined type of midwife that fits into this model, either.

Considering all of the above, various scholars have arrived at the conclusion that the very definition of midwife is politicized and under debate in Mexico (Argüello and Mateo 2014; Laako 2017a, 2017b; Mateo and Argüello 2018). As previously indicated, these debates about what constitutes a midwife are not new. Yet at the moment this debate is particularly marked in Mexico, which has seen a growing movement to bring back (professional) midwifery. This tendency has grown stronger since the 1990s as part of global policies to reduce maternal mortality, which have favored an institutionalized model of birth and access to clinical care (for example, Ban Ki-Moon n/d ; Castañeda et al. 2004; Freyermuth and Sesia 2009; UNFPA 2014; Freyermuth 2015).

The link between maternal mortality and midwifery is evident, but complicated. While this link has served to promote a certain kind of *professional* midwifery both in Mexico and worldwide as a means of reducing maternal mortality, this same process had implied a degree of displacement, disintegration and invisibilization of *traditional* midwives. Therefore, this process has been considered especially threatening to Indigenous midwifery, whose role in maternal mortality is often cited as unclear (see, for example, Sarelin 2014). Moreover, in this scheme, professional midwives are predominantly perceived as "assistants" to the official, biomedical system—their own, autonomous midwifery centers and practices are given little consideration, as described in Chapter 3.

In 2012, the Mexican Association of Midwifery (*Asociación Mexicana de Partería*, AMP) was established to create and promote midwifery as an autonomous profession in Mexico, in the tradition of the 19th-century Mexican League of Midwives (Carrillo 1999; Laako 2017a). However, given the complexity of midwifery models within the country, the association has struggled to generate an adequate, widely acceptable definition of a midwife. This definition would need to be sufficiently integrative and inclusive for this complicated context, while at the same time enabling the creation and maintenance of some sort of guidelines for regulation, certification and education,

which are the foundations of contemporary professional autonomy (Laako 2017a). Thus, the AMP in its short history has become the remolding space for the definitional debates, and is also subject to differing ambitions and criticisms.

It is noteworthy that there are no clear opposing parties on these issues in Mexico. For example, some Mayan midwives in the Yucatán peninsula clearly supported regulation and certification, while other Indigenous midwives, for example in Chiapas and Oaxaca, fiercely opposed it when Laako was carrying out her fieldwork between 2014 and 2016. The same applies to midwives who could be classified as "professional" or "autonomous."

Since such labeling also generates artificial and stereotyped divisions, one could question whether labeling of midwives makes sense anyway. However, given the restrictive international definition, which to some degree determines midwifery politics and politicization in Mexico, labeling is a way of understanding what is happening with the midwives and *midwiferies* in the country. Secondly, labels (along with classifications and positionings) are precisely the sorts of things that the situated-theory frame of this book encourages us to critically examine.

Hence, it is important to flag this situation because the chapters that follow in this book make reference, in one way or the other, to this particular issue, and also deepen it. Another purpose in referring to these definitional challenges is to explain that, in this book, we start from the position of defining midwifery more broadly. As we consider the sort of midwifery described by the international definition to be excessively technical and scholarly, with little adaptability in the current context of Mexico, we rather understand midwifery as a vocation in childbirth craft, related more to apprenticeship-based healing professions (Jordan 1993). This does not exclude the modern, institution-based definition, because it is a fundamental part of the contemporary reality of midwiferies. However, we also extend beyond it. In this context, we prefer Brigitte Jordan's (1993) apprenticeship-based understanding of midwifery, which also enables us to analyze more critically the developments in this profession in time and space, wherein the current technical, institutional and scholarly career represents only one historical phase and model.

Apprenticeship-based professions, generally speaking, are more focused on *practice* than *theory* (Jordan 1993). This practice is empirical and lived; there is no strong differentiation between professional and personal spheres. Thus these professions are learned in more bodily and intuitive ways. According to Jordan (1993), apprenticeship-based professions are also based on story telling and sharing. Instead of studying for academic examinations, apprenticeship-based professions are usually more about developing one's ability to encompass a social scene in its totality—i.e. they are about a progressive socialization that eventually leads to the ability to assume the whole set of responsibilities related to the vocation (Jordan 1993). This model of midwifery was historically common, and is still present in those regions in which traditional midwifery continues.

Thus, the definition of midwifery in these broader terms related to apprenticeship-based professions helps one to inquire more generally about what happens to women's long-standing professions—in other words, to use a genealogical approach to the study at hand. This way of defining midwifery also helps to amplify the panorama of *midwiferies* and to understand the current interior conflicts and tensions among the different models of midwifery.

For example, Susan Pitt (1997) has explained that many contemporary dilemmas related to midwifery derive from the stark differences between midwifery's original philosophy and that of the now-predominant medical model. According to her, while the allopathic biomedical system is fundamentally based on the idea of avoiding risks via control and intervention to arrive at the desired clinical conclusion—a healthy mother and baby—midwifery in its origins has been more focused on viewing birth as a normal part of life and allowing nature to take its course. While the biomedical system's discourse is focused on distinctions between the normal and abnormal, midwifery has tended to focus on the process and its emotional and psychological aspects, in addition to the physical ones. While doctors have tended to distinguish between their professional and private spheres, traditional midwives live the personal and the professional as a continuum. Finally, when attending a birth, doctors are more focused on intervening to ensure that the mother and baby are safe, while midwives are more inclined to inquire: "As there is always anxiety at birth, how can I soothe it?" Yet, as pointed out by Pitt (1997), these distinctions are only general illustrations. For example, some rural doctors are more inclined toward the midwifery ideology/model of care, just as some career midwives have allopathic, medicalized views of birth.

Although social scientific scholarship on midwifery is somewhat scarce in Mexico and Latin America, it is noteworthy that most of the scholarship on midwifery in Mexico—which stems predominantly from anthropology—is focused on traditional or Indigenous midwives (Sánchez-Ramírez and Laako 2018). However, the current link between maternal mortality and professional midwifery has generated a recent boom in midwifery studies, particularly those related to increased research funding by international organizations.[1]

Inspired by the deep, illustrative and comparative Western midwifery histories published by Marland and Rafferty (1997), we sought recently to produce something similar on Latin America. We also wished to help remedy the serious gap that we discovered in comparative, academic midwifery studies on this continent (Sánchez-Ramírez and Laako 2018). We were, basically, interested in exploring the ways in which the Latin American midwiferies (versus the Western ones) had developed over time and space, while simultaneously giving attention to important differences among Latin American countries.

However, when we published 2017 call for papers for a book on Latin American midwiferies, we soon ran into challenges. While we initially received a rich body of proposals, most of these were focused exclusively either on

maternal mortality (not precisely on midwives) or on empirical observations on midwifery movements (not academic studies). As most of the proposals focused on Mexico, we found it difficult to cover the whole Latin American continent. Given that our desire was to strengthen academic midwifery studies in Latin America, and to maintain some kind of balance between Mexican studies and those from the rest of Latin America, we were left (after a very critical evaluation process by anonymous reviewers) with seven chapters from ten Latin American contributors. These ten scholars—all of them women—described their midwifery research as a "lonely practice" which, additionally, involved the tremendous labor of capturing centuries of unexplored women's history as related to midwiferies, or contemporary women's struggles related to midwiferies in terms of obstetric violence and humanization of birth. We contributors were all happy that we had found each other, however limited the starting point was.

We are explaining this process of finding each other in detail because it also forms the basis of this book. By means of these pages, we seek to continue our work of strengthening midwifery studies in Latin America. We titled the previously mentioned book *Midwiferies in Latin America: Different Territories, Same Battles* (Sánchez-Ramírez and Laako 2018) because we had indeed learned, through this initial, comparative study of midwifery and women's histories in Latin America, that the battles we found that were related to midwiferies were very similar in many aspects, albeit located in different territories.

However, it is also important to emphasize that, because significant differences among Latin American countries exist, excessive generalization should be avoided. For example, in Chile, professional midwives—*matronas*—are heavily institutionalized, and played an important role in moving birth into hospitals during the 20th century, while traditional midwifery in Chile was eliminated long ago (Zárate and González 2018). In Peru, traditional midwives continue to struggle as a result of the medicalization of birth, but health policies increasingly acknowledge *interculturality* (Quiróz-Peréz 2018). In Argentina, the re-valuing of midwives came about during the second wave of feminism, with criticisms of the medicalization of birth, and with movements against obstetric violence and for the humanization of birth (Felitti and Abdala 2018).

The model of medicalization and institutionalization of birth in Mexico follows the above-described Latin American tendencies. Until the 1970s, births were attended mainly by traditional midwives, and still mostly at home, even though the institutionalization of birth had already begun (Carrillo 1999; Sánchez-Ramírez 2016). Currently, "techno-births" predominate in Mexico (and Latin America in general), with extremely high levels of cesarean sections (C-sections) and interventions: the C-section percentage in Latin America and the Caribbean (44.3%) is the world's regional highest (Boerma et al. 2018). In Mexico alone, the rate is currently 46% (CONAPO-INEGI 2015).

Under international pressure, Mexico has sought to lower its maternal mortality ratio.[2] Yet the hospitalization of births in Mexico has had the opposite of its intended effect, which was to reduce maternal mortality. Instead, maternal mortality has increased due to saturated and low-quality medical facilities. This unfortunate situation has spurred the publication of increasing amounts of literature on the concepts of *obstetric violence* and *humanization of birth*—concepts that originated in Latin America (see Villanueva 2010; Laako 2016; Badillo 2018; and Chapters 3 and 5 of this book). These concepts have to do with making visible the pending problems of hospitalized births in Latin America, where health facilities often do not have the capacity and quality to ensure respect for women's rights during childbirth. Thus, from the early 21st century onwards, midwifery increasingly has been tied to the issue of human rights as the means for reducing obstetric violence and promoting a more "humanized" model of maternity care.

Currently, Mexican midwives, autonomous as well as traditional, are at the forefront of the struggle for women's rights. Therefore, the chapters of this book bring forth the complex characteristics of the contemporary political activism, struggles, and dynamics of Mexican midwives in relation to global and national politics of maternity care; the biomedical system in Mexico; and the maternity care-related global, national, regional and local alliances and networks. As the chapters of this book show, the dilemmas of the Mexican midwives are intimately related to those of women's movements, Indigenous movements and human rights in development (see especially Chapters 2, 4 and 5).

Although room certainly remains for further exploration of the situation of Indigenous midwiferies in Latin America and Mexico, some of these countries have started to examine *intercultural approaches to health* in terms of governmental policies—at least on paper (Page 2002; Villanueva and Freyermuth 2018). These countries include Mexico, Ecuador, Peru and Guatemala. *Intercultural health* refers to the valorization and revitalization of autochthonous Indigenous medicines, and is internationally backed (at least in theory) by declarations such as Alma Ata (1978) and the C169—Indigenous and Tribal Peoples Convention (1989). In Mexico, the Secretary of Health issued a definition of traditional midwives related to rural and Indigenous midwives, and promised culturally sensitive healthcare and some entitlements for traditional midwives, although these promises seem to be more on paper than applied in reality (Villanueva and Freyermuth 2018). Indeed, traditional or Indigenous midwives have been subjected to unsystematic trainings; denied the right to attend births; and largely displaced by other personnel (Villanueva and Freyermuth 2018). Thus, the marginalization of Indigenous midwives has continued. This also implies that only a relative self-determination of women exists as to whether to choose a midwife as a birth attendant (Villanueva and Freyermuth 2018). In addition, Laako (2017a) has suggested that, since Indigenous midwives, at least in Mexico, are often placed within the much

broader category of "traditional midwife," their positioning within the frame of Indigenous rights may be obscured.

Consequently, professional as well as traditional midwives in contemporary Mexico often have to work in legally vague or semi-clandestine conditions, and are frequently harassed by authorities. For example, some midwives' websites have been closed down, and their birth centers have been searched and closed. The difficulties that midwives face in obtaining and granting birth certificates represent yet another obstacle to their real possibilities for attending women, even in homebirths, which are formally allowed as a choice for women. It goes without saying that Mexican midwives suffer from denigrating stereotypes and prejudices.

This context also implies inevitable challenges for researchers. For example, occasionally the research context was excessively politicized over whose voices should be heard, and how, and who were the sufficiently "legitimate" midwives to be studied in the first place. In the case of Laako's research (e.g. 2017a, 2017b), the principal interlocutors consisted of autonomous midwives, who insisted (quite courageously) that we include their real names so as to make their voices heard. For that purpose, they also greatly polished their narratives. (This did not change Laako's research conclusions.) In contrast, Sánchez-Ramírez (2016) found that the midwives she interviewed felt so vulnerable and at risk that most of the birth centers she contacted declined to participate in the research, despite being offered anonymity and being endorsed by the Mexican Midwifery Association.

It should be emphasized that both authors focused their midwifery research predominantly upon professional, autonomous or urban midwives, whose situations and work have been less explored in the Mexican case. Therefore, this research is novel, in this sense. This is not to say that the literature on traditional and Indigenous midwives has become saturated. Indeed, although the principal research results in this book correspond more closely to the middle-class or autonomous midwives, the traditional or Indigenous midwives are not absent. In addition to interviewing various kinds of traditional and Indigenous midwives during our research, we have taken part in events in which their voices were heard, and have explored extensive literatures concerning them. In this book, we make an effort to engage in conversation with *different midwiferies* on this basis, and when a certain aspect of that conversation is outside the scope of our principal research results, we refer to other literatures for further information. We do not report research results that are not strictly based on our own methodologies.

In accordance with our theoretical frame on situated knowledges, our perspectives and positioning are always partial. Thus, despite its multiscale perspectives, this book can only offer a partial glimpse into contemporary Mexican midwiferies.

Overall, our research discussed in this book derives from work carried out between (approximately) the years 2011 and 2019, and is based on previous

peer-reviewed publications, mainly in Spanish. We acknowledge that there are more recent developments that are not covered in this book. These developments consist of tendencies in the literature on midwifery, as well as in midwifery itself. For example, we have not been involved with recent developments that involve the previously mentioned AMP, and thus cannot report on what is currently happening with this association. We also acknowledge that we have not been able to engage with some recent English-language scholarship related to Mexican midwifery, such as that of Vega (2018), which focuses on humanized vs. traditional birth, and Jaffary (2016), which is immersed in 19th- and 20th-century women's sexual and reproductive health in Mexico. As we write these lines, a new book has just been published on obstetric violence (Quattrochi and Magnone 2020). Some Mexican midwives have established a new Facebook network called "autonomous midwives," and a new project is emerging to map and resist the institutionalization of traditional midwives in Mexico (www.parteriatradicional.mx).

We also emphasize that our research is first and foremost embedded in the Mexican and Latin American academic scholarships for the simple reason that we, as women and researchers, are permanently located there, and form part of those intellectual traditions. Our Spanish-language publications, which are the foundation of this book, were originally reviewed by scholars located in this region. In a similar vein, our broader objective and desire are that this book, as well as our previous publications, might help to catalyze the growth of conversations among scholarships in different regions and in support of the development of midwifery studies in Latin America.

The first part of the remainder of this introduction is the methodological portion, in which each of us describes her midwifery research, as well as her relationship to midwifery. We then briefly outline the structure and contents of this book.

Situated author: Hanna Laako

My situatedness in terms of midwifery is both personal and academic. My research on midwifery—synthesized in this book—was carried out mainly between 2013 and 2016. I am a Finnish political scientist with specialization in International Relations and Latin American studies, and have lived in Chiapas, Mexico, for over a decade. My early research trajectory dealt with Indigenous movements and decolonization, particularly the Zapatista movement (2005–2011). My current research has to do with borderlands studies and conservation politics in the Maya Forest. As can be perceived here, the topic of midwifery is, and was, somewhat different from my previous and subsequent fields of inquiry. Nevertheless, I mention this research background because my research on midwifery has drawn greatly on my empirical and theoretical backgrounds. In addition, I find it relevant to mention that my research on midwifery was not characterized by a brief visit to Mexico, but instead stemmed from my daily life here.

I gave birth to my second daughter at home, in Chiapas, Southern Mexico, with midwives attending. I decided to birth at home—thereby coming into contact with the midwifery topic in Mexico—because of the somewhat traumatic experience I had had 14 years earlier, when I gave birth to my first daughter in a public hospital in my native Finland under the country's institutionalized midwifery model. Although the birth was classified as low-risk and normal at all times, and was attended by professional midwives, I was subjected to a series of interventions typical of techno-births. As a result, I was not initially particularly enthusiastic about midwives. My perception of them back then was rather characterized by the modern stereotype of the midwife who is more interested in managing interventions and machines than in giving emotional support and guidance. Later on, however, and when I was already immersed in my Mexican midwifery research, I also grew interested in the midwifery history of my home country, and eventually contributed, among others, an article about trends in Mexican midwifery in the journal of the Finnish Midwifery Confederation.

When pregnant with my second child eight years ago in Mexico, and due to my fears about hospitalized births (given my earlier experience), I was desperately looking for more loving birthing options, and eventually found out that one of my friends, Beti Flores, had just finished apprenticeship midwifery training in Chiapas. This was the beginning of a long road that firstly led to an empowering and healing homebirth in Chiapas (attended by midwives Beti Flores and Guadalupe Blanco) and then to a midwifery-related research project during the following years. Indeed, for me, the final months of my pregnancy worked as a window to Southern Mexican midwifery struggles and to the midwives' ongoing collective action. I started to wonder what was going on with these midwives; what were they fighting for; and why the situation of midwifery in this country was as it was. Soon, my previous perceptions of midwives started to shift.

As a result, I carried out my research project "Autonomous Midwives in Mexico" between the years 2014 and 2016. The project was supported by a two-year postdoctoral scholarship in the Mexican Autonomous University (UNAM). During that research, which is discussed in my chapters in this book, I visited and interviewed autonomous midwives in various contexts in Mexico, ranging from megacities to rural regions: Chiapas, Quintana Roo, Oaxaca and Mexico City. I conducted 15 in-depth, semi-structured interviews, in addition to informal conversations that are described in detail in Chapter 2. My interviews focused on exploring the ways in which these women had ended up becoming midwives; the midwifery models they supported, or that had influenced them; and the problems and dynamics they saw in contemporary Mexican midwifery. At the time, the establishment and early stages of the AMP were addressed extensively, although not all the midwives were interested in taking part in this particular organizational process. Some, in fact, were rather critical of it. I learned a lot from my time with these midwives: about their struggles and political skillfulness, the ways in

which they owned their own *herstories* and even what they considered to be their failures or challenges. Their emotional maturity made me grow as well, in many ways.

In addition, I took part in various midwifery events, particularly ones related to the AMP. In those contexts, I also spoke with many midwives (not all of whom were what I call "autonomous") who formed the principal focus of my research. For example, around 15 Mayan midwives filled out my questionnaire in Quintana Roo. I also attended various academic seminars focused on midwifery and medical anthropology, some of which also included midwives. In all of these settings, the participants accumulated, exchanged and shared important knowledge, even though some of the events were heavily politicized. As will be apparent in my chapters in this book, I drew from social movement theories, situated knowledges and postcoloniality, all of which are strongly related to my previous research practices.

My midwifery research continued for a while afterwards—for example, between the years 2016 and 2017 in the research institute El Colegio de Frontera Sur (ECOSUR), while collaborating with Georgina Sánchez-Ramírez on our publications. In early 2017, I assisted a project called "Birth Centers in Mexico," conducted by the Luna Maya civil association. While birth centers have been researched and attested as safe birthing models globally (see, for example, Walsh and Downe 2004; Davis-Floyd et al. 2009; Walsh and Devane 2012), midwifery centers, specifically, are less explored. The term itself lacks an adequate definition. Indeed, the aforementioned project ended up giving preference to the concept of "midwifery center" to increase awareness of midwives' role in this model of maternal care and in terms of birth centers (Alonso 2018, 2019; Stevens and Alonso 2020).

Since some years have passed since my interviews with the midwives whose stories are partially republished in this book, two of those midwives—Beti Flores and Guadalupe Blanco—wished me to update their trajectories. They mentioned that, during the past years, they have inclined toward offering midwifery training in Chiapas. Their principal platform has been a midwifery training course offered by the Mexican Red Cross. So far, they have trained over 30 midwives. Beti and Guadalupe mentioned that the participants have mixed profiles. Hence, Beti's and Guadalupe's experiences in training these aspiring midwives have been very diverse. While some participants have been students in different majors, or even healthcare professionals in urban contexts, others are women from rural and Indigenous communities in which they wish to continue working. Thus, Beti and Guadalupe comment that the training experience has encountered some language barriers. In response, they are preparing illustrated didactic materials to facilitate training of aspiring midwives who speak only Indigenous languages. Finally, Beti and Guadalupe have launched prenatal, contraceptive and family planning services in these rural areas, free of charge. The other midwives whose stories are included in this book did not mention particular updates, but did insist upon appearing with their real names.

Finally, I find it important to mention that, as part of my midwifery research, I developed a research project called "Postcolonial Midwifery" that was designed to compare midwives and midwiferies in two different countries. The project aimed, particularly, at addressing Indigenous or Native activism in midwifery. This project came close to being funded—it won the Seal of Excellence of the Marie Sklodowska Curie Scholarships of the European Commission in 2016—but I had to let go of it in April 2017, when I was offered another research post that eventually shifted my research focus from midwifery to nature conservation politics. Nevertheless, Chapter 5 of this book includes a literature review that draws from the intended "Postcolonial Midwifery" project.

Situated author: Georgina Sánchez-Ramírez

Similarly to Laako's research on midwifery in Mexico, mine stems from my experience as a mother, and thereafter, from my academic research. Thanks to my formation in demography, I knew that midwifery had enjoyed a Golden Age in Mexico (as it did elsewhere in the world). However, professional and urban midwifery was displaced by the arrival of modern obstetric gynecology, which served the post-revolutionary Mexican state's interest in ensuring the survival of its national population. Eventually, this process moved from the center to the periphery, which displaced professional and urban midwifery in Mexico and left room only (and not everywhere) for empirical, rural and Indigenous midwifery. The latter groups of midwives have not been free from persecution, as mentioned previously in this introduction.

Therefore, for me it was a pleasant surprise when I rediscovered during my pregnancy (15 years ago) that professional midwives were back in the cities, albeit in yoga centers and as givers of prenatal support. In other words, professional midwives worked at the margins of the law, but were already on an extraordinary path toward the recovery of autonomy of birthing women, just as in other historical times.

From that time onward, I became the faithful follower and admirer of these midwives. Thanks to my own expertise, developed during more than 20 years in the field of gender and health, and as a feminist professor-researcher in the Health Department of ECOSUR, I was able to start research projects concerning Mexican midwiferies. These projects studied (variously) rural, empirical and Indigenous midwives in Chiapas, as well as professional midwives throughout the country. As a result, I gained eight years of experiences and wonderful learnings. In all, midwifery has given me much more than I have given it. My midwifery research has included different kinds of works (publications, conferences, supervision of dissertations, announcements and interviews) from the perspective of gender and health, which I have carried out both *for* the midwives and *with* the midwives.

In this book, I have had the opportunity to "deconstruct" as well as deepen two major works of mine. The first, which has become Chapter 3, is

my original book on birth centers (Sánchez-Ramírez 2016), now reworked and strengthened by the concept of *body-territoriality* (a perspective used herein for the first time in the context of births). The second of those earlier works (which has become Chapter 4 of this book) consists of an unpublished document and dissertation that I reworked with the valuable collaboration of my colleague, feminist Geicel Llamileth Benítez Fuentes. Both of these previous works of mine were carried out from the gender and health perspective, and with feminist ethnography as a basis, which in turn is based upon the premise that there is no hierarchical relationship between the researchers and the researched. Feminist ethnography also posits that scientific production is achieved by means of the knowledges of the women who take part in the research, and which serve to augment the heritage of women's knowledges in the world (Ortiz 2006).

The above-mentioned works and/or chapters are also based on my knowledge as a situated, Mexican, *mestiza*, middle-class, highly educated, feminist woman, who identifies herself as a defender of sexual and reproductive rights, and who relentlessly criticizes the current hegemonic biomedicine and the androcentric, Eurocentric, egotistical academic perspectives on it.

Chapter 3 of this book, which is based on Sánchez-Ramírez (2016), was produced at the request of the AMP, which asked me to investigate and publish about the birth centers in Mexico in order to make those centers better known, and to speak about their favorable as well as problematic sides. My research on these birth centers stemmed from narratives that were obtained via the snowball method. The interviewed women gave their informed consent. They did not have Indigenous origins, and were mostly middle class with high or very high education levels. Importantly, they introduce us to a birthing world in the perspective of non-infantilized body-territoriality, which shows a responsible and conscious attitude toward prenatal preparation. This attitude is a stark contrast to the modern Ob-Gyn culture in Mexico, whose obstetrically violent practices are constantly increasing.

The fieldwork on which Chapter 4 is based was carried out by the previously mentioned colleague, Geicel Llamileth Benítez Fuentes, for her MA dissertation. Her work was foundational—from it, we extracted information for this particular piece of research. The midwives described in Chapter 4 had empirical training, and were firmly supported by the residents of their own rural contexts. Some of these midwives have Indigenous origins. Luckily enough, they allowed us to hear their incredible stories and experiences regarding medicalized abortions, with which they helped women from all kinds of backgrounds, even though abortion is penalized in their contexts. This research, too, was carried out with informed consent, localized by the snowball method. We expect to meet these midwives again soon, after the COVID-19 pandemic, to hand them the systemized research results to which they contributed through their narratives. We are happy to share with them the evidence that shows that, through their work, they are saving many lives by carrying out safe abortions.

My sincere thanks to Hanna Laako for having invited me to take part in this book initiative of hers, which is a deep sea that she knows very well, but for me was a real challenge.

The structure of the book

This book's five chapters explore different aspects of midwifery in Mexico according to our theoretical premise of political situatedness and situated politics: (1) the *situatedness* of Mexican midwiferies in historical, multiscale perspective and as two meandering paths of professional and traditional midwifery; (2) the *situatedness* of Mexican autonomous midwifery between the professional and traditional, and as part of women's collective action and human rights; (3) the *situatedness* of Mexican professional midwifery in generating semi-clandestine spaces in which middle-class women may birth differently; (4) the *situatedness* of Mexican traditional and Indigenous midwifery as human capital in their rural contexts, in the form of safeguarding the rights of their communities' women to safe abortions; and (5) the *situatedness* of Mexican midwiferies with each other and in relation to other midwiferies in the postcolonial perspective, and in the frame of Native midwifery, women in the Global South and human rights in development.

Chapter 1, by Laako, begins by outlining the theoretical frame of situated knowledges, then discusses the ways in which midwives have been politically situated in historical, multiscale perspective. Based on a literature review, the chapter examines the construction of modern midwifery as a middle-class, academic profession with consequences for traditional midwifery. The chapter also explains the emergence of the postmodern and autonomous midwife as a politically active contemporary midwife who bridges professional and traditional tendencies. The chapter then turns to analyzing the meandering paths of professional and traditional midwiferies in Mexico in the context of: (1) the hegemonization of allopathic medicine; (2) the elimination of professional midwifery in the country; and (3) professional midwifery's resurgence, along with women's rights, since the 1990s, which is then re-addressed and deepened in Chapter 2. We will see that the situation of traditional midwifery and the attempts to bring back professional midwifery are also related intimately to various turning points that have to do with maternal mortality, Indigenous rights and neoliberalism. Since professional autonomy is precisely the central, political element of contemporary midwiferies' struggle in contemporary Mexico, the chapter concludes by taking up the concept of professional autonomy as a key to understanding the contemporary situatedness of midwifery.

Chapter 2, by Laako, explores the emergence and contemporary situation of autonomous midwives in Mexico by using the frame of social movement theories, which enable one to situate these midwives in broader contexts of political collective action. This empirically based chapter is particularly focused on examining the links between human rights and social movements in the

case of autonomous midwives. The chapter shows how the theory of new social movements, with its focus on human rights, can serve as a useful tool for investigating how women engage in political activism. The chapter builds on the existing midwifery literature that has located midwives clearly within the political spheres of collective and professional action. The chapter concludes by extending the concept of autonomy, understood as self-determination and self-government and related to human rights in contemporary Mexican midwifery, beyond professional autonomy and toward various dimensions of individual, bodily autonomy; personal, political autonomy and public, political autonomy.

Chapter 3, by Sánchez-Ramírez, presents a different angle on the political situatedness of contemporary Mexican midwiferies: the semi-clandestine birth centers run by urban, middle-class midwives. Based on empirical research, the chapter outlines the midwives' political situatedness in multiple ways. First, it describes the contemporary institutionalized, allopathic birthing model, which has infantilized women and subjected them to obstetric violence—a contemporary concept that emerged from Latin America to make this mistreatment of birthing women visible. The chapter then discusses the ways in which the birth centers are situated in the Mexican context as semi-clandestine facilities led by midwives, who attempt to provide an integral, conscious and humanized model of maternity care to women. As noted by Sánchez-Ramírez, in contemporary Mexico this kind of professional midwifery care is available only to middle-class and higher-middle-class women. By using the innovative Latin American concept of *body-territoriality*, Sánchez-Ramírez concludes that, despite the existing risky conditions, these birth centers succeed in providing a space to birth differently, in more empowering ways. The chapter shows, importantly, how midwives have constructed a marginalized but vital space, despite being hindered by a system that does not recognize them as valid.

Chapter 4, by Sánchez-Ramírez and Benítez Fuentes, presents cutting-edge health and gender research on safe abortion as carried out by traditional midwives operating at the margins of the law in the state of Chiapas, Mexico. In this empirically based research, various traditional and Indigenous midwives were interviewed. They play a crucial role in their communities in providing maternal, neonatal and general gynecological care. In addition, they support the women in their communities and neighborhoods by carrying out voluntary and safe pregnancy interruptions in accordance with the criteria set by the WHO. In this way, as the authors note, these traditional midwives carry significant human capital in rural contexts. Abortion is an important women's right globally, but is also one of the most controversial, politicized rights. As it is illegal in many parts of the world, and in 30 states of Mexico (including Chiapas), midwives have often denied their role in abortions. As a consequence, few studies deal with the links between abortions and midwives. In this sense, this chapter goes very much to the heart of *situated politics* by presenting the work done by traditional midwives in rural contexts to safeguard the reproductive rights of women in their communities.

Chapter 5, by Laako, focuses on postcolonial midwifery. By means of postcolonial reading, the chapter returns to the theme of midwifery in the context of the Global South and Indigenous peoples. The chapter discusses the emergence of the movement for the humanization of birth and against obstetric violence in Latin America, and its ties to human rights in development as a contentious terrain for women in the Global South. While these mobilizations are important in reviving and strengthening midwifery on the continent, tensions emerge within these movements in relation to Indigeneity. Indeed, the chapter situates results from research on autonomous midwifery within the context of Indigenous and Native midwifery. The chapter inquires about the extent to which midwifery will be challenged by Indigenous rights movements in the future. Laako relates this discussion to developments in North American Native midwifery as a builder of nations in Indigenous territories. While various tensions and problems emerge from her postcolonial analysis of different *midwiferies*, the chapter calls attention to the ways in which these differently situated midwiferies are in dialogue, and are sharing knowledges.

In our "Conclusions: Situatedness and the Making of Worlds in Midwifery," by both authors, we return to the frame of political situatedness and situated politics, and the ways in which Mexican midwives and midwiferies can contribute to enriching that frame as a research tool.

Notes

1 McArthur Foundation, in particular, has been an important financer of midwifery research and maternal mortality in Mexico. See, for example, McArthur Foundation (2013); Freyermuth (2015); Alonso (2018), (2019); and also UNFPA-Mexico (2014).
2 The maternal mortality ratio for each 100,000 infants born alive has substantially improved during the last three decades in Mexico. According to the various reports and calculations, in 1990, the maternal mortality ratio was calculated as 85 for each 100,000 (Morales-Andrade et al. 2018, 65), and in 2019 as 31 for each 100,000 (Secretaría de Salud 2019). Yet, these ratios are still far from ideal ones, such as Canada with its 10 for each 100,000 (Atlas Mundial de Datos 2018). The maternal mortality ratio continues to be an important indicator of health conditions for women of reproductive age.

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1 Underdogs, turf wars and revivals

Politically situated Mexican midwiferies in historical, multiscale perspective[1]

Hanna Laako

Introduction

The objective of this chapter is to shed light on the evolution and developments of Mexican midwiferies in historical and multiscale perspectives. It also introduces the main theoretical frame of this book: situated knowledges—a theoretical perspective born within Western feminist studies but currently at the intersection of various fields, such as the subaltern and the postcolonial. Situated knowledges emphasize intersectionality. This entails research that considers different geopolitical, gender, class and ethnicity intersections, i.e. contexts, perspectives and dimensions. Although each chapter of this book has, in addition, its own particular theoretical frame (such as gender and health, social movements and postcoloniality), what they all have in common is the undertone of "situatedness": we seek to weight strong contextualization and consciousness in the positioning of our subjects (midwives) and also in the lenses through which each of us examines these topics.

In addition to presenting what is meant by "situated knowledges," this chapter outlines and analyzes the historical and global context of Mexican midwifery. The analysis is based upon a literature review, and also draws from research that I carried out between 2013 and 2016 on autonomous midwives in Mexico (see for examples Laako 2017a, 2017b). I first describe the theoretical frame of my subject, and then move to midwifery history. Currently the English-speaking literature offers rich, detailed analyses of the role of midwives in societies, especially in modern times. However, in order to give weight to the history of Mexican midwiferies, I focus on the Western parts of those aspects, which I consider relevant for describing the dilemmas of the modern midwife.

As I seek to show in this chapter, contemporary midwifery history studies have importantly shed light on the construction of what I call (following Hilary Marland (1997)) the *modern midwife,* who, for survival, had to adapt to certain processes of professionalization and institutionalization. This concession led to various dilemmas, particularly related to the positioning of modern midwifery as a middle-class, urban profession. The processes of professionalization and institutionalization later resulted in the birth of the

"postmodern" or "autonomous" midwife, who (in Mexico as elsewhere) continues to confront many dilemmas related to the contemporary characteristics of midwifery as a middle-class, urban profession. The same processes have also had long-lasting effects upon traditional and Indigenous midwifery.

In what follows, I focus on the Mexican context. First, I discuss what is known about the situation of midwives in colonial Mexico, after which I give special attention to their situation during the 20th century. Although the advance of the allopathic medical profession in Mexico followed the same course as in other parts of the world, I emphasize that, in Mexico, it had to negotiate and battle with Indigenous medicine, homeopathy and other types of healthcare, including midwifery, in order to achieve cultural dominance.

Toward the end of the 19th century, Mexico began to offer advanced obstetric careers for midwives (albeit accessible only by upper-class women) and Indigenous and traditional midwives enjoyed a certain status in the society. However, by the mid 20th century, professional midwifery was eliminated, and traditional midwifery was gradually affected by the modernization process. Although I try to connect Mexican developments to the broader Latin American context, it is noteworthy that only a handful of historical studies exist on both (Sánchez and Laako 2018).

However, and finally, given the context of women's movements and rights since the 1960s, and particularly since the 1990s in Mexico, another kind of midwife has emerged in the USA and elsewhere. Robbie Davis-Floyd (2005; Davis-Floyd et al. 2018) has called this midwife *postmodern*. In my interpretation, the postmodern midwife as a political actor emerged as a way to resolve some of the dilemmas of the modern midwife by positioning herself between the professional and traditional. In the case of Mexico, I have called her the *autonomous midwife*. As I will conclude, autonomy is crucial for contemporary midwifery, particularly in Mexico, because autonomy is what midwives have been struggling for.

Situated knowledges

> Theories travel, I heard, and when they get places, they are transformed, transcultured. But what happens when theories travel through the colonial difference? How do they get transcultured? I also heard that when theories get to places where colonial legacies are still in the memories of scholars and intellectuals, traveling theories may be perceived as new forms of colonization, rather than as new tools to enlighten the intelligence of the theories' host or to reveal a reality that could not have been perceived without the theory's travel, or inviting a theory to stay just as it was going by. … The questions then shall be, "Where are theories produced? Where do they come from? From the perspective of those hosts of traveling theories? What function or role did theory X play in the place where it emerged and what is the function or role that such a theory played in the place where it traveled or has been exported?" The issue is,

> briefly, "What is the ratio between geohistorical location and knowledge production? What are their local histories?"
>
> (Mignolo 2000, 173)

The concept of situated knowledges—currently derived from fields focused on the subaltern, race, ethnicity, gender and Indigenous people—has been employed in studies ranging from histories of slavery and colonialism to criticisms of capitalism, imperialism and patriarchy. These sub-disciplines originated in contentious social movements, particularly those linked to human rights, women and Third World liberation from the 1960s onwards (Mohanty 2004, 197). Situated knowledges are, generally speaking, influenced by academic postmodern and postcolonial tendencies, which share a critical perspective toward Western universalizing, positivist, Eurocentric science. These disciplines tend to demand respect for the differentiated knowledges and histories of the populations and regions frequently overlooked or denied by mainstream social science.

Thus, the concept of situated knowledges, now emphasized in subaltern, postmodern and postcolonial canons, can be defined by the *politics of location*, which highlight historical, geographic and cultural *differences*, in marked contrast to the universalizing tendency of Western science. The theories of situated knowledges argue that such Eurocentric science contributes to suppressing other, non-Western knowledges at the same time as it ignores its own historical and political positioning by hiding it behind a false objectivity, neutrality and universality. In other words, scholars of situated knowledges call for the exploration and recognition of the ways in which all knowledge, including that of biomedicine, is historically, geographically and culturally situated. As Walter Mignolo (2000, 173) asks in the passage quoted above: What is the relationship between geohistorical location and the production of knowledges? Where are theories produced? What are their local histories?

To answer these questions, Mignolo (2000, 2002) introduced the concept of "colonial difference" to frame the ways in which theories travel and arrive in places where colonial memory is very much alive, and where the theories may indeed be perceived as new forms of coloniality. The concepts of colonial difference, Eurocentrism and the coloniality of knowledge and power all form part of Latin America's enduring critical theory tradition, which also informs Latin American social scientific research. This tradition is also linked to broader theories of world systems and dependence originated by Wallerstein (1999, 2000), and nowadays also found under the banner of Southern Epistemologies (see, for example, Mignolo 2000; Lander 2005; Leyva Solano et al. 2015). These theories seek, fundamentally, to decolonize the social sciences; that is, to no longer depend upon the modern Eurocentric epistemology of the North Atlantic when producing, transforming and disseminating knowledge (Mignolo 2002). Instead, these theories intend to respond to the needs of subaltern subjects, frequently located in the Global South.

In this context, decolonizing the social sciences as part of situated knowledges has also implied considering the Global South as a location of production of knowledges. In other words, decolonizing social sciences is not just about *bringing regions in* but about studying and engaging with concepts, theories and knowledges emerging from those regions (Gruffydd Jones 2006; Leyva Solano et al. 2015).Thus, situated knowledges currently emerge particularly from those non-Western peoples, movements and communities that have been subject to Eurocentric research, classifications, definitions and categorizing (Tuhiwai Smith 2005; Leyva Solano et al. 2015). The criticism of Eurocentric science has sprouted from all sorts of "margins"; borderlands; supposed peripheries; and/or subaltern peoples and movements less visible in mainstream social science.

The concept of situated knowledges was pioneered by Donna Haraway (1988), who was interested in reframing Western feminist theories (1988, 586). Initially, she was particularly focused on the question of scientific objectivity. Haraway argued that feminist scientific objectivity was gained through the appreciation of situated knowledges—an appreciation that implied recognizing the partiality of all knowledge. From her perspective, scientific objectivity was achieved by breaking with the false universal, transcendental vision of objectivity, and by sustaining the partial, subjective perspective. She maintained that the recognition of partiality would actually contribute to objective science by being more real and transparent (Haraway 1988, 583–589):

> There is no unmediated photograph or passive camera obscura in scientific accounts of bodies and machines; there are only highly specific visual possibilities, each with a wonderfully detailed, active, partial way of organizing worlds. … I am arguing for politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims.

It is noteworthy that Haraway (1988, 583–584) also comments critically upon three often-debated issues related to situated knowledges. First, she underlines the risks of adopting subaltern positions, particularly those related to romanticizing the less powerful or appropriating their visions. The ability to see and to analyze "from below," she argues, is not simple or free of problems or power relations, including when "we" claim to inhabit this sub-terrain of subjugated knowledges. Not all of the subaltern's viewpoints are innocent ones, nor are those of the scholars who claim to adopt them.

Secondly, Haraway insists upon differentiating situated knowledges from relativism. Situated knowledge, as she puts it, has to do with partial knowledge, which is critical and traceable, while relativism has to do with being nowhere while claiming to be everywhere. The claim for equal positioning, for her, has to do with denial of responsibility and critical research.

Finally, Haraway draws a distinction between the concepts of situated knowledges and identity politics. For her, one cannot be immersed—as a woman, as a colonized person, as a worker, etc.—if one seeks to study critically from that positioning. In this sense, she is firm in her belief that the concept of situated knowledges must take a critical distance from entertaining an "innocent identity." Instead, the concept of situated knowledges seeks a subjective positioning, which establishes a partial connection or lens to the research subject. In this frame, situated knowledges refer to visions and communities, not isolated individuals.

Haraway's analysis of the adoption of subaltern visions, relativism and the pitfalls of identity politics forms the subject of key debates in studies dealing with situated knowledges (see for examples Moraga and Anzaldúa 1988; Spivak 1988, 2004; Tuhiwai Smith 2005). Although identity politics is not the focus of this chapter, it is noteworthy that this topic is intimately connected to a certain scholarship of situated knowledges. This strand considers the concept to be not only a basis of theoretical elaboration, but a bodily one as well; one of practice. In this context, situated knowledges are understood as part of political activism (Leyva Solano et al. 2015). In other words, situated knowledges are not only about a situated theory or a researcher, but also about lived lives and bodily experiences (Moraga and Anzaldúa 1988).

Haraway's work is part of the third wave of feminism, and is fundamentally about challenging the premises of Western, white, middle-class feminists and their solidarity based on universal, sisterly claims. The challenge came particularly from Afro-descendant and other feminists of color who spoke of *intersectionality*. They used this term in asserting that the historically situated experiences of women are related not only to gender, but also to social class and ethnicity/race. The Afro-descendant and other feminists of color maintained that these intersectionalities can make many women's historically situated experiences quite different from—even crucially different from—those of white, middle-class women.

An influential contribution to this line of thought was, and still is, *This Bridge Called My Back* by Moraga and Anzaldúa (1988), in which the concept of "bodily theory" or "in the flesh" was developed, based upon subjective positioning. *This Bridge* became particularly important for Third World feminisms and Global South feminisms as a way to criticize Western feminism, and to call attention to differences among women on the basis of geopolitical positioning, social class and ethnicity.[2]

Chandra Mohanty (2004) has specified that one reason for the emerging criticism of Western feminism was the construction, by white, academic, middle-class Western women, of a "Third World woman" stereotype that did not consider "her" historical, cultural and geographical specifics. Intersectionality and the revival of situated knowledges draw our attention to the ethnocentrism underlying the academic construction of white, middle-class culture as a norm. This construction frequently represented Western

women as educated, modern, in control and with freedom regarding their bodies, in contrast to the "other" women—Black, Indigenous and Third World—who fell short of this norm, and were generally portrayed as hapless victims of their conditions.

Mohanty (2004) called the construction of such norms "methodological universalism." To illustrate its deficiencies, she drew from the example of reproductive rights. Many Indigenous women in the Global South have lived and experienced a history of population control and abuse of sterilization programs. Thus, these women may be ambivalent toward abortion rights. The reasons for that ambivalence might remain invisible and inexplicable if the intersectionality and positioning of these different women are not considered (Mohanty 2004, 54). Thus, Mohanty proposes analyzing the links between social positioning, historical experiences and contexts while still emphasizing the connections between the local and the universal.

Yet Mohanty joins Haraway in warning us of the risks of producing simplistic visions under the banner of situated knowledges. Both authors suggest taking critical distance from identity politics. Mohanty argues that situated knowledges and intersectionality do not assume that the histories of women of the Global South/North would automatically be different. Indeed, some strands of postcolonial literature, too, have emphasized the error of assuming that non-Eurocentric histories would automatically be what Eurocentric histories are not (Wallerstein 1999; Leyva Solano et al. 2015). Similarly, Mohanty (2004) warns about the risk of overlooking the profound class, ethnic and racial differences that also exist among women in the Global South.

Mohanty (2004, 202–203) is also conscious that, when classroom discussions about differences, intersectionality and situated knowledges are centered excessively on personal identity experiences, the result may be superficial binary exclusions that are of little help in addressing global structural inequalities:

> If all conflict in the classroom is seen and understood in personal terms, it leads to a comfortable set of oppositions: people of color as the central voices and the bearers of all knowledge in class, and white people as "observers" with no responsibility to contribute and/or nothing valuable to contribute. In other words, white students are constructed as marginal observers and students of color as the real "knowers" in such a liberal or left classroom. … Thus, while it appears that in such a class the histories and cultures of marginalized peoples are now "legitimate" objects of study and discussion, the fact is that this legitimation takes place purely at an attitudinal, interpersonal level rather than in terms of a fundamental challenge to hegemonic knowledge and history. … Thus, while "experience" is an enabling focus in the classroom, unless it is explicitly understood as historical, contingent, and the result of interpretation, it can coagulate into frozen, binary, psychologistic positions. … [and] is problematic because it leads to an attitudinal engagement that bypasses

> the complexly situated politics of knowledge and potentially shores up a particular individual-oriented codification and commodification of race.

Intersectionality and situatedness have also become important tools for Indigenous studies, particularly for those that deal with Indigenous women. Mohanty (2004) mentions that the struggles of Indigenous women add further elements to the binary division between "First Worlds" and "Third Worlds." For example, the Maori researcher Linda Tuhiwai Smith (2005) mentions situated knowledges and the criticism of Western science by subaltern and feminist studies. However, she situates her own work in an even broader historical, political and cultural context of Indigenous peoples, as a particular way in which these peoples have been objectified by Western research while being subject to classifications and knowledge extraction and appropriation as othered peoples.

She also draws attention to the contrary type of Indigenous research, which portrays Indigenous people as authentic, essentialist and (for example) profoundly spiritual. As mentioned by Tuhiwai Smith (2005, 72–74), the colonization of Indigenous peoples research-wise is characterized not only by portrayals of inferiority and otherness, but also by claims of "authenticity." She further asserts (2005, 72) that such portrayals often serve to fragment and marginalize those who speak for and in support of Indigenous affairs. Such accounts also tend to silence or make invisible the presence of other groups within Indigenous nations and communities, e.g. women, or the urban Indigenous who either lack tribal status or are considered too "white."

For Tuhiwai Smith (2005, 73), the problem with the concept of situated knowledges is that the desire for authenticity can lead to essentialism, which seeks to find a pure or ideal being. She cautions that essentialism has been a deleterious element in Western science and in decolonization struggles that appeal to an idealized past and future. In the latter, essentialism has served as a relevant political strategy for constructing a subaltern group identity in order to defend Indigenous rights. However, such essentialism easily falls into the traps of racism, colonialism and exclusion.

In the case of Indigenous women, the Indigenous Sami researcher Rauna Kuokkanen (2012, 2015) has emphasized that, in intersectional politics, Indigenous women tend to be situated within at least two subordinated groups with conflicting agendas: the (often) male-led group of Indigenous peoples focused on self-determination (with less consideration of Indigenous women's rights); and the women's rights movement (with less consideration of Indigenous rights or conditions), both of which are important realities of Indigenous women; thus they fall in between. For example, when the international women's movement has focused on the dichotomy between private and public spheres, Indigenous women have often found themselves in a complicated intersection between individual and collective identities, with greater focus on the practical effects of colonialism (Kuokkanen 2012). However, Kuokkanen (2015) also suggests being careful with the repetitious

narrative on colonization, because in such a narrative Indigenous women may become invisible within the broader masculine project of decolonization and self-determination. Indeed, Kuokkanen wonders whether colonialism should be the only category in which to analyze the situation of Indigenous women.

Mary Louise Fellows and Sherene Razack (1998) took situated knowledges, and their shortcomings, to a new level by introducing the notions of "competing marginalities," "race to innocence" and "toehold of respectability." By race to innocence, the authors refer to a type of situated knowledge in which a group of women imagine that their own claim is the most urgent one, and that they are not implicated in the subordination of others. Thus, the race to innocence has to do with a model in which oppressions are added up to measure who is the most repressed (for example, a white disabled, heterosexual woman, or a colored, lesbian, non-disabled woman).

Fellows' and Razack's "toehold of respectability" notion refers to a process in which a group of women do achieve liberation, but in a way that leaves the subordination of other women intact. Thus, what the first group achieves is not a real liberation of women—only a toehold of respectability. Indeed, Fellows and Razack (1998) explain that the three phenomena (competing marginalities, the race to innocence and the toehold of respectability) arise as differing groups of women seek to secure their positioning as the most oppressed ones in the margins, so that this positioning might become more visible. When women are participating in these three phenomena, the way in which they listen to the narratives of other women is the same as that in which dominant groups listen to the stories of the oppressed: since some women do not experience the same oppression as those "other women," such groups may consider their oppression less important than that of the others. Whenever we as women consider ourselves innocent in this way, we are unable to confront the hierarchies produced among us (Fellows and Razack 1998).

On the basis of Fellows' and Razack's work, Eve Tuck and Wayne Yang (2012) introduced their own concept of "settler moves to innocence" to illustrate the contemporary forms in which white settlers adapt decolonizing language to reconcile their guilt and complicity. According to Tuck and Yang (2012), the race to innocence gives white settlers a chance to obtain a professional boost or greater social capital (by being sensitive) without having to address the privileges, power or other advantages that they enjoy as a result of colonialism. Tuck and Yang emphasize that solidarity is always uneasy, reserved and unsettled—indeed; they conclude that decolonization as such is not accountable to settler futurity. Instead, they note that perhaps we should abandon the hope that settlers may one day be commensurable with Native peoples.

It could be argued, then, that using the concept of situated knowledges as a framework for research implies uneasy, unsettled analyses in which much is at stake. Despite that challenge, the concept of situated knowledges can indeed be a fruitful one, particularly for rethinking midwifery in the contemporary

world: the concept enables researchers to debate and make visible the differences and similarities among the experiences and situations lived out by midwives around the world. What could be more "situated knowledges" than those of the history of women's professions?

Indeed, it could be argued that midwifery by definition represents a challenge to the concept and dilemmas of situated knowledges as a multi-class, multi-ethnic, ancient and global profession. Midwives are (mostly) women with a vocation, who tend to cross divisions of class and race, immersing themselves into different worlds when attending women in different contexts. Moreover, midwifery as a profession continues to be politicized. The ways in which midwifery is positioned in the world, in different times and locations, constantly transforms midwives into unsettled political actors, particularly in contexts such as Mexico, where midwifery is only vaguely recognized as a profession. Indeed, midwifery escapes easy binaries of situated knowledges and universalizing typologies, such as "professional" vs. "traditional."

In addition, although situated knowledges are importantly embedded in subaltern, feminist, and Indigenous studies, the case of midwifery also brings back into view the middle classes, often discarded in the increasing scholarly focus on the subaltern. The middle classes have often been perceived as a homogenous popular majority, formed of urban dwellers who either facilitate the status quo or are principally driven by aspirations to become part of the elite. Indeed, Fellows and Razack (1998) note that the "race to innocence" is based on the emergence of the European middle classes, which sought an elevated position somewhere between the subaltern and the aristocratic.

However, within the frame of situated knowledges it is worthwhile noting the existence of many kinds of middle classes within the middle classes. Scholars of diaspora, for example, have long taken a critical distance from such essentialist or universalizing categories, which are also entertained occasionally by postcolonial literatures (Toivanen 2014).

As a contrast, Silvia Federici (2010), for example, has pointed out that it would be an error to emphasize only the differences that exist among women, given that issues such as the division of labor are intimately connected to women worldwide. Her study also showed that, while the witch hunts targeted Europe's peasant women, some middle-class women too were ridiculed, discriminated against and persecuted. Finally, Federici (2010) argues that it would be erroneous to assume that the European proletarian class was always supportive of colonization and complicit in the sacking of the Americas: historical evidence indicates that some servants and workers of European ancestry in the "New World" conspired with the Natives, taking their side, and thus represented a threat to the dominant classes.

Hence, instead of taking existing categories or binary divisions as givens, this book and chapter ask, on the basis of situated knowledges, *How are midwives immersed in different hierarchies, intersections and positionings in Mexico, and in relation to other parts of the world?*

The birth of the modern midwife and her dilemmas in the Western world

> One day I asked Sister why she had given up her life of wealth and privilege for the humble life of a nurse, a midwife and a nun. She winked at me. "So you think our life 'humble', do you? Nonsense. Fiddlesticks. Ours is a life of adventure, of daring, of high romance." "I agree with you there", I said. "Almost every day comes as a surprise. But I started nursing when I was eighteen because there was no other choice. But why did you? You had plenty of choices". "You are wrong, my dear. The choice of which pretty dress to wear? Pooh! The choice to spend each afternoon 'visiting', and taking about nothing? Pooh! Pooh! The choice to spend hours embroidering or making lace? Oh, I couldn't stand it—when nine-tenths of the women of Britain were toiling with their half-starved, stunted broods of children. I could not leave my father's house and start nursing, or lead any sort of useful life until I was over thirty".
>
> (Worth 2009, 65–66)

This is how Jennifer Worth (2009), a British midwife, described her conversation with Sister Monica Joan—a nurse, midwife and nun with aristocratic roots—in her now famous trilogy *Call the Midwife*, which became a popular BBC TV series in the 2010s. In her first book (2002), Worth mentions that she got the inspiration to write about her experiences in the East End suburbs of London in the 1950s as a result of a contemporary awakening of British midwives that occurred at the end of the 1990s, when these midwives came to feel that their work was completely invisible in contemporary society. The midwives also felt that their professional work continued to be charged with old imaginaries and stereotypes. In addition, they considered that the midwives' histories were completely absent in world literature.

In effect, Worth (2002, 2005, 2009) manages to give center place not only to these British midwives, but also to the population they attended—the densely populated districts of postwar London in the 1950s. She narrates the lives of the midwives, nurses and nuns with whom she worked—such as Sister Monica Joan—and also the lives of the women of the Poplar district in which they worked—their families, and their community. Worth does not overlook the many problems that all these women and families faced. Her books importantly reveal societal stratification in its different levels: a stratification that forms the everydayness in which the midwives were immersed as situated women. Some were from working-class origins, while others, like Worth herself, were from a middle-class background. Yet others had aristocratic roots, as shown in the quotation above.

These modern midwives replaced the community midwives who had been born, lived and worked in the tenements alongside the people they served, who were trained via apprenticeship and were phased out of existence in the early 20th century in favor of the type of formally trained nurse-midwives Worth

describes. This new breed of midwife attended births in the communities to which they were assigned until the late 1960s, when almost all British births were moved into hospitals and most nurse-midwives moved there with them.

It is not the objective of this chapter, nor is it possible, to outline the whole worldwide history of midwifery, and still have space to treat the Mexican context. However, above and in the following I do outline some main developments that illustrate the challenges midwifery poses to the 21st-century Western world, before moving on to Mexico. The developments that I discuss are those that came to define the *modern* midwife and her dilemmas, which (I argue) are intimately connected to the contemporary challenges of midwives in Mexico.

Barbara Ehrenreich and Deirdre English (2010) have extensively discussed the long historical chapter of the destruction or diminishment of midwifery in the Western (or English-speaking) world in the midst of the professionalization and hegemonization of the medical professions, including nursing. These authors have emphasized the masculine, high-class aspects of this process of academic medicalization that contributed to the decline of midwifery, particularly of traditional midwifery related to ancient healing practices. Ehrenreich and English (2010) vividly describe the effects of this long-standing campaign against midwifery in the Western world, where in the midst of the emergence of the medical profession, aggressive and negative stereotypes of midwives were generated and still prevail, particularly in the Americas. Ehrenreich and English (2010) also emphasize the effects of this historical process in generating the existing divisions between nurses and midwives. Originally, a nurse took care of the ill or the wounded (i.e. nursed), whereas a midwife focused on childbirth—albeit by making use of her medicinal and healing abilities. Nursing as a modern profession was founded by aristocratic English women such as Florence Nightingale, who made it clear that nurses were to be the handmaids of doctors. Suffice it to say that nursing, too, has suffered from many contemporary problems and challenges related to women's oppression, work-wise as well as class-wise.

In my analysis, however, what Ehrenreich and English (2010) importantly bring to the table is the issue of modern professionalization and what this modern professionalization implies gender-, work-, health-, class- and race-wise, as a potentially elitist, exclusive practice. In other words, Ehrenreich and English place *modern professionalization*, and not just "women" or nurses or midwives, under the critical eye of situated knowledges and the "toehold of respectability." In my interpretation, these challenges and divisions are not just about historically competing professions, but also about what modern times have implied in terms of professionalization, with the exclusivity it entails. For once a profession is legally established, organized, governed and regulated, those who practice it without a license become marginalized and often persecuted.

The past decades have seen a great increase in studies on the history of medicalization and midwifery, particularly in terms of women's roles in these fields. In addition, scholarship on the history of midwifery is slowly expanding

beyond the predominant English-speaking Western countries, although those countries are still the focus of most research on the subject. The Finnish historian Kirsi Vainio-Korhonen (2012) notes that, although historians have indeed explored the agency of women in more dynamic and complex ways since the 1970s, the history of midwives remains a challenge because midwives cannot be type-cast easily as subordinated, nor can they be cast as the holders of authority/power. Similarly, midwifery itself has been anything but frozen in time. For example, Vainio-Korhonen (2012) has shown that, in 18th-century Finland, midwives were not under the tutelage of their husbands. Rather, they formed part of the labor market as privileged and autonomous midwives, even though the predominant pattern of the time placed women under masculine family authority. In this situated history, midwifery was not a profession of widows inherited from the husbands—as was often the case for independent professional women in Europe—but something that these women themselves had achieved without the permission of their masculine family members. The history of midwifery as an emerging field of study has questioned and revolutionized various mainstream views of modern and women's history.

The book *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period*, edited by Hilary Marland and Anne Marie Rafferty (1997), offers a complex and detailed account of midwifery history in different European countries and in the United States. The editors argue that, in these cases, modern midwifery history was very much defined by the rights, restrictions and tasks that midwives could or could not undertake in different contexts. These editors concur that the Western countries had to deal with the fate of midwifery somehow, and thus midwifery "has come to represent a metaphor for the broader struggles and debates about race, class and gender which have so energized the social history of medicine in recent years" (Marland and Rafferty 1997, 3). The authors of this book draw our attention to the diversity of cultural expressions in midwifery, and to the challenges and dilemmas related to modern professional legalization and regulation, which vary among Western countries. Yet, the authors agree that myths, training and mortality are the three cornerstones most commonly used as evidence to marginalize midwives, or to distance them from groups that have portrayed themselves as "socially and medically superior" to midwives, which is something that seems to occur also in Latin America (Sánchez and Laako 2018).

In addition, Marland and Rafferty agree that, although the "trio of competition" among midwives, doctors and nurses has certainly existed, other important aspects must be also considered—for example, the emergence of hospitalized births and medical interventions, which fundamentally remolded midwifery practices and possibilities within the modern medical hierarchy. In the case of Europe, important elements also included declining birth rates and the challenges that economic crises posed to the public healthcare sector. All of these phenomena affected groups of midwives, many of whom opted

to participate in the introduction of technology and to form part of the new, institutionalized health agendas.

Thus, Marland and Rafferty (1997) importantly explain the emergence of the "modern" midwife, who, according to Anne Thompson (1997), reflects the changes in the status of women in society. The modern midwife, according to Thompson (1997), faced the challenge of creating a new public image that would help to foster her professional identity—an identity much needed for the success of the professionalization process.

In the context of inter-war Europe, midwives' desire for a professional identity also led them to establish the first international organization of midwives: the International Union of Midwives (1919), which later became the International Confederation of Midwives (ICM 1955). Indeed, Thompson (1997) argues that, without these international organizational efforts, which enabled midwives to speak with a unified voice, midwifery probably would have disappeared as a profession in Europe. The process of midwifery modernization was unavoidable in the context of the obstetric takeover of birth and Europe's declining birth rates—a decline that encouraged many midwives to join pro-natal movements and to expand the scope of their care from childbirth to postpartum and neonatal care and, in some places, to lifelong well-woman care.

A second phenomenon that threatened midwifery in Europe was the increasing medical competition over childbirth care. This competition was accentuated by the categorization of births as "normal" and "abnormal," later "low-risk" and "high-risk." This categorization contributed to discrediting midwifery work, thereby transferring more and more births into medical hands as increasing numbers of births were classified as "abnormal" or "high-risk," such as births to older women, or births in the breech position—which midwives have long considered simply a variant of normal. This transfer served to increase both the importance and the economic resources of the medical profession. Thompson (1997) emphasizes an additional motive that the medical profession had for transferring births into medical hands: the birthing women provided "didactic material" for medical students.

Together, these elements fostered the transfer of birthing women from homes to hospitals and to the medical sphere. As a result, the midwives who had attended women mainly in their homes were left out, unless they too transferred to hospitals. Although it was the home, fundamentally, that symbolized the autonomy and power of the midwife, birthing women in postwar Europe were increasingly drawn to institutionalized births as part of the modern lifestyle. According to Thompson (1997), many European midwives were leery of the scope of institutionalized births, which had now become universal and systematized. However, for many midwives, following that trend represented the only option for continuing to work as a midwife.

In some European countries, the tendency toward institutionalized maternal and newborn care also replaced midwives by increasing the involvement of new categories of health workers and assistants, who assumed the

role of "social" or "welfare" providers in the community. Some midwives responded to this tendency by turning toward nursing careers, while others rejected this option completely.

Finally, Thompson (1997) considers it important to note that the issue of fees has always been complicated in midwifery. She shows that, in the European history of midwifery, it had been common for midwives to receive no salary for their work. Instead, they won their bread from client payments, and thus often felt obliged to offer their services to women of higher economic status. Of course, a salary offered by the state helps to guarantee that midwives can provide their services to women irrespective of their social class. Yet, as Vainio-Korhonen (2012) shows, even in Finland, where the midwives were hired by the municipalities to serve all women, midwives used to suffer from lack of resources when they retired or became ill.

Thompson (1997) concludes that the redefinition of the role of the midwife in European societies has been central to midwives' survival strategies in modern times. In postwar Europe, midwives organized themselves internationally with the objective of expanding their political agenda toward social work and maternal–infant care, including hygiene campaigns and the right to give vaccines and prescribe some medicines.

Some of these achievements were important. For instance, from the 1930s onward, midwifery organizations in many European countries were successful in reducing the incidence of child abandonment, which had been common. However, these organizations ignored other social problems, such as the question of abortion, in order to avoid being accused of complicity in illegal activities, depending on the country in question. This project of creating the modern midwife, notes Thompson (1997), also necessitated that professional midwives distance themselves from traditional and empirical midwives, particularly those who were linked to abortions.

In this way, a relatively autonomous, modern midwifery was established in some Western countries. In postwar Europe, midwives became particularly autonomous professionally in the Nordic countries, the Netherlands (where they had long been so) and to some extent in Britain. In many other Western countries, where midwifery did not manage to safeguard its professional autonomy, many midwives took up nursing careers or practiced in hospitals as nurse-midwives subordinated to obstetricians.

Another aspect of the book edited by Marland and Rafferty (1997) that I consider important to outline is its demonstration of how the process of the modern professionalization of midwifery became tied to urban, middle-class women at the expense of the rural traditional midwives—and of the women living in those rural areas. This phenomenon occurred throughout Western countries. For example, Romlid (1997) notes that the more rural the country or location was, the better the midwives managed to hold on to their autonomy by attending rural women with distant (or no) access to hospitals. Such was the case in Sweden and Finland. In contrast, midwives lost professional autonomy in Denmark and Norway, which were more urban and

more medicalized. However, the governments in all these countries sought to establish midwifery as an urban, middle-class profession. As a result, strong resistance arose in rural areas where the illegalization of traditional midwifery would have left women without any maternal care—as indeed did occur (Romlid 1997).

The promotion of modern midwifery as an urban, middle-class profession found itself in multiple paradoxes (Marland 1997) in various European countries. Midwifery schools, usually led by doctors, were opened in urban areas to address the lack of trained midwives, which was especially acute in rural areas. As a result, modern midwives now had to cope with the perceived ignorance, dirt and poverty in those contexts, where they soon encountered additional problems. On the one hand, they faced the resistance of rural communities and their traditional midwives. On the other, the contrast between the solitary work in isolated rural communities and the urban school context brought complications. Some of these midwives found it difficult to put into practice what they had learned at school, or were simply not accepted by the communities. Also, local values and bases for status were frequently in conflict with those of the urban midwifery schools. This phenomenon augmented the young midwives' sense of sacrifice at being relocated to rural, poor areas (Marland 1997).

It is noteworthy that, in rural and urban contexts alike, midwives were considered as representing the contact between life and death. Therefore, they were treated both with great trust and with tremendous suspicion, even disdain (Løkke 1997). According to Marland (1997), the construction of the modern midwife fundamentally attempted to provide a neat and clean image as a contrast to these prevailing superstitions.

In other cases, as in England, the emergence of the modern midwife derived from middle-class women's desire to support women in poor neighborhoods by taking on the role of health missionaries and advancing the women's rights movement. However, the membership of early midwifery organizations tended to be exclusively for working-class women (Hannam 1997). Thus, while the modern midwife was supposed to work in rural and poor contexts, it was difficult for a woman from those contexts to become a (now modern) midwife.

In the USA and Canada—to be brief—modern times did not exactly renegotiate the role of the midwife (modern or otherwise), but instead saw a direct, aggressive medical and nursing attack upon midwifery (Devries and Barroso 1997) in the early 1900s that nearly resulted in its complete elimination in the USA and did result in its elimination in Canada (where it was not fully legalized until 1993, first in Ontario, after a decade-long battle). Although this attack provoked deeper divisions between midwives and nurses, it was also the impetus for collaboration between them. By 1955, there were enough practicing nurse-midwives in the USA to form the American College of Nurse-Midwives (ACNM), which proceeded to establish a government-recognized training and certification system for this new profession. So great was the medical resistance that it took these nurse-midwifery pioneers until

the mid-1980s to achieve legalization, regulation and licensure for nurse-midwives in all 50 states. Today, in the USA, around 12,000 practicing certified nurse-midwives (CNMs) attend only around 9% of all births, mostly in hospitals (Davis-Floyd 2018a).

The 1960s witnessed the emergence of social movements of all kinds in the USA (see Chapter 2), accompanied by a strong criticism of technology—including of the many technologies employed in institutionalized births. During the 1980s and 1990s, in the aftermath of this wave, many homebirth midwives, called "lay" midwives at the time, sought to achieve the "toehold of respectability" in the USA and Canada (DeVries and Barroso 1997).

To do so, these midwives, particularly those who had always taken critical distance from nursing and institutionalized births, sought to empower themselves. They founded, in 1982, the Midwives Alliance of North America (MANA), which eventually formed a section eligible for membership in ICM. This membership gave them greater credibility and some international influence. In 1989, MANA members created a daughter organization—the North American Registry of Midwives (NARM), which in 1994 created a full-fledged certification program that also became nationally recognized.

In order to overcome the stigma of the word "lay," these midwives picked the appellation "CPM"—certified professional midwife (Davis-Floyd 2006, 2018a). The first group of these formerly lay midwives to gain this certification did so in 1995. These are "direct-entry" midwives, meaning that they do not go through nursing but rather enter directly into midwifery training. Thus, in the USA, midwives can currently receive certification from NARM as CPMs or from ACNM's certifying body, the American Midwifery Certification Board, as CNMs. There are around 3000 practicing CPMs, who are not allowed to practice in hospitals, but only in freestanding birth centers and homes. Achieving legalization in their respective states took decades of political effort; still today CPMs are only legal, licensed and regulated in 35 states. Their battle for legality is ongoing in the rest (Davis-Floyd 2018a). US midwifery is a fractured profession, and thus does not serve as a good model for others to emulate (Davis-Floyd 2018a).

I go into this detail because CPM certification has particular relevance to the Mexican midwifery situation, as MANA for a long time had a Mexican division, and held annual MANA Mexico conferences around the country, which some of the midwives I speak of here—both professional and traditional—attended and helped to organize. In addition, a number of the pioneers of autonomous Mexican midwifery hold that certification. The CPM credential is not legally recognized in Mexico, but it does provide those who hold it with a mantle of credibility, as it situates them within a professional group that has been demonstrated to have excellent outcomes (Johnson and Daviss 2005, Cheyney et al. 2014), and many of whose members do practice with high degrees of autonomy.

> I feel like a country mouse as I stand in the ornate lobby of the Grand Hotel, clutching my brocade suitcase. What a culture shock. There are

> midwives everywhere, in all different shapes and sizes! There are sleek, cosmopolitan nurse-midwives from urban medical centers; groups of colorfully dressed Mexican parteras, chatting excitedly in Spanish; and many apprentice-trained midwives, like me. … In the end, 150 midwives came from all over the country. This meeting will prove to be the historic beginning of the renaissance of the world's oldest helping profession. Many of my heroes are here, the women who are the foundation stones of this new movement. They are charismatic, skilled, feisty, articulate, wild and beautiful midwives. Even with all the diverse backgrounds, what we find most inspirational is our own commonality—our steadfast dedication to improving health and welfare of mothers and babies, and our mutual respect and admiration for each other. … The workshops are informative and educational, but the real event is the storytelling that goes on everywhere until the wee hours of the dawn. It is phenomenal that we have all come to the same conclusions, independently, all across the country. Midwives are listening raptly to each other's stories, laughing, crying, eyes dancing with the joy of it. … I didn't sleep the entire time I was there. We sit hunkered at the hallways, squatting in doorways, lying on beds in clusters of enthusiastically gesturing women, exchanging story after story. This is where the real teaching occurs. We are thirsty for all the powerful knowledge we can finally exchange with our peers. It also validates my skills as a relatively skilled practitioner. … I am so grateful. I have finally found my sisters. I came home, buoyed and supported by the underground network of the wild and brave women who attend births around the country. Our ancient art, which once was associated with the past, the poor, and with witchcraft, is coming out of obscurity to be recognized as a viable new profession.
>
> (Leonard 2008, 72–73)

The above passage describes the first national gathering in the USA of the then-called "lay" midwives, which indirectly led to the establishment of MANA in 1982. Here, the story is told by US direct-entry midwife Carol Leonard in her biography (2008). She is considered one of the pioneers of the (post)modern midwifery movement, and is a co-founder and ex-president of MANA. The citation well characterizes the emergence of the "postmodern midwife," a concept introduced by Robbie Davis-Floyd (2005). She uses the term to capture the contemporary tendencies of midwifery in the aftermath of the construction of the modern midwife. She refers particularly to the *political* aspects of contemporary midwives who take a radical critical stance toward the biomedical system.

Davis-Floyd (2005) outlines the characteristics of postmodern midwives as follows:

1. They are informed by science, but seek to combine professional knowledge with the knowledge systems of traditional midwifery, and to complement them with other alternative systems, such as homeopathy and

herbalism. In other words, they practice *informed relativism*, learning various knowledge systems and picking and choosing what works best in a given situation.
2. They have high local, global and historical consciousness about their positioning in society as midwives, and of midwifery as a differentiated, unique profession within society.
3. Considering the above, postmodern midwives have a strong vision for the future of midwifery and a mission to preserve midwifery as a profession, which they believe to be in women's best interests.
4. They emphasize their autonomy as professional practitioners.
5. They reach out to their roots: postmodern midwives are dedicated to a model of care with a humanistic, transnational and transtemporal sense of midwifery.
6. They are often involved in political activism, at governmental levels ranging from the local to the regional or national. They are also active in transnational midwifery organizations and networks.
7. Thus, postmodern midwives see the construction of alliances, networks and associations as fundamental to the further development of the profession.

According to Davis-Floyd, for postmodern midwives, *the professional is political*, as they must constantly fight to achieve favorable legislation and regulation or to maintain what they have already achieved. Davis-Floyd (2005) also insists that postmodern midwives include professional as well as traditional midwives, as she interviewed, observed and lived with Mexican traditional midwives who are familiar with biomedical as well as traditional knowledges and consciously practice informed relativism (see Davis-Floyd et al. 2018). Thus, the notion serves to soften and elide the divisions between the two. The author also underlines that not all contemporary midwives are postmodern—they coexist with modern midwives and often challenge their ideologies and praxis—and argues that the postmodern midwife has roots in the revival of midwifery in the 1970s in the USA—the precise revival that generated the broader homebirth movement (see Chapter 2). Hence, in this re-emerged midwifery version, the holistic and empirical aspects of their praxis become highlighted as part of the broader counter-cultural mobilizations.

In my interpretation, this postmodern midwifery movement is intimately related to the dilemmas of the *modern* Western midwife, which in turn have to do with the professionalization and institutionalization of birth in which midwifery became positioned as a middle-class, urban profession with complicated connections to rural and/or economically disadvantaged contexts. Postmodern midwives are immersed in these dilemmas, which they seek to resolve by employing creative combinations of science and traditions while also seeking to remain true to the ideological root of the profession—the "midwifery model of care" (Davis-Floyd 2018b)—and engaging in political activism to improve the profession's autonomy. Yet there is nothing easy

about this political situatedness, as will also be shown below in terms of the Mexican case.

Two meandering paths: Mexican professional and traditional midwifery in historical perspective

> If we have received and obtained our diploma it is because we demonstrated competency in our exams. How can it be that today, in the nineteenth century, with all its progress, advancement, and civilization, when even today's *campesino* has rudimentary knowledge, that we are prohibited from exercising a part of our profession, in those things that we know and are capable of doing? … We cannot understand [the reason for these prohibitions] and can only speculate on the selfishness of the doctors who participated in the formulation of the aforementioned statute; they have taken away the lucrative part of our profession, leaving us to perform a role that a *rinconera*, as untitled and uneducated midwife aficionados are vulgarly called, could do…
>
> Rómula Bravo, President of the League of Midwives Society to the Mexican President Porfirio Díaz in 1892 (excerpt from Penyak 2003, 83)

> Some midwives have launched a discourse to the President of the Republic complaining that the edict issued this past March by the Supreme Board of Health infringes upon certain constitutional articles by severely limiting their professional practice, and that it hurts the interests of these women while favoring those of doctors … Our legislation guarantees all rights including free trade, but the police seize rotten meat that they find in the marketplace and punish the merchant who traded in rotten meat. The right of midwives to freely practice their art is indispensable, but the Board does not have fewer rights itself, [for it is] duly authorized to establish limits and issue edicts intended to stop excesses and avoid atrocities … [Midwives claim that doctors] have taken away the lucrative part of our profession … Now we come to the crux of the matter. The lucrative aspect! … To suppose that [doctors] have been guided by such a sad objective as to compete with midwives over the financial spoils of a few sick women [and] take advantage of their own elevated social position … can only make one smile at such nonsense.
>
> Response by Dr. Andrés A. Quijano to allegations made by League of Midwives in 1892 (excerpt from Penyak 2003, 84–85)

The above excerpts are drawn from the publications of the US historian Lee Penyak (2003, see also 2002), which are used here because they are translated versions from Spanish originals. The same excerpts, in Spanish, appear in articles by the Mexican historian Ana María Carrillo (1998, 1999, 2002, 2006).

The present section of this chapter is based mainly upon the works of those two authors, who explored archives in great detail. Their results coincide in many ways, although both authors focused primarily upon different centuries of midwifery history in Mexico.

In the beginning of the 20th century, the work of midwives in Mexico and many other parts of the world became increasingly regulated as a result of the expansion of the medical profession. During the 19th century, the Mexican professional midwives—called *parteras tituladas*—had actually gained access to university training in obstetrics. Ana María Carrillo's research (1999) has become a reference point in explaining how later, in the mid 20th century, these trained midwives were eliminated. The exchange of letters quoted at the beginning of this section is an example of the battles in which these midwives engaged while confronting the increasing restrictions imposed upon them by doctors. The letters deal with the 1892 prohibition against midwives attending complicated births. The then-extant League of Midwives reacted to this reduction of their professional activities by sending a letter to the President Porfirio Díaz. The League of Midwives emphasized that they had undergone the same training as the medical students who were allowed to attend such complicated cases. The League also communicated its speculation that the prohibition was an attempt by doctors to gain more lucrative space for themselves. However, the restrictions not only remained, but increased over time.

Indeed, Carrillo (1998, 1999, 2002) has shown that the initial support for training and certifying middle-class or higher-class midwives in Mexico was intended to eliminate the country's traditional and Indigenous midwifery. However, the traditional/Indigenous midwives have resisted even to this day, despite the enormous diminishment in their numbers, while professional midwives were gradually but completely excluded from the official healthcare system by the 1960s. Thus, the history of contemporary Mexican midwifery consists of two intertwined, meandering paths—the professional and the traditional—which are intimately connected, but also in tension with each other. These two paths are also important for understanding the emergence of autonomous midwives—an equivalent of postmodern midwives in Mexico—in the 1990s. Their emergence will be discussed further in Chapter 2.

Alongside the predominantly Western midwifery histories, there should, of course, be more studies on the Latin American history of midwifery. In addition, the English-language and Spanish-language scholarships should also engage more with each other. In Latin America, while studies on gender, health and professions are increasing on this continent (see, for example, Abreu et al. 2006), there is a lack of broader, comparative midwifery history accounts. We sought to contribute to closing this gap by publishing an edited collection of articles by Latin American scholars (Sánchez and Laako 2018). However, room certainly remains for further exploration.

In the case of Mexico, studies on traditional/Indigenous midwives form the mainstream of research on midwifery, which is also a reflection of the fact that, within the social sciences, it is predominantly anthropology that has

dealt with the topic of midwifery (such as Zolla 1988; Freyermuth et al. 1989; Campos-Navarro 1992, 2002; Sesia 1992; Freyermuth 1993, 2003; Menéndez 1994; Page 2002; Araya 2011). Currently, there exists a revival of midwifery studies in which urban and middle-class midwives are gaining a "toehold" in Mexican academic scholarship (for example, Sánchez 2015; Laako 2017a). Suffice it to add that authors such as Davis-Floyd (2001; 2018c [2003]; Davis-Floyd et al. 2018), Dietiker (2014) and Jordan (1993) have also written about Mexican midwives.

In the Mexican context, a midwife is commonly understood to be a person who is dedicated to communal service, and does not charge, or charges little, for her services. More importantly, midwifery is traditionally related to *curanderismo* (folk medicine and healing) (Carillo 1999)—many traditional midwives also know how to set bones and treat many illnesses, and are often in charge of celebrations of fertility and birth. The traditional massage (*sobada*) forms a major part of their prenatal care. Midwives held, and in some regions still hold, a position of respect within their community. According to the *Traditional Mexican Medicinal Dictionary* (2016) of the Mexican National Autonomous University (UNAM), the term *partera* (midwife, from *parto*—birth) has various synonyms in the country, including the Spanish terms *abuela, abuelita, comadrona, matrona* and *madrina* (many of which refer to older women as "grandmothers" or "godmothers") and various equivalents in multiple Indigenous languages. Linguistically, many Indigenous languages refer to the midwife as "the wise one," "the capable one" or the "one who gives life" (*sabia, hábil, diestra, aquella que da vida*). According to the above-mentioned *Traditional Mexican Medicinal Dictionary*, *partera* generally refers to women who are specialized in traditional medicine and who focus on maternal care, in addition to general postpartum, newborn and gynecological care. In other words, the general word for a midwife in Mexico, *la partera*, tends to connote the traditional midwife.

In the Mexican context, it is common for these traditional midwives to have acquired their knowledges through experience and oral transmission, often since girlhood, and by following family traditions and communal circles. Sometimes knowledge is also acquired through dreams or divine signs; many say that they acquired both their calling and their knowledge "from God." Since such midwives are part of rural communities, Mexican institutions have at different times solicited their services. Nowadays, these midwives are often called traditional, Indigenous or empirical, even though many have also received training in public health services, such as vaccination. Indeed, according to Sánchez (2015), these younger-generation traditional midwives have also been called "trained," "technical assistant" or "hybrid." When involved in family planning and reproductive health, they are sometimes referred to as "promotors" or "pillbox *parteras*."

During the colonial era, midwives were classified as healers because they lacked formal authorization from the *Real Tribunal del Protomedicato*, which was the technical body in charge of monitoring, training and authorizing

health professionals in colonial Mexico (Penyak 2002, 2003). Medical studies have existed in Mexico since the 17th century, but women were not allowed to study medicine—albeit technically, as shown above, they could certify as midwives. To do so, they had to prove their "purity of blood" (their Spanish lineage), complete three years of training under medical supervision and pay a fee.

Penyak (2002) has also shown that, during the colonial era, tribunals, lawyers and judges actually used midwives as expert examiners in legal cases concerning rape, premarital sex, incest and prostitution. Penyak outlines how the Mexican legal system between 1740 and 1846 benefited from midwifery knowledge in these ways. Midwives were displaced from these expert positions in 1850, when the medical system emerged as the authority. However, Penyak found 37 testimonies of midwives given in legal cases between 1740 and 1846, and concluded that, because of the high demand for such services and the paucity of health professionals (due to strict requirements for certification), most of the population—including officers of the legal system itself—recognized and used these non-certified practitioners. Midwives were particularly solicited when no doctors were available.

Although the testimonies found by Penyak (2002) were mostly from Mexico's capital area, the midwives who testified were ethnically diverse: 41% were classified as Spanish, 36% as Indigenous, 18% as *castiza* (one-fourth Indigenous) and 5% as *mestiza* (of mixed Spanish and Indigenous heritage). After Mexican Independence in 1821, such racial differentiation was no longer allowed. Fifty-one percent of the testifying midwives were widowed, and 38% were married women. Their average age was 49; most were between 40 and 60 years old. The majority were from humble backgrounds, and not one could write her own name. The tasks allocated to the midwives were completely racialized: midwives were asked to attend only their own class or an "inferior" one. Penyak (2002) also notes, on the basis of Hernández Sáenz (1997), that during the colonial era only two midwives were certified by the *Protomedicato*.

Between 1842 and 1898, midwives could take obstetric classes with medical students, which was a policy that slowly permitted women to enter the medical profession (Carrillo 1999; Penyak 2003). Obstetrics as a university specialty (formed in 1830) was also accessible to women, although they still could not become doctors. However, a career in obstetrics did permit them to certify as midwives, and thus to be integrated as part of the health professions. Nevertheless, as described at the beginning of this section, the restrictions upon midwives became ever greater, with the result that, as the 20th century dawned, midwives were permitted to do little more than assist in low-risk pregnancies. Nevertheless, Penyak (2003) notes that many midwives appear to have gone beyond the limitations imposed upon them during their time in service.

During the late 19th century, Mexican doctors engaged in the same sort of smear campaign against midwives that their fellows had been carrying out in other parts of the world (Penyak 2003). Although the history of midwifery

in Mexico is different than in Western countries, the discursive campaigns that raged in specialized journals and newspapers were similar to those found elsewhere. According to Penyak (2003), the Mexican doctors tried, on the one hand, to masculinize birth care, and on the other, to frustrate women's attempts to enter into medical practice.

> Mexican doctors throughout the nineteenth century made blatantly misogynistic statements. Flores y Troncoso's four-volume work published in 1886 is filled with sexist comments against women in general and midwives in particular. He describes colonial midwives as "ignorant and vulgar" and states that Mexican women were especially inept at practicing medicine because of their exaggerated imagination and emotional state; he suggests instead that they dedicate their efforts to the arts and the household.
>
> (Penyak 2003, 63, footnote number 15)

These results coincide with those of Carrillo (1998, 1999, 2002, 2006), although Carrillo (1999) also emphasizes the increasing attacks against traditional midwives. Nevertheless, 19th-century midwives could achieve certification, obtain posts and win a salary, thereby becoming respected professionals. In this regard, Mexican midwifery may have been more advanced than in some Western countries because obstetric training was made available to midwives early in the presidency of Porfirio Díaz, when hundreds of women successfully graduated in the field. However, and contrary to Western histories, non-licensed midwives continued to practice in rural regions. Indeed, until the 1970s, over 70% of Mexican births took place at home with midwives. Carrillo (1999) prefers to refer to these midwives as traditional, rather than "empirical," because they performed—and still perform—many tasks besides birth care. Traditional midwives are the therapeutic underpinning of their communities, and also provide help with (for example) fertility, abortions, breastfeeding and even external versions of fetuses (turning babies in utero from a breech to a head-down position), at which many are adept (see Davis-Floyd et al. 2018 for a detailed description).

According to Carrillo (1999), the allopathic medical profession sought ever-greater access to rural women; thus, medical professionals needed to replace the traditional midwives. To accomplish that replacement, the medical professionals both supported and subordinated professional midwives to themselves, while using them to establish contacts with traditional midwives in rural areas. By 1932, 627 midwives had graduated and been certified in Mexico. All were upper-middle-class women because the graduates needed to show abilities in reading, writing, arithmetic and French, inaccessible to lower-class women. Their studies, obviously, took place under the tutelage of (male) doctors.

In the beginning, certification of midwives did not imply institutionalization of births. Instead, the certified midwives—the *parteras tituladas*—attended

women in homes. The massive institutionalization of births in Mexico did not occur until the 1970s. Yet there was also an increase in the creation of "maternities" annexed to hospitals and clinics (Carrillo 1999). Carrillo argues that these "maternities" were established mainly for didactic purposes as venues for instructing medical and obstetric students. However, some maternities were closed down because increasing numbers of birthing mothers claimed that they were subjected to painful practices without consent (an irony, as that still often happens in Mexican hospitals, where obstetric violence is prevalent). Many of these maternities were created as justification for infanticide, and dealt specifically with single mothers.

Carrillo (1999, 2002) also emphasizes that it was not only the midwives who were under attack by doctors: so were other, competing health and medical professionals in Mexico. The country's academic, allopathic doctors did not automatically hold a monopoly over the healthcare system. Rather, they were imposed upon to attend the poor for free, and the state intervened greatly in doctors' training. Doctors had to convince society of their own medical superiority, because so-called domestic and Indigenous medicine were common, widespread and considered useful and legitimate. In addition, Indigenous medicine was protected by *Leyes de Indias* (Carrillo 1998, 151). Thus, in the Mexican case, the academic biomedical system had to co-exist with other forms of medical knowledge, a co-existence that has always implied to some extent a plurality of care (Carrillo 1998, 151).

By the 19th century, doctors had succeeded in positioning themselves at the upper level of the health profession hierarchies. However, regular doctors enjoyed less prestige than surgeons, phlebotamists, pharmacists, midwives and dentists. Doctors also enjoyed less prestige than nurses, whom they sought to control or assimilate. Doctors openly attacked other health professionals—religious, homeopathic and Indigenous—and ran campaigns to discredit them.

These conflicts, Carrillo (1998) argues, were of great importance in Mexico. The Catholic Church played a fundamental role in organizing healthcare in the country—including the building and management of hospitals. Homeopaths, another group that enjoyed considerable support in Mexico, openly criticized the abuse of surgery and the prescription of multiple drugs. Homeopaths also had more clients than allopathic doctors at that time (Carrillo 1998, 162), and considered homeopathy to be an improved version of scientific medicine. Thus, they had various schools, consultancies, professional organizations and journals. Carrillo (1998, 163) also reminds us that, in the 19th century, the majority of the Mexican population did not resort to allopathic or homeopathic medicine, but to Indigenous and popular folk medicines, including various versions of home remedies known to most women. Of course, the millennial Indigenous medical knowledge was classified as "vulgar" by the medical profession (Carrillo 1998).

In addition to these conflicts, Carrillo (1998) notes that there were interior struggles within the allopathic medical profession, such as generational

differences, conflicts between rural and urban doctors, between Mexican and foreign doctors, between doctors from different social classes and between general and specialized doctors. These kinds of struggles also existed within other health professions, including midwifery.

Nevertheless, during the 19th century, the allopathic biomedical system succeeded in positioning itself atop the hierarchy, eventually with the support of the nation-state. Thus began the process of modern professionalization and institutionalization. In this respect, the developments in the Mexican medical system are similar to those in other Latin American countries. However, as this history shows, it is important to bear in mind that within Mexico were thousands of traditional and popular doctors who had inherited the pre-Hispanic folk medicine. For that reason, allopathic medicine has never been able to take its position for granted (Carrillo 2002, 374–375).

This same era witnessed increasing control over midwifery, including its biomedical replacement. Expectant mothers were encouraged to seek medical attention. The criteria for obstetric careers increased, and many traditional practices of midwives were denounced as harmful, including the use of herbs, the traditional *temazcal* steam baths and upright positions for birthing (Carrillo 1999). The *parteras tituladas*, of course, attempted to defend their rights. To that end, they established (for example) the League of Midwives in 1898. The League could be considered an antecedent of the contemporary Mexican Midwifery Association (founded in 2012), which includes and has mostly included those midwives who support professionalization and regulation of midwifery in the country.

Carrillo (1999) notes that, at the beginning of the 20th century, most of the *parteras tituladas* were found in the capital area of the country. In 1911, the nursing career was established; shortly afterwards, nursing training was made a requirement for midwifery. Thus, midwives were reduced to "specialized nurses," today called LEOs—*licenciadas en enfermería y obstetricia*. Obstetric midwifery schools were reduced, while nursing schools increased. In 1944, the Mexican Social Security Institute (IMSS) was created, and the LEOs (nurse-midwives) were put in charge of maternal care within that system. According to Carrillo (1999, 187), this step marked the beginning of the institutionalization of births, which increased during the 1940s and 1950s. Yet these hospital births were mainly attended by nurse-midwives. Thus the care was still more expectant than interventionist, although medical procedures started to prevail.

Mexico's introduction of the university-based nursing degree in the capital area in 1967 finally suppressed the obstetric midwifery degree. The existing *parteras tituladas* were replaced by obstetrician/gynecologists (Ob-Gyns) because nurses did not qualify as midwives. In the 1950s, the posts held by professional midwives in hospitals were frozen and from the 1960s onwards hospitals started to prohibit them from attending births (Carrillo 1999, 188). According to Carrillo (1999, 190), the *parteras tituladas* protested, but did not succeed in presenting an organized response. Instead, they focused on

criticizing uncertified midwives, but did not dare to fight against the powerful medical profession.

Carrillo (1999, 190) concludes that the same healthcare institutions that favored the elimination of professional midwives also promoted training for traditional midwives. However, the health institutions' motive was not really to improve the care given by these midwives; instead, the institutions sought to access certain urban and rural contexts via those midwives. The research of Page (2002) and Araya (2011) on traditional midwives confirms this observation.

Maria José Araya (2011) distinguished "traditional medicine" from pre-Hispanic medicine in the sense that the former is born from interrelated processes between colonized peoples and settlers; thus contemporary "Indigenous" or "traditional" medicine represents a reconstruction of medicine rather than an essentialist one frozen in time. Traditional or Indigenous medicine itself has three types of practitioners: Indigenous doctors (healers—*curanderos*), seers and sorcerers (*adivinos y hechiheros*) and midwives (Freyermuth 1993; Araya 2011). Of the three, midwives have tended to occupy the lowest hierarchical rank because their work has not required sacred-magical rituals, although they also enjoyed a special status in communities because their practice is highly valued as heirs to a broad cultural and herbal heritage.

Jaime Page's exploration (2002) of 19th-century Mexico's health system focused on Indigenous medicine in the southern state of Chiapas. According to him, Indigenous medicine has been one of the country's most persecuted health systems, while also being one of the most resilient. In his view, the persecution of Indigenous doctors abated in the 1970s. At that time, federal policies shifted from the medicalization of culture and the elimination of autochthonous medicines to an apparent attempt to conserve, control and incorporate these systems into the official healthcare system. Thus, Page (2002) agrees with Carrillo's (1999) observations about the contradictions present in the Mexican state's health policies: the state attempts to incorporate the traditional medicines into the official healthcare system while simultaneously trying to discredit them. As a result, some of the state's strategies helped to foster these alternative medical systems (which represent a cheap way for the state to attend to its poorest population), while others led to their decline.

According to Page (2002), the Indigenous practitioners involved in various organizations are well aware of the benefits and disadvantages of the Mexican state's shifting policies toward traditional medicine. In post-Revolution Mexico, particularly since the 1930s, the "Indigenous problem" was recognized in the country. This recognition brought about integrationist politics, in contrast to the earlier attacks and prohibitions against Indigenous medicine, which had led many of its practitioners to work clandestinely. In 1949, the National Indigenist Institute (INI) was created with the objective of attending to the "Indigenous problem." The idea was to integrate the Indigenous peoples into the nationalist project by means of education and services that addressed the basic needs of this population. As a result, notes

Page (2002), a type of modernization and medicalization was carried out in Indigenous communities. Culturally inappropriate, biomedically oriented training programs were instituted for traditional midwives, in which they were taught, for example, that women should give birth on their backs (Jordan 1993). In the 1970s, government Indigenist politics (nowadays criticized by many scholars) transformed into a model of support, which sought to emphasize human rights and ethnic pluralism, at least on paper. Health services were introduced in rural areas, thereby reproducing within those communities the same problem that the modern midwife faced in Western countries: it was difficult to hire academic doctors from urban areas to work in rural areas with Indigenous doctors.

In the 1990s, Mexican politics took a "neoliberal turn" (Page 2002). Thus what emerged was a bipolar health politics that sought to generate market-based health services while directing public services mainly toward the poorest segment of the population. At the same time, Indigenous rights movements were gaining strength worldwide. According to Page (2002), the combination of neoliberalism and emphasis on Indigenous rights tended to leave Indigenous peoples alone to assume responsibility for their destinies.

In some Latin American countries, such as Peru and Bolivia, Indigenous medicine has managed to enjoy a special status. In contrast, attempts to preserve Indigenous medicine in Mexico have diminished, even though many Indigenous organizational efforts were made in the context of the 1994 Zapatista uprising (Page 2002). These efforts include the *Consejo de Organizaciones de Médicos y Parteras Indígenas Tradicionales del Estado de Chiapas* (COMPITCH), *Organización de Médicos Indígenas del Estado de Chiapas* (OMIECH), *Organización de Terapeutas Indígenas Tzeltales* (ODETT) and the *Consejo Nacional de Médicos Tradicionales* (CONAMIT), which during the 1990s included over 57 different Indigenous medical organizations in the country.

During the past decades, maternal mortality has been the principal reason for the attention given to traditional/Indigenous midwifery. However, while it goes without saying that maternal mortality is a high-priority problem for healthcare, it has also served to medicalize birth and to stigmatize traditional, Indigenous midwives (Araya 2011).

The two meandering paths in contemporary perspective: The emergence of autonomous midwives

> Beyond its undoubted social value, motherhood represents a deadly risk for many women … The WHO [World Health Organization] considers maternal mortality to be an indicator of insufficient coverage and quality of maternal and reproductive health services in the country, and research indicates that the vast majority of the causes of these deaths are closely related with the socio-economic conditions of the population. Hence the high percentages of maternal mortality in women speaking Indigenous languages in five states: Oaxaca, Guerrero, Chihuahua,

Yucatan and Chiapas … Many women prefer to give birth at home for the simple reason that they want to have a humanized birth. What does that mean? Basically it means having proper health conditions, as well as emotional ones. Professional care in a humanized birth implies, among other things, that the person who delivers the baby puts the needs of the mother first. This represents a radical change from the traditional gynecological approach … Thus, it is clear that it is important for traditional midwives to become professional. The Center for Adolescents of San Miguel de Allende (CASA) is a community-based organization in Guanajuato that opened its doors in 1996 and has the only government-accredited professional midwifery school. It aims to expand the model of professional midwifery to reduce maternal mortality, to eliminate unnecessary C-sections [cesarean sections], and to improve the process of pregnancy so that the newborns weigh more and arrive in better condition. Its goal is that in every rural community in Mexico there will be a professional midwife to accompany the birth process in an effective and humanized way.

Dr. Marta Lamas 10/06/2012
An excerpt from an article "Maternal mortality and humanized birth" in the Mexican newspaper *Proceso* 1858 (pp. 56–57, author's translation)
(Lamas 2012)

When talking about maternal mortality related to the medical practice of traditional Indigenous midwifery, it is crucial to define what you mean by traditional midwives and which group of practitioners you are referring to, and, further, what are the technical considerations that support the promotion to a professional or humanized birth, as you indistinctly call them … The developments in research on maternal mortality in the country are limited to only one part of classical epidemiology: the statistics. While these are extremely important, when used alone they are reductionist and incomplete. Maternal mortality must be addressed in its multiple bio-socio-anthropological determinations in order to avoid falling into "mere interventions" in the training of traditional Indigenous midwives, since the only thing being accomplished here is a medical ethnocide, by leaving Indigenous communities without an alternative care that has not even been investigated by bio-social scientists, and by turning traditional Indigenous midwives into nurses, at best.

Dr. Rafael Lavin (OMIECH advisor) 02/07/2012
An excerpt from the response to Lamas in the Mexican newspaper *Proceso* 1861 (p. 81, author's translation)
(Lamas 2012)

The considerations that lead me to support CASA's work are the following: their Professional Midwifery School works to prepare

competent midwives with a mixture of ancestral Indigenous knowledge and current gynecological-obstetrical knowledge. This blend of tradition and modernity has made midwife graduates well received in rural communities, while at the same time, as the studies are incorporated within the Guanajuato Secretary of Education, they are paid well by the government. I support CASA because its pedagogical model recovers many Indigenous practices that you mention, and because the multidisciplinary nature of the teaching team seems appropriate, ranging from certified professional midwives to traditional midwives, from doctors specialized in ob-gyn to anthropologists and psychologists. In addition, every semester the students spend two to four weeks visiting different states of the Republic to do fieldwork, with traditional midwives as teachers.

Dr. Marta Lamas 02/07/2012
An excerpt from the response to Lavin in the Mexican newspaper *Proceso* 1861 (p. 81, author's translation)
(Lamas 2012)

Mrs. Lamas also says that the pedagogical model of the school "recovers many Indigenous practices". Perhaps it is so; however, in their long presentation to us, CASA never mentioned any. Instead, at the end of their visit, the heads of CASA expressed very clearly what could be achieved, according to them, in terms of traditional midwives. They said that for the traditional midwives, it would be puny [*canijo*] to be recognized by the government and that given this, the best thing to do is to open a training school for their daughters or granddaughters (authorized by the government) so that they could work in peace and also receive a salary from the government. … They declare that there are only 23,000 midwives left in the country for a universe of more than 100,000 communities, and that is why CASA was created. However, despite all the private and governmental support they have received and used for the development of their model, as they told us, in their 13 years of existence, they have graduated only 60 students. At this rate, it would take something like five thousand years to barely reach the number of traditional midwives that exist in the country today, and 20 thousand years, double the current human history, to achieve [CASA's] goal of providing universal coverage of a professional midwife in every community of the country. Would it not be more sincere, more fraternal, or at least more realistic, to propose to fight for the 23,000 midwives who already live, and with them their own system, which also happens to be the one on which the cultural bases of our Mexico are born?

Sebastiana Hernández Intzin (President of OMIECH) and Micaela Icó (trained in traditional Indigenous medicine) 15/07/2012
An excerpt from the response to Lamas in the Mexican newspaper *Proceso* 1863 (p. 96, author's translation)
(Lamas 2012)

> I apologize for not having been sufficiently precise in my article and having led to a misunderstanding. I hope that my slip has not become a source of conflict, because I consider it very important to [maintain in the forefront] the concern that you and CASA share for the future of midwifery and for women's sexual and reproductive health. I understand, as you have already made clear, that there are different perspectives to address midwifery. In our country, with such a diversity of Indigenous and traditional cultures, there are also different perspectives on midwifery; its transmission to other generations; and [its] economic self-reliance. Not all midwives give importance to the same objectives, and precisely because there are so many difficulties surrounding the exercise and future of midwifery, it seems to me that dialogue between different views can be helpful.
>
> Dr. Marta Lamas 15/07/2012
> Excerpt from the response to Hernández et al.
> in the Mexican newspaper *Proceso* 1863
> (p. 96, author's translation)
> (Lamas 2012)

Attempts to bring back professional midwifery in Mexico have increased since the 1990s. As shown by the important discussion above, which also underlines the subtle tensions between contemporary midwiferies in Mexico, these attempts continue to be linked to the destiny of traditional/Indigenous midwifery in the country. Thus, the two meandering paths of professional and traditional/Indigenous midwiferies continue in the 21st century, now accompanied by the revival of what could be called postmodern or autonomous midwifery, together with shifting rights and policies related to midwifery work.

According to Karina Felitti (2009), fertility politics related to the demographic explosion in Latin America in the 1960s are strongly linked to current family-planning politics, which in the 1990s, again, were particularly linked to the emerging human rights discourse. Thus, a tension exists between governmental public policies on sexual and reproductive health and the respect for privacy, intimacy and autonomy of every person to decide for themselves about their sexuality and reproduction—a key element of the current reproductive rights frame. The former has often generated obstacles for the latter (Felitti 2009, 57).

These tensions can be perceived, for example, in the evolution of contraceptive methods in Latin America since the 1960s. In addition to bringing societal changes and economic development that transformed the position of women in Latin American societies (especially of women in urban and highly educated classes), the evolution of contraceptive methods was tied to demographic control. Although family planning has become more related to human rights than to geopolitics and demography (as previously noted), it still forms part of the historical context of these policies in Mexico (Felitti 2009).

In the late 1980s, the emergence of the concept of sexual and reproductive rights positioned women more as principal subjects and agents of these policies, supported by the Latin American feminist movements (Felitti 2009). Since the 1990s, these frames have been particularly linked to the problem of maternal mortality. It is noteworthy that, although international policies now emphasize access to health services as a way to reduce maternal mortality, Mexican research has shown that about 70% of Mexican mothers who die as a result of childbirth do so in hospital facilities, and not at the hands of traditional midwives (Freyermuth 2013, 2015; GIRE 2013; Sesia 2013). Nevertheless, the same international policies had serious consequences for traditional midwives, who were displaced from maternal care with the justification of the high rate of maternal mortality, which was easy to blame on them.

The consequences for midwifery are varied. As will be discussed in Chapter 5, the focus of international policies on maternal mortality increased the institutionalization of birth and threatened the work of many traditional/Indigenous midwives. On the other hand, the human rights discourse, which later gave birth to the Latin American concepts of obstetric violence and humanization of birth, helped autonomous or professional midwives to re-launch in Mexico (see Chapter 2). Simultaneously, Indigenous rights movements emerged forcefully in Latin America during the 1990s. Thanks to that emergence, Indigenous doctors and midwives could, at least potentially, argue for their own healthcare system in the frame of Indigenous rights and reproductive justice.

These developments have also given rise to "intercultural health" as a concept during the past decade, although this concept is still far from being a reality (Sesia 2013). *Interculturality* is an increasing field of academic study in both Latin America and Mexico, and is mainly tied to education, although medical and health system fields are emerging. It is also noteworthy that, in Mexico, there is a strong distinction made between *multiculturality* and *interculturality*. Multiculturality as "sensitivity" is understood as a notion driven by the dominant society's attempts to reconcile guilt while maintaining the same societal stratifications. Interculturality, again, is understood as a concept that underlines equality and true integration of Indigenous cultures into society while maintaining their rights to their own culture and medicine.

Yet maternal mortality has been the principal issue to promote professional midwifery and/or the modern professionalization of midwifery in Mexico (Freyermuth 2015). Indeed, as indicated in the discussion at the beginning of this section, CASA—one of the first schools for training and certifying professional midwives—was created in 1996 to reduce maternal mortality. According to Mills and Davis-Floyd (2009), another objective of CASA was to carry forward the knowledges of the aging traditional midwives with whom the CASA students are required to conduct internships. Other venues for professional midwifery training have since come into existence, such as the midwifery school in Guerrero, which is based on the CASA model, and *Mujeres*

Aliadas in Michoacán. Both also aim to diminish maternal mortality, especially among the Indigenous populations.

Again, Mexico's autonomous/postmodern midwives, who will be discussed further in Chapter 2, mainly emphasize another set of women's rights linked to social movements and societal criticism. They tend to have well-educated, urban, middle-class backgrounds but they also lean toward the roots of midwifery and the Mexican traditional/Indigenous traditions. These autonomous midwives emerged in the 1990s, first with the creation of *Parteras TICIME* in Mexico City and Tepoztlan, Morelos, and thereafter created many other regional associations.

In "*La partera profesional*: Articulating identity and cultural space for a new kind of midwife in Mexico," Davis-Floyd (2001) explains that the first autonomous, non-traditional midwife to practice in Mexico was Patricia Kay, an American homebirth midwife licensed in New Mexico with ties to CASA. She and her husband ran the TICIME clinic in Tepoztlan for over 10 years, where Patricia attended births either in the clinic or at home. According to Davis-Floyd (2001), Patricia helped to create two streams of autonomous midwifery in Mexico:

1. She conducted a professional three-year training for a small group of formerly traditional midwives, including Antonia Cordova, who later professionally trained four other formerly traditional midwives. They became the first midwifery staff at the CASA Hospital in San Miguel and Antonia became its first Clinical Director, teaching the CASA students clinical skills for many years.
2. Patricia also conducted a three-year professional midwifery training program for a group of urban, middle- and upper-class women in Mexico City (Davis-Floyd 2001), some of whom later traveled to Texas to obtain further training and practice experience at the autonomous border clinics in El Paso such as Maternidad La Luz.

One of these original autonomous midwives trained by Patricia is Laura Cao Romero, the founder of Parteras TICIME in Mexico City. Laura is one of the pioneers of postmodern/autonomous midwifery in contemporary Mexico.

When I interviewed her in 2015, she told me about her history within Mexican and global midwifery:

> I had a so-called natural birth myself, but in the hospital, a long time ago. However, I thought that the hospitalized births were attended very mechanically. So little by little I found out about other things, especially the book *Parto renacido* [*Birth Reborn*] by Michel Odent. It was influential. It opened for me the alternative option to attend births that I had been looking for but hadn't found. Later, I traveled to London and Vienna and found out about homebirths, and started to reconsider that option. In Mexico, in the 1950s and 1960s, they had closed all the midwifery

> schools and replaced all the *parteras tituladas*, just as Ana María Carrillo writes in her articles. So, luckily enough, I met Patricia in Tepotzlán. She was like a model of the professional, autonomous midwife. We started to think about a group and a program, about what to do with professional midwives in Mexico in a more independent way. Many of us had carried out our practice in the US, especially in the maternity schools in El Paso, Texas. Obviously, it is important to note that while we were in this particular struggle, the traditional midwives had not been forbidden, although their work was reduced to mere participant-observant. I refer to those hospitals that claimed to be bicultural and invited midwives, but it was more about the task to take care of patients during postpartum and in the birthing room, they were mere bystanders. Their positioning in Mexico has not been easy, either, although they preserved a little margin in which to exercise their profession.

Laura considers that, in the late 1980s and early 1990s, a kind of initial search for new paths was carried out in Mexico by midwives of two types: those who had previously been certified, but subsequently replaced, and new ones who sought to become professional midwives. According to Laura, this search had to do with globalization, in the sense that new information and consciousness about different options for birthing were arriving in Mexico.

> Yes, thereabouts between 1980 and 1987 we were at least three midwives who tried to establish birth centers more independently. We didn't want to be nurses, because that is not midwifery, and we didn't want to be dependent on the doctors either. There was also an excess of medical obstetrics, and it just seemed impossible that the midwife could emerge from there—their organizational heads even told me so in 1994. So we basically had to create our own space elsewhere. And so globalization arrived, the information and consciousness about how to attend births in other countries … We informed ourselves. We had also been part of the waves of feminism in the 1970s, especially against violence. I suppose that is where what Robbie Davis-Floyd has called the "postmodern midwife" was born; which is in the crossroads of all this, between the biomedical and the traditional that was born in the context of activisms. We have asked a lot about how to promote midwifery in Mexico, how to promote humanized birth, and which model of midwifery would be ideal for Mexico. We need autonomy, but also a model of midwifery different to Holland, Chile or France … I mean, our own system, and a system that would favor the autonomy of the woman—she has to be in the center of the mission. We have to collaborate so that each woman can decide what the best is for her, and not to impose, because sometimes this also exists in both systems. I mean, the natural birth sometimes also has these characteristics of imposition and so we have to be also self-critical. … But the challenge of self-regulation in midwifery in Mexico, it is important,

> but has to do with the variety of techniques: what will be our techniques of evaluation of midwives within the multiple models of midwifery in the country without being too exclusive? Especially when the midwives tend to have strong personalities, and many of them have formed their own models to do things. There are many who do what they do or can do in their contexts, and they are very difficult to judge from the outside. They also resist co-option, because this is fundamentally an autonomous profession for them.

Indeed, Laura also acknowledges the existence of a division between traditional and professional midwiferies in the country, as different models. Nevertheless, she also points out that midwifery, as an apprenticeship-based profession, has always involved sharing of knowledges:

> The thing is that traditional midwifery … they tend to be the wise women of their communities, I mean, it is the community that creates their midwives but also sets the conditions for collaboration. It is another kind of midwifery, in this sense. It is the relationship that the midwife has with her community, it is from there that she emerges and performs her role. Now there is a rupture, a change in these traditional models because currently the government employs coercion by which it takes away the autonomy of the traditional midwife. This has to do with the high rates of maternal mortality, especially in rural areas, the use of C-sections, the fear of complaints, all these things in Mexico that are simultaneously under the watchful international eye to reduce these rates. So, in the rural areas they obligate the midwives to take their women to clinics to birth, to avoid maternal mortality. I cannot say that this system promotes humanized birth … Now there are also many midwives, who are young Indigenous and they are more allopathic than we!

Laura also highlights that, in her experience, collaboration with traditional midwives, especially Indigenous midwives, always had to do with an exchange of practices, not training of Indigenous midwives:

> This is the way that midwifery has always been. It is in its nature. You learn by sharing knowledges because midwifery is based on apprenticeship. A great deal of midwifery is based on conversation between midwives; the way in which we casually share about the profession. So in this sense, I don't believe in training but sharing. … Indeed, in the beginning, perhaps during the first half of my life as a midwife, I concentrated on creating networks between traditional midwives and other countries. We published a bulletin called *Conversando entre Parteras* [*Conversations among Midwives*] during ten years, which also served this purpose. These networks consisted of different midwifery conventions in the US, Spain, Brazil and Canada. We made exchanges. I also carried out research on the

> linguistic exchange between midwives and doctors in different geographical locations. [I also] made a video showing the different techniques of massage to show in an anthropological conference and to spread these practices. In my case, I never had the impression that they [traditional, Indigenous midwives] would feel that I stole their knowledges. They saw me as their equal. They would say: "Despite the fact that you are from the capital, you attend [births] like us." In this bulletin, which I am thinking of writing in [the form of] little books some day, we published testimonies from traditional midwives, doctors, mothers and fathers, also from historians writing about ancient Mexico. I [make this known], I suppose, because I think we managed to create a small but interesting network that worked like a window to the foreign midwifery world, about the worth of midwifery and Indigenous medicine in our country. I think this also differentiated us from the "brood" of professional midwives of the 19th century and mid 20th century. We didn't want to distinguish ourselves or to discriminate against the traditional midwives. Afterwards, we sort of disappeared as a civil association because we didn't have the funds any more and we dedicated ourselves to attending births, so we couldn't continue this work of constructing bridges of understanding, as we were more focused on attending the birthing women.

However, Laura feels that currently the times are more favorable to midwifery in Mexico than in past decades:

> I see more force now in all the levels. The women seek more midwives now. It is possible that now there are more options, as well. Globalization also helps in this way. However, what we lack is that the birthing women mobilize more themselves. We need the women to mobilize against obstetric violence and for the humanization of birth. … Yes, traditionally it has been the middle-class women who seek midwives because they have more resources and access to globalized criticism of birth. You also have to remember that there were maternity lodges before, which is not a new invention. There have always existed different models in which women have given birth. Yet, in our experience, there are more and more lower-class women also seeking us now; the [globalized criticism of birth] is arriving there, too. There are more and more women who seek a different kind of care, and more force in all levels to drive the midwifery work. It is, at the end of the day, a women's movement, not just of midwives.

Laura ends by making reference to the recent developments related to the perspective of human rights in childbirth:

> Let's see, we in the *Parteras* TICIME, like many other midwives in Mexico, we have formed part of midwifery politics at the international level for a long time, especially in the congresses of MANA. It is from

> these collaborations that were born, at the time, the CASA [1996] and the midwifery school in Guerrero, which has been in existence now for five years [as of 2015]. Also the doula movement is part of all this, for humanized birth. In 2007, we also established the *Parto Libre* A.C., which had on its agenda, among other things, human rights in birth. This process took place after the first Congress of Humanized Birth, carried out in Brazil in 1985, and afterwards also in Brazil in 2000. So it is there that we made visible the indiscriminate use of technology in births. From there onwards, the Network for the Humanization of Birth [ReHuNa] was established and has existed now for 15 years. It is a group of people to humanize [birth]. Brazil has really been the node of this mobilization.

Conclusions: Autonomy in midwifery

This chapter has discussed the "meandering paths" of Mexican midwifery in historical and multiscale perspective. I began by outlining the theories of situated knowledges, which fundamentally allow one to analyze a case like midwifery in its multiple intersections related to geopolitics, class, ethnicity and gender. As my historical and multiscale analysis reveals, midwifery's position at those intersections makes it a curious case that escapes easy, binary divisions—it certainly escapes all attempts to essentialize it. Although midwifery is deeply immersed in different kinds of societal divisions and tendencies (which vary among locations and historical times), it has been practiced by all kinds of women in all kinds of societal stratifications. In some places, at certain times, midwifery has disobeyed predominant tendencies and shown long-term resilience and resistance. At other times, in other places, midwifery has been involved in turf wars. Usually midwifery has gone with the modern, professional, exclusionary flow. Yet it has also managed to revive itself in various adverse conditions.

This chapter has attempted, especially, to shed light upon the dilemmas of the so-called *modern midwife*. In Mexico, this type of midwifery was born in the context of the 19th-century hegemonization of medical (Ob-Gyn) practice. Thus, it was born just when many (health) professions were beginning to struggle for space—a struggle related to changes in demographic rates, transformation of geopolitical and cultural policies and the institutionalization of birth. For many midwives, these changes meant adapting to the modernization of the profession, with its often harsh implications. Specifically, modernization meant professionalization, which implied exclusion for non-professionals and a turn toward an institutionalized, high-tech, middle-class and urban version of midwifery. In some cases, as in Mexico, this turn was rendered impossible, and professional midwifery disappeared for a time. In rural areas and more marginalized regions, too, the process of modernizing professions had consequences—and continues to have them. In those regions, the chances for local women to provide and obtain basic health services in

their communities continually diminished. Thus, situated knowledges and the case of midwifery importantly illustrate intersected tendencies in women's professions, historically and geopolitically.

In a context such as Mexico, where rural and Indigenous communities are strongholds of traditional and Indigenous midwifery, the modernization process of the professions has entailed many threats. Thus midwifery, as a historical and intersectional profession with complex roots, stands out as a particularly important case in the postcolonial world (see Chapter 5). Yet, in line with Ehrenreich and English (2010), I can say that what matters is not only what midwives do or decide not to do, but also what happens to different professions in different eras. What are the possible choices at given moments for women in history, and for their professions, crafts and vocations? There is certainly more room for exploration of these questions.

The final contribution of this chapter is its attention to the concept of autonomy in midwifery. Autonomy is central to the legitimization of any profession in (post)modern times. However, it is particularly so in the case of midwifery, whose autonomy has been at risk for centuries, and is increasingly so today. Although in many countries midwifery has an autonomous position—albeit with a great diversity related to exactly what this autonomy comprises—midwifery is struggling in many others. This situation has been emphasized regularly by the ICM (2011).

According to Alison Herron (2009) in her dissertation about autonomy within British midwifery, much confusion surrounds how to exercise this professional autonomy in clinical contexts. She defined "autonomy" as being related to terms such as self-government, self-management, freedom, power and authority. Indeed, according to Herron (2009), autonomy is a complex concept in the sense that, for an individual to have autonomy, she needs to have a degree of freedom to follow her professional preferences. Thus, individually speaking, autonomy refers to the control that a professional can exercise over her own practice. Autonomy is simultaneously related to responsibility, integrity, self-reflection, consciousness and ethics to adequately confront the dilemmas and conflicts that occur in any autonomous practice.

"Professional autonomy," again, can be considered its own category, which fundamentally refers to a group rather than an individual. According to Herron (2009), professional autonomy implies the capability of a group to define its practices, its members and its education without interference from other groups. Indeed, ICM (2011) has defined professional autonomy as the sort in which midwives are the ones who have the power to determine and define who is a midwife, as well as to set the standards for their education, regulation and practice. In addition, the ICM (2011) maintains that this kind of professional autonomy should not be confused with working alone, nor does it have to do with working independently or privately. Rather, professional autonomy has to do with the fact that midwives as professionals should be able to define for themselves who qualifies as a midwife, and what her tasks and protocols are, without interference. Professional autonomy also means,

eventually, that midwives are free to exercise and make collective decisions concerning their profession.

In this chapter, and in my other chapters in this book, I show that autonomy continues to be a key concept in midwifery's struggles, historical as well as contemporary. Autonomy has many additional implications as a politically situated and charged concept, used also by certain midwives in Mexico to position themselves as professional, politically situated women with anti-systemic criticisms. These midwives are firmly positioned to struggle for their professional autonomy and for women's rights, but at the same time, the concept also characterizes their frequently fragile positions among the meandering paths and contemporary dilemmas of professional and traditional midwiferies.

Notes

1 This chapter draws from my previously published book: Laako, H. 2017. *Mujeres situadas: Las parteras autónomas en México*. Mexico: ECOSUR.

2 These issues were deeply discussed in our informal international network seminar (SVI) between the years 2011 and 2012 in CIESAS, Mexico. The seminar led to the publication of Leyva Solano et al. (2015). Situated knowledges—particularly as lived, bodily experiences—became an important theoretical strand within this seminar on subaltern, postcolonial women. Many Latin American social movements have criticized solidarity in a way similar to that of Tuck and Yang (2012). For example, the Zapatista movement criticized International/Western Zapatismo for gaining political capital from solidarity with the Zapatistas. I have previously dealt with these issues; for example, in my doctoral dissertation (Laako 2011) and in the chapter (Laako 2015) that appeared in Spanish in Leyva Solano et al. (2015).

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2 She breaks paradigms and leaves a trail

The contested terrains of midwifery activism[1]

Hanna Laako

Introduction: Midwives and contentious politics

This chapter explores the reemergence of Mexican middle-class midwives from the 1990s onwards. These midwives are part of broader (advocacy) networks and women's collective action that seek to strengthen and deepen the reach of women's human rights in childbirth in Latin America. This chapter is one of the first academic efforts to specifically explore the political activism of midwives in terms of both social movements and human rights related to the contemporary reemergence of midwiferies in Mexico since the 1990s (Laako 2016). In this book, this chapter connects Chapter 1 on the history of Mexican midwiferies, which led to their present search for professional and other *autonomies*, and Chapter 5, which probes the roles of midwives in campaigns for the humanization of birth and against obstetric violence.

This chapter particularly shows how human rights are a contested terrain for social movements, internally and externally, and how midwifery forms part of such struggles. At the same time, the chapter unfolds the concept of autonomy as embedded in the midwifery movement. I suggest that the autonomous midwives' movement is relevant because, even though midwives are relatively marginalized in Mexico, this movement makes visible both struggles for autonomy and for women's movements for reproductive rights in Latin America. Contemporary midwifery activism in Mexico, as unfolded in the politicization of autonomous midwives, sheds light on the differences, tensions and possibilities of political networking among women in the Global South. These midwives are in a situation of politicization that intertwines several rights as well as aspects of class and ethnicity. Therefore, the midwives' situation is one in which these aspects can be studied conjointly in the context of social movements.

To develop my argument, the chapter is structured as follows. I begin with contextualizing midwifery in Mexico and present the methodology of the study. I then outline the principal theory of social movements, especially in terms of the link—which is fundamental for this chapter—between social movements and human rights. This section shows that the human rights claim has become a substantial topic in recent scholarship on networks of

transnational activism and international advocacy. To examine the scope of the midwifery movement, I particularly use Keck and Sikkink's theory (2000) about advocacy networks to emphasize awareness and the mobilization around political networking, women's rights and creation of alliances. I continue by arguing that midwives' political activism can be understood, theoretically and empirically, as a social movement. I explain briefly how the collective actions of midwives have been studied in the frame of social movement theory. This discussion shows that midwives extend their mobilization beyond the defense of their own profession, while shedding light upon the question of which birth knowledge systems predominate in Mexico. The link between human rights in childbirth and midwives will be revisited in terms of obstetric violence and humanization of birth in Chapter 5.

Based on fieldwork results and triangulation of various research materials, I then discuss the reemergence, politicization and political activism of autonomous midwives in contemporary Mexico from the 1990s onwards. While being challenged by the competing meanings of midwifery in Mexico, the midwives in my research were politically organized and perceived their political advocacy to be not only for autonomous midwifery but also for women's autonomy in general as part of human rights. I define autonomy here as self-determination and self-government, which can be professional, individual and collective. To support these findings, I include two *herstories* of autonomous midwives, which outline the motivations behind their political action. In the case of Mexico, midwifery activism fundamentally includes the need to engage with the situation of Indigenous peoples.

Social movements are generally defined by the existence of collective action. They are understood as self-aware groups with flexible organization—not necessarily formal associations or organizations, or of those of masses—that mobilize against entities they perceive as authorities and/or elites, regarding actions or situations that they consider to be misguided or unfair. In most cases, the activists comprise grassroots groups, networks and organizations that come together to make visible or to resolve an existing social conflict. (See for examples Tarrow 1998; Keck and Sikkink 2000; McAdam, Tarrow and Tilly 2001; Ibarra, Gomá and Martí 2002; Smith 2008; Juris and Khasnabish 2013.)

However, social movement scholars have emphasized that the emergence of collective action cannot be explained only by the existing injustices (Tarrow 1998; McAdam, Tarrow and Tilly 2001; Ibarra, Gomá and Martí 2002). Rather, the emergence of collective action implies the existence of a common awareness of these perceived injustices. In other words, social movements are born either because the opportunity structures within a society have changed, or because a newly emerged interpretive framework for the existing conditions has generated collective action. Indeed, social movements have formed an important field of research because they have been perceived as agents that produce social change by practicing *contentious politics* (McAdam, Tarrow and Tilly 2001). In other words, they produce social change through collective

political struggles that target the authorities (the official system or elites) as objects of their claims. Although they are not yet a fully recognized field in the study of social movements, Mexican middle-class midwives and their activism have engaged in precisely this sort of struggle during recent decades.

Autonomous midwives and the methodology of this investigation

The argument presented in this chapter is based primarily upon extensive fieldwork that I carried out during the years 2014 and 2015. I had also conducted initial interviews in 2013 (Laako 2015, 2016). I interviewed 15 midwives in depth in the Mexican states of Mexico City Federal District, Chiapas, Oaxaca and Quintana Roo. The midwives who participated in this research constitute a representative national sample. The interviewed midwives themselves estimate that there are 20–50 "autonomous" midwives in all of Mexico. Although the autonomous midwifery movement is a small one, it is influential because of its participation in larger networks.

According to the report of Comité Promotor por una Maternidad Segura en México (the Mexican Committee for Safe Motherhood, 2014), of the 104,379 healthcare providers engaged in sexual and reproductive healthcare in the country, only 78 are officially registered midwives who attend births. This figure does not include traditional midwives, who number about 15,000 according to the previously cited report. The caregivers who attend births in Mexico include professional midwives, nurse-midwives, general practitioners and obstetricians/gynecologists. However, only midwives devote 100% of their time to this particular work. As mentioned in the introduction to this book, there are four midwifery schools in Mexico: the CASA School for Professional Midwives in Guanajuato, the *Escuela de Mujeres Aliadas* in Michoacan, *the Escuela de Partería* in Guerrero and the *Escuela de Iniciación a la Partería Luna Llena* in Oaxaca. In addition, nursing and obstetric careers are offered by the National School of Nursing and Midwifery (see for example Carrillo 1999; Page 2002; Araya 2011; Argüello and Mateo 2014; Sánchez 2015).

The midwifery centers visited for this research included *Luna Maya, Nueve Lunas, Madreluz, Osa Mayor* and *TICIME.* At the time of their interviews, around half of the interviewed midwives were members of the Mexican Midwifery Association (*Asociación Mexicana de Parteria* (AMP)), which was established in 2012. Others have not been members and do not seek to become members at this time. Still others had been active members, but have resigned for the time being. At the time of this research, the AMP had just emerged as one of the principal organizing and networking forums for those midwives who sought professional autonomy, certification and regulation in Mexico. Yet, in this mission, the activities and efforts of the AMP also generated heated debates and struggles of different kinds. My research was related to AMP but not reduced to it nor was it the principal focus.

One of the main objectives of my in-depth interviews with the midwives was to explore how they decided to become midwives, and why. Also of

interest were how they tell the story of midwifery, and what they believe is at stake with midwifery in Mexico today. The interviews also explored aspects of the agendas of these different midwives: what unites them or makes them different from each other, but also what kind of midwives there are in Mexico, and how these middle-class or urban-origin midwives are related to traditional midwives. In addition to the interviews, I carried out participant observation in April 2015 during the First Regional Congress of the AMP, in the state of Quintana Roo. At that Congress, a questionnaire was completed by 15 midwives—mostly traditional Mayan midwives from Quintana Roo, but also some from the state of Chiapas. These midwives' responses made possible an initial comparison among different types of midwives.

In addition to the interviews and questionnaire, my research is based upon a triangulation of various materials: websites, brochures, reports, articles, videos and social media sites in which the midwives' debates and discussions took place.

It is important to note that the midwives interviewed and discussed here are of the type that I have defined as *autonomous* as a result of this research. By "autonomous midwives," I refer to politically active midwives who mainly have a middle-class, urban profile, who are critical of the official medical system (i.e. anti-systemic), and therefore prefer to practice their profession outside the institutional environment. Several of them, however, since becoming midwives had relocated in rural areas, where they also adopted different lifestyles with the pursuit of getting closer to the Mexican rural, traditional and Indigenous roots as well as pursuing environmental sustainability. Most of the interviewed midwives were Mexican, but foreigners with permanent residence were also included.

Thus, my focus was with those midwives who identified themselves as autonomous or engaged with this notion in multiple ways during my research. They have also been active in establishing midwifery centers, associations and networks in their pursuit of strengthening "autonomous" midwifery in the country.

The concept of autonomy was a necessary point of departure of this research because these midwives called or labeled themselves as "autonomous." By using that term, they seemed to indicate a critical societal stance that was importantly tied to the reemergence of a particular type of midwifery activism in the country, and which also set them apart from the categories of professional and traditional midwives. Thus, I started with the objective of exploring who these "autonomous" midwives were, given the previously explained complicated context of Mexican midwiferies (see Introduction and Chapter 1). During my research, the concept of autonomy was deepened and extended, and was continually emphasized by this particular set of midwives to describe the kind of midwives they felt they were.

As noted in the introduction to this book, the International Confederation of Midwives and other major international organizations define a "midwife" as one who has graduated from a government-recognized program, as indicated by the adjective "professional" (International Confederation of

Midwives, 2011a). In practical terms, that definition excludes the majority of midwives in a country like Mexico. To be sure, some midwives of my study had credentials from abroad while others had been trained via apprenticeship with other Mexican midwives. Thus, most fall outside the official international definition and its scope.

The definition of the traditional midwife is even more problematic. Internationally, a traditional or empirical midwife is coded as a "traditional birth attendant" (TBA), as she lacks the government-recognized certification required of a professional midwife. However, these midwives constitute what is still probably the majority of midwives in the world, especially in rural and poor regions. In general, and as is often the case with artisanal professions, these midwives have learned their profession in a way that is hereditary and (as the term implies) empirical, via experiential learning during their apprenticeships; their mentors are often older family members such as mothers, aunts and grandmothers. Some say they learn in dreams or from God (Araya 2011; Arguello and Mateo 2014); others simply learn by doing, without any teachers at all. In the Mexican context, it is often thought that traditional midwives are those who identify themselves as Indigenous; however, this perception can be misleading. Although many Indigenous midwives do define themselves as *parteras tradicionales*, this category is very broad and complex due to several simultaneous processes. For example, in Veracruz many midwives have recently certified as "traditional."[2] This certification, above all, allows those midwives to detect possible risks and they are usually encouraged to deliver women to hospitals. However, the certification also seeks to bring traditional midwives within the state legislation in attending pregnant women and homebirths to reduce maternal mortality.

Yet this example is only one among many, and the situation of midwifery certification is complex and murky in Mexico. To better understand the contemporary legal context and its problems in terms of midwifery in Mexico, I recommend consulting the introduction to this book as well as López et al. (2019). Here I have mentioned the example of Veracruz to show how ambiguous the categories of different midwives are in Mexico, with ever more complex legal implications. For example, according to my interview results, many of the registered "traditional" midwives in Veracruz have not been Indigenous but rather semi-urban *mestizas*.[3] Indeed, some autonomous midwives interviewed chose to seek certification as traditional midwives, despite being urban, middle-class and highly educated. They seek this certification because it is the only one available to them—there is no national certification for professional direct-entry midwives.

Another sector of midwives are the *licenciadas en enfermería y obstetricia* (LEOs), nurse-midwives who graduate from four-year university-based programs, and tend to practice in hospitals and to be more inclined toward nursing than midwifery.

Indigenous midwives do not form a homogeneous group either, as they include both "traditional" midwives and trained midwives who incline toward

the biomedical system, thus ceasing to correspond to the common image of traditional/Indigenous midwives. Some midwives have referred to themselves as "hybrid midwives" (*parteras híbridas*), as they are a mixture of the traditional and the professional-biomedical.[4]

Finally, a sector of midwives includes the technical midwives (*parteras técnicas*), who graduate from one of the government-recognized midwifery schools in Mexico. Most of these midwives work in hospitals and clinics; many, like the LEOs, exercise a more nurse-oriented role (Carrillo 1999; Davis-Floyd 2001; Seymour 2010; Sánchez 2015). Some are part of today's wider midwifery movement in Mexico, which intends to establish more midwifery schools in the country, and to achieve certification and better positioning of midwives within the healthcare system.

I emphasize that, although the essential objective of this chapter is to understand the particular activism of autonomous midwives—as will be shown below—this collective action in its broader sense also includes other actors, such as feminist groups, perinatal educators and doulas.[5]

Midwifery in Mexico today is conditioned by different contexts: rural, urban, economic, regional, class and ethnic. Each midwife, depending upon her location and context, is subject to policies that condition her work. At the same time, she positions herself in particular ways to confront policies that tend to impede her work. Therefore, the researcher needs to maintain a critical distance from the essentialist definitions of different midwives as "frozen in time." Only by doing so can the researcher locate the definitions of midwives in a shifting, politicized, debated field, which is recognized by the midwives themselves as a disputed terrain. Indeed, the imagery of "the midwife" has played an important role globally and historically in the midwifery battles and counter-battles. Thus, I emphasize that, while my use of the term "autonomous midwife" seeks to identify and highlight a particular type of midwifery activism and reemergence of midwives in Mexico since the 1990s, it is not a strict, closed definition, but rather an instrumental and illustrative one, which has its own shortcomings as a result of the complexity of the context. However, it does incite us to rethink political activism, autonomy and human rights in contemporary midwifery.

On human rights in social movements

Social movement theories emerged with vigor in the 1960s and 1970s as part of the critical theories in the social sciences. These critical theories included, among others, political science's critique of established political institutions, and the critique of state-centrism in international relations. In other words, the arrival of social movement theories is connected to the theoretical critique of conventional politics and its borders. To be sure, mainstream political science perceived the social movements for quite some time as immature, isolated incidents not suitable for serious political analysis. Thus, social movement studies represented a radical field of inquiry by considering social movements

as agents of societal change, which, after all, is their purpose. However, this field has also suffered from its own kind of shortcomings over time, including the aforementioned state- and Eurocentrisms, and even androcentrism. Thus, many movements that were and have been researched are those that have gained the most public visibility for including mass demonstrations that were led, more often than not, by men (McAdam, Tarrow and Tilly 2001; Smith 2008; Juris & Knasnabish 2013)[6].

Since the 1990s, and largely due to debates over globalization and transnational activism, social movement theories have expanded their analytical scope. Researchers are increasingly interested in explaining the formal and informal networks of transnational activists. A pioneering work in this sense is the book *Activistas sin fronteras: Redes de defensa en política internacional (Activists without Frontiers: Networks of Defense in International Politics)* by Keck and Sikkink (2000), in which the authors developed their theory of advocacy networks in international politics. The authors defined those networks as the actors and activists—including social movements and non-governmental organizations—who are working transnationally on one particular issue. United by shared values and a common discourse, the networks extensively share information and services. Keck and Sikkink (2000) also pointed out that the activists in such networks seek not only to influence formal policies or state politics, but also to transform both the terms and the nature of the debates within nation-states and in international organizations.

The authors argue that advocacy networks have been important in the debates on human rights in particular, and on topics concerning the environment, women, children's health and Indigenous peoples. They note that, given the types of pressures and political programs of the advocacy networks, the networks rarely involve mass mobilization, except perhaps at decisive times. According to Keck and Sikkink (2000), the successful cases of advocacy networks are often those that include: (1) issues related to physical harm to vulnerable groups or individuals, especially when there is a clear, short chain of causation (or a story) that points out the responsible parties; and (2) issues of legal equality or opportunity. The success stories of such advocacy networks and activism include issues such as torture and disappearances, political prisoners, environmental protection and the protection of peoples.

Keck's and Sikkink's work (2000) is relevant to this chapter because they reveal, and extend, the links between human rights, social movements and networks in transnational activism. Indeed, the theory of new social movements was the first to show precisely that "the new" in the new social movements—from the 1960s onwards—was the discourse linked to human rights. The new social movements, unlike the "old" ones—principally first-wave feminism and workers' unions and movements with class-based claims—are based on the defense of a contemporary generation of rights, including reproductive rights. The difference between the old and new movements reflects the differences in character among their respective protagonists: activists involved in the so-called new social movements tend to be more middle-class and educated, and

focused on rights related to identity politics, although it can also be argued that all politics are identity politics to some extent (Cornwall and Molyneux 2006). It has been argued that the new social movements from the 1960s onwards include Western student movements, second-wave feminism, peace movements, green movements and lesbian and gay movements. According to Stammers (2008), the Black civil rights movement and Indigenous peoples' movements have sometimes been considered as new social movements, although the former one has also been considered to be transitional between the old and new movements.

During the 1980s, a wide range of movements in Eastern Europe, Asia and Latin America were also identified as new social movements (Escobar 1992; Ackerly 2008; Leyva Solano et al. 2015). Finally, many global and transnational movements from the 1990s onwards, such as the Mexican Zapatismo movement and the World Social Forum, encompass elements of new social movements, albeit not always analyzed in this category by other scholars (Stammers 2008).

According to Stammers (2008), the theory of new social movements is based upon a two-sided argument. First, the theory argues that in the Western world these new social movements are a consequence of the fall of corporatism and the welfare states. Secondly, the theory argues that the activists are formed from a generation that has been excluded from the benefits of the corporate welfare state. However, this explanation lacked a more comprehensive approach that would have included the movements that emerged in low-to-middle-income countries (LMICs). Even so, the theory called attention to the silent emergence of non-material values that distinguished the new movements from the old ones, which had referred mainly to rights and conditions of workers.

Thus, the approach taken by the theory of new social movements enabled researchers to maintain a critical distance from the idea that material conflicts are the only axis of analysis: the new approach transferred the focus from the material and emphasized identity and human rights instead. However, the question of political identity was frequently reduced to analyzing the "immaturity" of the activists. In other words, the theory of new movements was downplayed as being focused excessively upon the middle class. Stammers (2008) argues that the established dichotomy between identity and economic interest was exaggerated in this debate, considering that most social movements share many strategic and expressive forms of collective action. Even so, the emergence of new social movements made possible a rethinking of social movement theories, among other things, by introducing new axes of analysis beyond social class—such as ethnicity, gender, caste—within the academic debates.

Most importantly, the link between social movements and human rights was articulated. Although the human rights aspect was not born with the new social movements, as Keck and Sikkink (2000) have shown, it did allow a deeper exploration of how these movements reinforced and disputed what

constitutes human rights. In this sense, the theory allowed human rights to be showcased as a contested terrain and central axis of activism in the movements' quest for social and political change (Ackerly 2008).

Yet, as Stammers (2008) has also noted, the speed with which the debate moved from the new social movements to transnational activism has limited the number of empirical studies on the link between human rights and the social movements. The paucity of such studies is a point to consider, as afterwards, and especially at the Latin American level, Indigenous movements emerged with global visibility with claims to Indigenous rights, which suggests that these demands are an issue that is not limited to Western, middle-class activists (Bengoa 2000; Brysk 2000; Speed 2008; Engle 2010).

Midwives, social movements and human rights

Social movement studies have served as an analytical tool, used mainly by anthropologists, to understand and make visible the political activism of midwives. Midwifery activism has been theoretically explored as a social movement, especially in North America, on the grounds that midwives have aimed at social changes in birth contexts (see Davis-Floyd and Johnson 2006; Daviss 2006; Nestel 2006; Burton and Ariss 2009; Craven 2010). For example, Burton and Ariss (2009) argue that the midwifery movement in Canada of the 1980s and 1990s was simultaneously fighting for social change in which births could be considered as natural, as opposed to pathological, as well as for the certification of midwifery from a counter-cultural position.

On the other hand, Nestel (2006), with her intersectional, professional battle approach, offers a critique of the "heroic" story of the midwifery movement in Canada to achieve legalization and certification in the early 1990s. Nestel argues that midwives of color were excluded from the construction of this movement for a new White middle-class profession—at the same time as some White midwives were traveling to the Mexican border clinics to practice their skills on the bodies of women of color. It should be noted that the contemporary midwives in Canada have benefited from Nestel's work and paid attention to righting wrongs.

Craven (2010) explored the pro-midwifery movement in the USA. There, in the context of reproductive and consumer rights, not only have the midwives mobilized, but also many mothers used midwifery services in defense of homebirths. Craven pinpoints several important aspects to consider. First, her research brings forth the lack of an established name for this type of activism and the relationship between reproductive rights activists and feminists. These two groups have occasionally had different views on reproductive rights and women's roles in maternity; in other words, pro-midwife mobilization makes reproductive rights a contested terrain. Secondly, Craven takes account of Nestel's (2006) approach to discussing racism within midwifery, noting that many African-American women prefer to speak in terms of "reproductive justice" (instead of reproductive rights), as they feel that their experiences of

reproductive struggles have worsened while reproductive rights have improved for middle-class and White women. Finally, Craven (2010) challenges the predominant perception that the midwifery movement is composed mainly of White upper-middle-class (and "'hippie") women. In reality, and according to her research, the spectrum of women in the USA involved in midwifery activism is much more varied: it includes, for example, conservative religious women of the far right. The political and economic spectrum of women who are pro-midwifery in the USA is broad. Therefore, the only common ground to be articulated in their struggle is through consumer rights, which has proved to be counterproductive because it promotes the same perception of women with resources who can and will choose their forms of birth, and thus be able to support midwifery.

As previously noted, Davis-Floyd (2005, 2018), one of the most influential midwifery researchers, has contributed to the construction of midwifery activism by introducing the concept of the *postmodern midwife* (see Chapter 1 for further details). The concept emphasizes the *political* aspect of the profession and its knowledge system, while building a radical critique of the biomedical system. In this sense, the postmodern midwife, as the ideal type, combines and integrates professional and traditional knowledge, linking scientific information with alternative systems in what Davis-Floyd (2005, 2018) calls "informed relativism."

As Davis-Floyd (2005, Davis-Floyd et al. 2018) defines them, postmodern midwives have local, global and historical awareness, plus a sense of mission to preserve the profession of midwifery in the interests of women. Postmodern midwives value and seek to achieve autonomy as practitioners, and are dedicated to a midwifery model of care based upon humanistic, holistic and transnational features. The postmodern midwife is politically active, lobbying with governmental authorities and working with organizations at local, regional, national and global levels. In this sense, the political focus of midwifery activism is on building alliances, networks and partnerships. Davis-Floyd (2001) has applied the term "postmodern midwifery" to the case of Mexico to describe the articulation and construction of identity and cultural space for *la partera profesional*—a "new type of midwife in Mexico." Davis-Floyd (2005, Davis-Floyd et al. 2018) is careful to note that the term "postmodern midwife" can apply equally to both professional and traditional midwives who practice informed relativism and can thereby work to elide the boundaries between them.

The political sense of midwives' campaigns, whose scope goes beyond advocacy for the profession, has been described and explained in works such as *Mainstreaming Midwives: The Politics of Change* (Davis-Floyd and Johnson 2006) and *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (Davis-Floyd and Sargent 1997). The first of those works tells the story of direct-entry midwives' struggles to achieve national recognition in the midwifery certification process—mainly in the USA, where midwives managed to generate public awareness of the profession itself, and of options

for women to birth outside of the biomedical system. The latter book is focused on Brigitte Jordan's concept of authoritative knowledge[7]—the knowledge that counts in a given situation, on the basis of which people make decisions and take action. Authoritative knowledge can reside in "the authorities," such as obstetricians, or can be collectively shared within a cultural group. Jordan (1993) stresses that the importance of authoritative knowledge is not that it is correct, but that it counts. Many of the chapters in *Childbirth and Authoritative Knowledge* reveal the strong differences in the authoritative knowledge systems of midwives and obstetricians and highlight the conflicts—and the overlaps—between them.

In many ways, these two works offer political criticisms of the Western "technocratic model of birth" (Davis-Floyd 2001, 2018a). This literature has strengthened research on reproductive healthcare systems, showing that births can be considered as culturally constructed (Jordan 1993; Davis-Floyd and Cheyney 2019), and in this sense, are ripe for social scientific research. This literature has also succeeded in placing reproductive knowledge systems more clearly in the political arena, even that of collective action. Here I point to the need to analyze the implications of this activism on social movement studies, especially regarding the form that advocacy for human rights might take.

The politicization of autonomous midwives in Mexico

Midwifery activism in Mexico, particularly in its organizational forms, has been observed empirically since at least the 1980s. In 1989, the civil association *Las Parteras TICIME* was established in Mexico City and Tepoztlán, dedicated to promoting midwifery and to liaising between professional and traditional midwives. From its inception, the association was linked to midwifery activism in the USA, in order to explore avenues for professional midwifery in Mexico. In one of my interviews, conducted in February 2015, the TICIME midwives stated that their activism began because all the midwifery schools in Mexico, which for decades had graduated *parteras tituladas* ("titled midwives")—professional direct-entry midwives who practiced in hospitals—had been closed in the 1970s, and midwives had been thereafter excluded from hospitalized deliveries (see Chapter 1, and Carrillo 1999). The decision to eliminate the *partera titulada* was made by obstetricians who wanted to get rid of the competition; from one day to the next, these professional midwives, who were quite competent practitioners, were forced out of practice. In addition, in the rural areas of the country, an inquiry emerged as to what to do about midwives who learned the craft from their mothers and grandmothers (Sánchez 2015).

I emphasize in this chapter that contemporary midwifery advocacy was not born in an isolated context or only out of a desire to practice a salaried profession from a subjugated position. These professional—and also material—aspects are definitely part of midwives' global and Mexican struggles, yet advocacy for the profession was born at a particular conjuncture, characterized

by increasing awareness of women's rights, criticism of the biomedical system and anti-systemic global movements combined with the particular situation of midwifery in the country. For example, in the case of TICIME, whose members have pioneered autonomous Mexican midwifery advocacy in the context of this reemergence, the drive for midwifery was born from the search for options to change from mechanically attended hospital births to more natural births in which women could exercise greater freedom over their bodies.[8] In other words, the impetus to become a midwife, in this case, implies in itself a political awareness arising from personal experiences. This awareness is linked in turn to an awakening of feminist mobilizations in defense of women's rights. The activist midwives oppose obstetric violence and do not conform to the dominant biomedical system as related to reproductive life. In this sense, in Mexico and globally, the struggle for the midwifery profession expanded from the personal to the political struggle for high-quality sexual and reproductive healthcare, and for more natural births. In the Mexican case, the struggle also involved a complex building of bridges between traditional and professional midwives.[9]

Since the establishment of TICIME, there has been an increasing process of establishing midwifery associations in various parts of Mexico. The year 2004, for example, saw the establishment of the *Casa de Partos Luna Maya* in San Cristobal de las Casas, Chiapas, and the association *Nueve Lunas* in Oaxaca City, both led by midwives whose approaches combined human rights and humanization of birth. This generated the interest of young people to become midwifery apprentices and the establishment of new, similar associations, such as the Association of Midwifery and Natural Health in Chichihuistán, Chiapas, and the *Casa de Parto Osa Mayor* in Tulum, Quintana Roo—both in operation since 2013. Both *Nueve Lunas* and *Osa Mayor* seek to promote "midwifery in the tradition" (*partería en la tradición)*, which distances itself from medically trained nurse-midwives—the LEOs—and is based upon rituals, cultural roots and wisdom emerging from traditional communities (see Chapter 5). The *midwifery in the tradition* trend also forms an organic movement of school networks at the Latin American level.[10]

In addition to founding associations, midwives have been creating informal advocacy networks based on the capabilities and personalities of different midwives found in these networks. These networks extend throughout the country. For example, my interlocutors consistently mentioned the organizational efforts of several specific midwives in Veracruz. Also mentioned was a famous traditional midwife of Temizco, Morelos, Angelina Martinez Miranda, who, in addition to receiving a large number of national and international apprentices, actively teaches in international midwifery conferences. Indeed, it is important to note that much of the midwifery mobilization and awareness raising takes place via social media networks. For example, the AMP's Facebook page offered and publicized a wide range of information, including services related to midwifery, the humanization of childbirth, obstetric violence and discussions of women's rights. In my interviews, several

midwives commented that the amount of information that women request via these means is almost "scary," and that it definitely represents an administrative challenge.[11]

A fundamental axis in this contemporary organizational effort has been the previously mentioned AMP. Established in 2012, it aims to bring together the various associations dedicated to midwifery. Fundamentally, the AMP has tried to create a common agenda to represent and defend midwifery in Mexico's particular context.[12] The mission to strengthen the midwifery profession in Mexico is based on a model that emphasizes women's sexual and reproductive health. The mission promotes women's autonomy and rights, as well as education and training for new midwives. One goal of that mission was, at least at the time of this research, to establish a College so that the midwives themselves can regulate and certify their professional practice. Autonomy is again a key factor: the AMP wanted to ensure that midwives are the ones who make the fundamental decisions about their profession, and about the grounds on which someone can qualify as a midwife.[13] Within this association, the concept of autonomy fundamentally refers to the professional one.

However, it is also important to note that not all midwives share the AMP's vision: there have been heated discussions within the association on the certification and regulation of midwifery in Mexico. Complicating the situation further, the AMP also includes members who are not midwives but rather interested consumers who have their own takes on what Mexican midwifery should be.

My research results suggest that the profession, politics, autonomy and women's rights tend to go hand in hand, supporting each other in the case of contemporary Mexican midwife-activists. Thus, awareness of these issues results from the intersections among movements and the conjunction of events related to one's own experiences and transformations that push women toward the decision to become midwives. These new midwives then continue to strengthen their mobilization based on these concerns.

In my analysis, the following four issues have an interrelated influence on the decision to become a midwife and to mobilize an autonomous midwifery movement:

1. Personal experience—bodily autonomy—in childbirth. For mothers who had positive and empowering homebirths, the decision to become a midwife stems from wanting to empower other women to have this experience. In contrast, mothers who have negative and disempowering birth experiences in hospital choose to become midwives in order to combat obstetric violence, disrespect and abuse, and to offer more loving services to other women. Many doulas, who have created their own social movement, make the decision to practice that vocation for similar reasons.
2. The desire to act for women's sexual and reproductive autonomy after a process of becoming aware of reproductive rights and health, women's rights and the general criticism of the biomedical system. Many of the

interviewed midwives had previously participated in other movements, or were influenced by (for example) anthropological literature related to natural or humanized births. A common thread in that literature is the criticism of the biomedical system regarding reproductive "management."

3. The influence of anthropology and/or Indigenous traditional midwives. The majority of the midwives interviewed have higher education, including in anthropology and sociology. Several have collaborated, in one way or another, with Indigenous or traditional midwives and/or Indigenous communities. They wish to learn from or with them, and have a desire to "return to the roots" and recover, in postmodern form, the ancestral and natural capacities of women, both to give birth and to take care of other women during labor. Some of the recovered capacities involve rituals, herbs and massage (*sobada*). Several of my autonomous interlocutors shared an interest in alternative medicine—for example, homeopathy.
4. Intersections with new activisms or current ideologies—which tend to emphasize political autonomy—both within Mexico and Latin America but also extending beyond the continent. In general terms, it can be said that several activist midwives share certain issues and links with other activisms, including: (a) being anti-systemic or being discontented in some way with the current system; (b) being feminist or femifocal/matriarchal; and (c) being influenced in some way by New Age tendencies linked to certain forms of spirituality; the revalorization of nature; "deschooling" and homeschooling; and the "new farmers" engaged in creating ecovillages or ecological farms. In some cases, these shared linkages involve the defense of Indigenous rights.

In addition, several points of politicization emerged during the interviews. Some of those points already existed among the so-called autonomous midwives, while other points were exterior, in relation to other midwives or the field of midwifery in general in Mexico. These points include the following factors, which are also interlinked:

- The territorial dispute or turf war between the biomedical system and midwifery, both globally and nationally. Autonomous midwives criticize the ways in which the biomedical system has appropriated births and women's bodies; hence, they define themselves as anti-systemic ("autonomous") in the search for femifocal maternal care that would respect women's own knowledge of birth as a right, while emphasizing human rights in childbirth that can be honored by midwives. Obviously, these arguments have generated—and continue to generate—a strong reaction in the medical field. Some midwives with medical ties seek to emphasize the complementarity of the two types of knowledge systems—obstetric/midwifery, or technocratic/humanistic-holistic—but most interviewees noted a severe division between the two.

- The definition of midwifery.[14] The autonomous midwives I interviewed represent a sort of midwifery that emphasizes the autonomy of their profession along with key elements of criticism of the dominant medical system, which is why they have chosen to work autonomously/organically/holistically. However, they also collaborated and sought to create their own protocols for midwifery care. This emphasis generates tensions with the biomedical trajectory of the LEOs. It also generates tensions around the issue of certification, because there is a debate about whether the path toward certification must be excessively academic, and whether any type of certification could be sufficiently inclusive for all the kinds of midwives in the country. The tension between nurse-midwifery and autonomous/organic/holistic midwifery, as well as between the midwifery models more inclined toward the career-academic and/or the empirical, prevails globally.
- For whom does midwifery in Mexico exist? This is a tough debate, particularly among the autonomous midwives, who are under the critical lens fixed on the ethnic and social class structure because of their predominantly urban, middle-class backgrounds. In similar vein, as noted earlier regarding the criticisms of new, largely middle-class social movements, autonomous midwives are criticized for the price of their services. Because of those prices, their clients are mostly urban, middle-class women, which is a problem in a country as full of inequalities as Mexico. Another sharp criticism is directed at the relationship between the autonomous midwives and the Indigenous and traditional midwives. On the one hand, it has been alleged that autonomous midwives have ignored the existence of the Indigenous/traditional midwives. On the other hand, it has been alleged that when there is an attempt at collaboration, the result is inevitably the "appropriation" of the Indigenous/traditional knowledges. This axis of politicization is strongly linked to the attempt to legalize and certify midwives, and of course to the discussion around what type of midwifery is needed in Mexico: Who are the women who can access this service, and who are the ones that have the right to provide it?

These three major tropes form the key to understanding the politicization of midwifery in Mexico, which is made visible, in the case of autonomous midwives, by the interaction between human rights and the question of class within the framework of social movements. In other words, there is vacillation between material values, class issues, human rights and social movement activism derived from the critical societal stance, just as addressed by the new social movement theories. The interviewed midwives, whatever their different visions, have all been able to argue that midwifery is for all women in Mexico, and that the vision of midwifery should therefore be expanded in the country. These midwives are unanimous in thinking that midwifery-centered homebirth should be for every woman and that midwives are not merely women with low economic resources (as traditionally perceived in the country).

Yet, the autonomous midwives tend to feel that, because of their location in middle-class and urban contexts, and because of the risks and liabilities of their work, they are entitled to charge for their services so that they can make a living. They point out that their particular purpose is not necessarily to go to communities where there are already midwives who were born in that particular context and raised to the craft in those particular communities. However, as previously indicated, some autonomous midwives are indeed located in rural contexts.

The midwives interviewed for this study were quite aware of the tensions related to the various intercultural and interclass aspects. Several of these midwives have been building bridges with Indigenous midwives for decades (this topic will be deepened in Chapter 5). However, this issue makes visible a particular tension among professional and Indigenous midwives, the latter of whom defend their knowledge in the framework of the rights of Native peoples.

In the two "herstories" of autonomous midwives in Mexico provided below, we can perceive not only these tensions but also the ways in which the concept of autonomy is articulated within this kind of contemporary midwifery activism in Mexico as part of broader women's rights concerns since the 1990s.

Herstory 1: Autonomous science- and spirit-based midwifery in Chiapas

Guadalupe Blanco, a medical doctor and midwife, lives and works in Comitán, Chiapas. We carried out our conversation in her clinic in 2015. Back then, her clinic offered both midwifery and medical services for pregnant women. Her family is from San Cristóbal de las Casas, Chiapas, but she was born in Mexico City. She considers herself part of her family history of doctors and herbalists. She carried out her medical studies in Morelia, Michoacán. She has lived in Comitán since 1996, working in her own family medical project since 2005. She decided to close it down in order to establish the association *Nacer Natural* with another midwife from Comitán. At the moment of the interview, they were attending homebirths within their association. As a doctor, Guadalupe knows how the medical world in Mexico deals with midwives—that is, mainly negatively, blaming them when an emergency case is delivered to a hospital. According to her, the medical world's attitude toward midwives is based on fear and ignorance about midwifery, because its knowledge system and model of care crucially differ from those of the medical profession and hospitals. She stated:

> The midwife combines the scientific part with the spiritual and emotional part in the attention she offers for women. However, I also acknowledge that the definition of a midwife is something we are constantly working on: a midwife is different than a doctor; she is not a doula or a nurse, either.

> What the midwife has is the ability to wait for the natural rhythm of birth to take place, to recognize the normalcy in this process, and to respect it by knowing that everything will be fine, unlike the doctors, who are constantly fearful about something going wrong—this is the pathological perspective. The traditional midwife has usually emerged from families of midwives; she has been the daughter or apprentice of a midwife. Generally speaking, she has not attended any midwifery school; rather, she has been trained by other midwives empirically. For a traditional midwife, the use of herbs, massages, and rituals is important. However, it is important to understand that the traditional midwife is not necessarily an Indigenous midwife: there are also urban and foreign traditional midwives, even if that sounds odd. Then again, there are some professional midwives who have studied nursing, and later attended workshops with traditional midwives. For example, you have the CASA school, which is more [medically] inclined. The professional midwife has studied; she is more technical and she reads books. The traditional one seeks to conserve the tradition that has been orally transmitted from her grandmothers.

Guadalupe then tells me, after a thoughtful pause, her observations about autonomous midwifery:

> The autonomous midwife … she creates her own protocol and mixes the two forms of midwifery: the professional and the traditional. The autonomous midwives [like the two of us who co-founded *Nacer Natural*], are not dependent upon an institution, but we seek to create our own protocols. In fact, we are in this process of creating our own protocols right now. The AMP is putting together a list of skills that a midwife should have in order to attend births. In general, midwives don't follow strict protocols; rather, they individualize their attention according to the needs of each woman or each specific birth; so, each time you attend a bit differently. So, the clients don't have a standard of what to expect.
>
> We, the various [autonomous] midwives here in Chiapas, we want to make agreements about some basic protocols so as to create a bit more of a standard of attention so that the women and their families know what to expect. For example, I would say that in hospitals they wait eight hours after the rupture of membranes to start with the antibiotics or induction or C-section [cesarean section]. In midwifery, we wait longer: some midwives wait 24 hours, others 72, and some up to five days, to mention some examples. Everything depends on how the specific case is presented. But then again, the women don't know if they were well attended or not when they compare these very distinct processes. The mother whose midwife waited less time could argue that [the midwife did not let nature take its course], while the mother whose midwife waited five days may think that the midwife waited too long, and put her at risk. In reality it was not the case with one or the other.

> Our intention is not to form strict protocols, as in hospitals, because then we would lose the essence of midwifery, which consists of attending each woman according to her needs and particular case. Instead, we wish simply to have agreements about the way in which "we would normally wait X time while doing other measures," and if required, it is modified. And so, if a woman was attended by me in Comitán in her first birth and in San Cristóbal during her second, she will not feel that everything is different, and she will know what to expect.

Guadalupe acknowledges and promotes the existence of autonomous midwives in Mexico, although she agrees that there are few of them—perhaps some 30—in the whole country. According to her, autonomous midwives are not professional in the strict sense of the word (i.e. according to the international definition). She thinks that these midwives consider themselves as "autonomous" because of the inconformity they feel as a result of their personal experiences with maternal care, or as related to their previous political activism:

> The autonomous midwives tend to emerge from a context where they have already had [negative] births. I mean, they are unhappy because of traumatic births. It is for this reason that they study and decide to become autonomous midwives, or alternatively, they have had really beautiful [home]births that they want to share with others. What they tend to have in common, then, is a kind of inconformity toward the system. They want another system or a new way of attending births. Many of us are violated moms [moms who were treated violently during birth]. This is what made us become social activists; this is the path that joins us. In this professional fragility it is very political to stand and say: "I am a midwife." But we need to stand up more often. I was very apolitical before, but after I became a midwife I realized that I have become submerged in a very political action. It is not the kind of political action of the great demonstrations; rather, it is something you do within the work itself. To be a midwife means highlighting the women's right to choose. I became political and I became a feminist although it was not my intention.

According to Guadalupe, professional midwives who work in hospitals cannot be autonomous for the simple reason that they are not authorized to govern themselves according to their own rules: within the hospitals, only the norms and hierarchies of the institution itself are accepted. She knows this from her own experience. After graduating as a doctor, surgeon and midwife from the Michoacán University of San Nicólas de Hidalgo, she worked for seven years in a hospital of her city as an obstetrician—attending births, performing cesareans and dealing with emergencies. Over time she developed severe frustration at not being able to attend properly to the needs of the birthing women among the continuous stream of patients. This tremendous frustration

finally caused her to seek better ways to help women in birth; therefore, she involved herself in perinatal training in Anáhuac University. She then carried out studies with Lamaze International and Waterbirth International. This transformation was slow and hard, but it started to underline the differences between medical and autonomous midwifery knowledge systems.

> I delivered by C-section myself. It was a harsh experience that pushed me to the path of midwifery. If I hadn't had a C-section, today I would be a surgeon and not a midwife. But, above all, I went through this path of being a doctor completely disconnected from my body. [That disconnect] little by little was revealed to me, and showed that something was wrong. I started to realize that there were more tender options for attention. My other path started when I woke up to this other form of care. I started with the perinatal training with the other Guadalupe, but the model I was taught there caused me such a huge personal crisis that it made me question everything I had learnt and been taught during my work as a doctor. For a moment I thought that I couldn't do it, but she [the other Guadalupe] sustained me.
>
> I first thought I was just going to do another kind of job but [my "programming" was completely rewritten], and it ended up transforming my whole life. I had a profound personal crisis that lasted like two years; a crisis that had to do with confidence. I had a crisis with the hospital system. We have been violent to women, but as doctors we were always legally protected. I was especially affected by a situation in which we faced a crisis in the hospital where I worked, when various babies died because a stream of high-risk pregnant women came in at the same time. I couldn't deal with it any more. I basically had to unlearn my previous expertise, and go back and learn a new way to attend the women. The essence of midwifery is so different, more spiritual, to accompany women in their process of pregnancy, birth, and postpartum … And only the other midwives could teach me.

Her words are echoed in the transformative experiences of humanistic and holistic obstetricians in Brazil, who went through the same kind of paradigm shift with many of the same difficulties as Guadalupe faced, as described in detail by Davis-Floyd and Georges (2018).

Guadalupe tells me how the way that she works as a midwife derived from this crisis and personal transformation. The experience has made her think that it is necessary that there be different kinds of midwives for different kinds of women:

> I also had to learn my own way of being a midwife because we are not all the same; we need different kinds of midwives. I have understood that my way of caregiving is precisely at the intersection between being a doctor and being a midwife. I am between the two models, and I attend

> the women who seek a midwife but who also want the sense of safety that a doctor can bring. These women tend to be middle-class, quite educated, with bad previous experiences in hospitals.

According to Guadalupe, Mexico is now going through a situation in which many women have become disillusioned by the biomedical hospital system, which has put them on the path of searching for other ways of birth care. She thinks that midwives are dealing with women who had been promised it all in hospitals, but instead found violence and disappointment (see also Chapter 3). Thus, they have two options: first, the C-section in private hospitals, which is easy for those with higher economic status ("easy—I get a private surgery so I don't have to suffer"); and secondly, the search for midwives, which is emerging only now. The women who choose the latter path face the difficulty of finding a midwife of the sort they need: Are there professional midwives to attend them? Are the traditional midwives trustworthy? Are there midwives in cities, or only in Indigenous communities?

It is for this reason that Guadalupe argues that, in Mexico, different types of midwives are needed for different types of women. In her perspective, the midwives who are now emerging in Mexico—the autonomous ones—are part of a generation of women who struggle for their rights. They combine different kinds of activism and consciousness, including professional rights. However, at the moment there is no widespread women's or consumer mobilization composed of those who have been involved with new birthing options. Rather, those who have mobilized are the midwives themselves. For Guadalupe, this is a typical tendency that can be observed in family circles and women's groups, which tend to disqualify the midwifery option, particularly for homebirths. What prevails culturally is the image that only hospital births are safe, and that midwives are only an option for the Indigenous and/or the rural poor. Yet Guadalupe feels that midwifery and the biomedical system should be complementary rather than competitors. Thus, according to her, midwives today in Mexico are not on a smooth road, but rather on an arduous path with many twists and turns:

> To be a midwife in Mexico is swampy, rocky. It is rare that a midwife is acknowledged in Mexico. In the system, there are no outside rewards, just risks. The Secretary of Health does not acknowledge the existence of midwives. Look, for example, at the work of Cristina for all the midwifery in Mexico. [Despite] all the training and workshops, there is no reward, just criticism. The situation of midwifery in Mexico is difficult, not only considering the context out there, complicated and prejudiced, but also among ourselves. We lack unity, and we lack common protocols. The idea of the Mexican Midwifery Association is to create these protocols and definitions so that we will be more united, and so that others [outside the profession] will not come to say who qualifies as a midwife. We have to have autonomy in the profession and self-regulation, so that it is we

> who define who is a midwife, and how one works as a midwife, along with the standards that we all comply with to serve the women. There is exterior pressure upon Mexico to train midwives, but there is no unity on the issue. There is much discourse and little action.

Guadalupe also acknowledges the difficulties related to social classes and ethnicity in such a complicated context as Mexico, where midwifery is embedded, not entirely comfortably, in the society:

> I think that the purpose of Mexican midwifery should be to improve relations between traditional and professional midwives. Both should have equal value. The traditional midwifery is worried about the tendency toward the professionalization of midwives because traditional midwives fear that they will not have a place in Mexican midwifery after the process. I think that we have to honor the mentor [i.e. the traditional midwives]. They are our masters, and they are not less than I. There are many regional midwifery associations in Mexico, and the ideal would be that all of them end up forming part of a national one. But at the moment, not all of them want to. The regional is the contemporary tendency of midwifery in Mexico. Also, the challenges vary according to the region. In rural areas, the majority are traditional midwives, and they are challenged by the system that cuts women off from economic incentives if they don't go to birth in hospitals. So this way they oblige traditional midwives to take their women to hospitals, meaning that the midwives will lose their vocation. There is a double standard in this sense.
>
> In terms of the middle class, especially in urban areas, there are two options: the hospital and a traditional midwife. I consider that it is in the working class that there is more criticism and need for midwives. It is in this context that the autonomous and professional midwives are embedded, but not without tensions. For example, I acknowledge that I charge a high fee, but I also make special arrangements depending upon the couple. The high cost is because of the risks that we assume as independent practitioners. But I also think that it would be disrespectful towards the traditional midwives if I now charged little or nothing. I would be kind of stealing their work. Additionally, I have to cover the expenses of urban life, the clinic, etc. The authorities require many things to do this, and they fine you for not complying. In our [AMP] Facebook sites, there is a lot of debate on this issue, about the autonomous midwives and the professional ones and why we charge so much. But I think we have to be reasonable, change our perspective, and think that there are different kinds of midwives for different kinds of women.

Still, Guadalupe thinks that the complexities of midwifery in Mexico go beyond the division between professional and traditional midwives. She explains that in the city of Comitán, for example, there are specific dilemmas

due to migration and the city's proximity to the Mexican–Guatemalan border. Migrant women have difficulty finding adequate services. She also notes the differences between Comitán and San Cristóbal (only two hours away by bus), which already has a culture of homebirth due to the long-standing homebirth services, and whose authorities (unlike Comitán's) have permitted a certain support for midwives. However, formally Mexican law does not recognize birthing centers—only clinics, which require an operating room and doctors (see Chapter 3). Thus, it is difficult for a midwife to create a birth center, though some do. Indeed, the self-professionalizing and self-named *parteras tradicionales* that Davis-Floyd (2018b) studied in the city of Cuernavaca, Morelos had their own birth centers right across the patio from their houses. Still, Guadalupe also has hopes for the mobilization for the humanization of birth, a movement that began in Brazil (see Chapter 5) and united a set of different health system actors, despite the fact that many find themselves offended by the vocabulary—*How can someone tell me that I am not humanized?:*

> I understand the doctors' sense of rejection when they hear about humanized birth, and even more so, obstetric violence. It's because nobody wants to think that their job is not humanized, or on top of that, violent. It's for this reason that the terminology causes rejection and aggression. I had a hard time first understanding and seeing it myself. It's because homebirths are completely different: They give women emotional space that you cannot find in hospitals. It is difficult to understand it if you haven't experienced it.
>
> As someone who attends homebirths, you have to learn personal emotional qualities that you didn't have before, because when a woman enters a hospital, it is the doctor who is the authority that rules and manages the business. But when you as a midwife enter the home of the birthing woman, you enter a different territory, the terrain of the woman and her family, which you have to respect.
>
> Even more, you have to know how to emotionally sustain the birthing woman and her family during the birth. You cannot let your own problems and emotions take over; rather, you have to be present and support them because they are the leading actors. Only through my own crisis and transformations have I been able to learn this. I suppose that in the Indigenous communities the traditional midwives have this ability, this resilience of the person that they have lived and learnt from a young age. For us, the more urban and globalized, it is more difficult to learn this type of resilience.

Herstory 2: Autonomous rights- and apprentice-based midwifery in Chiapas and Mexico City

> Midwives are comets; the nurses, stars in a constellation. This is the essence of being a midwife: a midwife wants to be autonomous. She

> doesn't want anyone to mess with her work. She breaks paradigms; leaves a trail along her way; she doesn't receive orders from a doctor and she doesn't adjust to hierarchies. She considers the doctor an equal.

These are the words that the autonomous midwife Cristina Alonso (originally from Spain) says to me, with a spark in her eyes, in her working space at her midwifery center in Mexico City. This is the second time I am talking with her. She is the founder of the association *Luna Maya*, which was established in San Cristóbal de las Casas, Chiapas, in 2005, then in Mexico City in 2015. Several midwives in Chiapas speak of her as "the motor of the mobilization of midwives in Mexico." She is also the co-founder of the AMP, and (at the time of our conversation) the president of the organization. Cristina is a professional midwife certified in the USA. She has been attending homebirths since 1998 in Guatemala, Mexico and the USA. Her work has always had to do with sexual and reproductive health; during the past decades, with a particular focus on Mexico and Central America. She is also an anthropologist with a master's degree in public health and a diploma in human sexology and sexual education. This is how she describes her path toward midwifery:

> I came to midwifery as a result of various events that changed my life. I resisted a great deal the idea of becoming a midwife, but it seems that life has always pushed me in that direction. I was born to a political family. I mean, my father was in government, and lots of political issues were discussed at home. In this sense, social injustices and the fact of doing something about them were always present in my life. My own trajectory has always been focused on two things: body and peace. I started with the situation of women in the Middle East and Palestine. I even studied Arabic for three years. I often asked, *Who decides about women's bodies? How is the woman's body defined, and who defines its future?* Obviously, the mutilation of women's genitals caught my attention in that part of the world—the influence of Islam. But I wasn't looking at it from a clinical perspective, rather from a political one. Things changed for me when I traveled to Ecuador, after which I was going to go to Egypt. In Ecuador I noticed the abuse of women in Latin America, and kept asking: "Why are women abused in Latin America?" The injustices [were happening right in front of me], and my friends said to me, "But Cris, why are you thinking of going to Egypt if you are here, in Ecuador, and we are not the worst?" So I took their word and started to study other things. I got interested in Nicaragua and the revolution, in feminist theory and how in Nicaragua they didn't achieve abortion rights because of relations with the Vatican. So I started to explore the feminism of the Sandinistas, the possibility to change the policies on abortion.

However, in Nicaragua Cristina's plans changed again when a woman she knew died as a consequence of an illegal abortion performed in the neighborhood

in which she lived. Thus, Cristina decided to turn toward anthropology and healthcare studies:

> I did my first university degree in Atlanta, at Emory University, where they have departments of anthropology and political science, but also a health department with connections to anthropology. So there I started to work on births, and I got to know Lynn Sibley, who had a long history in midwifery and research in promoting the reduction of maternal mortality … So I started with the topic of midwifery by reading these recommendations, and I did a small thesis based on interviews with moms who had birthed in hospitals and moms who had birthed at home. The result was what usually comes out of these studies; I mean, the same story that we have heard since the 1990s: women who had birthed in hospitals describe their experience as something that disempowered them because they were subjected to interventions that they suffered. But the women who had homebirths described theirs as an event that empowered them, as something in which they were the leading actors, and that it had been a spiritual and transformative experience that changed their lives.

After finishing her studies, Cristina traveled to Guatemala with a team of researchers. From there, she took off to Mexico to learn midwifery as an apprentice. Afterwards, she did a master's degree in public health, while getting certified as a CPM—certified professional midwife—a certification administered by the North American Registry of Midwives (NARM). She stated:

> At first my objective in Central America was to work in public health, but I ended up becoming a midwife. For a long time, I considered myself rather as a health-issue worker (*salubrista*). After my masters I worked some years as an evaluator of sexual and reproductive health programs in Guatemala, Costa Rica, Panamá, Honduras and some Asian countries. But women continued to seek me, and they always asked me to attend their births. And so, little by little, I became a midwife, although for a long time it was rather like a hobby to me.
>
> When I came to San Cristóbal, Chiapas, I worked one year in Marie Stopes-Mexico, where I followed an initiative, related to the McArthur Foundation, for reducing maternal mortality. I realized that we are in danger of obliging all women to have their births in hospitals with a doctor, and that this was going to turn into more C-sections, obstetric violence and disassociation between mothers and their babies. This phenomenon was already becoming endemic in Chiapas. That's why I opened Luna Maya, to create a space for peace for women to birth with dignity at the same time as we could be training new midwives. I thought that my work there would be temporary; that I was only going to open the place, then continue on my way, but it became something bigger. As I say,

> I think I fought a long time with myself trying to be a health worker more than a midwife, but the circumstances and events made me a midwife. Although now I have realized also that you can do both at the same time.

Thus, since 2004 Cristina has been training midwives and attending homebirths at Luna Maya*:*

> I like the model of attention in midwifery; in midwifery the woman is in the center. I also think that a midwife should give continuity of attention during pregnancy and generally in gynecological health concerning women. I practice births outside hospitals because for me it is more authentic … I also believe in regulation of the profession. I think that the lack of regulation inhibits the possibility of having systems for midwifery training. In Mexico we now lack midwives just when we need more of them.

Of the midwives I interviewed, Cristina is the one who emphasized most the notion of autonomy in midwifery and the ways in which autonomous midwives work. During our conversation, I was particularly interested in going deeper into her views on this matter:

> The autonomous midwife is born in a complicated context, which is connected to the difficulty of defining a professional midwife. To call us professional midwives in Mexico is problematic because we don't really exist. There is no definition of a professional midwife. And at this moment it is practically impossible to become a professional midwife in Mexico because there are [too few] schools. There are also criticisms of the international definition, and in terms of what are the elements that make up a professional midwife. We are currently working on this issue. Here in Mexico we have had various autonomous midwives because they are part of this contemporary history, from Patricia to Naolí to Laura and Alina, and many others. Angelina is also an important reference point in the modernization of traditional midwifery …
>
> We have CASA and its work on this issue, and the great work of Mari Cruz in Guerrero. Some of the CASA midwives remained outside the system, but I consider them revolutionaries also: Claudia and María Cecilia. And close to them are Alison, Cristina, and Araceli, especially in terms of midwifery in tradition. And there are the obstetric nurses like the Guadalupes who are fighting for peace in hospitals, or Doris in Monterrey, maintaining the flame of midwifery in the North. Sabrina in Tulum is another example of traditional midwifery crossing the barrier towards contemporary versions. And I have been here since 2003, training and forming midwives. The discussion of certification of midwives has always existed in Mexico, and at the same time we have maintained ourselves in resistance against medicalized birth and obstetric violence. It's

> for that reason that the topics of regulation and education have been so complex. We are the postmodern midwives, as the anthropologist Robbie Davis-Floyd says.

From Cristina's point of view, the existence of autonomous or postmodern midwives should be understood in the context of their historical position as discriminated against and despised, particularly in relation to the biomedical system. However, in her emphasis on the responsibility for two lives that the midwife assumes without legal protection, Cristina highlights the autonomous midwives' struggles against the hippie image:

> The autonomous midwife is anti-systemic, but she also carries a huge responsibility. It has to do with a reaction [to the hospital experience] that says: "This birth is my experience, it is happening to me." It is a movement that fundamentally wants to say: My body is mine. It is very different from the dominant model that wants to sell us the perception that a birth outside a medical institution is not safe. In this sense we, who identify ourselves as autonomous midwives, tend to be critical of the other, medicalized models of attention. We are worried that nursing or midwifery students would have to carry out their practices in hospitals where they are obliged to exercise obstetric violence, and we feel that in those spaces the essence of midwifery is lost. We cannot confuse ourselves with machines, and midwives cannot turn themselves into victims or assistants of aggressors. Midwifery is political because women's bodies and autonomy are political. Abortion, birth and the decisions over them are now in the hands of a patriarchal system that has little interest in empowering women.

Cristina also thinks that autonomy in midwifery is intimately connected to autonomy in employment. She calculates that approximately 35,800 births are attended by midwives each year in Mexico, including those attended by both traditional and professional midwives:

> I calculate that we are around 50 autonomous midwives in Mexico, of whom around 35 are postmodern, integrated in the Mexican Midwifery Association. In the association we also have traditional midwives, obstetric nurses and even doctors who practice midwifery. … I figure that at the moment here in Mexico, there are types of midwives other than the professional and traditional. There are the traditional, the hybrid ones—I mean, who have traditional origins, but who are already medicalized or have received technical training. Then there are the midwives who studied in formal programs, and there are the autonomous. There are also doctors who attend homebirths, and women who don't have any training as midwives, but sometimes assist at homebirths. There are the obstetric nurses and perinatal nurses. I would be in the category of the

> autonomous because of my foreign [the US CPM] certification, which is not acknowledged in Mexico. But I think that this division of categories is detrimental to us midwives because it breaks our unity. Here in Mexico we need traditional midwives in the rural Indigenous communities, while the urban neighborhoods require professional midwives at the ground level, such as in homebirths, centers and tiny hospitals. And then we need perinatal nurses in second-level hospitals. All women need a midwife.

She also points out that the emergence of this midwifery mobilization in Mexico was only a question of time:

> This movement had existed already for some time, but it was invisible, like a secret, and it was connected to other global movements related to bodily autonomy, such as in Spain, Brazil, and many other countries. In the United States the movement included the midwife Ina May Gaskin and homebirths. The midwives in Mexico have had networks with homebirth midwives from other countries; there are apprentices who come here, and vice versa. Obviously the certification of midwives in the United States influenced the processes in Mexico, too, and later the entrance of the human rights discourse in childbirths. You can read the book by Carol Leonard [*Lady's Hands, Lions Heart: A Midwife Saga*], for example. Then again, as we are involved with so much violence here, we have to make sure that midwifery will advocate for peace and good treatment. Is there violence in midwifery? We cannot let go of self-criticism either.

For Cristina, the essence of midwifery is distinct from that of the medical profession, as well as from that of nursing. In addition, for her, midwifery is fundamentally related to the model of apprenticeship rather than an academic career:

> I think you shouldn't have to leave your community to become a midwife. This is the traditional model of midwifery; this is the history of midwifery. It has been learnt through the apprentice model located in one's own community. This is also common among us, who identify ourselves as autonomous midwives. Thus, we are not interested in attending in hospitals. Instead, we collaborate in networks, through word of mouth, and turn towards alternative medicine. In this sense, we also want to be autonomous, we don't think we first have to become nurses, and then train ourselves as midwives afterwards. These are two different professions. We are not submissive, but strong women who don't want to follow orders or subject ourselves to hierarchies. And thus, for many of us, it has meant not working in hospitals or within the formal healthcare system. All women deserve a midwife, but the majority goes on giving birth in hospitals. We prioritize our wellbeing, and we are assertive about our autonomy. I think I wouldn't tolerate working in a big hospital. We also prioritize

> our profession over our personal lives, because this is a *vocation.* It is in this sense that I say that we are comets that break paradigms, while nurses are constellations working for a system.

Cristina argues emphatically in favor of certification within Mexican midwifery, which has been one of her principal axes of work since she started as the president of the AMP. She is also of the opinion that certification tends to foster autonomy:

> I believe that certification improves the autonomy of midwives in Mexico, but it depends through which kind of system we get certified. I mean, we cannot let the government decide and validate. Rather, it has to be us, the midwives, who decide how. It also has to be voluntary, I mean, we cannot [arrive at a situation in which] we become illegal if we don't certify. The multicultural context of Mexico is very important. We are trying to create a certification that would recognize the variety of cultures that are present, but at the same time [a certain minimum standard of practice would have to be met by] midwives, for our own safety and for the mothers and babies. From the certification committee we have a team formed of different types of midwives so that it would be representative, and the AMP insists upon not using last labels for midwives because we are all *midwives*.
>
> So, each one of us speaks from her vision; each one of us focuses on the kind of midwifery being practiced and known. I defend homebirths and the apprenticeship model with a technical level of certification. I say this because we also have to improve our results and base ourselves upon techniques that [demonstrably reduce] maternal mortality. There is a lack of evidence that traditional midwifery can do this, because there are no good studies that would integrate traditional midwives into healthcare systems—they are just being criminalized and discriminated against. In Mexico, [the authorities] have tried to eliminate midwifery, and now there is a call to get it back. Midwifery in Mexico is multidimensional. We also have to open more midwifery schools.
>
> Still, I always come back to the question of autonomy: those who teach in these schools must be midwives. All the professions in the world are taught and regulated by their own professions, so we are not proposing anything radical. I do believe in education. I think education in midwifery is important. And I think that a midwife trained in certain skills or techniques is fundamental; that there are things that a midwife must know and be trained in. In this sense, I also believe in the mandate of ICM [International Confederation of Midwives]. By saying this I am not implying that some sorts of midwifery should be eliminated, as they are all important for all the women in Mexico. But I do believe that you have to train the women well to become midwives. For me, it is a human rights issue: first, the right of women to study midwifery; second, the right of

> midwives to exercise midwifery; and third, the right of women to have access to a midwife. At the moment those three rights are being violated, and women are dying or going through obstetric violence for lack of personnel, or because they are being attended by over-qualified personnel who are over-medicalizing a process that should be physiological.
>
> My vision is that there should be a midwife for each woman, and we should go on training more midwives, but with different options or routes. First, the midwives in the institutions and hospitals that have passed through a clinical-medical school, because that is the way that those places work; and secondly, the midwives who cover the percentage of population that wants to or can give birth at home. So we should have an apprenticeship model of midwifery for these autonomous midwives. Here the challenge is the training of midwives, because not all rural women can leave their communities to graduate from universities, and there is huge need for midwives in the communities. So there should be some sort of supervising system, evidently from the communitarian perspective [a community-based approach].

Cristina also points out that regulation is one of the principal challenges for midwifery in Mexico. Among other things, she mentions:

> The main challenges for midwives in Mexico … Exactly, to create a regulatory system for and by the midwives themselves, focused on the midwifery model of care and other ways of training. One challenge is the lack of educational opportunities for midwives. The lack of interest of many midwives to take part in the association. The empowerment of midwives to contribute in creating a more just world for them. Many have fears about demanding their rights. We also continue to suffer from the negative image produced by the obstetric system that demonizes midwifery. The situation is horrendous, ridiculous. It's tiring. I know a few obstetricians in the country who have a more or less decent and realistic idea of what a midwife is, but in general the construction of identity is based on fear and medieval superstition.

Conclusions: Articulating and unfolding autonomy in midwifery

This chapter has shown that the reemergence of a particular kind of midwifery in Mexico since the 1990s is fundamentally tied to the concept of autonomy and related to women's rights. The chapter has insisted that the contemporary midwifery reemergence in Mexico is not born in a vacuum or reduced to professional aspects—although they are included—but that this process is tied to a broader context of human rights and social movement activism. As noted by Cristina above, "[m]idwifery is political because women's bodies and autonomy are political." Cristina, indeed, comes from a political background and it was politics that incited her midwifery pursuits in Mexico. Again, for

Guadalupe, it was midwifery that made her political in the intersection of the personal, professional and public spheres.

They both—like many others (see the "herstories" in Chapter 5)—have identified themselves as "autonomous midwives." The concept of the autonomous midwife emphasizes what is at stake with contemporary Mexican midwifery, and their political stance is articulated as a broad set of rights. The concept of autonomy forms a fundamental element in the collective actions of these midwives, precisely because autonomy is what they struggle for. Since autonomy was a key concept for their struggle, they sought to place emphasis on this aspect. It forms part of their self-identification, which then was articulated and unfolded as a key to understand the reemergence of midwifery in Mexico.

In this chapter, I have defined autonomy broadly in order to capture its meaning in the contemporary reemergence of a particular set of midwives in Mexico. By autonomy, I refer to self-determination and self-government, which can be professional, collective and individual. As such, it can be understood as related to human rights, which are basic freedoms that belong to every person in the world. Human rights tend to be based on shared, universal values like dignity, equality, respect and independence.

My finding is that autonomy has been re-signified, verbalized and unwrapped in various subtle and deliberate ways by these midwives in Mexico:

1. It has to do with *professional autonomy*, for example, the rights on the part of midwives themselves to decide about protocols; independent practice; professionalization and midwifery training; and appropriate and necessary knowledges.
2. It has to do with *individual, bodily autonomy* as a woman's right, articulated very broadly from a woman's own birthing choices for respectful care and decision making.
3. It has to do with *personal, political autonomy* in terms of such issues as the right to decide to create a profession and to study it, the right to autonomous practice, the right to self-govern and to have options related to professional practice.
4. It has to do with *public, political autonomy* expressed as a critical (anti-systemic) stance to the predominant medical system and unfolded in social movement and advocacy network activisms. The latter sort of political autonomy also refers to independence from the predominant political system or party politics.

In terms of midwifery, the autonomous midwives in Mexico have clearly opted for a midwifery-led, humanized, non-institutional and apprenticeship-based model, which draws from both scientific and empirical-traditional knowledges. The need for Mexico's own midwifery model that would consider rural, traditional and Indigenous contexts was often emphasized.

In this chapter, I explored the autonomous midwives and the reemergence of midwifery in Mexico within the theoretical frame of new social movements and advocacy networks, which have developed links between social movements and human rights. As I have shown in this chapter, the activist midwives have been previously studied within social movement theories, which have allowed for the location of midwifery within political spheres and as subject to research in terms of politicization and politics. Building on this scholarship, I have explained the link between midwifery, human rights and autonomy. For activist midwives in Mexico, the professional continues to be political, of course. Yet the new social movement approach, in particular, permits the generation of links to broader women's rights mobilizations and to intersections related to class, gender and ethnicity.

The theory of advocacy networks by Keck and Sikkink (2000), again, may importantly shed light on women's collective actions, such as the midwifery movement in Mexico, which is based on advocacy networks with global ties. By focusing on human rights, new social movements may, again, place emphasis on women's contentious politics, which often get overlooked by scholars more concentrated on mass mobilizations, class struggles and revolutions. Thus, the study of midwives as a new social movement challenges social movement theory by asking about the particular ways in which women produce and engage with contemporary political activism.

In my interpretation, the difference between old and new social movements is connected to the broader paradigm shift within critical social science theories, which divided into two tendencies from the 1960s onwards: The first one is the traditional production-based paradigm focused on class struggles, capitalism, revolution and global division of labor. This paradigm is fundamentally tied to Marxist approaches. The second one is the communication- or recognition-based paradigm focused on identity. This paradigm is usually linked to the Frankfurt school of thought and has to do with recognition-related struggles, such as those of gender, sexuality, race and national liberation and/or minorities and Indigenous people. In this latter paradigm, which I understand as including the study of new social movements, more weight is placed on the issues of human rights and citizenship. Nevertheless, both paradigms share the study of movements that seek emancipation, that promote more just political arrangements and criticize repressive social practices. Both paradigms also enclose a transformative dimension and involve profound historical processes. Although nowadays many movements encompass various intersectional elements (class, ethnicity, gender), I consider that making the distinction between old and new movements can help to illustrate the paradigm shift within the movements toward the emphasis of particular rights, and also to give more weight to women's movements.

Yet, as also indicated by the case of autonomous midwives, politics is always about identities, too, and midwifery activism also continues to be tied to professional and material aspects. In addition, the case of the autonomous

midwives makes visible the complex roles played by social class and ethnicity—issues that surround human rights in social movements as a terrain of dispute.

Several recent studies have shown how the human rights discourse has entered the field of international politics, particularly in the sphere of development. As an explanation for the legitimacy deficit that the idea of human rights suffers among populations of the Global South, various authors have discussed how human rights discourse is used to promote development. Thus, some scholars have begun to draw attention to the impact of social class in human rights as an elitist movement. (See for examples: Cornwall and Nyamu-Musembi 2004; Cornwall and Molyneux 2006; Uvin 2007, Lettinga and Van Troost 2014; and the website of Open Democracy).

However, this approach may neglect the active roles of the various groups that interpret, dispute and build their visions of human rights—as shown above in the case of Indigenous rights and women's rights movements in Latin America (Brysk 2000, 2013; Speed 2008; Levitt and Merry 2009; Engle 2010). This type of exploration is important, not only to highlight the role of the "subordinate," but also to understand more deeply the politics of human rights in social movements. It may also permit the exploration of the roles of midwives in the frame of postcolonial rights in the Global South.

The autonomous midwives of Mexico will certainly challenge us in academia in terms of these topical, theoretical issues related to their assertive, multisided political take on the concept of autonomy, and to their intersections with various rights and activisms in terms of their profession, social class, gender, geopolitics and ethnicity. Autonomous midwives are creating a social movement based on a radical critique of the biomedical system related to women's rights to education, profession and midwifery care, and tied to human rights in childbirth. Enhancing midwifery care for women and midwives forms a significant part of these dynamics.

Notes

1 This chapter was originally published as: Laako, H. (2016). Los derechos humanos en los movimientos sociales: El caso de las parteras autónomas en México. *Revista Mexicana de Ciencias Políticas y Sociales* 227, 167–194. And excerpts from: Laako, H. (2017). *Mujeres situadas: Las parteras autónomas en México.* Mexico: ECOSUR.

2 Here, my research results are based on observations made by two midwives, who took part in my research and had been present in the process of certification in Veracruz. In fact, both of them were certified as traditional midwives although they had middle-class and non-Indigenous backgrounds. According to them, most of the certified midwives they saw in the process were semi-urban *mestizas*. For more information, consult for instance the following brief report by the Mexican News Agency Más Noticias RTV: Veracruz, líder en certificación de parteras tradicionales (May 7, 2014). www.youtube.com/watch?v=-TsgUCnNPM8 (consulted April 2020).

3 Interview with two such certified traditional and autonomous midwives (January 2015).

4 Questionnaire filled by an autonomous midwife, Mexico City (May 2015).

5 A doula is a birth attendant with experience and knowledge who offers emotional support and attends the birthing woman during birth. A doula is not a midwife, nurse or obstetrician, but someone who accompanies the woman during labor and birth for support.
6 The Latin American and Mexican cases seem to follow suit, although in this chapter it was not possible to deepen on the Latin American context. Yet, social movement studies have been focused on massive mobilizations, in which, for example, Zibechi (2003) identifies three major social-political trends: ecclesiastical communities, Indigenous emergence and *Guevarismo*, which are all present in the most famous, contemporary Mexican case of Zapatismo. I have previously studied social movements and Indigenous movements in Latin America; see, for example, Laako (2011) and Leyva Solano et al. (2015).
7 The term *authoritative knowledge* is understood here as originally developed by Brigitte Jordan (1993). By conceptualizing authoritative knowledge, she exposed the ways in which socially constructed information and authority over that information have built and maintained a particular system of birth in different parts of the world. The concept has shed particular light on the ways in which hospitalized births are carried out in North America, and the ways in which authority over the birth is handed over to the doctor, rather than to the woman and her body.
8 Interview with two TICIME midwives (February 2015).
9 Misión de TICIME (2015): http://parteras.org/parteras/mision/ (consulted March 24, 2016).
10 Interview with a midwife, Oaxaca (February 2015).
11 Interview with a midwife from Oaxaca (February 2015). It is noteworthy that women who have birthed at home have mobilized very little with midwives, unlike in the United States. The interviewed midwives mentioned this aspect on several occasions, and suspected that it was due to the stigma related to homebirthing in Mexico. It is also worth mentioning that the midwives have been subject to harassment, and that many of their websites have been closed down by governmental authorities.
12 Interviews with midwives in Oaxaca and Chiapas (February 2015).
13 Interview with a midwife in San Cristóbal de las Casas, Chiapas (February 2015).
14 The definitions of midwifery and of midwives are under debate within the movement. Autonomous midwives usually emphasize the difference between midwifery and nursing. Here, too, the notion of the "autonomy of a profession" is significant in two ways: (1) in understanding that a midwife is not a mere assistant of a doctor, but offers a certain set of independent services and knowledges; and (2) given the first point, it should be the *midwives* who define what is midwifery, and how one qualifies as a midwife. See for examples Herron (2009) and ICM (2011b).

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3 From infantilization to body-territoriality

Birth centers in Mexico[1]

Georgina Sánchez-Ramírez

Introduction: Hospital birth in modern Mexico

> *Imagine that you are about to give birth; a desired, planned baby. You are expecting only that the baby be born well, and that you will be fine, too. You enter the hospital and have to comply with the whole protocol: your partner and family have to say goodbye to you at the hospital door. In the birthing room, the nurses will not even look you in the eyes. Instead, they dress you with a poorly fitting hospital gown; they shave your pubic hair; and they refer to you as "the tummy." They do not allow you to move. If you complain, they call you weepy. Everything around you is insensitive, and there is no privacy anywhere. You are surrounded by other women just like you—all alone, just about to give birth, vulnerable and treated like "patients," who are not supposed to complain. You are expected to follow the medical orders. But it is difficult to evaluate all this right now. You are exhausted, in pain, about to give birth, alone, cold, thirsty, unable to move, obliged to remain on your back in the bed, unable to speak more than to plead that it would be over soon, even if it is at the cost of more intravenous oxytocin and an unnecessary tear in the perineum. They do not allow you to be with your newborn immediately. They hand your newborn over to you when they get tired of your pleas. Nobody will help you to breastfeed. A family member can accompany you for a couple of hours, and they ask him or her to leave when a doctor comes in to check you with his team of students. The only thing you desire is to get back home soon, to the warmth of your loved ones.*

This is the best-case scenario for what happens in any public maternity hospital in Mexico.

The history of healthcare in several Latin America countries, including Mexico, exhibits a particular balance of care provision, in which parts of the populations have depended on midwives for healthcare. These midwives continue to have an important role in rural and/or Indigenous contexts. This type of midwifery, usually called "empirical" or "traditional," is not limited to attending births: it is also a resource for general healthcare in places where geography and social vulnerability constitute factors of exclusion. Thus,

despite determined campaigns to end this kind of ancient midwifery, now often seen as outdated, these midwives continue to exist where they are sorely needed (Sánchez and Laako 2018).

In Mexico, midwives are also found in urban contexts working in new spaces of care. This chapter focuses on these midwives, and these particular spaces. In contemporary Mexico, this urban birthing option is a recent evolution. As explained by the historian Ana María Carrillo (1999), professional midwifery training programs were gradually closed down in the mid 20th century, for reasons related to the federal state's desire to obey demographic policies dictated by the global economy and to obstetricians' desires to gain control of birth as a source of income.

The state, in accordance with the prevailing economic interests, directly influences how many children women can have, and when feminine reproduction ought to take place. Currently, these issues are also tied to the question of *how* and *where*. At the beginning of the 20th century, Mexico promoted high fertility as a response to the depopulation suffered in the aftermath of the Mexican Revolution (1910–1920) and the Cristero War (1926–1929). In this way, from 1928 to the beginning of the 1970s, the discourse on population focused on promoting fertility, endorsed by the country's first population laws. For example, the first Population Law in 1936 (CONAPO 1937) sought to consolidate the nation by supporting very early marriages of prolific families (Sánchez-Ramírez 2016, 23–24).

The second General Population Law, in 1947 (CONAPO 1948), was based on the same principles as the previous one, and made marriage legal for women of age 14 and men of age 16. The same law also promoted the reduction of mortality, legal protection of childhood, improvement of children's diets and hygiene in the home and workplace. This law also prohibited any kind of promotion of contraceptive products and their supply (Sánchez-Ramírez 2016, 25–26).

The legislation related to population fostered a pro-natal society, outlawing abortion since 1937. These pro-natal measures translated into one of the world's highest population growth rates during the mid 20th century. As a consequence, the Mexican state then needed to change drastically to a fertility reduction stance (Sánchez-Ramírez 2016, 25–26).

In Mexico, the process of hospitalization of births has advanced simultaneously with these policies. So has the positioning of modern obstetrics—a positioning which has to do fundamentally with displacing midwives from attending births (and the closing of midwifery training schools) in the beginning of the past century. Births were increasingly placed in the hands of medical and obstetric professionals, who were predominantly male. At the same time, the place of birth transitioned from the birthing mother's own home or a midwifery center to a hospital or clinic, in rural as well as urban contexts.

In 1973, the third Population Law was decreed in Mexico (CONAPO 1973). Generally speaking, this law continues to be valid. The law endorsed the free supply and use of contraceptives, combined with a forceful campaign

to promote the benefits of having few children. Simultaneously, the plan ensured the availability of maternal and infant care in hospitals and public health centers, as part of the interest in improving the population's conditions. However, this emphasis on hospitals and public health centers also implied control over the bodies of women of reproductive age as "captives" of international family-planning populations for low-to-middle-income countries (LMICs).

This control and condition as "captives" is simultaneously tied to where, and with whose assistance, to give birth. In the 1970s, many women in urban as well as rural areas of Mexico still gave birth at home with family doctors or midwives. However, when the third General Population Law came into effect, along with Mexico's aim of reducing the rate of population growth via use of contraceptives, the state needed to push births into hospitals. In effect, the discrediting of midwifery care escalated (Sánchez-Ramírez 2015; Sánchez-Ramírez 2016, 23–33).

In Mexico, as in many other parts of the world, hospitalized births have been considered a public healthcare achievement. In 2018, 2,162,535 births were registered in the country, of which 89% had taken place in a hospitalized space. Only 4% were attended by midwives (INEGI 2018).

In the case of Mexico, however, hospitalized birth cannot be considered safe: obstetrics-gynecology (Ob-Gyn) has become the specialty about which the greatest number of complaints are received by the National Commission of Medical Arbitration (*Comisión Nacional de Arbitraje Médico* (CONAMED) 2012). According to CONAMED (2012, 8), "[Gynecology and obstetrics] is the specialty that is the most related to permanent damage or death when associated with bad practice."

Furthermore—again in Mexico—documentation of medical practices and interventions during birth continues to mount (e.g. Cárdenas 2002, 2014; Sánchez-Bringas 2014; Castro and Erviti 2015; Organización Mundial de la Salud 2015; Márquez-Murrieta 2019). Most notably, almost half of all babies are born via cesarean section (C-section): "In the period between January 2009 and September 2014, from each 100 births, 46 were born by C-section and 54 vaginally" (CONAPO/INEGI 2015).

As mentioned above, this process of medicalization and hospitalization of birth converges with the federal state's intention to control fertility, because attending births in medical institutions transforms women from mere consumers of maternal healthcare into captives of the state family-planning aims. This transformation has directly affected the bodies, consciousness and sexual and reproductive health of women in general.

The Committee on the Elimination of Discrimination against Women (CEDAW) has reported that, globally, many women are considered as instruments to achieve birth or of medical control, including via sterilization against maternal consent or even awareness (CEDAW 2012). This is especially the case with women in particularly disadvantaged conditions, such as young, Indigenous, illiterate or economically marginalized women, or those with

many offspring. Such procedures can only be performed in hospitals, and also need to be captured within the official health system in order to accomplish the demographic aims of the nation-states. In this respect, the nation-states are not respecting the *body-territoriality* of their feminine population.

The concept of body-territory (*cuerpo-territorio*) arose during the past two decades. It has been developed in Latin America as a way of both theorizing and working in practice within the Latin American feminisms. The concept is particularly focused on violence against women, which is fundamentally written in their bodies. This violence has a geographical place, and is intersectionally traversed. Thus, the concept of body-territoriality enables women to deal with the violence they have suffered, and with their bodily experiences, both geopolitically and in terms of their gendered conditions. For example, scholars researching forced disappearances in armed conflicts in Latin America and the increasing femicide[2] in Mexico have used this concept to explain in greater detail the violence directed at women's bodies (Gargallo, 2012; Federicci 2014; Belausteguigoitia and Saldaña-Portillo 2015).

In this chapter, the concept of body-territory is used for the first time in the frame of gender and health to discuss maternal health and care in Mexico. According to Giulia Marchese (2019), the *body-territoriality* or body-territory can be defined as follows: "The body of each woman is what permits her to experience the world, an experience that is structurally marked by selective violence and parametrized according to sex/gender, race, skin color, age, nationality, and class-condition."

In other words, in this chapter I argue that the notion of body-territoriality encapsulates the fact that not all women are treated the same way within the world's systems of sexual and reproductive healthcare—especially maternal healthcare. The treatment received depends upon the prevailing gendered culture, which goes hand in hand with economic, medical, democratic and political resources related to equality in each country.

In the case of Mexico, the "change of scenery" in terms of how and where to give birth has displaced birth practices from the sphere of women and their midwives, who used to share their knowledges and empowerments about the feminine body, toward the expropriation of women's bodies and of midwifery knowledge as a result of the hegemonization of modern Ob-Gyn culture. Both elements (how and where to birth) fall back on to the body that reproduces life: that of the pregnant woman.

To analyze Mexico's birth centers and their relationships to women's body-territoriality, this chapter will first outline the Mexican context—a knowledge of which is crucial to understanding the resurgence and importance of birthing spaces that are not hospitalized. These spaces are called *casas de parto*—literally, "houses/homes of birth," but in English usually referred to as "birth centers" (BC). The chapter then explains, briefly, the situation of BCs globally before describing the methodology of the research in its health and gender perspective. I then demonstrate the characteristics of BCs in Mexico; the services they provide; and their legal context. To illustrate the importance

of BCs in Mexico, I analyze the practice of "giving birth differently," while building on mothers' voices and experiences of "humanized" or "conscious" births. Finally, the chapter concludes that, in a context such Mexico's, where a persistent abuse of authority over gestating women's body-territoriality exists in the form of modern Ob-Gyn, some women nevertheless do seek to give birth differently. In the BCs, they find a space for that and care that allows them to manifest emotional and bodily empowerment through birth—an empowerment that is an affront in countries where women are expected to be submissive to the hegemonic, macho medical power.

From infantilization to empowerment: The "conscious birth" and birth centers

Hospitalized birth care in Mexico is subject to statutes defined by the Mexican Official Norms—for example, in the Norm for Birth Care (NOM-007-SSA2-2016). These norms determine with great precision how to give birth, but without necessarily taking into account the autonomy of birthing women. Thus, by no means are these norms defined from a health and gender perspective. Rather, they contain a demographic discourse on maternal health achievements, combined with complex language and exhausting content, which raises question about how this kind of normativity operates in spaces such as the health sector, where the areas dedicated to Ob-Gyn care are often saturated or overcrowded.

Indeed, various scholars have reported on the different factors that prevent the expansion of maternity services in the country, despite the high volume of hospitalized births, combined with various official "justifications" for the precarious care given to women in these facilities. Numerous studies have exposed the indifference and even cruelty of the system to the majority of women and their families, who do not claim their rights but instead conform to simply escaping alive from the experience of hospital birth. (See for examples Cárdenas 2014; Sánchez-Bringas 2014; Castro and Erviti 2015; Meza et al. 2015; Marquez-Murrieta 2019.)

In addition, the Mexican hospital system reflects the lack of a budget that is sufficient to achieve an adequate level of healthcare. This lack is attributable to the persistent professional and political immaturity that is not examined duly despite the unfortunate but evident national indicators; for example, the previously mentioned C-section rate and the slow reduction of the extensively studied maternal mortality in some of the poorest regions of the country (Heredia-Pi et al. 2013; Freyermuth 2014; Hogan et al. 2016; Pisanty-Alatorre 2017). The situation revealed by those indicators is obviously coupled with an excess of interventions in women's bodies during pregnancy and birth.

The societal transfer from homebirth to hospital birth had immediate consequences, such as the use of oxytocin to accelerate the birth. Oxytocin, a hormone produced in the body, helps to provoke uterine contractions and stimulate milk flow, but it is also pharmacologically prepared as a synthetic

drug, and used to induce labor, strengthen contractions, control postpartum hemorrhage and provoke milk flow. When oxytocin is used to speed birth, doctors electronically monitor the heartbeats of the baby and mother. The result is a labor and birth in which the woman is connected to a monitor, completely immobilized in the bed, on her back.

Since the administration of synthetic oxytocin often provokes contractions that are more painful than the physiologic ones, demand increases for pain relief during the birth. When lumbar or sacral epidural analgesia arrived on the market, painless birth became an option for birthing mothers. However, this drug prevents women from moving, thereby diminishing the sensitivity and strength of pushing. As a result, the time it takes to push out the baby increases, as does the use of instrumental "help" (Fernández 2014; Nascimento do et al. 2016; Sibrian, 2016; Arango et al. 2018; Hernández-Garré and De Maya 2019).

All these "technological innovations"—which benefit the pharmacological and clinical technology industries—have also favored and fostered medical interventions. In Mexico, they also require the constant presence of the obstetrician in the birthing theater. When medical attention is more focused on the gadgets and the uterus, there is no time or space to consider the woman's own needs and capabilities. Perhaps the most unfortunate phenomenon in contemporary birth is that most women are not conscious of this abrogation of autonomy and body-territoriality. The sad part is that, in contemporary Ob-Gyn culture, the birthing mothers delegate all the responsibility for their births to the corresponding medical staff, including C-sections, as if they (the mothers) are passively assuming the infantilization of their own person during a natural, physiologic process. This critique applies to all those women who are not clinically diagnosed as at risk (Castro and Erviti 2015).

It is also important to mention that this excessive medicalization has opened doors to a phenomenon that has recently been denominated as "obstetric violence." Although this phenomenon is not the principal focus of this chapter, I must note that Latin American researchers have published extensively on this subject (Silva da and Santana-Brito 2017; Barbosa-Jardim and Modena 2018; Díaz and Fernández 2018; Hernández-Garré and De Maya-Sánchez 2019 ; see also Chapter 5). "Obstetric violence" is not a globally recognized legal term. The term has legal roots, but thus far has been used in the legal system only in the Latin American context. Venezuela was the first country to legally define it and to classify it as an offense in Article 51 of the "Organic law on women's right to life free of violence" (*Ley orgánica sobre el derecho de las mujeres a una vida libre de violencia)* in 2007. In 2009, Argentina enacted Law 26.485, "Law of integral protection to prevent, sanction and eradicate violence against women in which they develop their interpersonal relations" (*Ley de protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales*). Article 6 of the mentioned law defines obstetric violence (Belli 2013).

In Mexico, obstetric violence has also been explored in the fields of anthropology and medical sociology, particularly in terms of women's testimonies about mistreatment during birth (Sánchez-Bringas 2014; Castro and Erviti 2015; Grupo de Información en Reproducción Elegida 2015; Meza et al. 2015; Pozzio 2016).

Mexico has the "General law of access of women to life free of violence" (*Ley general de acceso a las mujeres a una vida libre de violencia*), but the bill to classify obstetric violence was precluded in 2015. ("Preclusion" is a legal term referring to a trial that is divided into stages, each of which closes the earlier stage without possibility of reconsidering it.[3]) Therefore, obstetric violence is considered only in state-level legislation, in nine federal entities (Sánchez 2016, 209–216).

Various concepts are used to name and characterize obstetric violence. Nonetheless, for the purposes of this research and on the basis of previously cited research on obstetric violence from the viewpoint of gender and health, the concept refers to both emotional and physical violence:

> Emotionally, obstetric violence refers to shaming, threats, humiliations, mockery, and discrimination on the basis of the woman's appearance. It also refers to (for example) lack of respect for the opinions or knowledge of the birthing woman, and to the withholding of information related to the procedures carried out on her body—including when the staff does not speak the pregnant woman's language. Physically, obstetric violence refers to invasive practices that include the use of unjustified drugs, routine episiotomy and pubic shaving, use of oxytocin to induce labor, enemas, excessive electronic fetal monitoring, and the use of forceps. Other forms of physical obstetric violence include not respecting the biological times and requirements of the birthing body, refusal to allow birthing mothers to eat or drink, and performing unnecessary C-sections. Obstetric violence also takes forms such as the application of temporary or permanent contraception without the woman's informed consent. In extreme cases, obstetric violence can lead to maternal mortality or the death of the unborn or newborn baby, through abuse of power on the part of the medical staff or via their ignoring of the information women try to supply about their condition.
>
> (Sánchez, Meza and Luna 2016, 21)

A contrast to births involving excessive medicalization or extreme obstetric violence is what has been called "humanized birth," or "conscious birth." The conscious birth refers to a labor that seeks to follow and learn from the logic of biological birth, coupled with a conscious childbirth education process carried out by the future mother and by the person who accompanies her through the process (partner, family or friends). In addition, that person—in the case of a midwife at her home, or in a birth center—is also adequately

trained to accompany the process in the way that is best for the birthing mother, detecting any complications requiring a transfer to a medical facility.

> Birth (*parto*) and childbirth (*nacimiento* [the baby's birth]) represent the beginning and starting point of life, and they are, therefore, processes that affect the rest of human existence. Thus, the humanization of (child)birth constitutes an urgent and evident necessity. Therefore, we firmly believe that the application of humanization in the care provided at the beginning of human life will be decisive and definitive for human societies.
>
> (Declaration of Ceará on Humanization of Birth, 2002)

In the two decades since this declaration, different kinds of studies have emerged on obstetric violence in Latin America, combined with research on "humanized" birth during the past five years (Campiglia 2017; Lázzaro 2017; Montero and Leida 2017; Borges et al. 2018; Muñoz-Dueñas et al. 2018). However, gender perspectives continue to be scarce.

"Humanized birth" has become a mere political label in some international platforms, without significant and real consciousness about the meaning of a "respected" birth. A respected birth is humane; birth cannot be humanized if there is no fundamental respect provided to the one who is the main actor in the birthing event—the mother. Given this context, in this chapter I have decided to use the concept of "conscious birth" instead of "humanized birth," although the two can be considered as synonyms and used interchangeably. We all birth as humans, but I suggest that we also need to have consciousness and awareness for labor and birth. This means considering all our emotions and wishes (including the contradictory ones), but also understanding that we cannot involve ourselves in this process by instinct alone because, according to Bomzdina (2014), we lost much of that instinct as we modernized.

The conscious birth is based on the understanding that giving birth is an event that involves the fundamental components of human life: thoughts, feelings and will (Glökler 2009). In terms of thinking, the authenticity of knowing is embedded in the process of delivery and in the kinds of practices that are taking place in the corporeality of the woman and the baby. In terms of feelings, the love for birthing. And in terms of will, the freedom to be the star of the event as a woman who wants to carry it out herself.

As a consequence, the humanized (child)birth is founded in the emotional-affective world based on the individual desires and needs of its leading actor(s)—the mother, father/partner, baby—and in the freedom of the women or the couple to make the decisions about where, how, and with whom to birth in one of the most powerful moments in their lives (Burgos 2015).
The aforesaid necessarily implies the following (Lutz and Misol 2016):

- Refraining from intervening or interfering in this natural process unless there is an evident situation of risk

- Acknowledging and respecting the individual needs of each woman/couple, and the way in which they desire to proceed with this experience (in an institution or at home)
- Respecting the intimacy of the surroundings during the (child)birth
- Favoring the freedom of position and movement of each woman during the (child)birth (squatting, water, semi-seated etc.)
- Promoting a personalized connection between the couple and the assisting professional group
- Respecting the needs of the woman in choosing the persons to accompany her in the birth (family, friends)
- Attending to the immediate connection of the mother with the newborn, avoiding subjecting the newborn to unnecessary reviving maneuvers or examinations
- Favoring a multi-disciplinary approach, with the participation of health professionals related to birth and maternity, such as midwives, obstetricians, neonatologists, nurses and educators
- Favoring integral attitudes and paying attention to the differing intellectual, emotional, social and cultural needs of the women, their children and families, rather than reducing care to biological needs alone (i.e. culturally sensitive care)
- Favoring family-centered care that addresses the needs not only of the woman and the baby, but also of the couple
- Favoring appropriate means while paying attention to different cultural guidelines that allow achievement of the corresponding objectives
- Bearing in mind the decision-making power of the women.

These elements form the basis of care provided by the BCs in Mexico. BCs are spaces headed by midwives with the help of doulas (a woman who is often the trainee of the midwife, but whose main task is to offer physical and emotional support during pregnancy, birth and puerperium). In BCs, the woman is usually in control of her pregnancy and birth, accompanied by the midwife, without the necessity of gynecological visits to doctors unless clinically required. The users are women with no previous pathology, and whose births tend to begin spontaneously.

Countries vary in their criteria for defining the kind of pregnant woman who can choose to birth in a BC. Generally speaking, BCs "exclude women with such previous pathologies as preeclampsia, multiple pregnancies, premature births, or women under 16 or over 42 years old" (American Association of Birth Centers 2015).

The BCs are an option for people who might otherwise choose homebirth, especially when the birthing mother's household is not suitable for homebirth. Thus, the BCs provide a middle-ground solution that compensates for the deficiencies of conventional living, and which offers an alternative to the aggressiveness of the hospitalized birth.

Lucia Rocca and Cristina Alonso (2020) note yet another benefit that the BCs provide in non-hospitalized maternal healthcare: for pregnant women, it can always be considered risky to birth in hospitals given the possibility of contagious infections. That risk has become more acute due to the COVID-19 pandemic. Lucia Rocca and Cristina Alonso (2020) insist that BCs become pertinent, particularly in LMICs, as a way to guarantee a separation in the maternal health system from hospitalized attention that focuses on pathologies and diseases. In addition, the BCs obviously provide harmonious, safe spaces for sexual and reproductive health for women who seek it.

The BCs have been established in different ways globally. Some are autonomous units, as independent centers geographically separated but part of the hospitalized system, and as centers situated near hospitalized birthing theaters, or as mixed units. The BCs usually qualify as such as long as the responsibility of the space rests on the midwife, and the mother is respected as the leading actor of the birth.

The objective of these spaces is to generate a comfortable environment, similar to that of a home, where the woman can give birth according to her own rhythms with minimal external intervention, resorting only when necessary to the least invasive method first (Lutz and Misol 2016). Additionally, BCs offer a range of services to accompany the pregnancy and puerperium.

Birth centers in global perspective

International reports on BCs are relatively new. The latest efforts have to do with approaches linked to the agenda of the World Health Organization (WHO) through the United Nations (UN) on the situation of midwives globally as an integral part of women's rights.

In its call for more midwives, the UN (Organización de las Naciones Unidas 2014) noted that a need exists in the world's 73 poorest countries (including Mexico) for access to the sort of high-quality sexual, reproductive, maternal and neonatal care that midwives can provide.

However, when analyzing these UN proposals from the health and gender perspective, one can observe that the proposals are rather limited, in the sense that they see midwives as potential healthcare providers only when they are "certified"—in other words, when the midwives can prove that they are licensed and receive continuous training. In the case of Mexico, what would really be useful is to "regulate the profession" in the country (López-Arellano, Sánchez-Ramírez et al. 2020).

The discourse is oriented toward donors, to convince them of the financial benefits of investing in midwifery formation in the developing world, rather than being motivated by an interest in learning about the real situation of midwives in this hemisphere. The financial benefits case, it should be noted, is based upon the argument that greater reliance upon midwives would lower rates of maternal and neonatal mortality (Crisp and Iro 2018; Iro et al. 2019).

These proposals are aimed at increasing the number of regulated midwives to attend low-risk births in distant locations, and to attend births referred to them by doctors who work in the health facilities as part of the official system. These facilities are certainly not spaces to birth differently (at least, according to this particular UN report of 2014), as would correspond to the definitional characteristics of the BCs. Thus, because the UN considers only the official healthcare systems and their concerns for finance, at this level, the UN does not really include BCs as birth models.

The aforementioned UN report (Organización de las Naciones Unidas 2014) provides estimates for the years 2014–2030. From the BC viewpoint of this chapter, that report's discourse is biased, in that it ignores this particular option as a birth model for the poorer countries, even though in many of the world's remote locations BCs could be the best alternative for bringing back humanized birth, with all its benefits for the health of women and their children (Alliman and Phillippi 2016; Sandall et al. 2016; Christensen and Overgaard 2017; Decieux et al. 2017; Reunión de Mejores Prácticas 2018).

The Global Midwifery Council, in its report entitled "Birth Situation Room" (2012), showed that, of the 27 countries where the research was performed, only 13 mentioned initiatives for opening spaces such as those of BCs (Finland, France, Hungary, Iran, Mexico, Nepal, Norway, Pakistan, Panama, Saudi Arabia, Trinidad and Tobago, Uganda and Ukraine). They were always found to be responses to the increasing medicalization of birth, in both high- and low-income countries.

In the other 13 countries included in the previously mentioned study (Argentina, Aruba, Australia, Bulgaria, Croatia, Ethiopia, Iceland, India, Kenya, Kuwait, Philippines, South Africa and Venezuela), birthing spaces of this sort are not mentioned. The report emphasized that, in these 13 countries (which include both high- and low-income nations), the situation of midwives was particularly complicated—they struggled to position themselves as a model of care and an option for births.

The above-mentioned report calculates that the model of medicalization of birth is increasingly conquering terrain worldwide, but particularly in high-income countries, including Iceland and France. In these countries, the midwives mentioned that they—and doulas—are already struggling with unemployment. This struggle was attributed to two advancing fronts: the countries' falling birth rates, and (secondly) the growing perception of hospitals as the clean, safe, modern option for birthing. At the same time, midwives in poorer regions struggled to certify their professions. Thus they were not considered as valuable providers of quality care (Global Midwifery Council 2012).

Germany deserves special mention in this context. The country's BCs (*Geburtshäuser*) are part of the health system. While some of these spaces are located just around the corner from maternity care hospitals, others are outside clinical zones. However, all are sufficiently close to hospitals in case of emergency transfers. These BCs are staffed by midwives, or *Hebammen*. With

the exception of special services (such as a family room), birthing in these spaces is covered by the public social security system. Thus, in Germany, the BCs represent a strong birthing option for women (Parker 2016).

In labor: Birth centers in Mexico

In Mexico, BCs are usually private or constituted by some civil association. BCs cannot be designated under this name (birth center), because the Ministry of Health does not recognize their legal status for providing birth assistance within their facilities.

One way in which Mexican BCs have been dealing with this problem is by registering the facility under the legal figure of a hospital or specialized clinic. However, the national norms require that these facilities exceed the minimum requirements indicated by *Comisión Nacional de Arbitraje Médico* (Mexican National Commission for Medical Arbitration: CONAMED) for attending low-risk births, namely:

> Approximately 70 per cent of the obstetric population has no risk factors, their control is simple, and they do not require high-cost infrastructure. The basic equipment required by the obstetrician consists of a physical place with adequate lighting, [ventilation (preferably natural) and temperature], a gynecological table, sphygmomanometer, thermometer, clinical scale with height scale, tape measure, Pinard's stethoscope, gynecological examination gloves, vaginal specula, and clinical record.
>
> (CONAMED 2012, 15)

As will be shown in this chapter, the visited BCs comply with these norms. Hence, a need exists to legislate in favor of BCs so that they are named in the norms as specific centers for medical care in accordance with the indications of CONAMED.

The BCs that function as part of a hospital or as specialized clinics must also tackle the obstacle of fulfilling the norm's requirement to have a professional person in charge of the facility. This person cannot be a midwife because, in Mexico, midwifery is barely recognized as a profession, and only in some states, and not explicitly even then (Sánchez-Ramírez 2016). In addition, although the regulation that deals with the provision of medical services formally provides that non-professional staff (technically trained staff) can attend births, in actuality this practice is only allowed in rural, communitarian contexts. These allowances are also subject to multiple other restrictions by the Health Ministry (López-Arellano et al. 2020).

Thus, suffice to say that the regulation of midwives—professional, empirical or traditional—does not exist in any clear, effectual legal or normative framework in Mexico (López-Arellano et al. 2020). In other words, Mexico's adverse conditions for BCs and midwives have driven both groups to operate clandestinely or in semi-secrecy.

Despite these adverse conditions, BCs do exist in our country, and function as spaces adapted to particular homes or facilities. Their role is to offer a comfortable environment for women who seek to give birth there, accompanied by their partners, family and friends. These birthing women are assisted by a midwife, who accompanies the process of birth, and by one or more doulas. These BCs can be found in Mexican middle-sized and large cities. Their costs vary—not all Mexicans can afford them. For that reason, Mexican BCs cover a very small sector of the population (middle-class, and upper middle-class). Most women who seek these spaces have high school or university education. Some are Mexican, and others are foreigners living in Mexico. The BCs are usually announced on the internet, or in the networks of women who have used the services before and communicated their preferences to their peers. This factor, too, limits the type of women who find out about and seek the BCs (Sánchez-Ramírez 2016).

It is also worthwhile clarifying the nature of BCs, and distinguishing them from those spaces that form part of the official healthcare system: the so-called maternity homes (*casas maternas*). These are spaces opened in locations with high maternal mortality. The objective of maternity homes—annexed to hospitals—is for midwives or health staff to examine pregnant women and provide prenatal care; however, at the moment that women are about to give birth, they are usually transferred to the closest public hospital facilities. These maternities depend on the Health Ministry, and are particularly focused on attending the Indigenous population or women with lower economic resources (Cruz et al. 2015). Unfortunately, no published studies assess the effectiveness of maternity homes in lowering maternal mortality, or the re-signifying of traditional midwifery in rural areas in terms of maternal care before and after birth. Midwives are not usually allowed to attend women during birth in these maternity homes. Thus, these spaces have been criticized for reducing traditional midwives to a mere assisting role, rather than a model for prioritizing the autonomy or body-territoriality of the birthing woman.

In contrast, BCs in Mexico do not belong to any official system, due to their specific definition described above. They are located in urban zones with their own model of care. Their heads are professional midwives who combine modern medical knowledges with traditional midwifery and their own contemporary experiences (López-Arellano 2019). In Mexico, the BCs fight constantly to win and maintain space as a different model of maternal and neonatal care.

Almost clandestine: Birth centers and the methodology of this research

As explained above, Mexico's Ministry of Health does not grant a regulatory status to the country's BCs. Since those spaces must therefore operate in semi-secrecy, it was of utmost importance for me to ensure their anonymity and confidentiality. To that end, I indicate the BCs by numbers, and

give the interlocutors pseudonyms. During this research, I visited five BCs in five states, covering different parts of Mexico: the North, the Center, and the South. In this way, I obtained a broader, more complete picture of the formation and functioning of the BCs.

Given that the BCs cannot announce themselves as such even on websites, I found them via the snowball method. This non-probability sampling technique is adequate for finding people who are otherwise hard to find (Baltar and Gorjup 2012). I found a total of 11 BCs in the country. However, not all of them were suitable for this research. Two BCs declined to participate because their directors considered the risk to the spaces' safety too great, should the anonymity protection fail. Three other BCs no longer operated as such because of threats of closure by the Secretary of Health. The threats were related to the service of attending births in these spaces. At the time when I contacted those BCs, their midwives or staff members were working independently, and only in homes (which is lawful). An additional BC was forced to close due to health problems among the leading staff just before the beginning of this research. Therefore, I carried out research on the remaining five BCs.

I scheduled our interviews in those five BCs between April 2015 and March 2016. The interviews included various visits to the facilities. The fieldwork was carried out on the basis of feminist ethnography and in the framework of gender and health studies, which emphasize that science is not objective, but partial, as it inevitably incorporates the researcher's own "social values." In other words, the researcher's background plays a role even if the scientific method is followed. The effects of that background can be controlled only when acknowledged during the research: a situated knowledge that can be understood as a scientific epistemology with a gender perspective, partial but localized, and critical toward the attitude of androcentric science, which assumes itself to be universal (Ortiz 2006; Castañeda 2012).

During the research, the directors, collaborating midwives and some clients of the BCs were interviewed according to a previously designed guide. The final results consisted of ten interviews with midwives, two with doulas, and eight with clients (a total of 20). My interlocutors allowed me to use a recorder, and to enter all areas of the facilities. Afterwards, the interviews were transcribed and analyzed using Atlas T. The results presented in this chapter constitute only part of this previously published, broader research. A letter of informed consent was signed at the end of each interview (Sánchez-Ramírez 2016).

The research results presented in this chapter correspond to the experiences and perceptions of the clients of BCs, as follows: (1) saying "no" to hospitalized birth; (2) being subject to criticism for having chosen a midwife; (3) the integral support system of the BC model; and (4) empowerment through the process of birth. Before turning to these results, I briefly outline the characteristics of the visited BCs and the model of care provided by the interviewed heads of the BCs—the midwives.

The visited facilities/homes

The visited BCs were comfortable houses/homes for carrying out all the activities related to pregnancy, birth, puerperium, breastfeeding and early parenting. The services also included contraception for those who were interested. These spaces included a reception area, a kitchen, consulting room(s) equipped for gynecological care and room(s) for birthing. These room(s) included a bath/shower, toilet, birthing chair, Pilates balls, birthing slings hanging from the ceiling for support, a king-size bed and basic supplies for receiving the baby.

The facilities followed ten principles to ensure a humanized birth in the facility (Lutz and Misol 2016): (1) preparation for birth during pregnancy; (2) the agreement of the facility to allow birthing there; (3) the principle to not employ episiotomies, enemas or pubic shaving; (4) freedom of movement and will; (5) presence of partner or family members; (6) freedom of position and place during birth (bed, chair, bath); (7) a trusting relationship between the midwife and birthing woman; (8) no hurrying or intervention; (9) detection of complications; and (10) immediate contact with the newborn.

In addition, the visited BCs offer services related to the postpartum period—a type of support difficult to find in other maternal services in Mexico: (1) placenta ingestion as prophylaxis (according to the principles of homeopathic medicine); (2) gynecological check-ups at home after birth; (3) accompaniment and help with breastfeeding; (4) non-invasive remedies, if desired (such as herbal baths, massage and aromatherapy); and (5) help with newborn care during the first month.

Several of the visited BCs also offer other services related to sexual and reproductive health. Thus, these facilities have become spaces for integral care of the women attending them, including their partners, offspring and families.

The five visited BCs have very similar dynamics. The care usually begins with a pregnancy test. If positive, the woman then chooses whether she wants to continue with the BC during the pregnancy. Another route is to seek the services at a more advanced stage of pregnancy.

It is important to clarify that, in order for a woman to be attended in the BC, the midwives must carry out a first evaluation to determine whether the pregnancy is low-risk. The midwives in BCs have been professionally trained to do this evaluation and to recognize the characteristics of a normal physiologic pregnancy and the woman's health history. Some midwives have been formed in the midwifery school of San Miguel de Allende in Mexico while others have been trained abroad. Some of these midwives running BCs began their careers as nurses or doctors and later turned to midwifery by assisting training with midwives in different regions of the country (Sánchez-Ramírez 2016). If the pregnancy cannot be categorized as low-risk, the woman is directed to a medical institution.

The follow-ups consist of prenatal appointments to screen the evolution of the pregnancy. During the first two trimesters, the appointment is monthly, then every two weeks, and (during the final month) weekly.

In addition to the appointments, the BCs offer workshops and classes on preparing for birth. The names of these classes vary, but they basically consist of discussion sessions in which the process of birth is explained, accompanied with didactic materials such as videos and drawings. These sessions are for groups, and are addressed to mothers and their partners or any other person who will accompany the birthing mother.

The BCs emphasize that the purpose of this process, including the classes and appointments, is to follow and support the mother emotionally during the different stages of (child)birth. The workshops and group sessions are spaces destined to generate important exchanges between the mothers and midwives.

The personal appointments tend to last around 60–120 minutes. The mother is physically checked (weight, abdomen measure, laboratory studies and sometimes ultrasound, if the facility owns the equipment). Much of the appointment is spent discussing the expecting mother's and partner's emotions about the pregnancy. Any doubts are clarified; fears and desires are discussed.

All the BCs tend to suggest some sort of physical exercise by which expecting mothers can strengthen their muscles and joints, and otherwise prepare themselves physically for the birth. Some BCs even offer services such as yoga, and can refer expecting women to places where suitable physical exercise for pregnancy is available.

The visited BCs also deal with the importance of diet during pregnancy. Some BCs offer workshops and group sessions related to adequate, healthy diet, while others offer this information during the monthly appointments.

Women who decide to give birth in the BC need to choose whether to birth within the facility or at home with a midwife. In either case, the expectant mother, together with her midwife, needs to decide upon an emergency route, or "Plan B," in which they agree on where the woman is to be taken if necessary—to the hospital, doctor or obstetrician who will attend her in the case of emergency (Sánchez-Ramírez 2016; Davis-Floyd 2018a)

In most cases, the relationship between the expecting mothers, babies and the BC lasts longer during the first childbearing experience. Sometimes this relationship develops formally—for example, in a parenting group formed within the BC—or affectively via lasting friendships formed between the birthing mother and the midwives who attended her.

Working the contractions: The birth model of BCs in Mexico

The model of care in the visited BCs was what is internationally known as the "midwifery model of care" (Alonso et al. 2015; Davis-Floyd 2018b)—an approach in which pregnancy and birth are understood as women's normal life processes.

> Midwife Gabriela: One of the things we work on with women during their pregnancies is that they manage to change the negative image of birth … That when they enter labor [*trabajo de parto*], they know the process, know their bodies, have patience with their bodies … [and] know that everything that happens during the labor is normal, is something good and healthy; that they learn how to support their bodies.

The model of care is thus rooted in respect and support for the woman to facilitate her conscious process of assuming her power to birth with freedom. The mother may also, if she wishes, bring the father to take part in the birth as a means of initiating his fatherhood. Before the birth, the midwife and expectant mother make a birth plan that outlines the principal wishes of the woman during labor, such as who will accompany her.

> Midwife Gabriela: One of the most important things is that someone can be with them [birthing women], a partner, and many times that is the only thing that a woman needs for her body to work well, so that her process runs smoothly. To be accompanied is very important.

Part of the midwifery model of care is to promote the free movement of birthing mothers and enable them to eat, shower and move during the labor. In addition, the model favors breastfeeding and early contact with the newborn.

> Midwife Gabriela: Here the women are free to choose the position they prefer during the labor; the one that [they think helps their progress] … During the labor and birth we adapt to the way in which she wants to do it: wherever she feels the most confident, there we go. Sometimes we have been working in the bathroom, in the bed, beside the bed, the obstetric chair we have, whatever works, different positions.

In striking contrast to the hospitalized birth's use of analgesia or full anesthesia, the visited BCs attempt to shift the perception of pain through various other techniques: massage, aromatherapy, water births, changing positions, listening to music and occasionally alternative therapies such as homeopathy and the traditional use of herbs:

> Midwife Cintya: [We maintain the bath water at] the temperature of the mother's body, which is a remedy, one more resource that provides help … It decreases the intensity of pain, so that it will not be sooo intense.

Another midwife mentioned that women of reproductive age need to know more about the benefits of these spaces (as opposed to what happens in most Mexican hospitals), and of birthing at home with midwives:

> Midwife Betzi: They birth in the hospitals but it is not the same as giving birth in a BC. In the hospital, there will be 99% women who labored and have a scar, have a episiotomy; another one has a C-section, yet another has the arm full of pricks in the veins, and the other one has a punch in the back, and another one couldn't breastfeed, and so … They were all abused, and their birth experience does not have the same reward.

The midwives in BCs avoid episiotomies and the abuse of technology (ultrasounds or electronic monitoring) as well as the unnecessary use of synthetic oxytocin or intravenous fluids.

> Midwife Gabriela: In one of the classes that we give here, [we] talk about the unnecessary interventions during birth, [mothers] learn to recognize that … What kind of medical interventions exist during birth, which ones are justified and which are not, like the one of shaving the pubic hair, use of intravenous solutions, episiotomy, the fact of lying in the bed without changing position, the continuous fetal monitoring, all these things … And here we try to do what is physiologically possible, whatever is possible to support the birthing body and to intervene as little as possible in the births.

Thus, the midwife-interlocutors emphasize that, in the BCs, the woman is the main protagonist of the process, and the midwife is only a companion and guide.

> Midwife Gisela: We make a team with the woman who is ready to find her power and to prove that her baby has the capacity to be born. And with the man who trusts in his companion and is ready to support her in the process of feminine assurance of being able to do this, and thus giving him as well a gift of being close to the miracle of life.

To sum up, the BCs in Mexico emerge and are maintained in a context where standard birth care is marked by human rights violations. The increase of obstetric violence in the country; the abusive use of unnecessary practices like C-sections in low-risk labors; and the high maternal mortality in the country's poorest regions make it necessary to find new paradigms for transiting pregnancy and giving birth more respectfully and consciously.

However, as previously noted, unlike BCs in many other countries, Mexico's cannot be announced as such. They basically operate in secrecy, and given that they are private initiatives, access to their sphere of services is expensive—affordable mainly by middle- and upper-middle-class women.

However, the histories of women who have given birth in the BCs in Mexico offer evidence as to why these spaces represent an option very different from medicalized birth, as well as an option for reducing obstetric violence. The key is that the midwifery model makes the women the protagonists and owners of

their maternity, thereby increasing the women's self-esteem (as we shall see in the following section).

Giving birth differently: Laboring naturally or consciously?

Something that characterizes the visited BCs is that the women who attend them do so absolutely voluntarily. Because BCs cannot be advertised, the woman who finds a BC must have deduced its existence from subtle information provided on the internet, or else had followed the recommendation of another woman who had given birth there. BCs have no signs on the doors that might indicate the kind of services offered there. Some women find a BC fortuitously, by first accessing other services such as yoga classes.

The interviewed clients of the BCs in this study were middle-class, highly educated (postgraduate), heterosexual residents of urban areas. All had low-risk pregnancies, according to the BCs' midwives. These women had chosen to birth with midwives who had BCs, but also offered the homebirth option. All of the interviewed women were between 28 and 38 years old at the time of the interview, had children younger than four years old and had found the BCs through other women they knew.

Saying no to hospitalized birth

Three of the interviewed clients of the BCs had chosen to birth in a BC in order to (and specifically to) refuse medicalized birth, and even more so the possibility of a scheduled C-section. They made quite clear why they did not want to birth in hospitals: they shunned what they saw as the cold, technical, impersonal hospital environment. This perception was based on the experiences of family members or friends.

AMARAL: I didn't feel like going there [to the hospital], so the first appointment I made was with a midwife, who attended me and she gave me a lot of confidence so it was easier in that sense. I know how the health system in this state is and it was not the place to which I wanted to go to.

When a woman's first birth is via C-section, doctors often impose a C-section automatically for each of her subsequent births, despite the solid scientific arguments for checking her general health and the time space between her births to assess whether she could still give birth naturally (see, for example, Ortiz and De Marcos 1998; Campos et al. 2007). However, women who seek a non-medicalized birth do not hesitate to inform themselves about these issues. Such is the case of an interviewee who had her first baby by emergency C-section, during which she was completely anesthetized. She did not have her first contact with her child until 11 hours after the birth. For her second birth, she desired to have a natural and conscious birth.

ÁMBAR: [After having my first child via C-section] I wanted to have an experience of a natural birth, not a medicalized one, without needing to go to a hospital. We inclined towards a BC because the conditions were more straightforward. Somehow for me and my partner being in a place filled with gadgets and extremely sterile, for us it does not equal greater safety, I mean that it would [not] automatically be better. It's for that reason that we said that a natural birth can be better, precisely because it will allow more positive things [to activate] in my body and in the baby than in a hospital. All the women in my family, who are there in the North of Mexico and in the United States, have had C-sections, none of them has asked themselves if they wanted to do it naturally. When their babies are born, they are given formula, they don't breastfeed. So, seeing all these things and also knowing the experiences of other women, well, here I defend myself, it will be simple for me, simple for my baby and to give the newborn breastmilk, and to be together.

Here, Ámbar did not want to repeat her first experience of a C-section, and she did not attribute the symbolic value of "safety and security" to the technical health spaces. She wished to experience breastfeeding her baby—an act that a C-section often complicates, thereby becoming a gateway for use of formula to feed the newborn (Caballero et al. 2013). Her desire to breastfeed contributed to her desire to birth vaginally the second time, with as little medical intervention as possible, as she understood those processes to be interlinked—which, of course, they are (Kroeger and Smith 2009).

In another woman's narrative, we perceive her fear that the birth could present complications, and that she might end up in hospital or require an emergency C-section:

ARLET: If I went to the hospital, they would probably recommend a C-section and no, I didn't want that …

Two factors made these women averse to going to hospitals for their deliveries: (1) the women's recognition that that environment deprives them of the personal, intimate experiences that should be part of birthing; and (2) the women's desire to keep from falling into the routines of medicalized hospital delivery.

Being subject to criticism for having chosen a midwife

Many studies have explored the history of midwifery. Sánchez-Ramírez (2015) detailed the many records of midwifery care in pre-Christian Egypt, then centuries of pregnancy, childbirth and puerperium care exclusively for and among women. The Middle Ages saw a gradual decline in the knowledges and skills of healers and midwives, followed by the systematic destruction of those knowledges and skills as the medical profession began to emerge.

Midwives came to be labeled as witches. Still, the 19th and 20th centuries witnessed the professionalization of midwifery. This period could be called the peak of midwifery's glory.

However, the profession's future is now imperiled by the rampant medicalization of healthcare in general, and particularly by the extreme medicalization of women's reproductive lives and childbirth. Fundamentally, this trend has delegitimized midwives as caregivers to mothers in the contemporary era (Sieglin and Sánchez-Ramírez 2015). This trend is endorsed by modern science, which plays with ethics and morality at its convenience, considering non-medicalized healthcare an archaic nostrum of ignorant people (see, for example, Riquer 1989; Esteban 2001; Blázquez 2008; Sánchez-Ramírez 2010).

Thus, in contemporary Ob-Gyn Mexico, women who decided to give birth freely and voluntarily with a midwife have been criticized for this decision and practice.

AZUL: The truth is that [birth] was fantastic because obviously I was very scared. All this context and then everybody told me, especially people who are in Mexico City, because we are from there, it was really a stage fright [reaction], of "Are you insane or what's wrong with you; with a midwife and in your home; are you committing suicide or what's wrong with you?!" So, the more prepared I felt I was for the birth, the surer I was about my decision.

The level of autonomy experienced by these women affected their decisions about the births directly. Usually, their commitment to birthing in the BC or with a midwife grew stronger during the appointments in the BC and with the midwives, who provided the expectant mothers with a set of elements to make themselves more secure despite the common opinions of the extended family.

ÁMBAR: We had a lot of pressure from the family; my parents are both doctors and from the beginning [they were] against having a natural birth. In fact, we didn't even tell them that we were going to birth at home … We didn't tell them until the baby was born; until he was born! We called them and said, "You know what? He is already born…," and honestly, the midwives, their care was really good in giving me confidence to understand my body a bit more, of how it works, that I can do it, they are like insurance because they have already attended many other, successful births.

As shown here, it is common for families to be doubtful about future parents because the families are so consumed by the predominant, contemporary cultural idea that a birth that is not attended in a hospital or by a doctor is unsafe. Women who decide differently have to be very firm in their decisions and in the discipline of continuing with the preparation for birth with midwives, as will be discussed below.

The integral support system of the BC model

Half of the women I interviewed decided to give birth in a BC, and the other half at home with the midwife. To inform themselves before making that decision, the interviewed women visited their BC during their pregnancies, and were well aware of the postpartum services and care that they could receive.

This aspect is fundamental to the humanized birth, as described at the beginning of this chapter. BCs in Mexico have a model of care focused on the services related to pregnancy and birth. They also rescue some ancient, non-intrusive remedies such as placenta therapy, homeopathy, Bach flowers, herbal baths, diet, breastfeeding support and even supervision of the new family's re-accommodation after the birth. The interviewed midwives in the visited BCs made many references to these sorts of integral support systems that they offered.

I insist that the moment of birth should be attended within the frame of humanized birth, which fundamentally implies respect for the protagonist of the birth—the woman—and her preferences for physical position, atmosphere and (among other things) to not be touched, to not be thirsty, to scream, sing, laugh, curse or squeeze. Respect for the woman's preferences includes being accompanied by her loved ones. The midwife remains calm and avoids jumping in with unnecessary interventions that could prevent a satisfactory bond between the mother and the newborn.

ÁMBAR: Ahaah, yes, I went there [the BC] for prenatal appointments. During the appointment, they weigh you, measure your tummy, try to listen to the heartbeat of the baby, and what's more, they ask you about your diet, your feelings, things like that, and also respond to your doubts.

AZUL: … In this first appointment I was with Isis and Ana and it was great, ha-ha, we were astonished, I got very convinced, I felt a great deal of empathy, of tenderness, but more than anything, I felt safety, they gave me a lot of certainty. I noticed that they were well trained; they knew what they were doing. They had this very warm way of explaining things, the place is hardly medicalized, it was like a home, like a normal bed. And I like the atmosphere a lot. I was really impressed, especially with Isis, they seemed very capable.

Here I emphasize that the interviewed women do not refer to "midwives" but call the midwives by their names—a reflection of the unique relationship formed between the birthing women and their midwives. While some midwives are more practical and others closer, a trusting relationship clearly exists between the attendant and the attendee, blurring the hierarchical line between the two.

In addition, as mentioned before, the appointments were not limited to physical care: they were also dedicated to calming the expectant mother's nerves according to the BC's model of care.

AMARAL: They were like therapist sessions because in the beginning, I was really calm and then like a month before [due date] I said to the midwife "I am really scared now" and I remember that she said to me "well, that is good because, ha-ha, I saw you too calm" … And I said to her, "I am scared now! What am I going to do during labor?" Because I thought that I had got sick and didn't feel very strong, I don't know, but … Yes, for me the appointments in the BC were, above all, a therapeutic space, of companionship, of how are you, how are you feeling emotionally, physically. They accompany you; I think that is not very common in other places.

In addition, BCs offer different services related to preparation for parenting beyond the "birth package," which normally includes prenatal and post-partum appointments.

AZUL: In this moment it was all good because [the BC] offered it all, there was yoga, there was a psychologist, to give birth, obviously, this was not a requirement as such, but it was recommended that if you wanted to give birth there it was better to pass by the psychological process to evaluate psychological risks. So they constructed with you the genealogical tree, about how your maternity process was going, how you were in terms of your own mother … If you were traumatized about something, then you started a psychological process with whoever was accompanying you in that moment, a psychologist, plus all the companionship of yoga. None of this was obligatory—only the classes for birth preparation that were eight sessions. And that's it. But the truth is that I kind of became one of the pieces of furniture of the BC, ha-ha, I mean, because I decided to participate in everything: The yoga, the classes, if they offered a course of breathing, I also went there, and to be honest it was all good because obviously I was quite scared.

As can be perceived above, the courses offered by the BC included several elements that gave future mothers and couples tools with which to face the moment of birth. One of the most frequently mentioned resources was yoga.

The stories provided by the interviewed women accentuated the connection that these women created with their bodily experiences; with their body-consciousness. This body-territoriality helps to soothe and prevent the alienation that may appear between fear and control of bodily functions. In addition, any exercise that consciously involves the body prevents the production of stress adrenaline and cortisol related to excess of tension and pressure. Moreover, this preparation via exercise allows the body to produce (for example) natural oxytocin, which is released during the labor, conjointly with other hormones such as prolactin, thereby diminishing the pain experienced and helping to improve the process for the mother and baby (Hastie and Fahi 2009).

The role of the midwife is key to helping the laboring mother feel calm, and to generating a trusting atmosphere so that the mother will have the courage to put in practice all the teachings of yoga and relaxation. Those teachings, again, help avoid the need for synthetic oxytocin (Fernández 2014). In this way, the practices of self-knowledge and self-control—like meditation and breathing—feed into self-consciousness during the process of birth, thereby diminishing the possibility of serious perineal tears, for example.

It is important to remember that these services offered by the BCs are not obligatory—which would contradict the principles of humanized birth—and thus, they are subject to the free choice of the expectant women.

Again, the midwives of the BCs ask women to sign an informed consent for the pregnant woman to be attended by the BC, and about the chosen procedure should complications emerge. The latter is also dealt with during the birth preparation.

AZUL: Yes, well, the horrible complications, they explain to you why they might transfer you if something goes wrong during the birth. If they consider that you are at risk, meconium for instance or whatever, they will transfer you and not ask you any more, because it is for your own good and for the newborn, for your wellness, they will transfer you. So in the consent you signed you have to mention the place and the indicated doctor. Information about being alarmed in pregnancy? Yes, during the course, there they inform you about everything, that if you bleed, have high pressure, inflammation, all that is given during the course.

Hence, in the model of care in the BC, there is a direct line of communication between the birthing mother, the midwife and the procedures, which establishes the conditions in which the childbirth will take place. The informed consent also frees the midwives from the responsibility in such cases in which the complications are not provoked by them.

In the case of the BCs, the process of birth involves broader dimensions also after the childbirth and expulsion of the placenta.

ÁMBAR: I already had the baby on my chest, the baby had started to feed a little and she [the midwife] said to me: "You will start feeling contractions again when he is sucking and also when the placenta is born, I think you will feel the contractions again." And so, I started feeling and all, and they said: "Well, let's see how the placenta is." So they checked the umbilical cord and said: "It is coming out." The placenta came out, we saved it so that they could prepare me the pills and I drank placenta smoothies for five days. I felt that I did really well and it helped me.

There are almost no studies with empirical evidence about placenta therapy[4] and its benefits to birthing mothers. Its historical roots are also vague given the historical undermining and disparaging of feminine (healer) knowledges.

Historian Jules Michelet (1987) mentions that the medicine employed by these female healers—in their majority, midwives—was related to pagan beliefs, and was considered a form of medicine in reverse: "The healer cured a person of dancing by making that person dance. A bold sort of homeopathy that was frightening at first; it was 'reverse medicine'" (Michelet 1987: 123), and midwives were the ones who taught the famous Doctor Paracelsus all he knew about women's health. This medicine of "witches or *Bella Donnas*" was completely opposed to the Jewish–Greek–Arabian medicine to which the Christians were more accustomed.

Possibly the greatest change introduced by this "medicine in reverse" in medieval thought was the belief that there was nothing unclean or impure in the womb and its "leftovers." I dare to highlight this bold homeopathy practiced by contemporary midwives regarding the therapeutic use of the placenta, which in the eyes of modern gynecology and obstetrics could be considered an act of barbarism. Perhaps this squeamishness toward the "unclean" afterbirth is more of a medieval thing.

The midwives whom I interviewed seem to remain calm during the birth process rather than rushing it. According to the interviewed clients of the BC, the midwives waited until the umbilical cord stopped pulsing before cutting it, following the scientific evidence showing that, as long as the cord is still pulsing, the newborn is still receiving the oxygenated blood the placenta provides, which aids in its transition to breathing. The midwives also avoided using certain other measures before and during the birth (e.g. cutting episiotomies) that are usually reported as creating more problems than benefits for birthing women (Hartmann et al. 2005; Rubio 2005, 117).

These humanized birthing processes were possible thanks to the time and preparation that midwives dedicated to avoiding complications and expressing respect toward the interviewed women, not only before and during the birth, but also during the afterbirth and puerperium.

ARLET: They [midwives] stayed the whole night there, because this baby was born like at 1 a.m. They checked me after the birth, and also the baby, and after like 40 minutes they weighed her, so … They took her measurements, these things, and … They stayed to check everything in the morning, so like 7 a.m. or 8 a.m., they checked me, like the vital signs, and the girl … And then they left. … And yes, they were there in the morning and the midwife came again to check me like 24 hours afterwards, the next day. I was checked and also the baby, we bathed the baby together, [the midwife] bathed her to show me how, and then the midwife came the following week, a week later and said: "If you have any questions, call me," and that was the last [home] visit.

Hence, the BCs importantly offer integral companionship not only through the pregnancy but also during the process of puerperium, as is also recommended by the previously mentioned Declaration of Ceará (2002): "Childbirth and

birth are the beginning and point of departure in life, and are, therefore, processes that affect the rest of human life." The postpartum stage can indeed be as vulnerable a stage as the others, especially for first-time mothers.

The literature provides scant empirical evidence about the lack of postpartum companionship during contemporary births. I attribute that scarcity of evidence to three particular phenomena:

1. The non-medicalized birth is increasingly less common; thus mothers are not completely conscious of the situation in their surroundings—mothers are not the protagonists. Moreover, no respect is shown for the intimacy between mother and baby that would create the first loving bond between them.
2. The increasing obstetric violence, which also translates into lack of attention during postpartum care. If the mother's leading role and wishes are disrespected during the birth itself, it is difficult to imagine that the empathy and calm that were previously lacking would somehow appear at puerperium.
3. Because some of the midwives' postpartum practices (such as herbal baths, checking on the newborn after a few hours and affectionate care to foster emotional and physical recovery) are disparaged as old-fashioned ones that lack scientific evidence. According to modern medical logics, those practices do not translate into formal postpartum care.

The practices described here correspond rather to the eras of homebirths, when midwives used to visit homes: midwives could not remain indifferent to the needs of mothers and babies. These forms of care and knowledge were transmitted between women, from generation to generation, but lost force with the advance of modern Ob-Gyn in Mexico, as described at the beginning of this chapter (Staples 2008; Sánchez-Ramírez 2010). However, under the model of attention currently provided by the BCs in Mexico, where little by little more women are becoming part of these processes of companionship in births and postpartum, the lost traditions might ratchet up and help to "bring back the grandmothers' care"—without such an unfavorable response from the medical system. These practices could benefit feminine health significantly.

Yet another important element of the postpartum stage is breastfeeding, which during the past 20 years has become recommended by the WHO, after decades of promotion and expansion of the use of formula (Carrillo 2008). Breastfeeding is again recommended, and represents a scientifically approved "rediscovery" (Black et al. 2013, 429):

> If a child is breastfed during the first hour of his/her birth, and the breastfeeding is then continued as the only diet during the first six months, followed by a partial breastfeeding until the child is two years old, each year over 800,000 children's lives would be saved.

I pause here for a moment to go back to the topic of postpartum intimacy during the first hours after the birth—the time when this kind of warm imprint can be offered. Women's experiences vary, but first-time mothers, especially, might require the attentive support of the midwife to generate this fundamental first breast–baby touch:

AZUL: When they passed me [the baby], (s)he [the baby] put my finger in [his/her] mouth and so I shouted "Wow, you put the finger in the mouth!" And I remember that the midwife laughed and said: "Well, give him/her something more interesting!", so I said Ah, yes, that's true, and offered my breast … With Mía it was the same, I mean, she was born, they handed her to me, I hugged her but we were still in the bath, and I offered her my breast, and she took a hold of it … With Leo there were [visits from the midwives] during the first week because I got mastitis, and [the midwives] never charged me for an appointment, they even came at the wee hours and never charged extra, it was all included in the birth and postpartum care.

Isabel Fernández (2012), who has documented the benefits of natural births in Europe for years, mentions the importance of breastfeeding in the bonding between the mother and the newborn. The sooner the contact is established after birth, the better the results, meaning that the easier is the beginning and continuation of breastfeeding without complications. Mothers who begin later—for example, after medicalized and anesthetized births—tend to struggle more. They are also more likely to give up breastfeeding after a few months (Fernández 2012, 179–182).

Laura Gutman (2009, 14) goes further, mentioning that physical nutrition is as important as spiritual nutrition, and that the way in which we receive our first feeding "will be reflected practically in all our future because we learn to nourish others and to be nourished according to the parameters of this first stage of vital experience."

Luckily, giving birth with midwives in the BC facilitates making the first imprint a positive, nourishing act. However, this first imprint is not sufficient. We need to assume more responsibility for following through on these statements about the wellbeing of the infant population because, as stated in the Ceará Declaration (2002), humanized care at the beginning of life can influence the future of societies. This observation implies that breastfeeding should be a real, supported option in contemporary societies (including in Mexico), and that good intentions must not be doomed to remain in forgotten articles in cyber-space.

Becoming empowered through the process of birth

In Mexico, a woman who opts for maternal care in a BC has probably adopted a certain viewpoint regarding other ways of giving birth. To explore those

viewpoints, this final section is dedicated to excerpts of narratives in which women tell how they decided to approach the BC, their assertiveness at the moment of birth, their trust in their midwives, their disagreement with some medical practices they did not want to do, including some measures related to neonatal care protocols in terms of their offspring (vaccines, vitamins and others). These narratives included even their personal recommendations about how to give birth like this—differently. In each of these stories, it is evident that their principal trust was not in the BC but in themselves and in the sisterly companionship they established with the midwives.

The option for a natural birth in a BC reflects, therefore, an important level of trust and empowerment, which translates into a conscious birth. In these excerpts from narratives about the moment of birth, one can appreciate how the birthing women demonstrated their self-confidence and clearly stated what they wanted and what they did not want, and the respect the midwives showed them in this process.

AMARAL: No, they don't [give me any instructions about the ways or positions to birth], never, well, just once they suggested, when I was already in the bath—I was there a long time—and the midwife, she didn't tell me explicitly "I think the bath does not suit you" but rather she said: "Why don't you try the bed?" It was a very subtle proposal and that was it. She never told me what to do.

AZUL: No, nothing, they [the midwives] didn't say how to [position] yourself unless you asked them … No, never, nothing … They apply things, like, they massaged my back, the sacrum. I understand that it is so that it hurts less or I don't know, but I felt it hurt me so I said: "Don't touch me!" And they won't. After two contractions they tried it one more time and if you repeat: "Don't touch", they will not repeat again. Perhaps they wipe your sweat, they offer you water, they ask if you want something to eat.

I would speculate that if a woman going through a hospitalized birth were to tell the attendants "Don't touch me!," she would very probably be ignored, even punished or given a tranquilizer—a response radically different than simply honoring her wishes and respecting her needs.

In the integral care provided by the BCs, the appropriation of the process of birth by the mothers and fathers is encouraged. As evidenced in the following narrative, the birthing mother felt confident enough to tell the midwife that she wanted to see inside the uterus to make sure that everything was fine.

AMARAL: When I was in the bed, there was a moment in which [the midwife] asks my partner to hold the newborn baby and I open my legs and she with her flashlight was there because it was nighttime, ha-ha [showing a gesture of holding a headlight like in a mine]. And so my partner is watching there and she [the midwife] says to me: "Wow! It looks like

everything is perfect!" and I saw the face of my partner like: "What? Ha-ha. What is that?" And I said: "I want to see, I want to see!" And so [the midwife] showed me by holding a mirror and I said: "Oh my god!" It [looked like an explosion had happened in there] [laughing].

How many women want to see their vagina after giving birth? If we, the women, do not know what our interior universe looks like, how can we be conscious of the changes, emotions and conditions that occur during birthing, so that we may confront them from our body-territoriality without self-delusion? What does it mean to have the confidence to say to somebody who attended your birth: "I want to see, I want to see!" given that medical personnel in public hospitals ask family members to leave before the woman is examined? Self-confidence allows one either to trust others, or to reject care from those who do not earn our trust. From their first contact with the mother until the birth itself, and beyond, the midwives use their skills and knowledge to foster that sort of self-confidence in the mother.

In the narrative that follows, the future mother tells how she continued to make choices even as the birth was in progress:

AMARAL: Yes, in the beginning [of the birth] we were all together [family members in the house] and hmm … we were in the living room. There were like two days of weird contractions, so during the first day, we were calm. We went for a walk. But there was a moment when my partner came and the contractions became stronger and we had talked a lot about how I thought it could be and he asked me: "Well, what do you want us to do, how do we support you?" So I remember that I told them: "Nothing, just don't ask me after each contraction about how it was." And so, there was a moment when I had a stronger contraction and I closed my eyes and breathed, and later I came back to calm and we continued chatting.

Questions like these from loved ones about the ways in which the birthing mother wishes to be supported make her *feel* supported and increase her self-confidence at the moment of birth.

To conclude this section on the empowering effects of births, I present excerpts in which these women told us what they would say about their experiences in BCs if asked by another woman.

AZUL: Oh yes, of course I would recommend [that other women birth in a BC]. It is great! Ha-ha, of course I don't have the counterpart of having given birth in a hospital but I cannot imagine doing that, I swear, I cannot imagine that you can do all these things in a hospital: screaming, shouting, singing, laughing in the moment of giving birth.

The empowerment of women is indispensable for their health (Lagarde 1996, 25). Processes such as pregnancy and humanized birth contribute to that

power. In contrast, the health of women is greatly endangered by births that are carried out under alienating conditions in which the hegemonic medical power over women's bodies displaces women from the leading role in their own births.

Returning to Marchese (2019), the body-territory of each woman means the concrete form of existing in the world for her—the context that surrounds her gives her the experiences and sensations. If women live in conditions of structural violence through their bodies, beginning even in childhood, then their need for re-appropriation of this body-territory is all the stronger at the decisive moment of becoming mothers. For these reasons, the spaces where women may birth differently are pertinent to all those women, so that each may seek a place to work consciously to release her fears.

Thus, it is essential that women share knowledges about other ways of living vital processes—in this case, pregnancy, birth and the postpartum period—that respect those processes and strengthen the women *as women*, and as citizens and humans. For these reasons, the objective of this chapter is to make these voices heard and multiplied within the universe of women who have not dimensioned other forms of giving birth.

AMARAL: Ah, my daughter [is what I liked the most about the birth experience], of course. What I liked the most? Well, I felt it so empowering, I was, well, the empowerment is good for all of us. But definitely yes, the empowerment I felt afterwards, of being able to say that I could, I did. And I am fine, my body can do this and I did it, not alone, there was my partner, the midwife, but still, it was my body, it was me. That was one of the things that I liked the most and has served me the most; giving birth on my own fostered my security, as if I had said to myself: "Okay, my body can make wise decisions, I can make right choices, so I will be fine."

ÁMBAR: Yes, yes, I loved it, yes, I liked it a lot. For me to have been attended by the midwives and the ones who are in the BC represents a lot—this effort that they have made to provide this information on how your body works and the other experiences in birth care. That it is not just the hospital; that it is not just the C-sections, rather they are other options and for me, this is so important. I think if I had not come to this city, I never would have thought about it, especially coming from the kind of family history that I have, I would have gone just directly to ob-gyn and my cesarean.

Throughout this chapter, I have mentioned a set of precepts related to the loss of a woman's power over her sexuality, reproduction and body—a body often relegated to serving others (the state, the partner, the children, the family and the community). Certain aspects of this loss of power are related to the medicalization of birth and obstetric violence. Those aspects are in opposition to the autonomy that entails the capacity of women to decide about how and

where to birth their children. Within the frame of humanized and respected birth, that capacity has the chance to develop.

Unfortunately, not all women are in a position to have births like this. The unavailability of that option is not only a matter of *economic resources* (although birthing differently is indeed an expensive option in this country), but also of *vital resources* (nutrition, education, class, age, generation and support networks) and *symbolic resources*. For example, resources that enable me to assume responsibility for the processes of my own body-territory; maternity; responsibility for choosing who will accompany me in the process; the value or self-esteem that I have about myself; and the kind of relationship I have with my partner. In addition, it is a matter of *gender resources*—of a question that might be stated as, "In the particular context, what is the significance of the way in which I unfold my feminine sexuality, pregnancy, birth, being a mother and my decisions about my body and health, to position myself as the conscious leading actor of the birth?"

Birthing differently in a BC should not continue to be an elitist option, but a *de facto* fulfillment of the sexual and reproductive rights that are ours, as women and as humans. I do not mean to say that the BCs should be instrumentalized, so as to "oblige" women to give birth in them, but that the BCs should instead become viable and integrated options within the public and private healthcare services.

Conclusions

In Mexico, nearly 90% of births are attended in hospitals. However, birthing in those venues does not guarantee good quality of maternal care, much less a care that is warm, pleasant and free from violence.

The revival of spaces for birthing differently, such as the BCs led by midwives and doulas, offers the possibility of changing the paradigm and scenery without implying an idealization of a "natural" birth, which "just happens" without entailing risks or efforts on the part of the birthing mothers themselves, or of those who accompany them.

In these BCs, throughout the preparations for birth, it is clear that there are commitments and responsibilities on both sides. The moment of birth and what follows are the result of a long process of conscious preparation and decisions. Although the normal physiologic processes are respected, nothing is left entirely to the vagaries of nature. Without a doubt, the midwives and mothers are capable of meeting great challenges within the BCs.

The experiences shared by the women who attended the BCs reveal the women's conscious processes, respected and accompanied by trained midwives, as quite different from that of a country filled with medicalized births, obstetric violence and faceless birthing women who are treated as objects, numbers and statistics.

The phrases that the interviewed women used to describe their conscious births define this new paradigm of BCs aptly: *I can; There are other*

birthing experiences beyond the hospital; It is not just the C-sections; There are alternatives; I trust my decisions; Everybody is free to choose the way to birth; Birthing [on my own, without medication or surgery] made me more secure; My body can make wise decisions; I can make correct decisions.

These women spoke to us about safety, freedom, wisdom, power and autonomy—concepts that become reality only when you have the possibility of deciding among a range of options at your disposal (Meza and Jasso 2016). In this case, we are dealing with access to a respected and humanized birth for expecting mothers in Mexico. The common thread here is the pairing *birthing woman–midwife*, which since medieval times has created suspicion and terror about women supporting each other.

It is indispensable to transform the generalized forms of giving birth in this country. In stating that it is not just about "trusting nature," I refer to the tangible knowledges and experiences of midwifery that have been expounded in this chapter. These knowledges can change the ways in which new generations are born in this country, as well as reaffirm the healthy empowerment of mothers. It is the midwives who support these birthing mothers in the processes of conscious, humanized labor and motherhood.

In this chapter, I have not mentioned so far that not all is perfect in the BCs. Nor is it in the maternity hospitals. I concur with Ekaterina Bomzdina (2014), who argues that hegemonic medicine is presented as the leading force capable of providing rational control over the "uncontrollable" body of a pregnant woman. This control is achieved mainly through a discourse created by the doctors—one that allows them to describe and classify changes in the maternal body. That discourse continues to be about control over women's bodies, rather than a discourse among women themselves about what is occurring in their bodies during the birth.

The "natural" birth requires a more complete preparation on the mother's part than does the medicalized alternative. The objective of preparations for "natural" birth is for the woman to acquire a new set of knowledges, so that she may improve her understanding of the processes that she will face. In Mexico, the medical services (public or private) use the label "patients" for the people who arrive for appointments. A woman emancipates herself from this kind of domestication when her improved understanding of body-territory processes empowers her to reject the diversity of violences to which she might otherwise be subjected during birth.

The midwives and doulas in the BCs serve as meaningful actors in strengthening women's capabilities during birth. The tactics for doing so include regulation of physical processes (such as breathing, knowing when to push) and psychological support for the women's self-esteem and safety. Achieving this strengthening usually requires a set of preparations during pregnancy, such as appointments, classes, courses and workshops offered by the midwife and the BC.

This prenatal preparation entails a high level of self-discipline on the part of expectant women, including the willingness to alter their daily routine

significantly to obtain the best results—in other words, to have a "natural" and safe birth. Hence, these mothers are not irresponsible and crazy, as their more conventional friends and relations often accuse them of being. Instead, they are more committed and conscious than those who abandon the decision making to others—specifically, to the Ob-Gyn teams in hospitals, where the women will be sedated, alienated, absent and without personal power during the birth.

In medicalized birth, it is generally the obstetrician who organizes the event. In the case of "natural, humanized" birth, nobody assumes total control, since everybody knows that the event will be unique, a journey, in the working pairing of *midwife–mother*. Here, the midwife acts as a guide, and the mother is the protagonist of the adventure where the "pragmatic control is embedded in the situation of *now and here* and cannot be predefined completely before the birth" (Bomzdina 2014). This adventure is an affront to the contemporary neurotic culture whose greatest illusion is the control of everything.

The conscious birth is a long path in which the three elements mentioned at the beginning of this chapter are key: will, consciousness and love. Namely, the will to birth naturally, the consciousness to know when self-discipline is needed in preparation for birth and the love to let the moment flow with the corporal knowledge that obeys ancient physical laws, trusting that the birthing is meant to be a great gift for mother and baby alike, and together.

Finally, the midwives in the BCs, for their part, are also conscious of what it means to guide the journey by putting their knowledges and learnings into practice. It is not always an easy task to guide that process. In the case of Mexico, this task is carried out in a situation of defense of spaces for birthing differently, and in a context where the predominant Ob-Gyn culture rejects acknowledging the meaning of the BCs' work in lighting the path toward new forms of citizenship, without violence over feminine body-territories.

Notes

1 This chapter is an abridged version of a previously published book: Sánchez-Ramírez, G. 2016. *Espacios para parir diferente: Un acercamiento a Casas de Parto en México.* Mexico: ECOSUR/ANP.

2 Feminicide (*feminicidio* in Spanish) refers to killing of a woman or girl on the basis of gender, i.e. for being a woman or girl, by a man. Currently in Mexico and Latin America, feminicide is considered the result of a drastic increase in violent *machismo*. For further information, consult for example: www.inegi.org.mx/contenidos/saladeprensa/boletines/2020/EstSociodemo/DefunHomicidio.pdf (consulted in June 2020).

3 For more information, see: https://definitions.uslegal.com/p/preclude/ (consulted in May 2020).

4 Placenta therapy refers to the therapeutic use of tissue from the placenta for the benefit of the birthing mother. It is supposed that the placenta contains high levels

of vitamin K, which benefits the coagulation of the baby's blood. This does not refer to the pharmaceutical cosmetic medicine industry that has profited from the placentas taken from young women, possibly without their knowledge or consent.

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4 *Dejar pasar*

The safe interruption of pregnancy by traditional, Indigenous midwives in southern Mexico[1]

Georgina Sánchez-Ramírez and Geicel Llamileth Benítez Fuentes

Introduction: Abortion and midwives in Mexico today

Abortion can be defined simply as a termination of pregnancy. The World Health Organization (WHO) identifies it as the expulsion of the embryo or fetus at any gestational stage up to 22 weeks. There are two types of abortion: spontaneous miscarriages and induced interruptions. Generally speaking, spontaneous abortions have physiologic causes related to women's physical health. Intentionally induced abortions—the ones we discuss in this chapter—are external interventions, unrelated to the natural functioning of the organism. There are currently two types of induced abortions: medical abortions and surgical ones. The latter type is also called endouterine manual aspiration (EMA).

According to WHO (2015), the safest practice for terminating pregnancy is the medical abortion. This procedure is also the more common one because it is affordable, easily available and does not require a hospital environment. More importantly, it is less invasive than practices such as EMA or curettage, as well as being more respectful of the woman's person and privacy (WHO, 2015).

In contrast, an unsafe abortion, according to the WHO (2015), is one performed by untrained personnel in environments that lack adequate medical conditions. In other words, it seriously endangers the lives of women who undergo it and can negatively affect their future fertility. However, unsafe abortions have long been the only possibility for women who are vulnerable because their ethnic origin or insufficient economic resources impede their access to safe abortion. The women's vulnerability increases their health risks, especially where abortion is punishable, thus creating a vicious cycle (Centro Legal para Derechos y Políticas Públicas 1997).

Unfortunately, induced abortions continue to be carried out unsafely in various parts of the world. This situation exists even though the field of sexual and reproductive rights, as defined by organizations such as the United Nations Children's Fund (UNICEF), the United Nations Population Fund

(UNFPA) and the WHO, emphasizes that the programs aiming at reducing maternal mortality in pregnancy-related events must be anchored (as a minimum) in five pillars: (1) family planning; (2) health education; (3) professional homecare attention; (4) timely access to emergency obstetric care; and (5) access to safe abortion (Rodríguez-Aguilar 2018).

The decriminalization of abortion at the international level has been widely discussed, for example in the context of the 1995 Cairo Conference on Population and Development, where the imminent risks and consequences of performing abortions under non-legal conditions were exposed (Galdós 2013). However, in Mexico (with the exception of Mexico City and the state of Oaxaca), abortion continues to be criminalized. Only in the case of rape is abortion lawful throughout the country, even though that restriction severely violates the sexual and reproductive rights of all women. However, the effect is greatest upon women in vulnerable, precarious conditions, such as in rural areas, economically marginalized regions and Indigenous communities. Underage and migrant women are amongst the most vulnerable (Sánchez-Ramírez, Moreno and Pérez 2015).

Mexico's regulatory framework could allow the federal government to decriminalize abortion on various grounds, to benefit citizens' health. Specifically, Article 1 of the Mexican Constitution refers to protection of the human rights of all people located in the Mexican territory, and Article 4 establishes that each person has the right to have her health protected. This right includes access to the corresponding services. Thus, in the event that a woman, for whatever reason, wishes to interrupt a pregnancy, she must be attended to in accordance with the provisions of the Constitution, which entails a guarantee that the procedure will be carried out in conditions that safeguard her integrity. Nevertheless, attending to women in accordance with those provisions remains illegal in Mexico, and women who have abortions are imprisoned if they are caught. As is well documented by Singh, Remez, Sedgh, Kwok and Onda (2018), the negative effects (in countries such as Mexico, where abortion is punishable) fall directly upon the health and lives of women who do not have the means to have a safe (medical) abortion.

In a study of unsafe abortion in Mexico, Angélica Sousa, Lozano and Gakidou (2010) explored the possible determinants that define those who carry out induced abortions in the country. Using logistic regression models to analyze data from the 2006 National Survey of Demographic Dynamics, these authors identified sociodemographic variables that interfered with unsafe abortions. It should be noted that, although this study was conducted in 2009, the data are from 2006, when medical abortion was not yet as widespread in Mexico as it is now.

The study included 14,859 women between the ages of 15 and 55; 966 of these women reported having had an induced abortion during the past five years. The authors learned that women from lower economic status, with less education, and from Indigenous origins were more likely to have had their abortions under unsafe conditions. The main variable used by the authors to

determine whether an abortion was unsafe was whether the abortion had been attended by a doctor or performed in a hospital setting. This criterion reflects an important assumption: that "In Mexico only doctors are formally trained to perform abortions" (Sousa et al. 2010, 302). Therefore, we ask: are all abortions that are performed in non-hospital settings and with non-medical personnel assisting the woman *ipso facto* unsafe, or is the role of other health agents and their ability to perform safe practices in countries like Mexico being underestimated? In other words, Sousa et al. (2010) seem to omit the fact that, in a country such as Mexico, the use of a wide range of medicines—usually referred to as "traditional" or "alternative"—has persisted since colonial times. These medicines continue to co-exist with the hegemonic (Western) medical practice, and it is common for people to hybridize different options to achieve equilibrium between health and sickness (Sánchez-Ramirez 2010). The case of induced abortion is no different, as this chapter will show.

In a more recent study, Fátima Juárez, Bankole and Palma (2019) mention that, despite the restrictive abortion laws in 30 states of the country, more than one million (induced) abortions occur each year. Their study analyzed the behavior of abortion-seeking women in Mexico; they conducted 60 in-depth interviews between 2014 and 2015 in three states where abortion is punishable (Querétaro, Tabasco and the state of Mexico). The authors concluded that, at present, the adequate use of medications is more decisive for women's health than the legal situation of the country. The authors suggested that, since many women seek abortions from local midwives,

> more research is needed so as to better understand the practices surrounding the use of traditional medicine, midwives, and concoctions [sic] for abortion in the country … little is known about the ramifications of abortions obtained through these providers and methods, including complications associated with them.
>
> (Juárez et al. 2019)

When did the persistent mistrust toward midwives' practices and knowledge about women's bodies begin? The answer is unknown. However, there is a burgeoning documentation of how in medieval Europe many women were burned—accused of witchcraft—when, in reality, the accusations had more to do with the fear that hovered over that epidemic-plagued world regarding midwives' practices and knowledge about pregnancy interruption, at a time when population growth seemed necessary (Sánchez-Ramírez 2010).

The research reported in this chapter focuses on traditional midwives (defined in this study as those who have no academic training, but who have been empirically instructed) and their knowledge of medical abortion in Chiapas: a southern Mexican state that borders on Guatemala. Taking guidance from Sousa et al. (2010) and Juárez and Palma (2019), we have followed their recommendations about the need to explore pregnancy interruptions in non-hospital settings. This description refers fundamentally

to spaces where medical personnel are not the main actors in performing abortions. Rather, we discuss a space where the role of midwives as health providers for women seeking abortion is highlighted.

Two prevailing conditions in Chiapas establish a context in which abortion is seldom done safely: abortion is criminalized in that state, and 77.1% of the population lives in poverty (Consejo Nacional de Evaluación de la Política de Desarrollo Social Pobreza 2012). Chiapas also has one of the highest maternal mortality rates in the country: 69/100,000 births, compared to the national rate of 31/100,000 births, according to data derived from the Secretaria de Salud (2020). In addition, 31 out of every 100 births in Chiapas are attended by midwives, compared to four per 100 births nationally (INEGI 2017).

As we focus on medical abortion in this chapter, we explore the combined use of misoprostol (or Cytotec) and mifepristone. These drugs represent a trustworthy intervention for pregnancy interruption given that there is no need for hospitalization or introduction of any kind of surgical instrument inside the woman's body. This method is employable within three months of gestation (Singer 2019). The drugs are used as follows. First, the woman takes orally a 200-mg tablet of mifepristone. Then between 24 and 48 hours after the first pill, four tablets of 200 mg misoprostol are applied simultaneously in the mouth, under the tongue, in the gums or in cheeks where they get slowly dissolved.

In Mexico, these pharmaceuticals are legally available in abortion support centers which perform safe abortions (in Mexico City) and illegally (in the rest of the country). However, in Mexico City, where voluntary pregnancy interruption is not penalized, only misoprostol is sold freely in pharmacies. Mifepristone is not, despite being an essential medicine according to the WHO. Thus, there is an urgent need to guarantee that mifepristone is legally and *de facto* available, including as an indispensable element in health centers for cases of incomplete abortions.

According to the WHO (2015), the advantage of medical abortions is that they can be administered not only by medical personnel and in hospital settings, but also by properly trained health personnel such as nurses, health promoters and professional midwives. However, traditional midwives are not mentioned in the WHO's report. Nevertheless, they will be discussed in this chapter, which argues that these midwives do indeed carry out safe and reliable abortions in line with the WHO's regulations.

To arrive at these conclusions, the chapter first provides a brief overview, which (1) explains why in regions such as Chiapas traditional midwives continue to be the first line of healthcare attention; and (2) notes the advantages of ensuring that midwives do not disappear from women's health options. Next, we describe our research methodology, including the profile of the interviewed midwives. Finally, the chapter discusses our results in terms of traditional midwives and their trained, appropriate use of medication for abortion. We show how the concept of abortion has changed over time; how it is being carried out in order to generate confidence in women; and

why women seek these midwives. Based on a gendered perspective, we conclude that these traditional midwives represent important human capital in safeguarding women's health and reproductive rights.

In terms of this principal argument, we emphasize that we are taking critical distance from those approaches that continue perceiving Indigenous women in rural contexts such as Chiapas merely as victims of their poor conditions, or only as subject to violence. Instead, our work is based on the premise that we are dealing with midwives who hold both modern and traditional knowledges, which give midwives powerful tools for safeguarding the lives of the women who seek their care.

Antecedents

Various scholars have shown that, in the Southeast of Mexico, it is generally the Indigenous, rural population with scarce resources that is most likely to seek traditional midwives to attend to their health needs. Midwives are not only sought for births but also for health issues related to the newborn, little children, family planning, nutrition and hygiene (see, for example, Argüello and Mateo 2014; Berrio and Loggia 2014; Sánchez-Ramirez et al. 2015). Frequently, the lack of access to other health services is a factor, as mentioned by Lina Berrio (2015, 5):

> In Indigenous regions, significant barriers persist that make it difficult for women to access health services. Some are related to elements of economic and geographical order, of the availability of service. Others are of a cultural nature. The practices of racism and discrimination that Indigenous peoples face on a daily basis when they go to institutions are a factor, as well as the deep relationships of inequality, subordination, or exclusion experienced by their healers and traditional medical systems with respect to the institutional model of health.

Thus, the midwives in regions such as Chiapas, who are perceived as traditional (and part of the alternative medical systems; see also Chapter 1) have historically been relegated and undervalued by the biomedical system. And yet, their practices are legitimized by the population from which they emerge, and which sustains them. In other words, the communities recognize the midwives as agents involved in primary healthcare, including the termination of unwanted pregnancies. Although there has recently been a resurgence of midwifery in Mexico (see Sánchez-Ramírez 2015, and Chapters 2 and 3), the pre-eminence of midwifery in the country has gone through various stages of inclusion, exclusion and conflict with the hegemonic medical viewpoint.[2] Therefore, many aspects of midwifery healthcare are still unknown, including the use of modern methods to terminate an unwanted pregnancy, as evidenced in studies by Sousa et al. (2010) and Juárez and Palma (2019).

For this reason, the object of this chapter (which forms part of a broader research project) is to shed light on some experiences of traditional midwives in Chiapas. Our interviews focused particularly on the midwives' practices for medically terminating pregnancy. As will be shown in this chapter, the midwives carried out these procedures despite knowing the legal risks, and despite the social stigma they receive for the type of support they provide for women seeking an abortion.

An extensive literature (e.g. Sousa 2010; Shah, Ahman and Ortayli 2014; Fullerton, Butler and Aman 2018; Singh et al. 2018) has documented the havoc caused by restrictive abortion measures. The same literature recognizes the role midwives have played in safe abortion in developing countries. These studies address, from different perspectives, the importance of midwives as providers of integral care, including voluntary termination of pregnancy. These authors have argued that the interruption of pregnancy by midwives has reduced maternal mortality in contexts where there is broad social diversity and inequality, which particularly affects the health of the most marginalized and vulnerable people.[3]

However, we could find only one study—published more than 15 years ago—of midwives and their involvement in induced abortion: that of Xóchitl Castañeda, Billings and Blanco (2003). This study explored a group of nine traditional midwives, aged 20–62, in a rural town in the state of Morelos. These midwives were interviewed about their beliefs and practices regarding abortion. By means of a discourse analysis, the authors discussed whether the midwives considered abortion to be a "failure" of women (when it was spontaneous). The authors also discussed the circumstances in which the midwives agreed to help women "let their periods happen" (*dejar pasar*).

Dejar pasar—which translates literally as "letting pass" and implies "letting go" or "letting bleeding happen"—is an expression commonly used by Mexican midwives to refer to pregnancy interruption. The authors emphasized that their study, published at the beginning of this century, was an initial approach to understanding the role of midwives in induced abortion and its care in Mexico.

The results of the above-mentioned research indicate that the reasoning of the midwives who were interviewed depended upon whether the case they attended was a spontaneous miscarriage or an induced abortion. Miscarriages were attributed to some combination of the pregnant woman's heavy workload, emotions such as anger and fright and the malnutrition and domestic violence suffered by the women in their living contexts.

The same midwives tended to refer to induced abortion as "a murder" or "a serious sin." These midwives also called those who practiced induced abortion as dogs or pigs. The midwives stigmatized women who were believed to have practiced it frequently as a contraceptive method. At the same time, the midwives' discourse was overtly contradictory: they explained that voluntary abortion was acceptable when (for example) the child had a congenital

defect (although it is not clear if the midwives could confirm such a defect via ultrasound or some other test), if the mother was unmarried or very poor or if the father was not the mother's current partner (i.e. in cases of abuse or infidelity). It is noteworthy that none of the interviewed midwives stated that they induced abortions. Most of them denied knowing of any method for doing so.

However, some of the midwives mentioned that they knew what *could* be used: a catheter inserted into the uterus; injections of Metherin; *zoapatle* (*Montanoa tomentosa*) with very hot chocolate along with a hot shower; hormonal injections, mainly progestin; scraping of the uterus (curettage); "suctioning with a syringe"; carrying heavy objects (which also causes miscarriages); and falling or slipping intentionally (Castañeda et al. 2003, 81). The midwives also showed that they knew about the consequences of incomplete abortions.

These midwives stated that men rarely got involved in inducing abortions. They also stated that their own greatest worry regarding abortions was not about God, but about the societal stigma. And yet, they mentioned that "however, when one makes a decision [to proceed with an abortion], the fear does not stop us" (Castañeda et al. 2003, 81). Thus, as can be perceived in this study, and also in our own (discussed in this chapter), many contradictions are present in the midwives' discourse about their clandestine abortion practices. Those contradictions can be explained by the legal and societal repercussions that midwives might suffer for speaking openly.

The midwives interviewed by Castañeda et al. (2003) also mentioned a series of herbal remedies and hormone injections with which they could "bring down the period" (*bajar la regla*). However, they also emphasized that, if this series made the period start, then the attended woman was not pregnant: a comment that again pinpoints the midwives' ambiguous position regarding abortion.

It was evident in Castañeda et al. (2003) that midwives put themselves in serious legal jeopardy by caring for women in their own communities. The risk was present even when attending women had suffered spontaneous, incomplete abortions: midwives might be caught by the police and imprisoned for doing nothing more than transferring such women to healthcare centers.

Finally, Castañeda et al. (2003) recommended that public health services in Mexico recognize and value the rich knowledge of midwives, as well as their closeness to and credibility with the female population in rural and Indigenous areas, especially in terms of practices for inducing abortion safely.

The foregoing provides context for the main objective of this chapter, which is to discuss the narratives of midwives interviewed in two rural regions of Chiapas where abortion is permitted only in cases of rape, congenital malformation or immediate danger to mother's life. Traditional midwifery continues to be widely practiced in those regions. Our research focused on evaluating whether medical abortion can contribute to opening up options for improving the health of women living in conditions where they are vulnerable.

The research was also motivated by the desire to demystify the idea that a safe abortion can be performed only in a hospital setting or by highly educated medical personnel.

Methodology and profile of the midwives

The issue of abortion as a voluntary decision taken by women has been analyzed academically throughout contemporary history, via various methodologies and inquiries. Prominent among those analyses are contributions from the fields of demography and epidemiology (such as Sedgh et al. 2016), which use economic approaches. A vast feminist literature explores abortion from different perspectives. However, the approach that has dominated this field of inquiry emphasizes women's rights and autonomy in terms of abortion (such as Lamas 2013; Shah et al. 2014; GIRE 2015).

This research builds on feminist gender and health approaches, which form one of the most praiseworthy achievements of feminist theory in academia (Fraisse 2016), and which have also directly influenced global health policies. The gender and health approaches highlight both the differences and the inequalities between men and women in terms of health and illness, thus making it possible to focus on various needs and processes of particular concern to women—in this case, in caring for and attending to their health throughout their life cycles (Sánchez-Ramírez 2010).

The feminist gender and health approaches also enable researchers to analyze intersections such as class, religion, ethnicity, age, sexual preference and education. The gender perspective, when applied to health, has made it possible to shed light upon different realities that have been subject to heavy generalizations within hegemonic medicine and its androcentric vision of humanity's health–disease axis. (See, for example, the works of Teresa Ortiz 2006 and Carme Valls-Llobet 2010.) Therefore, use of the gender-and-health framework is crucial when addressing the issue of induced abortion because an induced abortion inevitably marks the decisions and the bodies of women who go through it, with consequences that vary according to the way in which all this happens. The women's experiences depend directly upon the intersections present in their lives, and upon the networks of support and care available to them.

In similar vein, it should be emphasized here that our approach seeks to take critical distance from mainstream Western anthropology, which frequently has contributed to a stereotyped vision of women in Southern Mexico as abused, deprived, racialized and vulnerable. Our work builds instead upon the innovative Mexican feminist anthropology (among others, Jules Falquet 2001; Aída Hernández 2001), which has reassigned the agency of Indigenous and rural women in poor regions such as Chiapas. These authors have highlighted, for example, how women in poor regions have become involved in politics and in the transformation of the traditions and customs of their (rural, Indigenous) communities. The involvement and transformation often

take place differently than in the predominant Western feminisms (Falquet 2001; Hernández 2001). Thus, we cannot emphasize enough that, despite the harsh conditions revealed by the narratives, what stands out, and is subject to our analysis in this chapter, is the agency, solidarity and wisdom of the women in contexts characterized by human rights abuses, a serious lack of access to basic health services and the criminalization of abortion.

Our research focused on exploring the points of view of traditional midwives regarding the termination of pregnancy in a context that criminalizes induced abortion. One point of departure regarding whether the woman is the one who decides whether she is to be a mother or not is the asymmetry of power between the autonomous female body and the body that has been infantilized by the state (see also Chapter 3). In this sense, and following Patricia Castañeda (2008, 14), the present work is motivated by the emancipation made possible within the research itself, as "of, with, and for women," and thus, with the aim of contributing to the scientific documentation of women's knowledge in the world.

Our methodology included the following stages. A total of nine traditional midwives were contacted for interviews. Each had been trained at some point, by the same international civil association, in the use of drugs to safely terminate pregnancy. As Chiapas penalizes this activity, the organization must remain anonymous. The objective of this anonymous organization is to supply contraceptive methods to a population that for various reasons has difficulties in accessing them. The organization also gives training, when sought, to doctors, nurses, midwives and health assistants in the field of sexual and reproductive health. The services are not free, but the cost corresponds to the needs of the public with whom the trainees work.

Five midwives were interviewed in an area of central Chiapas (referred to as Zone A) and five more in an area bordering on Guatemala (referred to as Zone B). The two regions were chosen on the basis of the midwives who agreed to take part in the research. We imagined that midwives from these geographically separate regions might provide different scenarios, especially because Zone A contained a larger Indigenous population, while midwives in Zone B attended more migrant women from Central America. Yet, as the chapter will show, the needs related to the attention and the midwifery practices were very similar in both regions.

These midwives allowed us to record their interviews. In order to learn about the practices related to induced abortion, we conducted semi-structured interviews, which were later transcribed. We kept a field diary to serve as a guide when analyzing the information. Our use of the tape recorder was based on informed consent. The objectives of the research and interviews were discussed and clarified with the midwives in order to avoid misunderstandings or harmful use of their narratives. These preparations were carried out in environments chosen as safe and trustworthy by the midwives themselves (Restrepo 2007). To process the information, transcriptions were made in Microsoft Word, and some comparative tables in Microsoft Excel. Atlas T

was also used. We conducted the interviews in person to guarantee the midwives' safety and confidentiality. In addition, the midwives' names have been changed in this chapter, and the exact locations of the interviews omitted. The midwives were asked for written informed consent (Sánchez-Ramírez 2016, 251). We carried out this fieldwork between March and July 2018.

On the basis of information obtained from the interviewees, we identified five lines for further research: (1) "letting go" (*dejar pasar*), or the termination of pregnancy from a historical viewpoint; (2) sorority; (3) the characteristics of the procedure; (4) the reasons for seeking a midwife for ending a pregnancy; and (5) what option women would choose if midwives did not exist.

Table 4.1 shows the ages of the midwives interviewed and how long they have been practicing. Initiation into traditional midwifery usually starts at a very early age, with some midwives attending births from the age of 14. The education level of the interviewed midwives varied considerably: some had no schooling, while others had completed high school. Considering that all these women were traditional midwives, it is interesting to explore the ways in which they obtained certain sets of knowledges. Most of the participating midwives said that they had learned the profession through knowledge inherited from their grandmother, mother, sister or (in some cases) mother-in-law. Some midwives had acquired this knowledge through dreams—a finding consistent with those of other researchers (Sánchez-Ramírez et al. 2015; Villanueva and Freyermuth 2018).

The mother tongues of the midwives we interviewed were usually those of the midwives' respective places of origin. One midwife's mother tongue was Tojolabal, but the other eight spoke Spanish, Tsotsil or Tojolabal as their mother tongue. All spoke Spanish as either their first or second language. Therefore, all could narrate their experiences in Spanish without need of a translator.

Although contemporary Chiapas has a multi-religious profile, most of the midwives interviewed declared themselves Catholics. That self-identification is significant, given both the radically conservative official position of the Catholic Church against induced abortion, and the decision of the interviewed midwives to do induced abortions anyway.

Economy-wise, most of the interviewed midwives are women with scarce economic resources who attend in their own homes. They are recognized in their communities for the work they do for the health of the community. However, this recognition does not exempt them from the stigma that can be caused by the practice of abortion as part of the double standard typical in such societies or communities. In other words, they are easily judged, while at the same time being sought out for safe termination of unwanted pregnancies.

Dejar pasar: Midwives and safe abortion in Chiapas

As mentioned in the methodology section above, the interview results were framed according to five categories (1) letting go (*dejar pasar*)—in other

Table 4.1 Profile of the traditional midwives studied

Name	*Age (years)*	*Zone*	*Education*	*Years as midwife*	*How the midwifery knowledge was obtained*	*Mother tongue*	*Religion*
Doña Isabel	53	A	Primary school completed	20	Taught by mother-in-law	Tseltal	Catholic
Doña Luz	63	A	Primary school completed	25	Taught by sister	Spanish	Catholic
Doña Rosario	39	A	Primary school completed	16	Knowledge acquired through dreams	Tsotsil	Community rituals
Doña Josefina	47	A	No schooling	25	Empirically by attending her own first birth	Tsotsil	Catholic
Doña Antonia	36	A	Primary school not completed	12	Taught by mother and acquired through dreams	Tsotsil	Catholic
Doña Socorro	62	B	High school completed	43	Taught by grandmother	Spanish / Tojolabal	Catholic
Doña Gertrudis	66	B	Primary school not completed	45	Taught by mother	Spanish / Tojolabal	Catholic
Doña Angelina	36	B	Secondary school completed	16	Taught by mother	Spanish	Catholic
Doña Lupita	57	B	Secondary school completed	40	Taught by mother	Spanish / Tojolabal	Catholic
Doña Margarita	59	B	Primary school not completed	45	Taught by mother and grandmother	Spanish / Tojolabal	Catholic

Source: Prepared by authors (Sánchez-Ramírez and Benítez Fuentes).

words, the termination of abortion then and now; (2) sorority; (3) the characteristics of the procedure to interrupt pregnancy; (4) how the women end up with midwives; and (5) what would have happened if these midwives did not exist to assist the women. In the sections that follow, the results are presented accordingly.

How has the language of abortion changed over time?

As mentioned above, in this research we sought to explore, among other things, the ways in which the midwives themselves defined and described the process of interrupting a pregnancy. We inquired about the changes over time; in other words, how abortion was perceived previously, versus now, and how the terms used for abortion have changed in the process. We discovered, in accordance with Castañeda et al. (2003), that the expression "letting go" (*dejar pasar*) referred to the abortion itself; that is, to the recovery of menstrual bleeding. We also sought to know whether, and how, the work of a midwife has been changed by the use of drugs to interrupt pregnancy:

ROSARIO (ZONE A): I didn't know what [an induced] abortion was, but now as we are part of an organization, I wanted to know about the procedure. It was never discussed or mentioned before. Yes, I had heard about it and I knew that [the women] had [induced] abortions, but they were just abortions. I wanted to know what an abortion with medicine is. [The women] aborted on their own, but I did not attend to those cases. I knew what was happening based on what people said, and because my mother sometimes told me. She was not a midwife, but [she] talked about what an [induced] abortion was, but without medicine. It just happened, like that, on its own. In Tsotsil it is called "*Tax yal yolik*," which refers to an interruption.

ISABEL (ZONE A): Well, I've always heard that the right word used, from the most humble people to what we call the *Caxlanes* [non-Indigenous people] is "abortion." It is abortion. It was never referred to as an interruption. The word interruption is better understood now because it does not sound that ugly. Before, abortion was crime, we didn't even pronounce it.

As shown by Rosario and Isabel, different expressions are used to refer to abortion. Those expressions have changed over time. The words "abortion" and "interruption" had different connotations: interruption is now considered more acceptable and less stigmatizing. By calling abortion an interruption, the midwife is able to define her work as non-criminal. Again, what can be perceived in the following is that the word "interruption" is still not used as commonly as the terms "abortion" or "terminating a pregnancy."

DOÑA LUZ (ZONE A): In those days it was not called an interruption, it was called abortion. Or rather, "I want to let it pass" (*quiero dejar pasarlo*), I want to let go of this, of what I have, because I cannot have it, or don't want to. There was some legal questioning before, but not as much as today. Now the question about what will be done to the person who wants to interrupt is more dangerous and more direct. Earlier it was just letting go of the [fetus], letting go of the pregnancy when they didn't want to have it.

Like the previous midwives, Doña Luz mentions the concept of "letting go" (*dejar pasar*). She also notes that the need for caution and discretion is greater now.

In the narratives above, one can appreciate that in Zone A there are different manners of referring to abortion—particularly in Tsotsil, which has a specific word for the termination of pregnancy.

Compared to the midwives in Zone A, those in Zone B elaborated more on the changes in the vocabulary surrounding abortion.

SOCORRO (ZONE B): In the environment where I grew up different diseases were heard of, and there were different ways [to say "disease"] but there were many taboos derived from our religion. It was very marked, and sometimes disease couldn't even be mentioned. I remember when I had my second pregnancy because the first one was high-risk, and my second pregnancy started within a year from the first one. I had my first baby, who was convulsing all the time because he was born with a brain paralysis, so my second pregnancy caught me off-guard, and my husband was far away. I sent him a letter to let him know I was pregnant, and that my son was very small. At this moment I was 19 years old, and to be honest, I would have liked to have someone to help me, but in those days you couldn't even mention it, not even to say it out loud, because it was all bad and shameful. It was all about the sin, everything was penalized, very demonized. And yes, I would have liked to have someone to help me. I always heard about it as an abortion, and they said "it's not that she would have aborted" or "it was an abortion." In those days it was truly demonized. We are talking about like 42 years ago.

In her narrative, Socorro makes a clear distinction between the perceptions of abortion before and now, recreating the difficulties that she experienced herself when confronting an unwanted pregnancy. She also notes that 40 years ago the word "abortion" was taboo. Even mentioning it was a sin.

LUPITA (ZONE B): My mom, who was a midwife, didn't do it; she said that it was a great sin. I always heard that they called it an abortion when the bleeding came, so what was done was to send her to the hospital or to a health center, the closest place that there was. Because of the bleeding,

well, it was about the life of the woman and because it was scary, but now we just go to the training center because we have learned to help the patient. There is more information now.

In Lupita's words, the term "abortion" is used in similar vein as in the previous narratives, but the difference is that in this *herstory*, the women are sent to hospitals to be attended. Now, however, the midwife has learned to help the women, thanks to training.

GERTUDIS (ZONE B): We never saw cases like that in the ranch, and my mom didn't do it. There in the ranch they said it was an abortion, and there were cases but they seemed spontaneous. Many of them were taken as fallings and this kind of thing. Now that we go to the courses and we know more, we understand why the placenta goes down, and that sometimes it was because the women lifted heavy things and started to bleed. Now we can already identify the spontaneous abortions. Before, we didn't know what was going on, but we attended them.

In the above citation, Gertrudis refers to inexperience and the unawareness of spontaneous abortions, concluding that because she now she has more knowledge, she can not only identify and prevent spontaneous abortions, but can also assist the women better.

MARGARITA (ZONE B): It was always said that some girls came to ask for some medication to abort, but well, I think in those days there were no medications, just herbs, with those herbs that now are not known any more. Because I was young I didn't pay attention, but I did see that they prepared some infusions for them. I cannot remember anything else about if they let it or not; just that [the women] came and said that they wanted to abort or let go of what they had, and that's it.

In Margarita's narrative, one can appreciate the information, albeit limited, about the use of some medicinal plants due to lack of knowledge about other remedies for pregnancy interruption. These other forms of inducing menstrual bleeding were the resources available to both the midwives and the women. In many cases those resources were sufficient, according to the midwives—at least in cases in which the problem was only a menstrual delay.

ANGELINA (ZONE B): We have heard and learned about it as an abortion. My mom did attend them, but my grandmother didn't. She was more squeamish about that topic, or perhaps she did it but wouldn't say. I think my mom started to work with abortions when they brought a young girl [a sexual worker] to her from the zone of tolerance. She smelled very bad, truly really bad, and I remember that time well because I ran out vomiting and wondering what happened to her, what is this. My mom

started to explain and told me, "This is a very delicate topic, but if you are already in it you have to know, because you can also help many women." And well, nowadays you don't have these cases any more but in those times supposedly they had inserted [a clothes hanger], a hook and a tube, and then my mom manually attended because what she had were the [unremoved tissues] plus a bad infection. And they brought her because they were from Honduras. They don't like going to the hospital, and [the women] think they will do something … And so, it was there and then that I started to know what an interruption was.

In Angelina's *herstory*, you can identify how the abortion was clearly dealt with before, compared to nowadays. The midwife also acknowledged that she was not sure if her grandmother carried out abortions or was just discreet or cautious about it. In this final narrative by Angelina, one can perceive an argument in favor of decriminalization of abortion to avoid clandestine practices that might jeopardize women's sexual and reproductive rights. Angelina also notes the situation of migrant women and their victimization.

Sorority: Toward the sisterhood

Mónica Pérez (2014) defines sorority as "a concept derived from the Latin *soror*, which refers to a sister. It is a way of referring to sisterhood among women in terms of gendered social issues." These relations (among women) may generate alliances, complicity and resistance. It is a term adopted and proposed by some feminists. Thus, in this section, we have categorized some of our results as sorority, which refers to the sense of mutual aid among women in search of a safe and non-judgmental solution for unwanted pregnancies.

ISABEL (ZONE A): I do help, for one, for being a woman. We all pass through different situations in life for getting pregnant, which sometimes is not wanted, or sometimes there are problems with the partner. Many say, "I don't want to get pregnant" or "I don't want to have it because my husband doesn't give me money to feed [the children]." There are lots of these things, so it is in that situation that one starts to explain: "Well, there is a treatment for that, it is delicate but you have to assess," so they explain to me and then I think, "I am a woman and in my case I will do it, considering how this other woman is suffering." It's for that reason that I always advise [pregnant women] that it has to do with the situation of life we are having, because what's the point of a baby coming along to suffer if s/he doesn't have clothes? So, I am touched in my heart by what they say to me, and I can see truly see it, when they say "It's because I don't have the money," or "What I am going to do with another child?"

As noted by Isabel above, two elements can shed light on the midwives' motives for attending cases of induced abortion. The first element has to do

with sorority in the sense of a shared gender condition, and the second one with empathy for the woman who lacks the economic resources to assume the responsibility of motherhood. The latter element, in fact, is a legal justification for abortion in two Mexican states: Michoacán and Yucatán.

DOÑA LUZ (ZONE A): Well, I am motivated by women who come in with lots of needs, and the thing is that we can see when there are lots of needs. In 2016 two girls died. One was five months pregnant, and the other was three months pregnant. They killed themselves—they committed suicide here in this municipality, because they didn't have any other means. But that was in 2016. The girls didn't search for us. If they had come here before and even without money, the organization that sells us the drug has the ability and authorizes people to be attended for free. That's what I have been told—that there is the possibility of getting help for free, because they don't have the money, they don't … have anything. I always tell them, "Look, you don't have to explain to me, I am not the one to judge. We are friends and I will help you. I don't want you to have to tell me these stories, because you know [your situation] and you decide what to do with your life. If I can, I will always help if you come in time." And they start telling me the date of their last period to see if they still have time.

This comment from Doña Luz is very centered in her personal interest in the women. Firstly, it makes reference to sorority in the sense of pointing out that no woman should commit suicide for lack of sufficient help to end an unwanted pregnancy. Secondly, it refers to sorority by showing willingness to support women without questioning them.

ROSARIO (ZONE A): Many of the women who seek an abortion are students. They ask for the drug to abort. They need me to help them, and I want to help them so that they won't have a pregnancy they don't want, I do it just because the help [is needed].

As the in the previous case (Doña Luz's), Rosario emphasizes her interest in "carrying out the abortion just to help."

JOSEFINA (ZONE A): Well, in my case, I think that there are many women who seek to interrupt their pregnancy because they already have a child who is just about to crawl, and then comes another one. I have had cases with this necessity and it's for this reason that I have decided to support them because, well, the couple doesn't want any more because they have this other child and another one along the way, so I needed to support them. Once it is over, I talk to them about [family] planning so they won't keep getting pregnant. But yes, it is a necessity because during all the time that I have been doing this work, those who seek me have not

been single moms. Instead, they come in with their partners. I have had many cases, and frequently for the same reason that they already have two, three or four kids, and the dad says, "I don't want any more, because I cannot do it—[I cannot] even provide sandals for my kids. Please do me a favor! Help me out!" And the truth is that they don't have the economic means to raise their kids, so I feel sorry for them because I see [the children] coming in—one on the mother's shoulder, one over there, one with the dad, and so lots of small ones. So, I have had this necessity, and they come in asking. We need to help them this way because it is the way we have left.

This *herstory* by Josefina is similar to that of Isabel in explaining that the reasons for "helping out" women to interrupt pregnancies are based on the economic situations of the women who seek them. The "need to help" also refers to the situation of having many children already, and not having the means to sustain them. As can be appreciated above, even couples solicit the help of the midwife to interrupt pregnancies. Here, it would be important to inquire about what is happening with the promotion of masculine contraceptive methods, because the above narrative suggests that women are frequently considered to be the ones responsible for unwanted pregnancies.

DOÑA ANTONIA (ZONE A): [It happens] because there is bleeding already and they have been nagged or scolded by their fathers. They have been thrown out of their homes, and the poor people have nowhere to go. And so, we feel sorry. There are some [women] who are thrown out of their homes, but we cannot help them because they come in four or five months pregnant, so no. If it is two months, yes, we can help but not beyond that. We help them when they are students, or when they don't have anything, because when they bring babies into this world, you have to give them education, everything. There are some women who are very poor, and sometimes they don't have dads, and so we help.

In the narrative from Zone A, Doña Antonia expresses a type of sorority similar to that manifested in the previous *herstories*. It can be summarized in the sense of empathy for the situation that confronts many women who seek induced abortions. This empathy becomes the prime motivation for midwives to carry out their work of interrupting the pregnancy.

Unlike the midwives in Zone A, those in Zone B did not emphasize the economic situation strongly as a reason for offering to help with abortion.

SOCORRO (ZONE B): I know very well what [the women] are talking about, and I know what they are seeking, so I don't even let them finish with their discourse, but I tell them, "I know what you want, but I also want to be honest with you, and I want you to be honest with me. I don't want you to lie to me so that I will help, because if it is not in my range of

knowledge, and I can't, there are other people who can help better than I. If it is within my possibilities, I will help you." What motivates me is [helping ensure that the pregnant women] don't do things that put their health at further risk, or their lives, because due to despair one can do all sorts of things, and due to ignorance, it is done and it ends with misery. I am motivated by the fact that if they need me and I have the means, well, yes, because without knowledge you cannot help. There are people who don't know, and they give the wrong kind of advice. So no, that's not good for the health. One must prepare oneself to help.

In Socorro's words, it is clear that the midwife assumes a great deal of responsibility by offering her support to a woman who seeks an abortion. Unlike the midwives in Zone A, Socorro is not interested in explanations for wanting to end a pregnancy. Rather, she is concerned about the safe conditions in which she can carry out her work.

ANGELINA (ZONE B): In fact, from the beginning when [the pregnant women] come seeking me, I speak to them and explain that there is a kit[4] that can help, and it is 100% effective. I always tell the women to feel sure about themselves because they constantly come in with this fear, and I let them ask questions until there are no doubts. They go and you become a friend. They write to you and say, "Hi, good morning, look—this happened." And I tell them, "Easy, it's fine." You have to offer them safety so that they are calm, and sometimes it is not just about the interruption because it also involves the family or partner, so it is all that. So [the pregnant women] are more involved in all that beyond their own problem, and are being told things, and so the fear starts, and that's where we midwives have to enter.

This *herstory* by Angelina is sustained in the understanding of the woman's emotional state and its consequences for the woman's health. Thus, Angelina is involved not only in resolving the problem of unwanted pregnancy; she also assumes the role of a trusted person who accompanies the woman through the process. Thus, it could be argued that the emotional work carried out by the midwife results in women feeling more certain about them, thereby returning to themselves their bodily autonomy of healing.

LUPITA (ZONE B): I was a single mom, and I would have wanted to be helped. I have a daughter, and I got pregnant when I was 17. Now that [pregnant women] come to me I first chat with the girls because I am working more on the family planning. I ask them why they don't use these methods, but when they are already pregnant, well, there is nothing more to be done than to support them or send them somewhere where they can be supported. We shouldn't abandon them because the girls, well—I call them girls even if they were 18—because they do inappropriate things

that damage their health and life, sometimes by taking things that are not appropriate. I try to give them advice, so that they might think better about what they are doing, because in a moment of despair, for example, if they fought with the boyfriend or husband. So I don't—I definitely don't suggest that they do something fast, to rush in, but I do listen and tell them to think well about the things to do. I suggest that they have an ultrasound and go back to their partner or family. I don't know with whom, because there is another detail: if we ask about a family member, sometimes [the pregnant women] don't want their families to know, so the partner is better, he has to involve himself and be in the process, to realize how much the woman is suffering [due to the induced abortion].

What calls our attention in Lupita's account, again, is the midwife's emphasis upon dealing with "her women" emotionally first, thus, returning to her the responsibility for her decisions. Giving them time to think about the option of pregnancy interruption also indicates that the midwife does not do her work for financial gain, but lets the women decide whether to proceed.

MARGARITA (ZONE B): Sometimes the girls come and say that there are people who rape them; sometimes it's the fathers-in-law. Sometimes the partner also comes, and the couple just doesn't want to have the baby, but considering the need, they can be attended when the pregnancy is not too advanced. So, it would be within four, five or six weeks of pregnancy.

Importantly, this excerpt by Margarita makes reference to sexual violence that many women who seek to interrupt an unwanted pregnancy have faced. These cases often include domestic violence, which leaves the women more vulnerable and with a latent risk to their lives and health—emotional as well as physical—particularly if they are alone without the necessary support networks. Thus, the supportive role that a midwife can offer becomes crucial.

The procedure: How to generate confidence?

The WHO (2015) has established a precise manner in which the interruption of pregnancy should be carried out medically. Therefore, one of the objectives of the interviews was to explore the ways in which the midwives actually carried out a medical interruption of pregnancy.

DOÑA LUZ (ZONE A): There are schoolgirls that come in, and they should always come accompanied by someone because someone has to know—because there is always the risk that the mother finds out. I don't know how, but she can, and then there exists the possibility that we go to jail, because the family was not considered or any other adult who accompanies the girl. [The girls] come here, we chat and I tell each one how the drug is applied, whether they take the pill here or take it with them or

come back later. In any case I will give them the instructions and they will employ it just as the protocol or instructions say, which I give them. The girls say, "Yes I will take it with me. So, leave me your number and I will be calling in so many hours."

Because I have already given them the first one, I tell them that the second dose is after 24 hours have passed, and then they apply another four, and so I go on calculating the time to call them to check how they are, and tell them all the side effects. The side effects after taking the misoprostol are dizziness—there can be diarrhea, contractions in the womb, fever and vomiting. These are the side effects that anyone can get. I have to tell them to come back in 21 days after having taken the drug, to give them another test to make sure they are clean, so I can be sure [the tissues have all] left. I also tell them that they remain fertile. If within eight to 15 days they have [sexual] relations without protection, they can get pregnant again. And they might say that the drug didn't help, so they have to come back in 21 days, before having relations, to make sure that they are clean. [I tell them], you are going to refrain for one month, then come back to take the test. There are those who come back and those who don't, but I am always available by phone. It is taken first by one pill, and then four more pills 24 hours later, applied between gums and cheek. The vaginal [procedure] is something that I have never done; I have never worked like that. I am scared because the pill will be in the cervix, so I imagine or think that it can provoke troubles or a sore. I don't know. I don't do that kind of work, and for the pain I tell them to take ibuprofen.

In Doña Luz's account (above), one can detect the four elements defined by the WHO (2015) as requirements for a safe abortion: (1) the woman is being accompanied by a trusted person; (2) the instructions for using the drug use are explained in an orderly manner; (3) there is a follow-up by telephone; and (4) there is a check-up after 21 days to make sure that the procedure has been completed. Doña Luz also makes clear how the medicine should not be used, so that she will have evidence of her due diligence should complications arise.

ROSARIO (ZONE A): Sometimes it happens with women who suffer violence and abuse. I have had one or two of those cases. [The women tell me privately] that they go through these things, and that they are held down forcibly and raped. These women come to me to ask if I have drugs to start their period; they usually don't say anything about an abortion—they just come in because they want to have their bleeding. First, I have to know how long it's been that they haven't had their period, to calculate the stage of the pregnancy. I touch them to know the dates because you can feel the womb when it is occupied, you touch the belly and above the pubic bone, and that way I can see if it is a pregnancy or a delay. To confirm, I will use a pregnancy test. There are also symptoms that indicate a

pregnancy: when it is just a delay there are no symptoms. Sometimes that is the difference; sometimes the women have dizziness or nausea, or they stop eating. Sometimes they have a headache. First [I give them] mifepristone, and 24 hours later the misoprostol. That is the procedure.

Although the description given by Rosario is not very detailed, she does mention the drug that is used. She also considers it important to assess the stage of gestation before starting the procedure. Unlike Doña Luz (the midwife who gave the first narrative), Rosario does not require that the woman be accompanied by a family member or other trustworthy person. Instead, she emphasizes from the beginning that most of the women she attends are victims of sexual abuse. In these cases, the need to be accompanied could make the woman even more fearful and insecure.

JOSEFINA (ZONE A): I feel them, but I refuse to attend them if they don't let me check how many weeks pregnant they are. The hands are [a practical way to check], and by knowing how many weeks pregnant they are, one knows what to do. I didn't use the drug before—just herbs, which did work, although not as well. The herb that we used here was called *Sapo*. We called another one *la Aquina*. It was used in a tea, but always when the woman was less than 12 weeks pregnant. The herbs helped me more or less when it was six or seven weeks, but from seven weeks onwards it didn't work so well. On the contrary—it just helped the baby to grow. Now I just combine the two. I give them the dose of medicine (mifepristone and misoprostol), and then I give them their hot tea. It doesn't take long: like one hour later the bleeding starts. They take a bit more water and it all comes out. They leave, and I just tell them that whatever happens, they should let me know, because even if I don't have formal studies, I do know how to start an intravenous and give injections.

For that reason, I tell them it is not necessary that they go to a health clinic, because there they start to ask questions, and they might say things that get us into trouble. For this reason, that I tell them to come to me and I will give them the intravenous or something else. I ask them to let me know, but thank God, a week later they come to tell me that everything is fine. So, it is my hands that check if the uterus is occupied and what size [the fetus] is. If the womb is very small, or if the mother is very chubby, I do a pregnancy test. Almost always they come back in a week, or they send someone to say they are fine. When they come back, I ask them if they want a family-planning injection. I have ones for a month, two months and three months.

In Josefina's *herstory*, the midwife has great confidence in her "hands that know," and in the use of herbs to interrupt early pregnancies. She also knows the procedure for accompanying the women in a less traumatic way. As in the previous narratives, she points out the importance of follow-ups with the

women to make sure that they are fine, including offering family-planning services. However, she also makes reference to the combination of different knowledges, and to the distinction between the modern and traditional methods: "I know how to start an intravenous and give injections." She is also worried about the legal consequences of inducing abortion. Therefore, she encourages the women to avoid health centers.

The three midwives whose narratives we've examined are in Zone A, but we shall see that, like them, the midwives in the Zone B also use more modern strategies.

SOCORRO (ZONE B): I never work like that, like in the air [i.e. without having solid information]. I always work with studies and the ultrasound so that they won't lie to me about the dates, which would get me into trouble, as they say. I avoid getting it wrong in terms of the dates. There have been women to whom the test is applied and it is positive, and I also check them, and I can see if it is an ectopic pregnancy, which is dangerous. To be honest there is nothing better than having an ultrasound in your hands. For dealing with all the sicknesses and consultations with which men and women come, I mix three things: medicine, herbs and all which is called homeopathy. That is great benefit because there are no difficulties and it is all faster. In the case of interruption [of pregnancy] there are herbs, too, so they are mixed with the drug that I apply. The person or patient is very satisfied because it helps to avoid a lot of pain and inflammation, and is quicker.

[The pregnant women] come and tell me what they need. We chat, and I listen to them and let them vent, and at the end I ask her, "Are you sure?" And I guide her because there is no more to be done, you have to guide her. As a Catholic I orient her and I make her see things, and at the end, well, the decision is hers. "Think about it," I tell them. "Think about it, this baby can pass you a glass of water." [That is, when the baby (child) has grown a bit, he or she can be a helper to the mother.] I raise consciousness. Look, I have trained myself for this. First, you take the mifepristone pill, and 24 hours later you give them the four misoprostol pills, which are applied between the cheeks and gums. Later I give them a sweetened tea if the blood pressure goes down, or in the case of nausea. It is a special tea, and with that I wait one or two hours. Then the bleeding starts. If she wants to go home, she can, or if she wants to stay she also can, but they usually want to go home, so then after the treatment and its remedies I make follow-up calls until I am sure that everything is fine.

I do an ultrasound and find out about the weeks of gestation so that I feel calm. It doesn't matter if they come accompanied or not—I don't ask for that. I will help a woman as long as she brings me her ultrasound, so that her life and health are not endangered. As you can see, there are lots of ectopic pregnancies now. No drug will be effective in those cases because it is not a normal pregnancy. If the ultrasound looks okay and

the pregnancy hasn't advanced beyond the time specified by the protocol, I support her, and I don't feel bad about it because I feel that I am helping the woman out.

In Socorro's account, more modern elements were brought than in the earlier narratives. For example, she uses the ultrasound to determine the weeks of gestation and the condition of the pregnancy. Still, this midwife also combined different remedies that are adopted from homeopathy, such as the use of herbs. Again, the procedure of accompanying the women is emphasized, including the work of raising consciousness about the abortion and emotional support. She also respects the decision of the women to proceed with abortion although it was against Socorro's own religious beliefs. The midwife even emphasizes her conviction that "I don't feel bad because I feel that I am helping a woman out."

GERTRUDIS (ZONE B): Here [the women] have come, but I attend only those who are a month or so pregnant, that is my limit. I don't [induce abortion] if the pregnancy is more advanced, because it might get serious or something. I feel them and this way, I identify the stage [of pregnancy]. From two months onward you already feel [something], and at one month you feel almost nothing. In the cases that I have attended, I used a drug and a chamomile tea with cinnamon and *mirlo* (an herb). It helps to reduce the pain. The drug is misoprostol. I apply one dose, and then the next day four more in the gums. Later they come back so that I know that it all went well, and that they didn't have any infections.

By comparing Gertrudis's narrative to the previous ones, we see that each midwife has her own protocols in terms of the time of gestation beyond which she will not interrupt the pregnancy. For Gertrudis, that time is four weeks.

ANGELINA (ZONE B): We use herbs. I give them a tea only if they suffer from a short delay, in which case I also massage their belly with a warm balm. In fact, it's the one I have just here: look, I prepare this balm, the warmer the better, and then you leave it with a piece of cotton on the belly. This has worked for me. But when [the pregnancy] is further along than six or eight weeks, I won't do it any more. The use of herbs … I do it when it is a delay of days or couple of weeks. The thing is that this remedy does not work for all women after 15 days. In those cases, the drug is used. There are more women, who prefer taking [the pills] home, and I call them to know if there was bleeding or how many sanitary pads they use. They send me pictures. Then, after the procedure, I check them, paying attention to everything, including their lips to see if there is dehydration. After the interruption an intravenous is started. If the woman is more than 15 days pregnant, I suggest that they take some yellow body [hormone] injections. I figure that this has really helped, in addition to folic acid. The yellow

body shots help to strengthen the uterus. But from there onwards I go on reorienting them, telling them that if they don't want to get pregnant again, they have to take care of themselves. For that reason, there are injections, pills, and the device [intrauterine device]. I start telling them about family planning. Look, each time that these cases happen I ask the women's partners to come, to raise their consciousness, at least so that they see all that's involved here.

In Angelina's account, we again see that the traditional and modern medicinal knowledges are combined, not only in terms of the drug used to interrupt the pregnancy, but also in the use of yellow body shots (which are injectable, hormonal solutions composed of synthetic progesterone and applied to women with hormonal deficiencies), folic acid, etc. Although Angelina does not mention using ultrasound, she tends to check her patients for each treatment, asking for follow-up photographs and phone calls during the bleeding. The particularly noteworthy point of this narrative is the importance of making the partner aware of what the woman faces during the abortion process.

There are also cases in which the midwife bases her procedures upon the date of last menstruation—a basis recommended by international studies as a reliable one for determining the safety of an induced abortion (Raymond and Bracken 2015).

MARGARITA (ZONE B): Well, for example, they trained us to have the first pill taken (mifepristone)—aha, to take that one, and then 24 hours later misoprostol in each cheek, and two more misoprostol 12 hours later. [The pregnant women] tell me their last date of menstruation. For example, a person comes and she says, "Hey, the 25th was my last bleeding." From the 25th I see how many, it was three days—the 28th—so from the 28th I count seven days more, so I calculate the dates, and can see how many weeks pregnant she is.

Viene gente de todo tipo*: The women who seek midwives*

We asked the midwives about the reasons for which the pregnant women had decided to seek them for an induced abortion. We were also interested in the social profile of those women.

DOÑA LUZ (ZONE A): You have to think about the mistreated women, you have to help, you have to wonder why sometimes these women are sad when they come in, and then I ask them about what is happening. They say, "My husband got drunk and didn't bring any money but hit me instead … And he wants me to continue having kids?" The majority are young women, between 18 and 20 years old. Some are 25. There are many ways in which these women connect with me. They tell me … for example, the one that came last night sent me a girl who said, "Listen,

they told me that you do pregnancy tests." "Yes," I said. "And how do you do it?" she asked. I replied, "No, look, in here I do the test and charge 25 pesos." "Ah, sounds good, I will let my friend know." The girl left, and at night the other one came alone. They start chatting, and well, they are embarrassed because she cannot have it for different reasons. The majority are single: there are persons with money as you say, with resources, including well-established families, but the reason is the same, because this is anonymous, so they are seeking to interrupt their pregnancy. Mostly they are from the ranches, humble people, but also all kinds of women.

In this account, Doña Luz emphasizes the phenomenon of spousal abuse in terms of the women who seek her for pregnancy interruption. She also brings up economic problems. Domestic violence and economic conditions are usually related. She suggests that there are cases in which the women do not wish to give any explanations for interrupting pregnancy. It is also noteworthy that Doña Luz indicates that it is never easy for these women to come asking for an abortion. She confirms that women come to her from all economic strata—a fact that she attributes to the discretion with which she operates.

ROSARIO (ZONE A): Some women come alone, but they are the girls who study. The rest, because they are married, come because they don't want to have more kids. Others do want to [carry their pregnancies to full term], but the fetus is not complete, and for that reason they want an interruption.

Rosario mentions congenital malformations, which can be a legal justification for abortion in Chiapas.

JOSEFINA (ZONE B): They come and tell me what is going on with them. They tell me, "Look Doña Josefita, I come like this and I need you to do me a favor to help me. I tried to be careful not to get pregnant, but it's been some time since I've had my period." This is what they tell me from the beginning. Sometimes, when the girl is dispirited, the man speaks, and tells me, "Doña, we just came to ask you a favor, to see my wife because we weren't careful and she got pregnant. To be honest, it was not planned, and what we want is to abort." (That's the way people here say it—they don't say interruption, just abortion.) "This is what we want, how can you help?" Just like that: directly. They are not ashamed; they just come and talk to me and tell me that they want to have a chat. So, then I know, and we concentrate on talking about their stories. Many come without money—how should I say it?—they don't have anything. You can see right away when a person doesn't have money. Sometimes, too, there are people with money, but I don't really care, I attend them all the same. I don't like telling them that because they have money, give me so and

so … But I tell you, it is impressive to see people who arrive in their cars [because that means they have money].

The case of Josefina in particular shows the relationship that the men, too, establish with the midwife, usually as a result of a confidence that she has already earned—for example, when she attended the births of the couple's children. Because of that relationship, the men will openly solicit an induced abortion for their partners. Also, in this case, the midwife receives clients from all social strata: "It is impressive to see people who arrive in their cars." In other words, these discourses show the high level of confidence that these midwives enjoy in their contexts.

To summarize, the interviewed midwives in Zone A have attended women from different socio-economic conditions, although women from humble conditions may dominate. Some of the pregnant women feel ashamed when they arrive, but others are rather direct in expressing their needs, perhaps because of the trust established in previous dealings with the midwife. As we will see, results from Zone B were similar.

SOCORRO (ZONE B): They come here, all of them—all kinds of women. They come alone or accompanied, with their moms or grandmothers. Some come with an uncle, or a partner, or husband, all kinds. Formal couples, students, people with resources and people without, including people who can go to or pay for a gynecologist, but they come to me. Look, there are couples so poor that I cannot charge them. Most are young people, although usually when I attend young people it's for family planning.

It seems that most of the women who come to Socorro arrive accompanied, not alone. She notes the presence of young people—as well as people from a range of economic strata—among those who come to her.

ANGELINA (ZONE B): They come shy and timid, like nervous or ashamed, and so I notice that and when I say, "Hey, good morning, how are you, come in, and you go on talking between you and me, don't worry. What do you need?" It is there and then that things start to work out. But what is typical for my case (*lo mío es*) is … for example, I told you that they had sent me a message in which a girl asked me and said, "Hi, good morning, Doña Ange, I wanted to know if you are going to be at home because I have a friend who has a problem, the one that you helped me with on the other occasion, and she wants to know if you can help."

In general, they are young women between 16 and 20 years old. In a very few cases the women are more than 36 years old. There have also been cases in which men came alone, asking for drugs for their partners. And women come alone, so that not even their partners know. When women come alone whose partners don't even know, that is when I support them the most because the women don't even want the partners to know who

gave them the treatment. For this reason, the women don't say much either. Many of the women who come alone, and who don't want their partners to know, tell me that their partners have other women. Although those men want to have the baby, imagine what kind of life the baby would have.

In Angelina's story, the nervousness and timidity of the women seeking her help are emphasized, just as it was in the narratives presented earlier. Most of the women appear to be relatively young, and the midwife works to establish ties of confidentiality with them. This confidentiality can be also perceived in the way in which the women who had previously been attended by the midwife continue to recommend her services to friends, even to the point of making appointments for them through phone calls and messaging. In Angelina's story, men are also mentioned as seeking interruption of pregnancy, although Angelina also brings up cases of women arriving alone because of problems with partners. The cases in which the male requests to be present are a double-edged sword: he may be important in supporting his wife, but may also make decisions that are his wife's to make, rather than his.

LUPITA (ZONE A): There are cases in which those who seek me are just high school girls, between 18 and 19 years old. They come to talk about their problems; they say that they know I am a midwife; that they would like to chat with me, but in secret. I tell them to come in; I tell them my name, and they tell me theirs. Then, as they come to trust me, they start telling me that unfortunately they didn't take care of themselves, and now they are four or five weeks pregnant, but they cannot proceed: that their parents don't know, or mainly that they don't want to interrupt their studies. So they want to interrupt [the pregnancy]. They always come with an adult, such as an uncle, an aunt, sometimes the partner, but when they come, we talk to them. Sometimes we persuade them to have [the babies], but well, our conscience does not allow it, because they already decided not to have it, and because we also know that [by going along with their decision to have the baby, we would be] interrupting their studies. How are they going to maintain their kids? So all that, or thinking, "Where will [the girls] go, who is going to do [the abortion if we don't], are they going to do it well?" So, there are many things [to consider].

For Lupita, most cases of induced abortion involve very young students, who establish a relation of trust with their midwife that takes the form of mutual respect for the decision to interrupt the pregnancy while guaranteeing that the procedure is done safely. The midwife clearly values the empathetic touch of her service in enabling the girls to search for the best options in their lives.

MARGARITA (ZONE B): Well, some start to tell me, with much shame that they have not menstruated for a month or a month and a half. Others are

20 days pregnant, or 15. I tell them about the results of the pregnancy test, and if it is a pregnancy, if the test is positive. Then they start telling me that they don't want to have it. They start mentioning some reason, and that they don't want it, because they already have many kids. Some women just don't want to. Well, here in my home I have had the chance to see girls who are 12 or 13 years old. We give them more consideration because of their age, but they should come even if their period is only days late, because that is also dangerous. Or they come because they have a boyfriend, and don't want their parents to know. In those cases, I ask them to come back with an adult.

Margarita makes particular mention of pregnant minors. The midwife is apparently touched by these girls because they are confronting the situation of interrupting a pregnancy. She also considers it important that they be accompanied by an adult, and after only a short gestation time to avoid putting their health at risk.

Without the midwives, who helps?

In its recent report, the UN Population Fund (Fondo de Población de las Naciones Unidas 2015) mentions that there is a considerable deficit of midwives, particularly in developing countries such as Mexico. Therefore, these countries should be promoting the expansion of midwifery—especially of trained midwives, who have contributed to improving women's sexual and reproductive health (including safe abortions).

In this last section, we present the thoughts of the interviewed midwives regarding what might happen if they could not offer their service of inducing abortions.

ISABEL (ZONE A): The health center tells us that we should not do things that affect us, but I think that because they [in the health center] are not concerned with listening to the women—the women come to us. I have received training in the health center. One doctor, who is nice (*buena gente*), always advises us, "Don't do pregnancy interruptions, just do your own work. That is, your massages and oils, and you will be fine. Charge for your work because life is hard now, and you are getting tired and never get anything." I understand what she says, the doctor, because she presents her life as an example. She is a doctor and she continues to train herself.

But the thing is that there is a lot of difference between a doctor and a midwife. That is what I think, but I have never told her. It's never going to be the same: the doctor has money, s/he is prepared and learns what s/he knows, like the doctor who trains us. Thanks to her, I have also learned a lot, even more than from the health center. She gives us two hours of her day each month, and I feel that it is a sacrifice because she doesn't

> charge us anything, not even for the room. We have already been working 16 years with her, and although she supports us greatly there always will be a difference. We don't charge money, but when one attends to a person, this person … they remain grateful because sometimes they don't have the money. I don't charge a lot, or little, but a moderate amount. But when I attend people, who don't have [the means to pay], I attend them anyway, because afterwards this person feels grateful and later will bring me a little bit of bread, or a coffee, and that is my payment.

As explained above by Isabel, the positions of the doctor and midwife are asymmetric in many ways. The asymmetries endure despite the collaboration and relationships of mutual trust and help. In this case, one person (the doctor) is positioned in the legitimation of a knowledge and profession, and the other one is established within a particular communal social stratus. At the same time both of them pertain to the same space of care. As a consequence, while there certainly is a level of sorority between the two, there is also a power game between the hegemonic medical control and the traditional midwifery model.

DOÑA LUZ (ZONE A): What I have seen here in my community is that a doctor from a health center said in one of the training sessions, "All of you midwives, when a woman seeks to interrupt a pregnancy, send her to me, send them here to the health center." So I started to ask why, and I said to a social worker, "What happened, Lupita? Why is the doctor saying that the women who don't want their babies must be referred [to the health center]? Are they doing an investigation, and that is the reason why they want the women to be sent there?" The social worker replied, "[It is] because, you see Doña Luz, it is in there where the interruption is managed." And I asked, "For free?" "Ah no! It has a cost." "Oh yes?" I responded. So I think that they ask us to send people there to be attended by private doctors.

As illustrated by Doña Luz, above, the practice of pregnancy interruption involves a level of lucrative competition between private doctors and midwives, even though both operate in the same clandestine environment and run the same legal risk. However, given the subordinate position of the traditional midwives, they cannot declare openly that they interrupt pregnancies, but they attend the unwanted pregnancies anyway.

JOSEFINA (ZONE A): Well, I think that if other midwives don't give this kind of help, it might be because they don't care about the poverty or the needs of the people, or because they don't feel sorry about the other people's lives, perhaps, even though in many cases we know about their suffering.

Josefina points out that, for her, the midwifery practice, including induced abortion, stems from concepts such as empathy (putting oneself in the place of another) and ethics (as a value based on easing other people's suffering). Thus, for her, these should form part of the work to be carried out.

SOCORRO (ZONE B): In fact, if there is someone else, who is from the community and is not a midwife, then he is a communitarian health promoter. He has had cases, so I have then supported his training and given him the drugs because he is from a community that is quite far away. He has known me for six years, and his community is like seven hours from here. He sought me like three or four times, and has spoken to me about the problems lived out by women in his community, and how it is so far away. So [the women] cannot come to see me, and as he is the promoter, he is worried. So, I decided to support him and offer him all that he needed.

Based on Socorro's testimony, it seems clear that when there are no midwives there is hardly anyone to help, except the community health promoters—people from the community who have received training from the Secretary of Health to perform some basic healthcare tasks in rural communities with difficult access to health centers. The inadequacies of healthcare in rural communities may underline the importance of traditional midwives in those communities, and particularly as part of the sorority among women regarding issues of health.

LUPITA (ZONE B): There are many things that can happen to a woman without the help of the midwives. For example, if the women are students, they have to interrupt their studies. If they go on taking drugs that are not suitable, they can die. It wouldn't be possible to avoid deaths, many things, mainly money because lots of people take advantage of the girls' situation and charge them. Some of these poor girls become indebted.

As Lupita makes clear, economic issues continue to be a key issue in midwifery practice. In fact, the midwifery practice here serves as a means of avoiding other medieval conditions that persist in rural Mexico in violation of women's sexual and reproductive rights, which are guaranteed by Articles 1 and 4 of the Mexican Constitution.

ROSARIO (ZONE A): I think we have the responsibility to help because midwifery is a gift and talent given to you.

In very few words, Rosario makes clear that trained traditional midwives are a sector willing and able to carry out safe, drug-induced abortions. In the long term, these midwives can help in reducing maternal mortality in contexts of high vulnerability, such as the two regions of Chiapas explored in this study.

Suffice it to say that these rural regions are similar to many others in Mexico and Latin America. Although this research has given some guidelines, it should be continued.

Conclusions: Midwives as human capital in rural regions

Traditional midwives have a series of characteristics that enable them to be sisters with other women, outside their communities as well as within. The sisterhood forms, especially, through the generation of ties of empathy that arise naturally while attending women who seek and undergo safe abortions. Relations of solidarity and secrecy among the women are fostered by several factors: geographical closeness, availability of time, a common mother tongue and the oral and bodily language of the midwives (among others) toward the women who seek the midwives.

Thus, when abortion is finally decriminalized throughout Mexico, these midwives will need to be made visible and acknowledged for their contribution in saving women's lives. As shown by this chapter, abortions induced via drugs have been carried out correctly, safely, confidentially and considerately by the interviewed traditional midwives.

Still, certain conditions are necessary in order for safe abortions to be truly possible. Not all of these conditions are linked directly to midwifery. First, abortion should be legalized nationwide. As shown by Singh et al. (2018), legalization on a national level significantly reduces the number of abortions that are unsafe—unsafe, that is, for the woman who seeks to interrupt her pregnancy, as well as for those who perform the procedure—in this case, the traditional midwives. Obviously, the legalization of abortion should be accompanied by the liberalization of sales for the required medicines (e.g. mifepristone and misoprostol), as recommended by the WHO.

We also agree with Juárez et al. (2019), who argue that it is indispensable to continue research on the pregnancy interruptions carried out by midwives, in order to evaluate their training and access to medicines. Such research can make the midwives' interventions safer while also helping to demystify several outdated ideas about midwifery that still prevail in society and within academia.

It is also essential to allow midwives to receive training openly—without having to hide their participation in that training from authorities—about the use of drugs for safe abortions according to the WHO (2015) recommendations. In this way, more options will be made available for women (marginalized or not) who wish to have safe, consistent interruptions of pregnancy.

As previously mentioned in this chapter, various scholars acknowledge the role of midwives in attending safe abortions in developing countries.[2] These studies have highlighted the importance of midwifery practice, including voluntary interruption of a pregnancy, as an integral form of care that has contributed to reducing maternal mortality in contexts of high social diversity

and inequality—contexts that frequently have direct consequences for health. In other words, the women most affected are those who live in places of high marginalization and vulnerability, which is the case for Chiapas and Mexico.

Here we strongly suggest the re-valuing of traditional midwives in the official healthcare system as an effective and culturally safe first level of attention, without discriminating against them based on the type of training they received. In addition, cases with complications should be handled without stigmatization and re-criminalization of the attending midwives' practices, provided these are carried out under safety protocols. Asymmetric power plays (of the hegemonic medical system against midwifery practice) should have no place in the handling of such cases.

There is much to learn from the midwives we interviewed: about the quality of their care in the rural context of Chiapas; their ancestral knowledges synchronized with new medical information; and their sorority/sisterhood with other women. As suggested by Oppong-Darko et al. (2017) in the case of rural midwives in Africa, support networks among midwives and women in rural regions should not be hindered by laws or religions. Contrary to the vision provided by Sousa et al. (2010) and Juárez et al. (2019) of women's knowledge as frozen in time, we perceive, in consonance with Castañeda et al. (2003), that many traditional midwives are skillful, diligent innovators who combine different sets of skills to improve the sexual and reproductive health of women in rural, poor and Indigenous regions where health services are deficient, inaccessible, too costly or entirely lacking.

In the case of Mexico, the door may open to innovative possibilities for safe, non-hegemonic forms of contributing to the sexual and reproductive health of women, which, as noted by Juárez et al. (2019), should be considered within the nation's health policies. In addition, openness to innovative possibilities may include reviving the sisterly alliances between women and their claim for autonomy within the health sector, based on free, voluntary, accompanied, dignified and safe abortion without being determined by privileged geopolitical, social, economic or ethnic conditions. This would also include, of course, the acknowledgment of other knowledges provided by traditional healers, including midwives.

Notes

1 This chapter is partially based upon the following dissertation: Benitez, G. 2019. *Parteras tradicionales e interrupción del embarazo con medicamentos en dos regiones de Chiapas. Una contribución a la salud de las mujeres.* MA dissertation. San Cristóbal de las Casas, Chiapas: UNACH.

2 The objective of this chapter is not to outline the history of midwifery in Mexico. We suggest consulting the other chapters of this book. In addition, we suggest consulting the extensive literature by authors such as Ana María Carrillo, Hilga Argüello, Georgina Sánchez, Graciela Freyermuth, Ana Cristina Rosado and Florinda Riker.

3 See, for example, Fawole-Adeniran, Adeyanju, Aremu et al. (2012); WHO (2012); Shah, Ahman and Ortayli (2014); Barnard, Caron, Min and Thoai (2015); Holcombe, Aster and Amsale (2015); Aniteye, O'Brien and Mayhew (2016); Cleeve, Byamugisha, Gemzell-Danielsson et al. (2016); Oppong-Darko, Amponsa-Achiano and Darj (2017); Fullerton et al. (2018); Johnson, Maksutova, Boobekova, et al. (2018); Singh et al. (2018).

4 This refers to medical supplies received by the midwives to carry out assisted, safe abortion by a non-governmental organization Chiapas. These supplies include the drugs misoprostol and mifepristone, pregnancy tests, painkillers, sanitary pads and the application guide backed by the WHO.

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5 Postcolonial midwifery

Midwives, territories and human rights in development[1]

Hanna Laako

Introduction

In recent decades, there has been an increasing debate over the entrance of the issue of human rights into development discourse (Cornwall and Nyamu-Musembi 2004; Spivak 2004; Cornwall and Molyneux 2006; Uvin 2007; Lettinga and Van Troost 2014; Gabay 2015[2]). Some authors argue that its entrance has benefited non-governmental activism, participation and the accountability of development projects, which, thanks to this new focus, now place more emphasis on the obligations of donors than on charity. Simultaneously, however, there have been critical accounts about the potential neoliberal project behind such transformation, including aspects of new colonization combined with a fear that human rights will inevitably lose their political edge and become co-opted empty slogans. Postcolonial scholarship in particular has viewed human rights as a problematic Western or Eurocentric intervention lacking legitimacy among the masses in the Global South.

However, some postcolonial perspectives differ in how they conceptualize human rights in the Global South. For example, Grovogui (2006) argues that it is Eurocentric to consider human rights only as a European invention, when claims to different kinds of human rights have historically been and currently are made at local and regional levels in different parts of the developing world. Several authors have analyzed how local claims concerning human rights have become globally visible, such as Indigenous rights in Latin America (Brysk 2000, 2013; Speed 2008; Engle 2010). Others have demonstrated how many global human rights are being vernacularized at local levels to achieve political change (Levitt and Merry 2009).

Ackerly (2008) argues that feminists have for a long time shown how human rights can be thought of as local, universal *and* contested terrains. She maintains that human rights can be a critical tool of micro-political forces and used against oppression by revealing previously hidden wrongdoings (see also Spivak 2004). A focus on human rights issues can imply an attempt to make the invisible visible.

This chapter builds on this timely debate by analyzing a to-date less explored case related to the fields of development and human rights: the

Latin American mobilization for the humanization of birth and against obstetric violence, which is fundamentally linked to the defense of midwifery in these regions and most especially in Mexico. This campaign is radical in many senses: by insisting on honoring the reproductive rights of women in the Global South, it challenges some dominant, core perceptions of reproductive rights in childbirth in development by arguing that the clinical-medical view, which has been focused merely on access to medical services as the main component of ensuring reproductive rights, does not necessarily safeguard the rights of women but, in fact, may jeopardize these rights by exposing women to obstetric violence.

The campaign for the humanization of birth and against obstetric violence, as shown in this chapter, is tied to particular criticisms of development and historically complicated links between demographic policies and reproductive rights in Latin America (see also Chapters 1, 2 and 3). The latter implies that, although activisms against the predominant biomedical techno-births, among others, can be found globally, there are elements in this Latin American campaign that are distinct, for example, to North America.

As was already discussed in Chapter 2 of this book, this mobilization is intimately linked to the defense of midwifery. Midwives, who until now have mostly been the underdogs of the official medical systems in Latin America in general and Mexico in particular, have emerged not only to defend their vocation and to improve the situation of midwifery in their countries, but also to speak for the reproductive rights of women. Many of these midwives may be considered as part of the more global movement for human rights in childbirth. By challenging the dominating perceptions of reproductive rights, this campaign might achieve a shift in development policies to favor midwives (UNFPA 2014).

Internationally, a midwife is defined as a government-recognized professional. According to the International Confederation of Midwives, and as endorsed by the World Health Organization (WHO):

> A midwife is a person who, having been regularly admitted to a midwifery educational program that is duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> (ICM 2011)

As noted in the Introduction to this book, this international definition of the midwife has caused much trouble in Global South and Indigenous territories, since most midwives fall outside this "academic" category. In many Latin American countries, midwifery is not licensed, leaving even some professional midwives outside this official definition. Second, to recap from Chapters 1 and 2, midwifery training differs considerably from medical training, as the midwifery body of knowledge—while it does overlap with

obstetric knowledge—is (or should be) much more focused on facilitating the normal physiology of birth.

Additionally, much midwifery knowledge is based on empirical and apprenticeship learning, especially in the case of the so-called traditional and Indigenous midwives, most of whom who do not meet the international definition. Most professional midwives who do meet the international definition are trained in university-based programs legally recognized in their jurisdictions. This leaves most empirically trained midwives outside legal recognition and protection. Historically, their different philosophy and form of caring based on empirical hands-on knowledge and community service for women have been under attack, as this particular vocation is positioned in a highly contested international terrain. Contestations also divide midwifery itself between academic- and empirical-favoring approaches. Traditional midwives, who still constitute possibly the majority of midwives in the world, are coded by the International Confederation of Midwives (ICM), WHO and other international development agencies as "traditional birth attendants" (TBAs). They generally do not qualify as professional midwives as they are empirically trained: they have gained their knowledge as apprentices, through dreams or simply as family heritage (Sarelin 2014a). In the case of Latin America, as elsewhere, TBAs include Indigenous midwives who are embedded in Indigenous communities and cultures, and are recognized in their own communities as midwives. Due to this divided and divisive international midwifery context, this age-old vocation has become deeply politicized.

The mobilization for human rights in childbirth globally and for the humanization of birth and against obstetric violence in Latin America can be perceived as a "transnational advocacy network," as described by Keck and Sikkink (2000). These authors define a transnational advocacy network as consisting of actors and activists (who may include members of social movements and non-governmental organizations) who work transnationally toward a particular set of goals, are united by shared values and a common discourse and who share information and services extensively. These authors note that activists in the networks not only seek to influence formal politics but also to transform the terms and nature of the debate within the nation-states and international organizations. According to these authors, transnational advocacy campaigns have been particularly successful when focused on topics related to human rights, nature, women and the health of children and Indigenous peoples.

For this chapter, I have relied on multiple sources and the results of my ethnographic fieldwork as described in Chapter 2. This chapter is structured as follows. I first look at the general developments related to reproductive health and rights, explaining what I mean by the dominant clinical perception of reproductive rights and noting a shift toward benefiting professional midwives at the expense of traditional midwives. In addition to bringing up the dominant "right to access to medical care" approach of reproductive rights,

I briefly discuss the origins of reproductive health policies in coercive population control.

Next I trace the origins and development of global human rights in the childbirth campaign and its Latin American counterpart, the campaign for the humanization of birth and against obstetric violence. I discuss the nascent human rights discourse within these campaigns. Finally, as in other chapters, I provide two *herstories*: the narratives of two autonomous midwives in Mexico who recount their experiences in rural, Indigenous Mexico, which illustrate both their links to broader Latin American mobilizations in terms of humanized birth and midwifery, and complex postcolonial relations and rights in terms of traditional, Indigenous midwiferies. I then retake the postcolonial approach to discuss and deepen the viewpoints of Indigenous and Native midwives at global levels with particular emphasis on Indigenous territories and motherlands. I also touch on the ethnic tensions within midwifery.

In conclusion, I touch on the situation of traditional/Indigenous midwives, who might challenge reproductive rights discourse with their focus on Indigenous rights. Thus, by using the term "postcolonial midwifery" in this chapter, I shed light on the complex, situated relations and rights among women in the Global South and Indigenous territories—in this case, from the perspective of autonomous midwives in the midst of Indigeneity in Mexico. I conclude by outlining some important pending issues for further postcolonial analysis of midwiferies.

Human rights in development, women's rights in childbirth: What about the women in the Global South?

Reproductive rights can be considered part of the newer generation of rights. In human rights literature, political and civil rights are usually considered the first generation of human rights, whereas the second generation focuses on rights related to equality. The third generation of human rights is more involved with identity and "soft laws"—laws that are passed to defend particular principles, such as women's rights to be free from obstetric violence, yet are rarely enforced (Kuokkanen 2012). Generally, statements about reproductive rights are not binding and are among the most disputed rights at national and global levels. These politicized issues include abortion, birth control, freedom from coerced sterilization, protection from female genital mutilation and access to good-quality healthcare, family planning and education on sexually transmitted infections. Various chapters in this book have made reference to these politicized rights in terms of midwifery, as well.

During the 1990s, reproductive rights became closely engaged with women's rights (Cornwall and Nyamu-Musembi 2004; Cornwall and Molyneux 2006). They were especially bound to the global campaign on making violence against women visible, bringing on to the agenda issues such as sex trafficking and rape as a tool in wars. According to Keck and Sikkink (2000),

the campaign raising the issue of violence against women developed one of the most successful transnational advocacy networks, not only in terms of including women's rights in the human rights agenda but also in uniting disparate groups of women from the Global North and Global South in a global women's movement, as exemplified and enacted in the international conferences held by the organization Women Deliver. Indeed, these authors note that the campaign raising the issue of violence against women consisted in part of a series of international conferences that enabled agenda setting and networking (among others, Cairo 1994 and Beijing 1995). Since this 1990s "gender mainstreaming," however, the issues of reproductive rights and women's rights have stagnated as a result of stronger political divides related to political and ideological struggles (Cornwall and Molyneux 2006).

Reproductive rights' origin in reproductive health has been closely linked to development policies, particularly to issues of population control (Hartmann 1999, see also Chapters 3 and 4). Initially, reproductive health policies were characterized by top-down approaches and the lack of a human rights perspective, particularly in many family-planning programs, which increasingly became subjected to women's health activists' criticism, especially during the 1984 United Nations (UN) World Population Conference in Mexico City (Hartmann 1999; Keck and Sikkink 2000).

In fact, given this background, characterized by coercive population control methods, for many women in the Global South, Indigenous women and for people of color in the Global North, "reproductive rights" as a continuation of earlier reproductive health policies in population control appear dubious. As noted in Chapter 2, instead of reproductive rights, scholars of color prefer the term "reproductive justice," which implies taking into account these previous coercive population control methods, including forced sterilizations (Luna 2009; Craven 2010). The proponents of the reproductive justice frame argue that, while reproductive rights have been won for affluent, middle-class White women, simultaneously those same rights have been diminished for women of color and women from lower-resource countries. Thus the particular cultural and ethnic contexts and differences play an important role in the interpretation of reproductive rights, often downplayed by Western feminists. According to some reproductive justice activists of color in the USA, the reproductive justice framework emerged in 1994 with the objective of bringing together notions of reproductive rights and social justice. As an intersectional theory, it highlights the lived experience of reproductive oppression in communities of color and expands the narrower focus on legal access and individual choice to a broader analysis of racial, economic, cultural and structural constraints.

In this sense, the tensions involved in reproductive rights issues are not only related to the increasing emergence of Islam on the global stage and to a growing degree of religious orthodoxy and conservative ideologies, as often argued by scholars in defense of reproductive rights, but also to the

very concrete and historical experiences of reproductive politics in action in different locations of the world and among different populations (Cornwall and Molyneux 2006).

One of the cornerstones of reproductive rights is maternal health and childbirth. The integration of a human rights approach into the sphere of development and reproductive health in terms of maternal health is a significant achievement in itself. The UN adopted improved maternal health as part of the Millennium Development Goals, viewing it in terms of sustainable development and gender equality in order to diminish maternal mortality (Ban Ki-moon 2010; Sarelin 2014a).

However, despite the advance of integrating maternal health into development agendas as a priority, a clinical, Western view continues to dominate: it is generally understood that, in order to diminish maternal mortality and to improve maternal health in low-resource countries, these countries must be provided with "improved," Western-style medical systems (Rosenfeld and Maine 1985; Sarelin 2014a). The dominating perception is that the problem with Global South or Indigenous territories is that women do not have sufficient *access* to clinics and hospitals or, for one reason or another, do not go to them in emergencies. Therefore development policies on maternal health continue to emphasize methods of transport to clinics and hospitals to give birth, or other means of increasing access to clinics and hospitals. Additionally, there has been a strong focus on providing finances to improve obstetrics and high-technology sub-specialties to tackle emergency situations in maternal health.

While it goes without saying that having access to quality care is an important human right, this dominant clinical view of reproductive rights in maternal health contains some key problems. First, the pending "problem" continues to be to get women to these clinics and hospitals. Indeed, there seems to be a neglected issue as to *why* many women in developing countries, even when possible, will not attend clinics and hospitals but might consult their community "TBA" instead. This, again, enters into the arena of reproductive justice: many women feel they receive bad, even abusive, treatment in these facilities. There are also indications at local levels that the politics of prioritizing hospitalization in childbirth has created a situation of facility saturation, causing poor-quality service or a lack of service, resulting not only in increased use of cesarean sections but also in increased maternal mortality (Penwell 2010; Freyermuth, cited in López 2013; see also the Introduction of this book).

Another dominant clinical approach to maternal health and reproductive rights has been the displacement of "TBAs." In the case of Mexico, this principally refers to Indigenous midwives. Argüello and Mateo (2014) extensively explore international politics dealing with birth attendants, especially traditional ones. They note that it is not until fairly recently in human history that births have become considered pathological rather than natural, meaning that births have been transferred from women's traditional care into the sphere

of Western biomedicine. This has often entailed the disqualification of traditional midwifery, since that type of midwifery care has been characterized by the empirical understanding of births in a natural physiologic manner, in contrast to the medical view of birth, which emphasizes risks. This second, problematic aspect of the dominant, clinical perception of reproductive rights can be understood as the right of women to qualified medical care, and even more so as to "enable" women in the Global South to have the same right to obstetric care in pregnancy and birth as in Western countries (Rosenfeld and Maine 1985; Sarelin 2014a).

Until the 1990s, according to Argüello and Mateo (2014), global politics on maternal and child care, especially after the declaration of Alma Ata (1978), took into account the need for all resources to be used to safeguard maternal and infant health, especially in developing countries. This politics tried to integrate traditional midwives in maternal care by capacitating them as a source for health services in remote areas. However, since the 1990s, international organizations have shifted their discourse to favor a similar type of development to that found in Europe and the USA. This has benefited the Western-style medicalization of birth, medical practice as a profession and the requirement for university education. What this implies, argue Argüello and Mateo, is a conflict between traditional midwives and the official healthcare system, in which Indigenous and rural women face a Western, masculine medical specialty that many of these women reject for various reasons; among them are racism and obstetric violence, massive overuse of technological interventions and non-consensual sterilization or obligatory contraceptive methods such as the unconsented placement of intrauterine devices (IUDs).

Yet, in the past few decades, a key shift has taken place in terms of international politics in maternal health: now there is a stronger preference for births being attended by professionals called "skilled birth attendants" (SBAs). This new focus implies, first, that traditional midwives, who lack official certification, as previously explained, are definitely excluded from the official maternity care system. Second, and in contrast, this international political decision has started to benefit professional midwives (UNFPA 2014). International organizations such as the WHO and the UN calculated several years ago that they need at least 350,000 more SBAs, mostly qualified professional midwives, in the Global South in order to diminish maternal mortality (ibid.). This call for SBAs constituted a significant turning point for the world's midwifery organizations, particularly in the Americas, where midwifery had been largely eliminated with the rise of the modern biomedical system. (To contrast, consult for example, Chapter 1; Marland and Rafferty 1997; Davis-Floyd and Johnson 2006: 32–38).This call might imply that, in the course of time, midwifery will come back from its positioning as an underdog of the official healthcare system. However, this also implies a potential, growing tension within and between the so-called skilled, professionalized midwives and the traditional, empirical midwives, not only because the traditional midwives feel threatened but also because the essence of midwifery has long been so strongly

based on empirical knowledge, not academic qualifications. Nevertheless, as Sarelin (2014a) notes, professional midwives have often joined doctors and obstetric teams in the attempt to eliminate traditional midwifery to gain professional recognition for themselves.

Righting wrongs: The humanization of birth and obstetric violence

The global mobilization for human rights in childbirth is intimately bound to the complex and subtle problematics of reproductive rights in maternal health that radically critique the dominant clinical/pathological or technocratic (Davis-Floyd 2001, 2018a) view. For decades now, global midwifery organizations and midwifery activists have tried to challenge this view by exposing the problems related to this technocratic paradigm, whose practitioners intrude on women's bodies and self-determination and cause increased risks via over-intervening in births. The late birth activist Sheila Kitzinger (2006) has noted that women who are distressed after birth use the same language as survivors of rape—e.g. "I was violated." Within medical anthropology, there is now a long tradition linked to studies of birth, reproductive life and midwifery, which have shown the problematics of the Western pathological understanding of birth as the dominant authoritative knowledge system—although, as Davis-Floyd (2003) has been careful to show, many women buy into that system and feel safer under technocratic care. These studies have also explained midwives' empirical knowledge on women's health and how the philosophy of this practice strongly differs from that of medical care (Rothman 1989, Kitzinger 2006, Jordan 1993, Davis-Floyd and Sargent 1997; Davis-Floyd 2018b). This literature constitutes a serious critique of the Western biomedical system and a revaluation of birth knowledge systems emerging from the Global South.

However, frequently the movement has been at odds with classic Western feminists, who have promoted the dominant, clinical view of reproductive rights because they intensely dislike being " 'essentialized" to their reproductive functions (see Craven 2010). As mentioned in Chapter 2, in the case of North America, the mobilization for midwifery and human rights in childbirth has shifted toward a discourse on consumer rights and midwifery as a "choice" for women, which has enabled women from different political backgrounds (meaning left- and right-leaning) to unite in the struggle. However, framing the struggle in terms of "consumer rights" presents the problem of excluding women from lower socio-economic backgrounds, which is why activists of color prefer the previously mentioned reproductive justice frame.

Nevertheless, currently this global mobilization has expanded and articulated itself rather from the viewpoint of human rights in childbirth, which combines midwifery activism with reproductive rights in maternal health. Sarelin (2014b) demonstrates that women now are using human rights as legal and political tools to demand change in childbirth. According to Sarelin (2014b), viewing childbirth mainly as an issue of access to healthcare

is changing and subject to a new set of questions: who decides how a baby is born? Who chooses where birth takes place? Who bears the ultimate responsibility for the outcome of a birth? What are the legal rights of birthing women? What are the responsibilities of the caregivers—doctors, midwives, nurses and other attendants? What are the rights and interests of the unborn and how do we protect them during childbirth without subsuming the needs of the mother to the perceived needs of the child? Sarelin (2014b) argues that the global human rights in childbirth movement: (1) seeks a system in which women own their own births; (2) demands women-centered care instead of practitioner-centered care, which usually implies prioritizing midwifery care; and (3) demands that women be respected as decision makers in birth.

There are numerous associations, organizations and actors involved in this mobilization. For example, the global organization Human Rights in Childbirth (HRiC) was established in 2012.[3] HRiC notes on its website that every day it receives reports of rights violations related to birth around the globe. The organization is compiling these stories to raise awareness of the routine nature of obstetric violence against women at birth. According to HRiC, a woman does not lose her fundamental human rights when she becomes pregnant, including the right to informed consent, the right to refuse medical treatment, the right to evidence-based healthcare, the right to equal treatment, the right to privacy and the right to life. HRiC has detailed eight forms of violence in childbirth, including physical abuse, disrespect, non-confidential care, non-consensual care, misinformed care, depersonalized care, discriminatory care and abandonment of care.

Two networks have a special emphasis on midwifery. One, Sisters in Chains, is a network that exists to secure the human rights of all mothers.[4] However, it has a special focus on supporting persecuted midwives, doctors and families. This organization also seeks to support mothers and families who have chosen a different type of care or assistant in birth (for example, a midwife) and are variously sanctioned or judged by persons or entities for choosing this option. The second, the White Ribbon Alliance (WRA), unites citizens to demand the right to safe birth with a local, community focus. While this alliance is less radical in its approach to the dominant, clinical view, it does campaign for the promotion of midwifery. Its members view midwifery care as a path to safe childbirth, which requires, among other things, a change in the public perception of midwives, and improvements in their working conditions and training. The WRA also campaigns for respectful maternal care, zeroing in on the mistreatment suffered by many pregnant women and birthing women, and noting that "Evidence is now emerging that this fear of being badly treated and abused in health facilities is holding women back from seeking help. It is proving to be as big a deterrent as cost of care and transport."[5]

In Latin America, the mobilization for human rights in childbirth has been organized around two concepts: the humanization of birth and obstetric violence. One of the driving forces has been the Latin American and Caribbean Network for the Humanization of Birth (*Red Latinoaméricana y del Caribe*

para la Humanización del Parto y el Nacimiento: RELACAHUPAN).[6] It is an alliance composed of national networks, groups and people seeking to humanize and to improve human rights in childbirth, and includes members from five Caribbean countries, four Mesoamerican countries, 10 Latin American countries and Spain, as well as Hispanics in the USA. It was formed as a result of the First International Congress on the Humanization of Birth in Brazil in 2000.[7] This congress was attended by almost 2000 people, including midwives, doulas, humanistic obstetricians, doctors and gynecologists, and also by many public health and development professionals, as well as lactation consultants, childbirth educators, nurses and others seeking to exchange information as part of what later emerged as the continental campaign for the humanization of birth. The Congress stated in its declaration that the notion of the "humanization of birth" is intended to form "the center and base for development in a sustainable society nascent in the 21st century." Brazil continues to form the focus of this mobilization, in part because in Brazil the movement also stems from within official agencies like the Ministry of Health, as some key proponents of the movement have positions there (Georges and Davis-Floyd 2018).

As the humanization of birth and obstetric violence are notions related to this Latin American mobilization, their definitions are subject to debate. The educational midwifery association Nueve Lunas in Oaxaca, Mexico, defines humanized birth in its informational portfolio as follows:

> A nonviolent pregnancy and birth attendance practice … ensures respect for fundamental rights, reproductive and sexual rights for women, couples and babies … reduces perinatal complications, maternal mortality and costs of medical assistance. A "humanized birth" [*parto humanizado*, humanized delivery, referring to the birthing woman] refers to a model that takes into account explicitly and directly the opinions, necessities and emotional values of women and their families in the processes of attention during pregnancy, birth and puerperium; having as a fundamental aim that they are living a special moment and pleasurable lived experience in the conditions of human dignity where woman is the subject and protagonist of her own birth, acknowledging the right to freedom of women and couples to take decisions about where, how and with whom to give birth in the most poignant moments of their life. The term "humanized birth" [*nacimiento humanizado*, being born in humanized manner, referring to the newborn] opens more elements, giving an important weight to the impact that this attention has on the newborn and its future development, considering its necessities to receive alimentation and affect immediately at birth, in a loving and nonviolent context.[8]

Again, the opposite of humanized birth is considered to be "obstetric violence." The Information Group on Chosen Reproduction in Mexico (*El Grupo*

de Información en Reproducción Elegida: GIRE (2013)) defines obstetric violence in the following way:

> Obstetric violence is a specific form of violation of human rights and reproductive rights of women, including rights to equality, non-discrimination, information, integrity, health and reproductive autonomy. It is generated in the contexts of healthcare services in maternal care in pregnancy, birth and puerperium—public or private—and it is a product of a multi-factor framework in which institutional violence and gendered violence converge. During institutional attention to birth, the violation of human rights and women's reproductive rights goes from scolds, jokes, derisions, irony, insults, threats, humiliation, manipulation of information and rejection of treatment without referring to other services to receive suitable care, postponement of urgent medical care, indifference to requests or complaints, no consulting or informing about decisions to be made during birth, to use a birthing woman as a didactic resource without respect to her human dignity, the management of pain during birth as a punishment and coercion to obtain "consent," to different forms in which it is possible to verify deliberate damage caused to the health of the affected person, or falling into violating more seriously her rights.[9]

The campaign for the humanization of birth and against obstetric violence shows how the issues involved in women's rights are contested terrain in Latin America. The campaign is radical in the sense of questioning the dominant clinical vision of reproductive rights in the Global South. As previously noted, the very existence of the humanization of birth movement highlights the ways in which the medical approach to reproductive rights (getting women into medical institutions) may actually jeopardize the reproductive rights of women in low-to-middle-income countries because of the obstetric violence they experience there.

Nevertheless, the terms "humanization of birth" and "obstetric violence" are also subject to debate within the movement itself. Some midwives in my study argued that the humanization of birth might be co-opted by the biomedical system, as have many other similar terms before, meaning that a humanized birth could simply come to mean "a nicely painted room" without any significant transformation in the violence-generating obstetric system (see also Davis-Floyd 2001). Such co-option would render the term "humanization" an empty signifier. Thus, in her delineation of "the technocratic, humanistic, and holistic paradigms of health and birth care," Davis-Floyd (2001, 2018a) is careful to distinguish between "superficial humanism"—the nicely painted room—and "deep humanism"—in which the deep physiology of birth is honored and facilitated and the woman is the protagonist of her birth. Other midwives argued that the term "obstetric violence" is too radical and might jeopardize political collaboration between midwives and doctors,

as "nobody wants to be labeled inhumane." These midwives expressed a fear that medical establishments might not receive emergency transport from midwives because of this labeling, which might make their personnel feel "criminalized."

In the following, two autonomous midwives in Mexico narrate their *herstories* in rural and Indigenous contexts in the country, and their complex relations to these women's rights and mobilizations, particularly in terms of humanized birth and obstetric violence.

Herstory 1: Rural autonomous midwifery in Chiapas

In the outskirts of the highland city of San Cristóbal de las Casas, Chiapas, lies a small town founded by persons who had been expelled from their homes in the radically Catholic municipality of San Juan Chamula, which has driven out many of its original inhabitants due to religious conflicts. The expelled population has established its own communities, most of them around San Cristóbal de las Casas, but others further away, near the Lacandon rainforest, which is nowadays composed of various Indigenous communities. The particular rural town that we will discuss here is tiny, with approximately 680 habitants. The illiteracy rate is around 23%; 15% of the adult population speaks an Indigenous language. What in the old days used to be a Spanish plantation (*finca*) is now divided into small, individually owned parcels for agriculture. The town also consists of some organic ranches established by previously urban, middle-class folks who seek alternative lifestyles in the rural sphere.

One such person is Beti Flores, who together with her husband bought land and created an organic farm on it in 2011. Since then, they have carried out various projects related to sustainable agriculture. Beti is also a midwife. Originally from an entrepreneurial family in Mexico City, she first graduated from a visual arts program, and then studied to become a pilot. However, her life changed radically with the birth of her first child in Cancun, attended at home by an autonomous midwife. During her first pregnancy, Beti and her husband visited various hospitals but felt that this way of birthing was violent. Eventually, Beti and her husband opted for a homebirth. As her first daughter was born, Beti started to wonder why there were no more humane options for birth in Mexico, such as those she had heard and read about in France and the Netherlands. At this point, she was familiar with authors such as Michel Odent, Fréderick Leboyer, Ina May Gaskin and Barbara Harper. Later, while moving to San Cristóbal de las Casas, she began to ponder the possibility of becoming such a midwife herself. She considered that, to achieve her goal, she needed—and wanted—to combine two different axes in her formation. First, she became involved in working as an emergency medical technician (paramedic) for the Mexican Red Cross in Chiapas. This path, Beti told me, enabled her to learn the medical aspect of births, which turned out to be revealing as she experienced many emergencies and high-risk births,

which she attended and transported to hospitals. She also learned how the hospitals worked when receiving these emergency cases, and observed how most Indigenous women were treated when they finally reached the hospital:

> I wanted to learn the medical side of being a midwife, but I did it from the very beginning with a critical eye, observing how they taught everyone to get comfortable for the delivery, always placing women on their backs for the comfort of the doctor … How it was always "best" to cut the episiotomy. When you admit a patient into emergency, you cannot criticize or suggest anything, especially if you prefer the transition to be gentle for the patient. Yet, I always told the husbands of the Indigenous women not to sign anything without knowing what it was that they were signing because frequently they are asked to sign documents in Spanish that they cannot read, and so they do not know what they are authorizing. Again, I have also seen cases in which I do consider hospitals necessary: there are emergencies that really require hospitals. In this sense, my work as a midwife and as a medical assistant has turned out to be complementary. When you have a real emergency on your hands, you cannot romanticize. However, I also think that we should always begin with the less violent option, and trust more in the bodies of women and the wisdom of women.

Secondly, she complemented her increasing medical knowledge with midwifery by involving herself as an apprentice in a midwifery center in San Cristóbal de las Casas. There she was trained by a midwife with focus on homeopathic remedies and the importance of accompanying women in their births. Thus, she attended an increasing number of homebirths in the Chiapanecan highlands' city. This is how she worked until moving to the rural town in 2012, where she now lives and works, attending mainly women from the community. Thus, she now defines herself as a "rural autonomous midwife":

> You have to have a particularly strong character to be a rural midwife. Well, imagine that an unknown man knocks on your door in the wee hours, gets you out of your marital bed, you leave your kids with your husband (sometimes you take the smallest child with you) and drive away with this unknown man to deliver his wife's baby. You walk around in communities at night all alone. Sometimes they offer you a community policeman to accompany you home safely. But not everybody is up to doing this kind of job. I have occasionally been afraid, and I am not a fearful person. Recently I went to attend a delivery in another community while my newborn baby was at home, waiting for her milk. I left the community at night, but then my car wouldn't pull up a hill halfway home, and there was also another hill behind me that I could not pull up either. I was locked in between. I tried many times, and then got scared that I couldn't get home and I would have to stay there in the middle of the

> woods the rest of the night. But finally I managed to continue. … Here in the community, they ask me for all sorts of things, not just births. Once they called me from my neighbor because their one-year old baby died. I couldn't do anything; from afar I could see that he was already dead. But for the family's sake I tried unsuccessfully to revive him. I then tried to hand him over to the family, but nobody would take him. Finally the grandmother took him. All night long we heard the mother scream in her house. I felt hopeless; I felt a complete lack of tools to manage the situation emotionally.

In 2013, Beti established a civil association in order to improve the quality of birth attention in the rural areas of Chiapas. Now she is a mother of three, all born at home. However, she has not been keen to take part in the organizational efforts of the Mexican Midwifery Association at national level, as she is not sure it would bring benefits to Mexican rural areas:

> I consider my case as different. I identify myself as a rural autonomous midwife, and I am interested in training rural midwives. Perhaps now the Mexican Midwifery Association is dedicating its efforts to certification, regulation and legalization of midwifery, but from a more urban perspective. The situation here in rural areas is different. What I see here are the traditional, Indigenous midwives, many of whom have already received medical training. They go on administering injections irresponsibly at any time, and this is not okay. Or the young urban-trained nurses come from the great Mexican cities to do their social service in order to qualify themselves without understanding anything about the context they are in. They demand gynecological examinations without respecting women's opinions, and punish the women with "misses" [rejected or missed treatment] so that the women don't receive the economic incentives that are contingent upon undergoing these examinations. This is serious because urban-trained nurses don't understand what 50 pesos means to a rural family … I am afraid that the regulation of midwifery in Mexico could make my work here more difficult, not easier. I mean, at present we rural midwives have a decent amount of autonomy to exercise our vocation, but I don't know what will happen if we achieve certification and regulation. What rules will be imposed then? In reality, will this obstruct or help our work? I'm taking into account that there already exist divisions and a worsening of midwifery in the country during the past decade because the health sector has generated division within traditional midwifery as well. I understand that in the urban areas the situation is different, and the effort the Association is making in terms of birthing centers is praiseworthy.

Beti also observed an emergence of a new generation of midwives, born from the current, violent Mexican birthing culture and rupture among traditional

and non-traditional midwives but also, therefore, tied to anti-systemic mobilization and human rights:

> There is a new generation of midwives in Mexico. I think we could call them autonomous midwives. I believe that the new kind of midwife has been born from the rupture among traditional and non-traditional midwifery, although both are also in crossroads. These are midwives who from the beginning have been involved in some sort of resistance to the dominant culture, I mean, they don't allow themselves to be put down. This is definitely a common thread. We are not many, perhaps 50 or so at the national level. The autonomous midwife is usually conscious of the problem of obstetric violence. She is educated. She is inclined towards homeopathy, herbs, acupuncture; in other words, holistic medicine or a holistic perspective in the way she practices midwifery. I think the autonomous midwife is linked to anti-systemic movements. We are anti-mainstream, anti-monopoly, perhaps some are even anti-government. I sometimes joke that we are the hipster-organic-alternative-conceptual midwives. But we are not many, and I would say that most of us are urban.

Beti perceives that the emergence of the new generation of midwives in Mexico, particularly the autonomous generation, has an important link to the movement for natural births or the homebirth movement worldwide:

> Talking about this distinct stream of midwives in Mexico, I think the pioneer was Naolí [Vinaver], a midwife who influenced many of us emerging autonomous midwives who sought her in Veracruz. Later emerged others, like Cristina in Chiapas thereabouts in 2005, who really made a great mobilizing effort. Of course, Sabrina in Tulum, originally from Switzerland, she forms part of the Mayan midwives who try to collaborate with the health sector there while maintaining an empirical and holistic perspective to midwifery. And then of course, Guadalupe the Educator, who did a great job in the creation of the Mexican Midwifery Association.

According to Beti, the path of the new generation of midwives in Mexico has been influenced by literature and the global mobilization for more natural births, such as the authors she mentioned as having influenced her. In Beti's view, midwives in Mexico started to realize that what was more broadly promoted as "humanized birth" was something that they had already been enacting in their philosophy, practice and model of attention. Thus, the link between humanized birth and midwives started to strengthen:

> Well, the books of Leboyer, Odent, etc., and their discourse on humanized birth found an echo among the midwives. Later others appeared, such as the midwife Ina May Gaskin, who paid attention to violence in

> hospitalized or institutionalized births; I mean, a version of what we call obstetric violence today. After that, in the 1970s and 1980s, there was Barbara Harper, who was really anti-systemic and spoke of homebirths in the sense of taking informed decisions about what you want for your birth. The hospitals' monopoly started to get criticized. And then, we started to get information about the positioning of other midwives in other countries, such as Holland, where they were respected, or in Britain.

However, Beti also points out that the emergence of the new generation of midwives in the country is also a result of the Mexican context, particularly in relation to the ruptures and the relationships that have worsened since 2000, and are fundamentally related to the situation of traditional midwifery:

> In general it is perceived that there is this division between traditional midwives and the non-traditional. However, it is especially since the year 2000 that there is a worsening of traditional midwifery caused by the health sector, which resulted in the introduction of the use of oxytocin, the spread of all kinds of knowledges in a completely confused manner, I mean, they introduce a little bit of this and a little bit of that, there is a loss of tradition and balance … And more and more restrictions. In my opinion this has resulted in a tremendous rupture among different midwives. There are the autonomous ones, the traditional ones, the young technical ones … There is a lot of debate over what it is to be a midwife and over what functions a midwife is supposed to perform.

In addition, Beti notes that the division among traditional and professional midwives is more complicated than might appear at first glance. She recounts several regional tendencies, especially in the case of the state of Veracruz, where the health sector has been certifying traditional midwives in order to diminish maternal mortality:

> Well, we went there, to Veracruz, to take the exam for being traditional midwives. The requirement was to have Mexican nationality and to have concluded secondary school. Foreigners could not take the exam for traditional midwifery. It was very interesting to see what kind of midwives were being certified there as the "new traditional midwife": these were women who graduated from high school, some with some kind of further studies, who seemed to attend suburban births, there, in Veracruz. They were mainly semi-urban or suburban *mestiza* women, middle-class or lower-middle-class. They are now certified as traditional midwives. Imagine that those kinds of midwives are autonomous or traditional in Mexico too! Who knows how many these sort of independent midwives there are in the urban suburbs. I have seen how this happens: someone simply hangs a sign on her door that says "I attend births," or you just know that "that neighbor lady" attends births, and you can knock on the

> door and receive service. I think there are no statistics on this, about how many births in Mexico are attended this way, and whether this sort of midwifery is autonomous, traditional, or what.

At the end of our conservation, Beti also acknowledged the debate within and outside Mexican midwifery on the problem of costs, in terms of professional and autonomous midwifery services versus those of the traditionals:

> Why are they not asking this same question about the highly educated doctors and obstetricians who charge high fees? Why shouldn't a highly educated midwife—who assumes the responsibility of two lives and puts herself at personal risk without legal protection—charge whatever she likes? Then again, I think there still is some nobility in this profession. When a woman comes to you and says that she wants to birth at home and can only pay a certain amount, of course we offer our services. In my community, I have been paid in installments, but also in goods and work … Once I received a turkey! … However, it is an ongoing issue, sometimes complicated. It has also happened to me the other way around, that the family I attended had come to an agreement with me about payment, but after the birth they have not paid all that was agreed. Their baby is healthy and was born just as they wanted; I gave them my time, my attention and knowledge … So, the negotiation over costs and prices is complicated. But what I can say is that it is still a beautiful and gratifying profession. To have become a midwife is one of the most beautiful things that have happened to me. I am grateful and proud to be a Mexican midwife and to be able to honor the herbalist traditions of my family as well as the capabilities I have achieved through formal studies to do this work.

Herstory 2: Autonomous "midwifery in tradition" in Oaxaca

Araceli Gil is a midwife whom I met in a café in Oaxaca City. She is the co-founder of the association *Nueve Lunas*, and of the midwifery program at the Centro de Iniciación a la Partería. She is a specialist in homebirths, is qualified as a therapist and has studied alternative medicine and medical plants. She has also taken part in various educative projects on midwifery, human rights and sexual and reproductive rights. Oaxaca, like its neighboring states in southern Mexico, has a high percentage of Indigenous and marginalized residents. According to Galante and Gil (2005), an Indigenous woman's risk of mortality during pregnancy, birth or the puerperium is almost three times higher than that of a non-Indigenous woman. By comparison, a US or Canadian woman's risk of dying during pregnancy and birth is 1 for each 3700. In Latin America and the Caribbean, the figure is 1 for each 130. Thus, Galante and Gil (2005), both of whom are midwives, emphasize that the repercussions of maternity for health and life are profoundly connected with women's situation

and power. Those repercussions have to do with cultural and gender barriers as well as socio-economic, religious and political factors. On the other hand, Galante and Gil (2005) have argued that Indigenous midwives are the "heirs of the pre-Hispanic medical woman, the protectors of health, the ones who know the secrets." They are usually favored by Indigenous women themselves because the women can then birth at home, speak the same language as the midwives, share the same culture and receive warm treatment and affection, even if these midwives have a limited capacity to intervene when severe obstetric complications arise. In this sense, traditional midwives fulfill an important role in the reproductive lives of women in communities, as acknowledged by community members.

However, many of the traditional midwives now practicing in Oaxaca are of an advanced age, and younger women have difficulties accessing a more structured formation that would allow midwifery to have a status as a profession and source of employment. Providing that formation is precisely what the association *Nueve Lunas* is attempting to do by focusing especially upon *midwifery in tradition (partería en tradición)*. Indeed, this is where our conversation begins, as Araceli explains in depth the objectives of the association in generating and strengthening what they call midwifery in tradition:

> What is midwifery in tradition? It means that we take the traditions as a point of departure instead of basing ourselves strictly upon the professional-academic. The traditional here refers to the Indigenous, fundamentally, as we are in Oaxaca. Traditional Indigenous midwifery has its foundation in oral tradition, so that is obviously one of the key elements of midwifery in tradition. Evidently we cannot be traditional in the essentialist way because we are not from that context, I am not an Indigenous. So, it is not a cultural definition but is rather based on rituals, the way of honoring the mentors, all the traditional Indigenous midwives in Mexico, who are our foundation. We don't seek academic acknowledgment that much, so, in that sense, it is not the academic aspect that we would be looking for. *Midwifery in tradition* is not limited to Mexico or Oaxaca; in reality, it is a type of movement as well that originates from a Brazilian–Argentinian line in which we search for the roots of traditional Indigenous midwifery instead of forming ourselves as mere academic midwives. In any case, I also understand that we are at the same time in this movement of defining ourselves from the roots, as an organic movement of self-definition. And we form part of the networks of midwifery in tradition schools. We have defined the "midwife in tradition" as the guardian of the millennial knowledges and practices of Native midwives. This way, the midwife in tradition seeks to create a connection and integration of the ancient and the modern, between the science (knowledge and tactics), the art (combination of creativity, intuition and criteria), the tradition (cultural rituals and ancestral knowledges of laws and

natural elements) and the spirituality (the sacred moment of transformation and access to other dimensions).

The midwife in tradition is an autonomous practitioner who has been trained by experienced midwives and provides care during pregnancy and birth, postpartum and breastfeeding as well as during all the cycles of the life of a woman. Her craft and intuition as well as her knowledge of culture and environment enable her to create a unique and intimate relationship with each woman, couple and baby, considering birth as a ceremony and a sacred event, both natural and physiological. The midwife in tradition is in connection with the spiritual guides of the ancestors, bringing to the present the memory of the wisdom in her daily practice. She has talents according to the region she is from, and she integrates in her practice a compound of healing methods of different sciences, believing in the universality of knowledges. She also knows and practices the sacred rituals to work with energy and spirituality in the births and in her life.

The association *Nueve Lunas*, founded in 2004 in Oaxaca, is dedicated to the formation/training of midwives with an intercultural profile (see also Gallegos 2019) and to promoting homebirths and humanized births. The organization also seeks to strengthen knowledge and information about reproductive health and rights. One objective of *Nueve Lunas* is to foster the cultural adaptation of midwifery, attending births and safe maternity. Additionally, the association seeks to recognize and reconsider traditional Indigenous midwifery as ancestral wisdom, capable of encompassing the needs of the complete human while returning birthing to its familiar, intimate and sacred sphere. Thus, the association has four lines of work: first, care during pregnancy, birth and postpartum; second, coordination of the midwifery training program (currently supported by the Oaxacan state); third, promotion of humanization of birth in the frame of sexual and reproductive rights; and finally, promotion of professional midwifery in Mexico. According to Araceli, the traditional and professional midwifery models are somewhat in conflict with each other at present, given that professional qualifications could invade or diminish the existence of the former model:

I think we should not have to choose between one and the other or to promote these kinds of divisions. I do not agree with the rigid regulation that would create a model excluding many [midwives]. This is the risk of regularization—it means reduction. *Midwifery in tradition* seeks to respect the foundations of all midwifery and the roots of Indigenous midwifery. The reduction must not end up destroying this broad spectrum of midwives. I understand that the Mexican Midwifery Association doesn't want to be defined from the outside; this is one of the most important battles. Many of us fall in between these old definitions: We are not traditional

> midwives, but midwives who work outside hospitals and who do not want outside regulation. The AMP (*Asociación Mexicana de Partería*: Mexican Midwifery Association] is calling for the formation of an association to represent the whole of midwifery in Mexico, and this is an historical precedent. So it must protect all the Mexican midwifery, taking into account that the majority are traditional midwives. Thus, its first objective is protection and defense. It is assumed that after that comes the regulation. This is complicated because of the tendency to leave the traditional midwives outside of the regulations, and then the government and international organizations promote just the academic formation of midwives. This breaks down the dialogue. The example of other countries shows that [by favoring professional midwifery] the usual path of regulation can cause other types of midwifery to die out. I see that the AMP risks falling into a merely elitist vision.

Araceli tells me that she has participated previously in the presidential board of the AMP, but withdrew due to differences over the process of creating regulation:

> The definition of midwife is problematic, it is a challenge. The key question is: where is the Mexican midwifery? I am searching for an inclusive definition that would extend beyond the technical, for one that would include spirituality, ancestrality, integral growth … And yes, a kind of leadership. The definition of midwife definitely includes leadership in terms of being an individual and being part of the community: she is the wise one of her community. She is the root and the pillar with connections to ancestors.

Yet for Araceli the question of leadership goes beyond how this concept is understood in the Western world. Her definition is founded in the community:

> The midwife grows with her women in each birth. She works with her own persona, her character; she works with her ego and humility to be at the service of the community. This kind of leadership requires spiritual growth, heritage and personal work. The midwife needs to be humble and communitarian. It implies a great acceptance of what life can give you. It is this type of emotional maturity that the traditional midwives have had. They have a lot of strength. I believe this is something that represents traditional midwifery in many parts of the world where it still exists, and it is precisely what is absent in the professional midwifery in the hospitals. There, in the institutional environment, you cannot develop this part. The professionalization would seem to reduce and eradicate this part of emotional maturity. For this reason I think that institutionalized midwives cannot help to end obstetric violence.

Continuing on the topic of humanization and obstetric violence, Araceli analyzed these concepts as strategies for dealing with the issue of human rights in childbirth, particularly in the Mexican context:

> The humanized birth and obstetric violence … They are a strategy to speak about human rights in childbirth and to open the topic of midwifery in Mexico. However, these concepts also have their risks: by qualifying everything as "humanized," that term becomes a slogan, and a very badly understood slogan. In this sense, I think that the concept of humanized birth did not work well because it was introduced to show how the woman is stripped of all her value in institutionalized births. But it should have been deepened. I think that to talk about human rights in childbirth is better, above all reproductive rights, because it is much more specific. I do think that to speak of rights in childbirth should be the feminist line of action in Mexico because so far we haven't even looked at what is happening in the births. It is also very distinct from issues of abortion.

According to Araceli, in countries such as Spain mothers have undertaken important movements to promote rights in childbirth. However, in Mexico, this mobilization has been very different, in addition to the fact that the situation is unfavorable:

> The Mexican context [is] very bad, in my opinion. During the past ten years, traditional midwives have been disappearing. In rural, Indigenous Mexico, perhaps for the past decade the traditional midwives have stopped attending births. The current policies do not encourage training and popular support. [The government] obligates the women to have [medical] prenatal consultations in which fear is instilled. Women's economic incentives are taken away [if they use traditional midwives], they have to go to clinics and hospitals to birth; there is no collaboration between midwives and doctors … This has major consequences: the social fabric of communities has been eroded. I mean, it is not only that the traditional Indigenous midwives are out of a job, but that the whole community and its fabric are affected.

Araceli has a certain perspective on this situation because she and the *Nueve Lunas* personnel worked in communities in Oaxaca 20 years before the association was established:

> We worked hard before the creation of the association. In the communities we asked: what do you want to do with midwifery? A hundred midwives responded: First, we want to improve [the care that we give]. Secondly, we want a midwifery school, and thirdly, we want our craft to be acknowledged and to receive sufficient pay for our work. This

> is the basis on which we established our association. We always try to do our job in line with traditional midwifery; we consider ourselves as their apprentices. For this reason it is important not to lose the original definition.

She also observed that, in recent years, there is a growing interest in midwifery, even a trend:

> This interest in attending births comes from various places. One aspect is the kind of New Age tendency that is inclined towards natural births. I think that this branch of action has to do with the escape from obstetric violence, the desire for something different, the wish for alternative health systems, another form of birthing and being born. On the other hand, we also have the women's rights. There is the dissatisfaction that has resulted in many women wanting to be midwives and doulas. There are also assistants from the sector of health, who ask, "How can we help the women?" And then there are the nurses who have rediscovered midwifery, I mean, there is a group of doctors and nurses who have formed specialized groups that seek to humanize themselves. They seek different paths; there are lots of workshops taking place … although we might also ask how deep this transformation is. I believe that in order to become a midwife you need to go through an interior transformation; the midwife is a companion of the birthing woman. She knows how to leave the leading role to the woman who is giving birth.

Indeed, for Araceli, being a midwife is profoundly political, particularly in terms of women's rights:

> Yes, it is political to be a midwife in the sense of women's rights. It involves acknowledging that childbirth has not been considered from the viewpoint of rights. The traditional midwife, of course, has always been political in the sense that she as a midwife is born from the community, and she works for the community. In the urban context, it refers to childbirth rights, which have not been taken care of. Here you have to distinguish between two things: the labor of the birthing woman, and the birth of the baby. The childbirth rights refer to the woman. The birth rights refer to the baby to be born.

Araceli is from Mexico City, but has lived in Oaxaca for more than a decade. Since 1992 she has worked in various civil organizations, particularly those in defense of women's rights. She was also strongly influenced by the Mexican Indigenous movement Zapatismo. She came to Oaxaca in search of learning how to better support women, which led her to the path of midwifery after serving as a therapist. She met the Italian midwife Cristina Galante in Oaxaca, and with her, she discovered birth as a moment in which women

show their true power. She considers that all her life trajectories have brought her toward midwifery. She believes that she became a midwife in the moment in which she realized that pregnancy, birth and the postpartum are transcendental in women's lives as unique, natural and sacred moments. Thus, Araceli says, she enjoys studying how health is a fabric woven of emotional, spiritual and bodily threads. She believes that it is necessary that Mexico value and recognize its own midwifery, although that recognition comes with varying implications:

> Obviously, because midwifery—and traditional midwifery in particular—seems to be something exotic, we receive many messages and people from abroad. Sometimes the traditional midwives are bored; they don't want to transmit their knowledges if the transmission is in only one direction. There should be a model of exchange that would not only imply giving wisdom; this is not transmission. We are trying to perceive ourselves as bridges and filters. We cannot give recipes; rather, we seek to transmit millennial knowledges, of maturity, a kind of leveling out.

Toward postcolonial midwifery: Bringing births back home in Indigenous territories

Above, the two autonomous midwives—Beti and Araceli—narrated their paths to Mexican midwifery in rural and Indigenous contexts. They clearly perceived that their self-identification as an "autonomous midwife" had to with being positioned between the professional and traditional (rural or Indigenous) as an important element of Mexican midwifery, and in "bringing back" a more holistic, community-based midwifery to their motherlands. They also discussed the ways in which contemporary Mexican midwifery had to do with women's rights in childbirth, and its links to humanized birth and obstetric violence—albeit not without contradictions.

They also clearly reconnected contemporary Mexican midwifery to other vocational and reproductive rights as challenges, such as the professional situation of traditional/Indigenous midwives in their rural territories, and reproductive rights of rural or Indigenous women in terms of (potentially unconsented/coerced) birth control application and sterilization, (the lack of) good-quality healthcare, and so on, all of which were also mentioned at the beginning of this chapter as part of contemporary politicized women's rights.

They both also subtly addressed something that I find important to revisit here: midwifery as part of women's *political-societal role* in general, in this case, particularly embedded in territoriality as builders of nations, autonomy and communal leadership. The two midwives pointed to a sort of community-related emotional maturity and autonomous positioning that was not possible, or desirable, to develop in urban, Western contexts, particularly in hospital facilities and hierarchies. These are all aspects that I found also when

exploring midwifery literatures in postcolonial perspective, which will be addressed in this section of the chapter.

Katsi Cook, a midwife and Mohawk activist from Canada, has described the importance of recovering midwifery among Native American peoples as part of their struggles for sovereignty:

> Well, I'd connect with what you said: I am writing my autobiography. I should explain that I'm not writing it with the intention of writing just about myself, but because I want to write something that will be useful in the training of a new generation of aboriginal midwives.
>
> (Cook 2006, 2)

> And so, this conference in '77 focused on the question of sovereignty. What did it mean to be sovereign? Because we started saying nation-this and nation-that, and sovereign-this and sovereign-that, without really thinking about what we were. We had a general idea of what we were talking about, but there we got specific. John Mohawk laid out five areas of sovereignty, which have to do with control of land; control of our language and psycho-religious life; control of jurisdiction on our land; control of our education; and—the part that got me—the control of production and reproduction. That's where midwifery—women's health, health, and well-being of communities—comes from: that aspect of our sovereignty.
>
> (Cook 2006, 8)

> That's why, in womanist, feminist movements, you'll see that difference between Native Americans and other Americans, that we bear the burden of knowing that our people barely made it through the colonial period and that our use of controlling our reproductive power—we need to be aware that there's a lot of ways you can lose your people, and it isn't just a matter of what birth control method you're going to use or not use. … And so, those are the concerns that our people have about any discussion that revolves around that aspect of our sovereignty that we would call production and reproduction.
>
> (Cook 2006, 20)

Interviewed in 2005 by historian Joyce Follet, Cook (2006) recounts her family roots from her Indigenous activism in the 1970s, to giving birth to her own children, and, later, to her entrance into midwifery, which has fluctuated between biomedical training and traditional learning. According to Cook, the practice of midwifery is a process of safeguarding cultural integrity, and is also a way to achieve environmental justice by empowering women and valuing their knowledge. In the interview with Follet, she recounts how she became deeply affected by Native women's lack of knowledge about reproduction in

general, and about native traditions of childbirth. She identified this loss of self-knowledge and cultural modes as a consequence of colonization. This awareness, along with community concern about the sterilization of women, led Katsi to call for childbirth on the land as fundamental to the survival of Native communities, and as a process of empowerment through which Native women could revitalize Indigenous cultures and strengthen the connections of Native peoples with their ancestral lands.

In addition to her midwifery practice, Cook became involved in many other projects, such as the Mothers' Milk Project of the Mohawk mothers, which in 1983 monitored the environmental impact of industrial development on breastmilk. The project has been cited as an example of emerging reproductive rights activism that expands from the usual Western-oriented focus upon abortion and adoption toward a broader social justice agenda. Thus, the situated reading of reproductive rights and development, particularly in terms of Indigenous women and those from the Global South, brings our attention to the ways in which autonomous midwifery, homebirths and Native midwifery have territorial implications and importance. Such reading inevitably uncovers the tensions among different types of midwives; however, it also unlocks the multiple ways in which different midwives have collaborated and contributed to each other along the lines of the theory of Keck and Sikkink (2000). Indeed, these two seemingly opposed aspects are not mutually exclusive.

As explained above, various authors have explored how modern medicine and obstetrics have increasingly prevailed in non-Western parts of the world as well, replacing Indigenous knowledge systems and transferring women about to give birth from their homes to clinics and hospitals in order to diminish maternal mortality (Jordan 1993; Sarelin 2014a). In this process, as Jordan (1993, 133) has noted, Indigenous systems and knowledges become symbols of superstition—the opposite of the modern, progressive and "scientific" ways. In the current development tendency that favors professional midwives, traditional, empirical and Indigenous midwives have been frequently reduced into mere "helpers" who provide a link between birthing women and the biomedical system when these midwives are forced to transfer their clients to a medical facility. This system of exclusion has been explored, for example, by Sarelin (2014a) in the case of Malawi; by Pigg (1997) in the case of Nepal; and by Kadetz (2014) in the case of the Philippines. Indeed, Kadetz argues that, curiously enough—and despite extensive postcolonial critiques of development—the biomedical model has remained largely protected from postcolonial criticism, as if it were situated outside the fields of culture and ethnocentrism—although the ongoing elimination of Indigenous midwives and their replacement by professional biomedical attendants in the name of "maternal safety" are fundamentally Western-based. Such exclusion is not new. According to Kadetz (2014), the roots of replacement can be traced back at least as far as the beginning of the 20th century in China, where the

objective of training professional midwives was to set traditional midwives aside, similar to the findings of Carrillo (1999) in the case of Mexico (see Chapter 1).

Such processes have not gone unnoticed amongst Indigenous peoples. The activist midwife Betty-Anne Daviss (1997) has described the process of returning births home in the Inuit communities in Canada. According to her, in the 1980s, while working in Povungnituk (now called Puvirnituq), Northern Quebec, the elderly people in the community took notice when she told them that the empirical/autonomous White midwives in Southern Canada were in the process of "bringing births back home," and that this process was being legalized. According to Daviss (1997), this news prompted the community to reflect upon what had happened to the births in their own communities, as since the 1960s they had accepted the Canadian government's forced evacuation of pregnant Inuit women to give birth in Montreal hospitals, separated from their families, communities and midwives, so that the pregnant women could have access to the "privilege" of having a hospital birth under the control of White doctors. Over the next three decades, the elimination of their own biocultural birth system became a political, personal and community axis of the Native peoples in Northern Canada. The Puvirnituq community managed to "re-matriate" birth by hiring a White autonomous homebirth midwife, Jennifer Stonier, to train Inuit midwives, who then practiced in a local maternity center and have since trained others. This model has become so successful that it has now extended to the entire Nunavik region, as other communities have created their own maternities staffed by local professionally trained midwives. These communities' ability to re-establish control over their childbirth culture—Daviss (1997, 443) argues—is a good indicator of community strength and of the importance to the Inuit of giving birth in their own communities and on their own land. As Epoo et al. (in press) show, despite the fact that the Nunavik maternities have no cesarean capacity and women in need of cesareans must be flown out, their outcome statistics are excellent and on a par with those of the entire nation of Canada.

Other authors such as Tabobondung et al. (2014) consider the defense and reconstruction of Indigenous midwifery to be an expression of sovereignty of their Indigenous nations. These authors are part of groups of Native women who, over the last few decades, have sought the reconstruction of their own midwifery systems, as Indigenous peoples with their own knowledge. For them, Native midwives are fundamentally builders of their nations.

Dorothy Green, a midwife of the Mohawk Nation and member of the National Aboriginal Council of Midwives in Canada (NACM), mentioned at the Third Annual Forum of the Mexican Midwifery Association, held in Mexico City in November 2015, that there were 87 registered Native midwives in Canada, while the total number of registered midwives in the country was 11,000. However, according to Dorothy, their organizational activism is increasing. In addition to the NACM, she mentioned other examples, such as Six Nations Maternal and Child Care in Ontario, and the Inuit Midwives

on the Hudson Bay. She emphasized that the Native midwives are involved in two fundamental tasks in their communities: firstly, in healing work, and secondly, in "returning the births to homelands." By "healing work," she referred to the need to recover from the structural violence and damage caused by, for example, the educational system, which separated Native children from their families. She was also referring to more contemporary problems related to colonial history, such as violence, suicide and alcoholism.

Still, it is noteworthy that not all traditional or Indigenous midwives engage in such brave attempts. Instead, as well illustrated by Davis-Floyd, Pigg and Cosminsky (2001), many adapt to the modern medical system as a means for survival. Thus, the concept of "the postmodern midwife" coined by Davis-Floyd includes not only the schooled Western midwife who turns to traditional knowledge for the evidence-based value that much of it contains, but also the traditional midwife who combines tradition with the professional midwifery and biomedical knowledge systems, in what, as described in Chapters 1 and 2, Davis-Floyd terms "informed relativism"—the primary characteristic of the postmodern midwife.

There is certainly space for more comparative studies on midwifery in the non-Western world, and on the relations among different midwives. Generally speaking, it is understood that midwives attend the whole society, especially women with fewer economic resources. Again, throughout modern Western history we have observed that, in Europe, the biomedical system encourages middle-class women to become professional midwives; professional midwives have long made up the vast majority of birth attendants in most European countries. In contrast, in the USA it took professional certified nurse-midwives from 1925, when that profession was founded, to the mid-1980s to gain legal recognition in all 50 states. Starting in the 1970s, the emerging "lay" midwives of the USA began an ongoing battle to secure legalization, licensure and regulation and have to date (2020) achieved these in 35 states. In Canada, similar types of midwives gained legalization in Ontario in 1993 and later on in the rest of the country—they are RMs, or "registered midwives." These gains have been the result of heroic battles told in many *herstories* (see Davis-Floyd and Johnson 2006 for some of these stories).

However, there are also some critical voices. As described in Chapter 2, Nestel (2006) argued that, in the process of legalizing midwifery in Canada, the White middle-class midwives distanced themselves radically from ethnic-minority midwives, as well as from traditional midwives, in order to form a new, "clean" and respectable profession for well-educated White women. According to Nestel, this distancing and exclusion was partially explained by the kind of struggle that the midwives faced, including the struggle against doctors whose verbal attacks employed the old, racist, stereotyped imaginary of midwives. Nestel also sheds light on the pre-legalization history of midwifery training, which frequently implied travel to birth centers on the Mexican–US border to practice on the bodies of birthing migrant women. This kind of practice is not new, either—Western or urban medical

students are known to have gone abroad to practice in the Global South, or in poor rural areas, to then qualify as doctors and to charge high fees in urban contexts. Yet, as shown in Chapter 1, Mexican midwives too have traveled to the USA to train and practice midwifery.

Nevertheless, Nestel (2006) importantly sheds light on the inner colonialism of midwifery, although midwifery itself has long been the underdog of the biomedical system. Although Nestel heavily criticizes "midwifery tourism and practice," she also explains that this phenomenon occurred, partially, in a situation in which Canadian midwives no longer had access to training in Britain, and therefore sought other means of gaining sufficient practice for becoming licensed.

Not everyone welcomes such criticism of this paradoxical side of midwifery, because such criticism could erode or undermine the processes of legalizing and regulating midwives, or even the very struggle for the midwifery model itself—as in Mexico, where midwives have been debating these issues. This dilemma is a common one for social movement researchers: should such tensions and contradictions be made visible within social or human rights movements? Or does that turn out to be counterproductive? Are we giving weapons to our opponents? In the face of such controversy, I note that I do not address these issues for the purpose of disqualifying or dividing, but because addressing them is necessary for self-reflection, learning and analysis. As has been discussed throughout this work (see, for example, Chapter 1), midwifery itself is traditionally based upon collaboration, in women's talk, in the sharing of knowledge. In this way, contemporary midwives have been active in building bridges with others and, yes, this has complicated relations among midwives from Indigenous, Western and Global South backgrounds.

In the postcolonial viewpoint, and with the emergence of Indigenous rights, the mutual learning has produced a critical side in the form of appropriation of knowledges among various types of midwives. Knowledge sharing is different from knowledge appropriation, in which members of one group take from another and appropriate that knowledge as their own, adapting it to their needs, without giving anything back. The postcolonial critiques of knowledge appropriation do not concern midwives alone, but have been particularly addressed to Western or urban researchers, activists, artists and collaborators, who have obtained some sort of social capital from these relationships and knowledge. The problem of extracting and appropriating knowledge has become a strong claim from Indigenous peoples over the past decades (such as Tuhiwai Smith 1999; Tuck and Yang 2012; Leyva Solano et al. 2015; Suárez-Krabbe 2016). This critical discussion has links to autonomous or postmodern midwives of Mexico, who, by definition, seek to connect with traditional or Indigenous midwives to learn and to exchange knowledges. These could be described or illustrated as the "two faces" of (de) coloniality within midwifery: positive knowledge sharing and collaboration among different midwives in the postcolonial world, and the darker side of appropriation.

The paradox of knowledge sharing vs. knowledge appropriation is also exemplified in the learning, naming, publication and teaching of "the Gaskin maneuver." Ina May Gaskin learned that technique—the all-fours position for shoulder dystocia and breech deliveries—in a casual encounter with a group of Indigenous Guatemalan traditional midwives and began trying it out as soon as she returned to the Farm Miwifery Center. Finding that it worked extremely well, she began to teach it to others and to publish about it. Needing a name for it, and not knowing the names of the Indigenous midwives from whom she had learned it, she called it "the Gaskin maneuver" because so many obstetric techniques carry the names of White male obstetricians from Europe and the USA, and she thought at least one technique should carry the name of a midwife—due to the underdog nature of even White, middle-class midwifery in the USA. This naming could be conceptualized as a form of colonialism, but is it? Those Guatemalan midwives shared that technique with Ina May in the hope that she would carry forward this important piece of knowledge, which she did. So I suggest that if this is to be coded as a form of "colonialism" at work, then it is an innocent one (see also Laako 2015).

Yet another form of innocent colonialism comes in the form of romanticism, particularly in the imaginary of natural childbirths in the Global South or amongst Native peoples, and is also connected to the ways in which autonomous or postmodern midwives promote natural births. On one hand, there exists the idealization of the non-Western, primitive birth as a powerful stereotype: the noble savage who goes into the bush to birth without help, pain or chaos; or even more so, the exotic and pure Mayan midwife frozen in time (Craven 2010, 51–52).

However, there is yet another postcolonial way of reading this imaginary: that of the extensive body of medical anthropology research that has contributed to describing and recording extremely different kinds of births in multiple countries (e.g. Jordan 1993; Selin and Stone 2009; Davis-Floyd and Cheyney 2019). What emerge are clear illustrations of the differences between hospital and community births in all countries. Pictures are painted of the hospitalized woman tied to the monitor in her institutional bed while "white coats"/medical practitioners (instead of the woman herself) "manage" her delivery, and where authority and knowledge over the woman's body are located outside herself, within the doctors, obstetricians and nurses according to their presence and hierarchical rank. These pictures are violent, though that violence is invisible as this is the normative view of birth around the world, radically different from portrayals of women attended by traditional midwives in Oaxaca, Chiapas or Yucatán (Jordan 1993). What emerges there is a vision of a woman more empowered and freer-birthing than the (Western) hospitalized woman. The literature on medical anthropology may offer unexpected (de)colonial aspects of the culturally, socially and politically constructed contemporary biomedical and birthing systems.

Yet, as suggested above, and simultaneously with these complex realities, there is significant collaboration among autonomous and Indigenous

midwives. For example, Mexican traditional midwives Doña Irene Sotelo, Enriqueta Contreras (aka Doña Queta) and Angelina Martinez Miranda have all spoken at international conferences where they freely shared their knowledge with White middle-class and other midwives (see Davis-Floyd et al. 2018 for a profile of Doña Irene). They have also traveled to Canada and elsewhere to meet with other Indigenous midwives and groups in the interests of knowledge sharing and collaboration.

In another highly postmodern twist, Mohawk midwife and activist Katsi Cook, speaking of the intentional community, the Farm, in Summertown, Tennessee, tells us:

> These people are not even related. They don't even know each other. They're just a bunch of hippies out of Haight–Ashbury in San Francisco, and look what they've done on 1500 acres of land. We have 52,000 acres of land, and we're all huge extended families with a common vision, common ancestry, common land base, and yet—they even had a way of getting along, a way of thinking about how to get along, that I thought we lacked. And I mentioned that at the Loon Lake Conference. I said, "You know, here's all these hippies and they get along well enough that they have all these institutions. They decided how they were going to do it on their own. Why can't we learn from that?" And so we did. We started sending a delegation down there and pretty soon, they started the Plenty International Midwives' Training Program. … I was so blown away by these hippies who had just gotten in school buses like we had to go to Kanienkeh, but the difference was they had their own school. *They had their own school.* They had their own food. They had their own economy. They had their own dairy, soy dairy. All the food on their table they got out of that bean they grew in their garden. They had their own infirmary. They had their own intensive-care unit. They had their own midwifery program: they called it the birthing crew. They had their own ambulance. They had everything that I thought we should be doing, but weren't.
>
> (Cook 2006, 28)

That is how Katsi Cook describes her journey to midwifery, where she learned in the Farm midwifery program led by the activist and Alternative Nobel Prize winner Ina May Gaskin. I quote Katsi to emphasize a successful and mutual collaboration among both White and Indigenous autonomous/postmodern midwives. And now I ask, to what extent can a common agenda be constructed among different midwives—professional, empirical, traditional, postmodern and Indigenous? Should the Indigenous midwives be left to wage their battles alone? Or should they be properly integrated into the professional organizations? The collaboration among different midwives and knowledge sharing—is it all a form of colonialism and midwifery tourism, or an achievement in postcolonial relations? In which ways can reproductive rights be exercised by all women?

There are no simple answers to these questions, given their individually situated experiences. Yet, in considering the contemporary history of Indigenous activism across the Americas, it would be difficult to ignore postcolonial criticisms and Indigenous rights. As indicated by Cook in the beginning of this section, the issue of Indigenous midwives involves colonial history and Indigenous rights, two spheres in which midwives perform a substantive function of re-establishing nations and knowledges.

Conclusions: Midwives, rights and territories

In this chapter, I have introduced the notion of "postcolonial midwifery." What could such a midwifery consist of? First, I emphasize that there are two ways to approach postcoloniality within social sciences. On the one hand, the postcolonial in its light version simply refers to the countries that became independent in the aftermath of decolonization. In other words, in this case, the postcolonial indicates the study of those "postcolonial countries." Here, "postcolonial midwifery" makes particular reference to midwiferies in those countries that were previously colonized.

On the other hand, the critical postcolonial canon dives deeper. This field fundamentally argues that colonialism did not end with the independence of the previously colonized countries but continues today in various structural forms. Thus, this postcolonial perspective refers to the study of contemporary forms of colonialisms inherited from historical colonization. This postcoloniality applies not only to postcolonial countries but also to Indigenous peoples, for example. Eurocentrism is, of course, a key concept in this canon, and it extends to the criticism of the colonized aspects of contemporary social sciences. Here, "postcolonial midwifery" would refer to current challenges within midwiferies that deal with multiple forms of contemporary colonialisms.

As noted by Kadetz (2014) above, it seems that the biomedical system—including many health professions—has remained less explored by the latter postcolonial strand, as it is generally assumed to be based on science and therefore culturally neutral. Yet in fact, this system is heavily culturally influenced, as various authors have shown (see e.g. Davis-Floyd 2003; Davis-Floyd and Cheyney 2019). As shown in the chapters of this book, the contemporary biomedical system is far reaching, and many healthcare professions are border crossing by nature: doctors, nurses, midwives and others often carry out their practices and tests, or accumulate and share knowledges, by visiting and working in differentiated, and previously colonized, locations. Thus, it can be argued that their work inevitably has to do with (post)colonialisms. Could *midwifery* be the space or place from which to generate new innovative models for healthcare systems that would improve the honoring of intercultural women's rights globally, including those of Indigenous women?

In this chapter, I have addressed postcoloniality in terms of rights and relations among some Mexican and Native midwives and midwiferies. I also

briefly discussed various postcolonial aspects that emerge from literatures related to midwifery. However, postcolonial midwifery is not reduced to these initial approaches. I have paid particular attention to the aspect of "bringing births back home" as defined by various autonomous and Native midwives with particular reference to reproductive-related territoriality, nation building, leadership and autonomy. Indeed, various autonomous and Native midwives are already immersed in such efforts, constructing or building bridges between midwifery and territory/motherlands. Various autonomous and Native midwives described in this chapter also suggested a distinct role for midwifery in women's societal-political leadership in rural and Indigenous communities that differs from the predominantly institutionalized contexts. I consider that these notions are of utmost importance for postcolonial midwifery, and also in generating connections between Indigenous rights and women's rights.

As shown in this chapter, in the complex postcolonial relations and rights among different midwives and *herstories,* human rights and reproductive rights, especially women's rights, remain nevertheless a contested and constructed terrain—not only in terms of facing conservative or fundamentalist approaches that threaten the development of such rights, but also within the very alternative pro-women approaches in which new interpretations are born from the existing frame of rights. These rights are also contested and constructed at local levels in the Global South. Currently the global human rights in childbirth movement, as well as the Latin American campaign for the humanization of birth and against obstetric violence, are challenging the dominant, clinical view of human rights in childbirth, making visible the ways in which the hegemonic biomedical system often jeopardizes or flat-out denies the rights of women.

The critiques of this hegemonic system present the need to critically view the differing perceptions related to such rights and their pitfalls. In the case of reproductive rights, for example, this means taking into account the history of reproductive health policies and population control methods that have affected women in both the Global North and Global South, and which are not divorced from the current context of how the implementation of new reproductive policies is received. Simultaneously, these critiques insist on carefully analyzing a particular context using a community-based approach to understand why women do not comply with the medico-obstetric insistence that reproductive rights consist primarily of the right to access care in medical facilities.

These topics are timely, as international organizations continue to promote human rights and reproductive health in their development policies. Over the past few years, those organizations have started to emphasize skilled midwives as useful practitioners for reducing maternal mortality (UNFPA 2014). However, while such organizations refer to the importance of "recognizing traditional midwives who have experience, knowledge, and proven practice, regardless of their schooling" and, from there, to build a maternal healthcare

system that would be "culturally respectful and appropriate," these policies often continue the exclusion of traditional midwives (Sarelin 2014a).

This situation could generate a very contentious intersection between Indigenous rights and women's reproductive rights, internationally as well as inside the mobilization. Although autonomous midwives intersect with rural midwifery, and are also located in the regions of recent Indigenous mobilizations—which makes this dynamic visible in a particular way—it remains to be seen whether the autonomous midwives can mobilize successfully, how they do so, with what agendas and whether that mobilization occurs along with or separately from that of traditional and Indigenous midwives.

I suggest that midwifery activism in Mexico and Latin America stands at a crucial crossroads: while international politics are shifting to favor midwifery, these politics are also stuck with the professional, medicalized approach to these birth attendants. This could mean a complex negotiation over various models of midwifery within the profession and an incentive for further mobilizations, some of which could give rise to other global advocacy networks, as outlined by Keck and Sikkink (2000). On the continent that witnessed a powerful emergence of Indigenous movements and rights in the 1990s, the struggle for rights for Indigenous midwives could become crucial, entailing the need to weave reproductive rights into Indigenous rights in an unprecedented way.

Notes

1 This chapter was originally published as: Laako, H. 2017. Understanding contested women's rights in development: The Latin American campaign for the humanization of birth and the challenge of midwifery in Mexico. *Third World Quarterly* 38(2), 379–396. The chapter also includes excerpts from: Laako, H. 2017. *Mujeres situadas: Las parteras autónomas en México*. Mexico: ECOSUR.
2 See also the Open Democracy debate, Mass or Elite Movement? www.opendemocracy.net/openglobalrights/human-rights-mass-or-elite-movement.
3 Human Rights in Childbirth: www.humanrightsinchildbirth.org/.
4 Sisters in Chains: www.sistersinchains.org/.
5 White Ribbon Alliance/Promotion of Midwifery: http://whiteribbonalliance.org/campaigns/promotion-midwifery/.
6 La Red Latinoamérica y del Caribe para la Humanización del Parto y el Nacimiento RELACAHUPAN: www.partolibremexico.org/relacahupan.php.
7 Declaración de Ceará en torno a la Humanización, 2000. www.tobinatal.com.ar/humanizacion/ceara.html.
8 Nueve Lunas AC. "Atención humanizada del parto y nacimiento" (author's translation). The Nueve Lunas website was closed down by Mexican authorities in summer 2015. Various midwifery websites have been closed down by Mexican health organizations at different times due to their consideration that these sites promote potentially harmful alternative health services not approved by the given authority. Currently the website of Nueve Lunas appears at: http://parteriayconocimiento.com/cip/ (consulted in May 2020) and on Facebook.
9 GIRE. *Omisión e indiferencia* (author's translation).

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Conclusions

Situatedness and the making of worlds in midwifery

Hanna Laako and Georgina Sánchez-Ramírez

This book has sought to contribute to the theoretical strand of situated knowledges by means of the approach of *situated politics* and *politically situated* on at least three levels: (1) by examining the Mexican midwives' intersectionally, with particular emphasis on contextual and relational aspects at multiscale levels; (2) by analyzing the various *midwiferies* as dimensions of a diverse profession, including through use of genealogical and historical perspectives; and (3) by discussing political situatedness as a means of constructing spaces and knowledges.

First, we have used situated politics to examine the complex realities of Mexican midwives, who are located within and also moving among different intersections (geopolitical, gendered, classed and ethnic). We have also examined (particularly in Chapters 2 and 5) the unsettled tensions and collaborative relations that emerge from the differentiated realities among midwives. These intersectional perspectives are encompassed within the theoretical frame of situatedness. We conclude that this sort of contextual and relational/intersectional analysis of midwives manages to escape essentialist, binary oppositions and categories. The fluidity and complexity of midwives' histories and contemporary positioning allow us to make visible (in addition to hierarchies and oppressions) midwives' cross-class and cross-ethnicity alliances, collaborations and activisms, particularly within the frame of human rights. Indeed, one of our principal findings is that Mexican midwifery today is intimately involved with different kinds of rights—women's, Indigenous and intercultural, sexual and reproductive, professional, health sector and those related to development.

Secondly, in addition to politically situated midwives, we have explored *midwiferies* as a vocation and profession (especially in Chapter 1). Midwiferies, again, have their own positionings in relation to other professions and knowledges, as well as in different historical contexts and genealogical locations (in terms of historical timelines). These positionings include the evolution of the health professions in the 20th-century modernization boom, and others related to contemporary development policies and politics in the Global South. The political situatedness of *midwiferies* beyond individual or particular groups of midwives permits other types of results to emerge as

related to professional and vocational evolution. Through this politically and professionally situated lens, midwifery becomes subject to the exploration of different models, philosophies and knowledges. This approach also includes analysis of the particular *tasks* related to the midwifery craft that vary across time and space, but continue to affect professional autonomy. This also put under our scrutiny, particularly in Chapter 4, the organizational and ideological changes in midwifery in relation to societal developments—such as the politicized issue of abortion, which divides midwives' focus between being of service to their communities and, at the same time, adjusting to shifting legislations.

Our comparative analysis of the political situatedness of midwives and midwiferies teases out results that are importantly interrelated, but also of differing kinds: the first situatedness corresponds to women's decisions around the craft and their evolving relationship to it, and the second corresponds to a vocation, with its broader circumstances of global structures and politics.

Thirdly, the results of this book indicate that political situatedness in midwifery is not only relational (as in connectivity between persons) or contextual (as in structural circumstances or surroundings, which can be multiscale) or genealogical (historical timeline and evolution) but also a matter of the construction of *spaces* (of physical rooms or areas, or of more expansive openings of spaces and opportunities). Midwives not only situate themselves in varying public and private spheres, but also create spaces of their own. As shown in Chapter 3, in particular, midwives create birth centers where women may birth differently and construct a distinct body-territoriality in the context of contemporary hospitalized, obstetrics and gynecology Mexico, which has long been characterized by obstetric violence and remains so today. Our other chapters too can be read through the lens of openings (or closings) of spaces of various kinds: networks, organizations, homes, communities, services for births in Native territories.

Indeed, we find that this kind of creation of spaces, even the marginal or semi-clandestine ones, is part of the capacity of the revival of midwifery as a whole. This finding also impels us to think about the theoretical frame of situated knowledges beyond intersectionality, which tends to emphasize relational and contextual analysis explored within a set of categories—a fixed place or positioning to be carved out. Instead, we have found ourselves extending our analyses toward spatial and genealogical dimensions, in addition to those previously mentioned.

In fact, analyzing Mexican midwives and midwiferies in the frame of situatedness has also prompted us to rethink their very *situatedness* as a politics of location, or positioning. These terms connote portraying, contextualizing, placing or relating. While these are important for differentiated oppressions, conditions, power relations and hierarchies, we have paused to think about the notion of *immersion* as part of situated midwifery politics. Immersion implies plunging into something that surrounds you. It has to do with involving yourself; taking the dip or absorbing; or engaging oneself in something more

deeply. In the pages of this book, the midwives and midwiferies have been, above all, *immersed* in different worlds and world making irrespective of their "label" as a midwife. They have also been immersed in societal stratifications and tendencies across time and space, and are often also working to elide those stratifications as boundary crossers and bridges. In so stating, we point out that these situated midwives are not only *situated-positioned* in the sense of taking a step forward or back, choosing sides or being contextualized within certain, given circumstances, but are also, and importantly, *situated-immersed* as agents in their contexts and relations.

In other words, while the midwives in this book are inevitably conditioned by certain circumstances, they are also taking part in the making of worlds. Those worlds are made in the bridges they construct, the people they bring together and in the ways in which they heal and empower the body-territories of birthing women in birth centers and homes. Native/Indigenous midwives make new worlds by bringing births back home to their territories as part of Indigenous activism and nation building. Traditional midwives make worlds alternative to those generated by laws as they save lives by carrying out safe abortions in their communities. And the autonomous midwives discussed in this book are part of making worlds as they bring new life to the organizational networks and associations of Mexican midwifery that explore and struggle for official recognition of new forms of midwiferies in the country. All in all, many midwives cross societal stratifications within and beyond their own original location, immerse themselves in politics and in women's lives and often take part in transforming those lives and spaces, thereby generating small yet significant changes in Mexican society.

"Immersion" as a term is often related to the arts. However, in the academic world it also involves "digging deeper" into something. The latter is often related to the fields of anthropology and ethnography as a way of plunging oneself deeply into a context as a researcher: a culture, a community, a language, a literature. While it is true that in our fieldwork and in this book we have also practiced this type of (partial) immersion within Mexican midwiferies, we are thinking, in this context, more about the midwives we have studied and their immersion in multiple contexts and worlds, and their re-shaping of those worlds.

Could the theoretical strands of situated knowledges and situated politics benefit from such a term as *immersion* as an analytical tool to better trace the connectivities and agencies of our structured and stratified realities? And how does the notion of immersion inform the *partial* lens of situatedness? Midwifery studies and critical social science research certainly could engage in these complex questions, which have been bubbling—mostly under the surface—throughout the pages of this book.

There are many ways in which Mexican midwifery and midwifery studies could be further researched within the social sciences. We conclude by emphasizing two particular issues which, in our analysis, are fundamentally related

to situated politics, contemporary midwifery and intersectionality: (1) postcolonial midwifery (Chapter 5); and (2) body-territoriality (Chapter 3).

Postcolonial perspectives on midwifery studies could be further developed. This applies both to postcolonial relations between midwives and to the postcolonial study of *midwiferies* as part of health professions. Various chapters of this book have brought up the problematics of modern midwifery as an urban-focused career. Many midwives whose voices are heard in this book pointed out the challenges midwives face in rural regions, but also noted the need for rural midwives to be able to take on this craft in their own home/motherlands and communities. Thus, in our view, the postcolonial perspective on midwifery should deepen the analysis on the rural–urban axis. However, this does not imply that only rural midwives are needed: especially in Mexico, there is a lack of midwives for urban, lower-class women, who have long been objects of obstetric violence.

The question of the *need* for more midwives motivates further postcolonial analysis in terms of *who* can work as a midwife and under what circumstances. Who are the ones who should train future midwives; where; and under what kind of programs? The postcolonial perspective on midwifery could also continue by addressing the global structures of the health professions. How is knowledge shared or appropriated? Where, how and under what circumstances are practices and skills passed on to others and didactic materials used? And we certainly find room for further explorations of the links between women's professionalism, autonomy and postcoloniality in general and as part of situated politics.

Suffice to say that all kinds of human rights are subject to postcolonial analysis, including Indigenous rights and women's rights of different kinds (including the right to safe abortion), and the multiple ways in which these are embedded in midwifery. In addition, the postcolonial perspective on midwifery importantly addresses the knowledge structures within academia: postcolonial scholarship has considered it important to engage with knowledges, concepts, theories and literatures emerging from the Global South.

The second and final issue we mention as worthwhile for further exploration is the Latin American body-territoriality concept, which delves into bodily experiences, whereas the postcolonial perspective is more about global structures and politics. Body-territoriality importantly sheds light on individuals' and women's bodily experiences, their autonomy (or the lack of it) and the ways in which women's bodies are culturally treated—in this case, with particular reference to birth cultures and sexual and reproductive policies. Western scholarship has often referred to all this under the concept of *biopolitics*. In contrast, the emphasis of the Latin American body-territoriality perspective stems fundamentally from bodily autonomy or experience, also informed by the effects of societal violence felt as a result of regional, national and global biopolitics. This perspective moves between biopolitical aspects and women's bodily experiences, without losing sight of the latter as a founding element.

We consider *body-territoriality* as a strongly situated, intersectional concept and an important tool for analyzing (at individual and societal levels) women's experiences and drive for autonomy. Thus, body-territoriality is embedded not only in biopolitics, but also in the empowering, healing or traumatizing bodily experiences of Latin American women. As such, it is intimately involved with midwifery and birth cultures. The concept of body-territoriality fundamentally makes possible an examination of midwiferies via the lens of women's experiences—in particular in societal contexts and circumstances such as obstetric violence; human rights in childbirth; humanized, respectful or conscious births; and access to safe, respected, voluntary pregnancy interruptions in all regions, regardless of their legal status.

These have long been, and remain, important contemporary issues today, in the year 2020, which the World Health Organization has denominated as the Year of the Midwife. In the midst of the unsettling coronavirus pandemic, midwifery and its spaces (homes and birth centers) are seen in a new light as hospitals and other health facilities are occupied with COVID-19 patients and perceived as sites of contagion that many pregnant women wish to avoid. Midwives across the globe have long argued that there are times when their ancient, handy capabilities and knowledges will be most needed, as women continue to go into labor even when facilities and technology fail. In such murky times, we need the midwives who are able to attend expectant women, births (risky or not) and babies under difficult and complicated circumstances, outside of hospitals and in low-tech, high-touch ways. This need has long been obvious to women living in disaster, conflict and war zones. Now, with the coronavirus pandemic and the climate crisis, which will inevitably result in more disasters, this issue has come squarely in front of the rest of us. We certainly hope that during this peculiar Year of the Midwife and beyond, this book, and the midwiferies described and analyzed within it, will contribute to dealing with these pressing global issues, and to the survival and revitalization of midwiferies in Mexico.

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