

UNIVERSITY OF CALIFORNIA, SANTA CRUZ

**UNTOLD DELIVERY STORIES: ZAPOTEC WOMEN'S BIRTHING
EXPERIENCES IN THE CENTRAL VALLEY OF OAXACA**

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Abstract: In Oaxaca, natural births have declined, with a rise in technological model of birthing seen in increased fetal monitoring, and cesarean sections. This ethnographic research in Oaxaca's Central Valley examines what actors are involved in the birthing decisions of Oaxaqueñas, to answer the research question: How are Oaxaqueñas from Oaxaca's Central Valley deciding their birthing option? From 28 in-depth interviews with mothers, expecting mothers, midwives, and medical personnel in the towns of Santiago Matatlan, Tlacolula de Matamoros, San Dionisio, and San Baltazar, I aimed to find an answer to my research question. I contextualize my findings with the theoretical framework of the state's biopower in reproductive control, medical personnel's construction of patient's compliance through subjectification, clinical gaze affecting the patient and medical relationship, and the medicalization of hospital births through cesarean sections. This research in Oaxaca's Central Valley will help shed light on the perinatal care Oaxaqueñas receive, and how the Mexican state exerts social control of a traditional birthing practice by medicalizing a woman's birth.

Keywords: Oaxaca, Home Births, Medicalization, Oaxaqueñas, and Biopower

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Mireya Mateo

April 3, 2016

This thesis is dedicated to my mother and all indigenous women, in recognition of their strength as they brought forth new life, especially in institutional settings that caused unnecessary suffering.

Table of Contents

Preface.....	
Introduction.....	
Background.....	
Literature Review.....	
Methodology.....	
The Push Towards a Modern State.....	
The Participation of Medical Personnel	
The Experiences of Expectant Mothers and Mothers	
Discussion and Conclusion.....	
References Cited.....	
Appendices.....	

Preface

My heart was pounding, palms sweating, and a lump lodged in my throat as I set foot in the Mexico City International Airport on June 25, 2014. This was the first time after 18 years that I set foot in my motherland, making me feel simultaneously joyful, proud, anxious, fearful, and enthusiastic. For most of my life, I was not sure when I would ever return. I am undocumented. I was brought to the U.S. at the age of three by my family, with my parents' dreams to provide me better educational and life opportunities. The ability to return to Mexico with some degree of certainty that I could get back into the United States has only been a recent possibility, the result of the Advance Parole policy through President Obama's program of Deferred Action for Childhood Arrivals (DACA). To obtain Advance Parole, I had to undertake a five-month bureaucratic process that was draining, taxing, and nerve-wracking, not to mention requiring expensive legal fees. I believe that I was the first UCSC student to be granted Advance Parole. To this day, I cannot believe I surpassed the immigration hurdles that seemed so daunting, but the impetus to do so was not just the desire to see my extended family and return to my homeland- I sought to conduct research on the birthing experiences and perinatal care of Oaxaqueña women from the Central Valley of Oaxaca. A project I am so committed to that I returned to Oaxaca, undertaking the Advance Parole process once again in the summer of 2015, to continue with my research. Giving voice to the birthing voices to the birthing stories of indigenous women makes the risk of going to Mexico- the possibility of being detained upon re-entry to the U.S.- worthwhile.

Much of my interest in the perinatal care of indigenous women lies in my

personal connection, as the child of Oaxaqueños from the Central Valley. I was born in Tlacolula de Matamoros, one of the communities where I conducted interviews, and the location of the main hospital in the Central Valley. Many Oaxaqueños, due to the high poverty rate of the state, are limited to the healthcare they can access; therefore many Oaxaqueñas give birth at the Instituto Mexicano del Seguro Social Hospital (IMSS), in Tlacolula de Matamoros. This hospital tries to provide the perinatal care of all indigenous women of the Central Valley, but as I explain in this thesis, the care given can be characterized as inadequate. Language can play a big impact to how perinatal care can be characterized as inadequate in the medical setting for an Oaxaqueña, since many Oaxaqueñas in the Central Valley speak Zapoteco and not fluent in Spanish. Being told that one needs a cesarean section for the wellbeing of the fetus and mother may not be transmitted correctly in Zapoteco from Spanish, making the doctor's recommendation seem inadequate for an expectant mother. Until now, IMSS has included few indigenous midwives in the delivery and operating rooms, giving many Oaxaqueñas the comfort and familiarity of these culturally important perinatal care givers, but I yet to see Zapotec speaking midwives in these spaces.

In 1993, when my mother gave birth to her first child, she did not have the opportunity to have my father or another family member with her in the delivery room, leaving her feeling alone and frightened at the sight of the medical tools that later came to be used for her cesarean section. My mother describes that moment as a time of isolation and terror. She tells me, "As soon as I entered that operation room, I did not know what was coming my way, the masked men frightened me and the booming sound of the

machines were slowly disappearing as I began to close my eyes not knowing if I would ever open them again.” Her delivery story was not the lovely story I would have preferred to hear, and even more traumatizing to know that this experience marked the beginning of constant pain around her cesarean scar, pain that persists to this day. I question the perinatal care she received in the hospital and after. My connection to the birthing experiences of Oaxaqueña women like my mother compel me to conduct this investigation, to provide women the space to tell their stories and begin to evaluate their perinatal care, but more importantly a call of representation for Oaxaqueñas of this region.

I hope to become a perinatal research evaluator, who examines program for indigenous women in Latin America and the United States to enhance their health and well-being. By conducting research with indigenous women of Oaxaca, I was able to picture myself in this role. Many were surprised to know that an Oaxaqueña native, who now resides in the United States, was interested in their perinatal care. This fact reflects the degree to which this population is marginalized, furthering my passion to advocate for their health and wellbeing. To them, I was not an outsider, but a friend who cared about their perinatal care. My unique position, as an indigenous woman who, through the actions and sacrifices of my parents, has come to be in a position to enact positive change, obligates me to serve my community. It is a privilege to do so, and something I am working towards through the support and mentorship of many others.

I want to thank Professors Lu and Zavella for encouraging me to conduct this thesis. Thank you, Professor Lu, for being there in the early stages of my senior thesis

investigation when conducting research in another country did not seem a possibility as an undocumented student. Thank you, Professor Zavella, for meeting with me weekly on the write up on this thesis and helping me with my Institutional Review Board application. Both of them wrote letters that enabled me to gain Advance Parole, which is only granted for applicants in the context of educational purposes, humanitarian reason, or work related circumstance. I want to thank the Garcia Santiago, Gomez Hernandez, and Mateo Hernandez families for the help they have provided me during my stay in Santiago Matatlan, from taking me to the different communities and being my translators. I also want to give thanks to my friend Marina Gonzalez Flores for extending me the invitation to come to Mexico to work with her in Yucatan, in the summer of 2014. If it weren't for her invitation, I might have never conducted my research in Oaxaca. And, I want to give thanks to my research partner Gabriela Garcia Santiago for making me feel at home in a country with which I had lost touch. I also want to give thanks to my friends who have kept me motivated in writing thesis: Martha, Teresa, Chris, Erika, Samantha, Mauricio, and Antonio.

I would have not been able to fund my research if it was not for the support of Oakes Special Project Fund, Nancy Pascal Fund, Joel Frankel Scholarship, Cynthia Matthews Scholarship, Pathways to Research Grant, Deans of Students Scholarship, Professional Development and Career Development Program, and the contributions of Estelle Leisy. Thank you for the economic support. I would also like to thank Alex and Cisca Sochian for providing me economic support my first year at UC Santa Cruz, when there was no financial help for undocumented students like myself, and Janet and Wiley

Greg for their economic help the following years. With the support of these generous donors I was able to continue my studies at UC Santa Cruz and continue dreaming of pursuing a profession in the public health field, which I will this upcoming fall at San Diego State University's Dual Program in Public Health and Latin American Studies.

Introduction

The forms of practicing home births in Oaxaca's Central Valley incorporate thermal baths, massages, spiritual cleanings (*limpias*), and the burial of the abdominal cord that unites a mother with her infant (Gálvez 2011). In a traditional home birth, a midwife knows (approximately) when the mother will go into labor and is either with her two days before her delivery or is in close proximity. The mother can also decide to go to the midwife's home and wait for her delivery there, which seemed to be more common in the towns I visited. When the labor pains begin, the midwife starts to boil water for tea, made of herbs to relax the woman's muscles. Two main herbs used by the midwives of this study were *ruda* and *manzanilla*, chamomile. *Ruda* is used to treat nausea and *manzanilla* is used for stomach pains, anxiety, and constipation (Gálvez 2011). The midwife provides some last massages, if necessary. If massages are not needed, the midwife waits until she senses that the baby has reached a position where the mother is able to push. During this time, the midwife tells the expectant mother that she will soon begin a new stage in life filled with beauty and responsibilities. The midwife in this circumstance acts as a godmother to both the expectant mother and infant. Family members can be in the delivery room, which tends to be a spare room the midwife has for birthing purposes in her home. The expectant mother can decide what position she wants to go into labor, which can be standing up or laying down. Midwives want to provide as much agency to the expectant mother making her the primary actor in her delivery and listening to her needs. This approach differs from a hospital birth, where the woman's preference often comes second to the guidance of the delivering physician.

Since the 1970s, the rates of natural births in Oaxaca, Mexico have lowered tremendously, concomitant with a rise in hospital births, which made 25 percent of deliveries in 1970 to now 50 percent (Cimacnoticias 2013). This change in natal practices is the result of the Mexican government and medical system efforts to integrate indigenous communities into the project of a “modern” Mexico, a notion that dismisses Mexico’s indigenous communities’ culture and traditional healing practices (Seia 1997).

Central to the traditional birthing practices is the role of the midwife as a source of guidance, comfort, and aid for the expectant mother. As would be expected from the decline in the incidence of natural births in the state of Oaxaca, during this time a decline in midwifery occurred. However, the nature of midwifery changed through the advent of a movement created by medical personnel to certify midwives. According to Seia (1997), the Mexican medical system’s intention with the midwife certification program was to increase reproductive control on the bodies of Oaxaqueñas, using midwives as potential intermediaries for the implementation of family planning services in their communities. In these courses *parteras*, midwives, were to “learn” course content, and interactional attitudes repeatedly stressing the appropriateness and implicit superiority of biomedical obstetrical care and family planning (Seia 1977).

There is existing literature on the birthing experiences of Oaxaqueñas in the United States, but very few on Oaxaqueñas in Oaxaca’s Central Valley through their perspective. The theoretical frameworks I used to make my argument regarding my research question in my discussion are: medical personnel construction of patient’s compliance through subjectification, medicalization as social control, clinical gaze, and

the state's biopower in birth outcomes. Medical personnel have shown to construct their ideal patients, which come to be the construction of submissive patients that they can easily control. Alyshia Gálvez addresses this stage of becoming submissive patients as "subjectification," which is enforced by medical personnel. According to Gálvez (2011), subjectification is a process of self-disciplining of patients that occurs in the clinics, involving the disciplining of expecting mothers behavior and attitudes toward their birth through schemes of surveillance, discipline, control and administration. In this investigation I aimed to see if clinics were the only place where patients were "constructed" to accept the mandates of medical personnel, and leave behind their traditional birthing practices, which can occur with subjectification. The subjectification that occurs on behalf of medical personnel can be associated to the clinical gaze they view their patients. The clinical gaze is a limited lens in which medical personnel are unable to see beyond the bodies of their patients when identifying the health problems of their patients (Holmes 2013). I attempted to see if the clinical gaze affected the birthing decisions of Oaxaqueñas.

The state like the medical system can control the bodies of women, which Mexico has done with Oaxaqueñas. According to Michel Foucault the control of a woman's bodies by the state is made possible through the implementation of "biopower." With biopower the state regulates the life of an individual and begins to discipline that individual until he or she self-disciplines themselves. In this investigation, I aimed to see if the state was the only actor involved in the regulation of birth outcomes and methods of Oaxaqueñas in the Central Valley. Women disregarding their ethnic, social, or economic

background should be given the opportunity to choose their birthing practice, which in this investigation I focused on the delivering experiences of Oaxaqueñas of Oaxaca's Central Valley, a group who has been historically marginalized by health services. The goal of this thesis is to bring awareness to the pleasant and unpleasant delivery experiences of these women, and work collaboratively to make future birthing experiences of Oaxaqueñas from the Central Valley and other indigenous women across the world pleasant.

Organization of the Thesis

This research focuses in Oaxaca's Central Valley to examine the influences and agents currently involved in the birthing decisions of Oaxaqueñas. The Central Valley is a region in Oaxaca that still proudly practices their indigenous culture, and an interesting site to explore this topic. What birthing practices seem more desirable for Oaxaqueñas and why? What types of resources are made available for Oaxaqueñas to guide them to a birthing decision? I argue that on a local level, municipal officials were pushing women from certain towns of Oaxaca's Central Valley to hospital births, to appear as a modern town for the recruitment of medical personnel. When this was not the case, medical personnel were the actors who pressured Oaxaqueñas to hospital births, and for many of these Oaxaqueñas seen through the surgical procedure of unnecessary cesarean sections. Lastly, midwives had minimal participation in the birthing decision of Oaxaqueñas of Oaxaca's Central Valley, due to the negative discourse that was placed on midwifery, relegating many to only advising Oaxaqueñas about a healthy pregnancy. Some

Oaxaqueñas are able to continue indigenous perinatal care by seeking the assistance of midwives throughout their pregnancy in the forms of massages.

The data were collected through participant observation and in-depth interviews from August 3rd through September 13th of 2015 and July 17th through August 25th of 2014. I began by conducting participant observation for three weeks in Oaxaca's Central Valley, a central method in conducting ethnographic fieldwork that enables the researcher to gain familiarity and build rapport. Then I transitioned to undertaking the main methods of investigation, in-depth interviews that lasted 30-60 minutes. I conducted 28 in-depth interviews with mothers, expectant mothers, midwives, and medical personnel in the towns of Santiago Matatlan, Tlacolula Matamoros, San Dionisio, and San Baltazar. This research reveals what pregnant Oaxaqueñas and Oaxaqueña mothers have to say about their birthing decision, along with what medical personnel and midwives have to say about their participation in Oaxaqueñas birthing decision. These conversations became more than in-depth interviews: for many of the research participants, they were a form of storytelling, revisiting events and emotions with candor and meaning. Through these interviews, I sought to better understand what institutional structures influence Oaxaqueñas in Oaxaca's Central Valley to their birthing decisions and outcomes. I was also interested in knowing how the birthing processes these women experienced affected them in the long run.

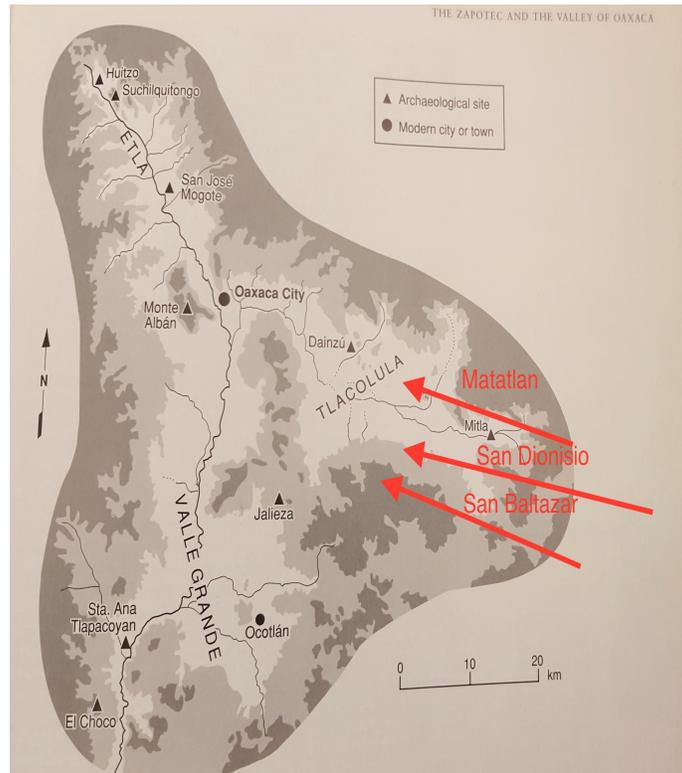
The thesis is organized as follows: the next chapter provides a background to Oaxaca's medical system, traditional birthing practices and culture. The subsequent chapter includes a review of the literature available on the birthing experiences of

Oaxaqueñas and other marginalized communities in the United States, to discuss the leading reasons to Oaxaqueñas birthing practice. I then discuss the methods used for conducting this fieldwork, introduce the participants, as well as reflect on the limitations I encountered. Next, I discuss “A Push for a Modern State,” which begins the conversation of why municipal representatives wanted women of their town to have hospital births and not home births. The chapters that follow are organized from the perspective of different stakeholder groups: midwives, medical personnel, expectant mothers, and mothers. The thesis ends with my discussion and conclusion, reiterating my argument and synthesizing results along with directions for future research.

Background

Oaxaca and the Central Valley

Oaxaca is a state in southern Mexico, one of the most culturally and ethnically diverse in the country. There are eight regions: La Mixteca, El Istmo, La Cañada, Papaloapan, Sierra Norte, Sierra Sur, La Costa, and Valles Centrales. Within these regions, there are around 17 different indigenous communities, including Zapotecos, Mixtecos, Chinatecos, and Mixes. Oaxaca is governed through different *municipios*, municipal governments; 418 of the 570 *municipios* are ruled by the cargo system of *usos y costumbres*, customs and traditions (Barabas et al 2003). This system involves a general assembly in which village officials and the general public are able to choose new representatives for their towns. The internal structures of communities can vary, but customary law requires local residents to fill public offices as a part of their responsibilities of participation in their communities (Stephen 2007). This investigation focuses in the Central Valley of Oaxaca, where the nearby rivers of Atoyac and Salado have produced a Y-shaped valley covering more than 200 km, and surrounded by forested mountains rising 3000m (Kent et al. 1996). The land of this region makes a great site for farming, which many Oaxaqueños have historically done for a living.



Source: Marcus et al 1996

Residents of the Central Valley identify themselves as Zapotecos and speak the Zapoteco language, whose language can vary from town to town. Zapotecos of this region are known as *Be'ena* or *Za'a*, the cloud people, and make up around 800,000 to 1,00,000 residents (Tintocalis 2010). They reside in the municipalities of Ejutla, Etlá, Miahuatlán, Ocotlán, Tlacolula, Zaachila, Zimatlán, and Centro. Traditionally, Zapotecos of this region, like other Oaxaqueños, relied on agriculture for their livelihoods and economic well-being, one main product being corn. The one product that still brings capital to this region is maguey, which people ferment to produce the alcoholic beverage of mezcal. However, with the implementation of the North American Free Trade Agreement (NAFTA) in 1994, making a living as a farmer became difficult. Oaxaqueño

famers were unable to keep up with the corn importation of imported U.S. corn, which was sold at a lower cost (Stephen 2007). This led a large migration from Zapotecos to the United States, especially to Southern California.

Zapotecos of the Central Valley retain many aspects of their traditional religion and culture. Villages such as Tlacolula de Matamoros and Santiago Matatlan have town festivities, which are known as *calendas*, to celebrate the saint of their town. In these *calendas*, women dress up in the traditional attire of this region, which is an embroidered blouse with a wrap red skirt, and a woven slash called a *ceñidor* along with *huaraches*, leather sandals. Women wear their hair in braids wrapped with a red ribbon and accessorize their attire with gold earrings and a *rebozo*, shawl. This celebration starts with a church ceremony to praise the saint of the town, leading to a procession around the town filled with live band music. At the end of the processional, women dressed in the traditional attire of the Valley participate in the dance competition where they are judged on best dance, best attire, and flower basket, which they dance with on their head. The event runs until early into the next day and ends with fireworks.

In addition to a rich and vibrant spiritual culture, Zapotec communities possess a rich material culture, as seen in the details in the flower baskets where some contain figures of the saint of the town, the one in Santiago Matatlan being the apostle Santiago. Another big festivity within Zapotec culture is *Día de los Muertos*, Day of the Dead. This festivity lasts for eight days starting on November 1st which purpose is to welcome the dead, demonstrating to their spirits that their loved ones they left behind still remember them. These events are filled with men dressing as abuelitos “grandparents”, or wild

animals and women preparing altars filled with homemade goods for their deceased.

There is no exact meaning to why Oaxaqueños dress as abuelitos or wild animals; it has just become a custom.

My research location is located in the district of Tlacolula de Matamoros where I conducted interviews in the towns of Santiago Matatlan, San Dionisio, Tlacolula de Matamoros, and San Baltazar. People in this region make a living by working in agriculture and as merchants. The leading indigenous group is Zapotecos, which all the interviewees described themselves to be. Traditional medicine plays an important role in Zapotec cultural practices, where midwives and healers have had a significant role in this region until recently.

Medical Care and Health

The Mexican state has undertaken a push towards modernization in the last 37 years to be seen as a developing society rather as underdeveloped, and one form has been through health programs. Such efforts have specifically focused on indigenous communities like those of the Central Valley of Oaxaca. Appearing as a modern society began with the domestic policy of the development of *Instituto Mexicano del Seguro Social Hospital (IMSS)*, Mexican Social Security Institute Hospital, during Luis Echeverría's (1970-1976) presidency. IMSS, now known as IMSS-PROSPERA, is a program under the Mexican healthcare system designed to help Mexicans who cannot attain health care on their own (Programa IMSS Prospera 2015). The main targets for IMSS were indigenous communities of Southern Mexico, with the intention of tying them to the modern society Mexico wanted to be. The presidents following Echeverria

also aimed for a modern society, but not as vocally as Carlos Salinas de Gortari (1988-1994). In his inaugural address, Gortari stated that the modernization of Mexico was essential to meet the demands of the 85 million Mexicans during his presidency, which meant modernizing politics, the economy, and society (Menocal 1988). His presidency, according to Alina Rocha Menocal (1988), was based on the philosophy that since ordinary people are not well equipped to govern themselves, they should be ruled by technocrats who not only poses superiority to know what is good for the society but also act upon it. The push to be seen as a modern state resulted in the decline of many traditional practices, including in medicine. As vital agents in both social and physical reproduction, Oaxaqueñas and their bodies were subject to these modernization campaigns. In particular, to elevate the standing of a technocratic form of health delivery, it was necessary to undermine the traditional forms of reproductive health, namely midwifery.

Midwives in rural Mexico used to attend over 80 percent of all births, but with IMSS-PROSPERA an increase occurred towards biomedical births, leading to a decrease in homebirths (Davis-Floyd 1997). Hospital births now make up more than 50 percent of deliveries (Cimacnoticias 2013). However, efforts towards legitimization and utilizing midwives have occurred in a selective manner (Davis-Floyd 1997). The eager construction of a modern Mexican state meant favoring the population of certain individuals, while other groups a reproductive control. The mid-seventies saw the reduction of the high Mexican natality rate through massive population control campaigns, where midwives were identified as potential intermediaries of the

implementation of family planning services in their communities. For the health system, they were ideal as intermediaries for Oaxaqueña family planning because they were already in the communities and did not represent any additional cost (Davis-Floyd 1997). The tactic to control the reproduction of indigenous women would begin with the training courses of IMSS.

In Oaxaca, training began between 1979 and 1985, where 779 midwives were certified (Davis-Floyd 1997: 399-400). In these trainings, the birthing knowledge midwives possessed was not valued; they were instead trained in biomedical tactics. Midwives had to learn course content, teaching methodology, and interactional attitudes that repeatedly stressed the appropriateness and implicit superiority of biomedical obstetrical care and family planning (Davis-Floyd 1997). In the training courses, midwives were discouraged to massage pregnant women, because according to medical personnel massages could allegedly cause harm to the fetus. Midwives no longer played the active roles of securing traditional birthing practices, as the push to modernity and population control was the national priority.

Currently, not much has changed with the training of midwives and biased perceptions of their supposed inferiority. Many medical personnel still believe midwives do not have the appropriate training to assist in a home birth, leading to increasing numbers of hospital births. The leading hospital birth practice is a cesarean section. There has been a 17 percent increase in cesarean sections among Oaxaqueña women from 2005 to 2013 (Cimacnoticias 2013). Advocates for home births argue that the high numbers of cesarean sections are a move for an economic profit by private

hospitals and note that the percentage of cesarean sections in Oaxaca are higher than the national standards of the World Health Organization, showing the need to re-evaluate the medical suggestions medical personnel give to Oaxaqueñas. In 2005, the cesarean section rate for Oaxaca was 34.06 percent; it is now 50 percent (Cimacnoticias 2013). According to the National Center for Gender Equality and Reproductive Health, a cesarean section in a private hospital can be a minimum of 23 mil pesos (\$230), which in a civic clinic a cesarean can be free (Cimacnoticias 2013). Furthermore, cesarean sections in private hospitals make up 80 percent of the births (Cimacnoticias 2013), meaning that Oaxaqueña women become passive actors in their delivery in these types of medical institutions. As more births in Oaxaca involve biomedical options such as cesarean sections, Oaxaqueñas are being removed from the beginning stages of motherhood. Giving birth is one of the incipient stages of motherhood, where the connection between mother and child is powerfully forged. What do the policies of the Mexican medical system signify for the birthing experiences of Oaxaqueña women and their formation of bonds with their children? The next chapter examines the state of scholarship on this and related topics, and highlights the gap in understanding this investigation.

Literature Review

In Oaxaca, the process of giving birth with the assistance of a midwife has declined significantly with a concomitant rise in hospital births. Much literature is made available on the decline of midwifery, but minimal research exists examining the birthing experiences of Oaxaqueña through their perspectives, and especially from Oaxaqueñas living in Oaxaca's Central Valley. Due to the absence of such information, I draw upon literature on the birthing experiences of Oaxaqueñas and other marginalized communities in the United States to inform understandings of the reproductive health experiences of Oaxaqueñas in the Central Valley. This literature review is divided into three sections to highlight the structures that can be involved in the birthing decision of Oaxaqueñas being (1) medical personnel construction of patient's compliance through subjectification; (2) medicalizations as social control and the clinical gaze; and (3) the state's biopower in birth outcomes.

Patients Compliance through Subjectification

The medical system has been the primary space where messages are given to women about their "optimal" birthing options and perinatal care, as well as models that produce "ideal" patients. Gálvez's (2011) ethnography on Oaxaqueñas perinatal care in New York illustrates the process of constructing the ideal patient, who is forced to leave behind her indigenous perinatal knowledge when she enters the clinic. She describes the construction of an ideal perinatal patient as "subjectification" that involves disciplining her behavior and attitude through "schemes of surveillance, discipline, control, and administration" (2011: 85, 119). The messages women obtain in the medical system

come to be portrayed as directives rather than suggestions, which contributes to the monitoring and construction of an ideal patient on behalf of the medical staff.

Galvez provides example of the directives given to Oaxaqueñas by medical personnel, with the treatment of expectant mother, “Jessy.” Gálvez states that a nurse scolded Jessy many times for screaming during her labor, and because she would not stop, the nurse decided to inject her with an epidural shot. Gálvez argues that “far from being given the option in an informed consent procedure of chemical pain management,” Jessy was given a “clear mandate” (2011:107). Through medical interventions such as epidural injections, women lose control over their birthing process, which Gálvez argues is easier to apply to marginalized groups like Oaxaqueñas and Latina immigrants, because they frequently arrive already socialized in their home countries to accept biomedical treatments (2011:107).

Davis-Floyd (1986) equates that socialization to “technocratic models of perinatal care and draws upon the work of Jordan (1992) to discuss such practice as a form of removing other ways of knowing through the administration of authoritative knowledge and practice. Jordan describes this socialization process as “legitimizing one kind of knowing [which devalues, often totally dismisses, all other way of knowing, [so that] those who espouse alterative knowledge systems are often seen as backward, ignorant or naïve troublemakers” (Jordan 1992: 2 quoted in Davis –Floyd and Davis 1996: 258). In such situations, the medical system possesses and utilizes social control to dictate what constitutes the ideal form of giving birth as well as implement the kinds of medical interventions needed to impose the ideal form.

Medicalization as Social Control and the Clinical Gaze

Conrad (1992) argues that the ability to execute medical interventions by medical institutions in the United States is the process of medicalization, which he describes is a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness or disorders. By medicalizing a woman's birth, medical personnel obtain the greatest social control form having the authority to define certain behaviors, persons and things, which add to Gálvez's subjectification process in the clinics. Medicalization, according to Conrad (1992), occurs on at least three distinct levels: the conceptual level, institutional level, and interactional level. In the conceptual level a medical vocabulary (or model) is used to "order" or define the problem at hand and few medical professions are involved (Conrad 1992). In the institutional level organizations may adopt a medical approach to treating a particular problem in which the organization specializes. Lastly, in the interactional level physicians are most directly involved.

I use Conrad's concept of medicalization to describe the high number of hospital births and the performance of unnecessary epidural injections, which often times lead to cesarean sections. Conrad (1992) argues that the push to hospital births among women of color has been possible with the "medicalization of birth" performed by the medical system. The medical system then sees the bodies of women of color as broken bodies needing repair. This has made unnecessary cesarean sections part of the norm. In this investigation, I examine medicalization at the institutional level.

Gálvez states that since Jessy was not acting as the ideal submissive patient the nurse wanted her to be, the nurse decided to interfere in her birth with the medical intervention of an epidural shot, leading to an easier patient to control. Jessy was disturbed by the way her labor and delivery seemed to become complicated when it had begun without complications, which was typically the experience of many of the Oaxaqueñas Gálvez interviewed. Gálvez's work provides a lens through which to examine the subjectification of ideal perinatal patients for Oaxaqueñas in the United States, and leading to the possible subjectification of Oaxaqueñas in Oaxaca's Central Valley. Conrad furthers the discussion on social control that occurs in clinics through the process of medicalization, but like Gálvez only focuses on experiences in the United States. Are women in Oaxaca's Central Valley experiencing medicalization at birth? Are they experiencing subjectification? These are the questions my investigation aims to answer.

While Gálvez does not focus on Oaxaqueñas in the Central Valley, Martin (2011) addresses the reasons behind a spike among cesarean sections among vulnerable populations. Martin focuses on poor women of color in the United States, which she argues are often placed in a position to not resist the exercise of control placed on their bodies by the medical system in this country (2011:150). This is the case because poor women of color may face certain risks if they were to resist a cesarean section. These worries are mainly centered around economic concern such as not having the financial resources to wait extra hours for their expected delivery in the hospital, and family members not having the flexibility to take days off to care for the mother and infant in the

hospital (2011:155). Another explanation Martin provides for the increase of cesareans among poor women of color is based on the historical tendency the U.S. medical system has had on introducing medical investigations on the bodies of poorer patients. As Martin states,

A historical pattern prevails: technology is introduced on poorer patients [of color] where it is tested, and where physicians learn to use the new methods, devices or medications; if accepted, it is then passed on the private sector and becomes the preferred “modern” style of practice (2011:151).

As one can see the bodies of women of color according to Martin are preferred for medical investigations, which can lead to another possible reason to high number of cesarean sections among these women.

While the work of Conrad and Martin provide conceptual tools through which to undertake this research Holmes (2013) adds other theoretical concepts as well as a focus on the specific population of interest. Through his work on the health access of Triqui Oaxaqueño farmworkers from the United States and in San Miguel, Oaxaca, Holmes investigates how social and economic structures affect health professionals, the ways they perceive and respond to their patients, and the care they ultimately offer. He describes this limited lens as the clinical gaze, which he derives from Foucault’s *The Birth of the Clinic*. Holmes (2013) states that with the clinical gaze, it is no longer considered necessary for doctors to listen to their patients describe their symptoms in order to diagnose and treat them. Through his ethnographic study with male farmworkers who experienced health problems, Holmes (2013) was able to point three important aspects of the clinical gaze being: physicians in migrant health-as in other biomedical spaces value their own observations and biotechnical testing of the patient’s body over the words of

the patient, physicians in migrant health as in other clinical sites may inadvertently blame their patients for their suffering and lastly structural violence victimizes not only the poor and the patient but also, though in a different fashion, the professional, the physician. Oaxaqueñas may find themselves facing these same aspects of the clinical gaze when seeking perinatal care from medical personnel.

Holmes (2013) notes that physicians in migrant health--as in other biomedical spaces--value their own observations and biomedical testing of the patient's body over the self-reports of patients. This was exemplified in the case of a Triqui farmworker who had a knee problem caused by labor practices, yet doctors paid little attention to his descriptions of his social and employment history. Holmes cited cases where physicians in migrant health inadvertently blamed patients for their own suffering. Yet these incomplete diagnoses cannot be entirely attributable to the fault of health providers. Holmes (2013) describes the lives of physicians in San Miguel as busy, involving a hectic environment with only partial information about the patient and perform an examination and an interview, and formulating and enacting a plan within a ten-to-fifteen-minute appointment.

Holmes (2013) argues that physicians in Triqui communities are unable to engage the social context that produces their patient's suffering, which is the effect of the clinical gaze. Holmes argues that physicians are also affected by social, economic, and political structures, leading to their clinical gaze. Some of their blindness to social and political context is caused by the difficult, hectic, and emotionally exhausting circumstances in which they work. It is caused by the way medical science is thought and taught in the

contemporary world. The lenses they have been given through which to understand their patients have been narrowly focused, individualistic, and social. Holmes differs from Gálvez, Martin, and Conrad because he incorporates the possible reasoning to the cold and distant relationship between medical personnel towards their patients seen through the clinical gaze.

State's Biopower

To summarize, then, Gálvez provides an analysis of the construction of ideal perinatal patients, Conrad and Martin provide the reasons to medicalizing a birth, and Holmes about the clinical gaze affecting how medical personnel view their patients. The underpinnings of all these constructions is biopower developed by Michael Foucault, which he defines as the “means through which the state regulates, manages, and produces life, which eventually is enforced by the individual itself” (2016:05). Biopower acts first at the level of institutions and then through the self-discipline by an individual, who comes to learn how he or she is supposed to act and then in society in order to be part of the norm. The action an individual or institution takes to enforce biopower is defined as biopolitics (2016:05).

Biopolitics can find their tangible expression through birth rates, fertility rates, and infant mortality among others, which was seen with black women of the United States. In her book, *Killing the Black Body*, Roberts (1997) illustrates how biopower has controlled the bodies of African American women since slavery to the present: during slavery there was a push for the reproduction of black women for a capitalist interest and now there is push for the control of their reproduction because they are not considered

“ideal” citizens for the state. The state has portrayed them as sexually active women and “monster” moms, leading to political statements of controlling the reproduction of this community. This has led to uninformed sterilizations by the medical system and constant monitoring by the state (Roberts 1997), all part of medicalization, and production of “ideal” individuals as expressions of biopower.

The scholars presented in this literature review demonstrate how the medical system and the state can control the bodies of women of color domestically and internationally through the process of medicalization and social control. But, they have not touched in depth how medicalization, subjectification, clinical gaze, or biopower affects Oaxaqueñas of Oaxaca’s Central Valley and specifically their birthing decisions. The work of Gálvez on Oaxaqueña perinatal experiences in the United States provides the entrance to begin discussing the birthing experiences of Oaxaqueñas in Oaxaca’s Central Valley. Conrad and Martin provide the political justifications to medicalize reproductive care. Holmes elucidates the reasons for the limited understanding medical personnel have to their patients suffering on a social context. Foucault’s theory of biopower provides the theoretical underpinnings tying all these concepts together. To all these studies, I add investigation of indigenous women and their experience in Oaxaca’s medical system. Not just another case study, my unique position as an Oaxaqueña also offers the possibility to start to hear the voices of Oaxaqueñas themselves.

Methodology

This thesis draws from ethnographic data collected from participant observation and interviews with self-identified Zapotec mothers, pregnant women, midwives, and non-Zapotec medical personnel of Oaxaca's Central Valley except with a doctor from San Baltazar, who is a Zapotec woman. Data were collected from August 5 to September 15, 2015. This investigation is also informed by my field experience in the Mayan communities of Chumbec and Xanlah in the state of Yucatan from July 1 to August 27, 2014. This earlier experience sparked my interest in continuing investigating the perinatal and birthing experiences of Zapotec women from Oaxaca's Central Valley. I spent around a week and a half each in the four communities of Santiago Matatlan, San Dionisio, Tlacolula de Matamoros, and San Baltazar, interviewing pregnant women and mothers of children under 18 years of age about their birthing experiences. The women I interviewed varied in age from 18-60. In addition, I had conversations with medical personnel and midwives about their encounters with Zapotec women. I interviewed four midwives, five medical personnel, seven mothers, and nine pregnant women.

In Oaxaca's Central Valley I stayed with family members, leaving me to travel by taxi to each community in this region. By staying with family members, I became known in the towns, earning trust from the women I was interviewing and confidence to engage in my fieldwork. In addition by practicing in the cultural practices of the Central Valley such as being a participant of the *calenda* of Santiago Matatlan, I was in the eyes of the public. This gave me an advantage when requesting interviews because my face became familiar to many women, as many Zapotecas/os attend *calendas*, leading to many of their

approvals for an interview when requested. During my stay in the Central Valley I also spend some time teaching English to young children in the town of Teotitlan del Valle, which gave me credibility as an Oaxaqueña who cared about their community because not all Oaxaqueños from the United States spend their summer teaching English, many instead visit Oaxaca to see family members and attend their town's festivities.

Study Participants

Pregnant Women

Women who at the time of the study were pregnant represent an important group for my investigation as their interview responses gave me insight into their decision-making processes, options and influences determining their birthing process. In terms of recruiting informants, I was able to identify women with the help of local midwives and medical personnel. I interviewed nine pregnant women: four from San Dionisio, four from Tlacolula de Matamoros, and one from San Baltazar. I was unable to have any interviews with pregnant women from Santiago Matatlan, as they either declined to participate or were out of town. Questions that I asked these women varied from what perinatal care they were using, to who was advising them about their birthing practice and can be found at the appendix of this thesis. The interviews were conducted at their homes and local clinics according to the preference of the informant. All of the pregnant women I interview only completed elementary are varied in age, the youngest being 17 years of age and the oldest 50. The median age of this group was 22 years of age. None of the pregnant women wanted to engage in a home birth. Only one pregnant woman out of the 13 I interviewed had her husband present when I was interviewing her.

Mothers

Mothers with children less than 18 years of age (yet who were at the time of the study not pregnant) were another group of informants, and, compared to expectant mothers, were easier to invite to participate in my investigation. Informants were recruited in Santiago Matatlan and San Dionisio through an announcement about my investigation given in talks held by Oportunidades-Prospera¹ staff in their town's clinic. After the talks by nurses and doctors on subjects such as lactation, I would ask permission to announce on my investigation. I would introduce myself to the mothers as a student from "*el Norte*", the United States, who was investigating the birthing experiences and perinatal care of Oaxaqueñas in this region. I told them that I was born in the hospital of Tlacolula de Matamoros and immigrated to the U.S at the age of three, but never left behind my Oaxaqueña roots, which was the reason to my return. I disclosed to them that coming back to Oaxaca was only made possible because of my research, since I did not have residency in the United States and could not jeopardize my education by coming before policies changed. I felt this information was important to disclose because I did not want my participants to see me as being ashamed of my Oaxaqueña heritage, which prevented me from coming back to Oaxaca. After giving them my script, many were willing to participate in my investigation. At that moment I realized the extent to which my indigenous background as an Oaxaqueña greatly facilitated my research. I wished that I had the ability to speak Zapoteco; I communicated with

¹ Oportunidades is a Mexican government program that was established in 1996, to

monolingual indigenous speakers through the assistance of my research partner, Gabriela Garcia Santiago, who lives in Santiago Matatlan and translated for me.

Like the expectant mothers I interviewed, all of the mothers of this investigation completed elementary and the median age of this group was 32. Some of the questions I asked included: What birthing option was recommended to you? Who recommended your birthing option? Do you feel that birthing option is adequate for you? How do you view traditional forms of giving birth and their accessibility for your community? (see complete Interview Guide in Appendix 5).

Midwives

I interviewed four midwives, one from each town. Since I was in the area the previous summer conducting preliminary fieldwork, many of the midwives remembered me, making it easier to have their consent to participate in my investigation. I went to each midwife's house and gave her my summary, and a consent form for the investigation. Two of the active midwives, Rosa Garcia of Tlacolula, and Vanessa Ramirez of San Baltazar², were the ones that helped me immensely in my investigation. Both of them took me around the town and helped me spread the word of my senior thesis. The youngest midwife I interviewed was 24 years of age and the oldest was 80.

Medical Personnel

² The names given are pseudonyms. I did not use the real names of my interviewees in this thesis.

The medical personnel from this investigation included doctors and health promoters. I interviewed two health promoters from San Dionisio and Tlacolula de Matamoros. I interviewed a doctor in Matatlan as well as in San Baltazar. All medical personnel except the health promoter from San Dionisio were women. The median age for this group was 30 and the doctors of this group attended medical school in southern Mexico, being Veracruz and Oaxaca. Doctors were the only individuals that did not want their interviews recorded. In addition, I interviewed a helper from the community home of Tlacolula de Matamoros designed for pregnant women, to know more about how it is run.³

Research Limitations

Even though my interviews were rich in descriptions, they did not provide quantitative data to support some claims my interviews made, like many women of Santiago Matatlan having cesareans for the economic interest of medical personnel. Not being able to interview municipal officials about their motive to encourage hospital births cannot strongly support my argument that they were doing this to attract visiting medical personnel to their town, because medical personnel prefer to work in towns where women are disciplined to accept hospital births.

³ Community homes were created within hospitals in Oaxaca during the 1970's to avoid infant mortality and secure a mother's life.

The Push to a Modern State

“*¿Xi guniu este’ena?*” (What are you doing later?) were the words I heard on my first day in San Dionisio by two children walking near me. I was surprised because the Zapoteco language of the Central Valley is not really spoken by young children. Mainly elders speak Zapoteco because Spanish has become the dominant language in Oaxaca. Now there is a push to increase Zapoteco in the Central Valley by teaching the language in some schools. I was able to understand a bit of the conversation the two children were having because my family in Los Angeles continues speaking Zapoteco. As I walked to the *centro de salud*, the health center, the conversations in Zapoteco were delightful auditory accompaniment.

When I reached the health center, the mostly female patients were once again speaking Zapoteco. I was surprised to see how modern the inside of the clinic looked, with colorful chairs, large windows, and newly painted in a shade of light yellow. This clinic reminded me of those I have attended in West Los Angeles. The San Dionisio clinic, aside from having a special room for presentations and one designed for pregnant women, had others for dentists, orthodontists, cardiologists and other specialists. The many medical personnel walking around were dressed in white jackets with an average age in the mid 20s. The patient response was fast, catching me by surprise because in clinics like Matatlan, cancellations on behalf of the medical personnel were frequent. During my visit, I asked the medical staff in charge if I could attain a meeting with the medical personnel who dealt with the care of pregnant women. The name I was given was José Romero, who I was lucky to find that day.

At the age of 26, José had been working in San Dionisio's health center for two years, and I had met him the previous summer. José was in charge of the perinatal care of all pregnant women in San Dionisio, which involved creating workshops for them and making sure they were regularly coming in the clinic for their checkups. He helped me connect with a group of pregnant women who would be at the clinic later that week. After talking to José, I left hopeful that the next time I would come to the health center I would be able to ask pregnant women if they were interested in participating in my investigation. On August 13, 2015, I was able to conduct five interviews out of the seven women that came to the clinic.

I interviewed all five women one by one to find out what birthing options they were planning and why. Some of the questions I asked included: What birthing option was recommended to you? Who recommended your birthing option? Do you feel that birthing option is adequate for you? How do you view traditional forms of giving birth and their accessibility for your community? (See complete Interview Guide in Appendix 5). Throughout my interviews, I came to notice that women from San Dionisio no longer wanted to engage in traditional forms of giving birth. One leading factor explaining this shift seemed to be the lack of access to a midwife.

Issues of accessibility to midwives came up in San Dionisio because the remaining midwives were elderly and municipal officials did not push for replacements to revive the practice. My first pregnant interviewee, a young woman of 17 years of age, said that if a woman from this town wanted a home birth, her alternative would be to look for a midwife in a different town, but the municipal officials of San Dionisio would look

upon this choice with disapproval. The same interviewee disclosed to me that municipal officials would announce mandatory meetings for all pregnant women to tell them that the “correct” birthing option was a hospital birth, and anything asides that placed their lives in danger, and example of the enactment of biopower through regulation of options, discouragement, and invoking of safety concerns with all promoted hospital births as the only option.

San Dionisio’s municipal officials were not only regulating the birthing options of women of their town through biopower, but as well with the process of medicalization. The ways that the birthing process was being talked about- not just by medical personnel but also municipal officials- conveyed it as more of a medical condition rather than a natural life process, and the discussion of the health dangers involved in home births- even the possibility of fatality- struck concern if not fear among women. This message early on in a woman’s pregnancy disciplines her to believe that the correct birthing practice is in a hospital and with a doctor; anything besides that made her an uncaring and even irresponsible expectant mother. If births are seen as medical conditions requiring treatment, then the only option for women in this town is a hospital birth.

I argue that the underlying reason that San Dionisio’s municipal officials harness biopower and medicalization in the birthing decision of Oaxaqueñas is in the larger mission of modernity, to appear as a thriving modern town that accepts hospital births and can thus more easily recruit of medical personnel. Bur this claim can only be made through inference because I did not interview anyone from the *municipio*. However, it is clear that Oaxaca lacks many health resources, one of them being medical personnel.

Many of the medical personnel in this southern state are visiting doctors mostly from urban areas that stay for a duration of two years to complete their residency in order to be certified doctors. They are required by the federal government to travel several hours away from their friends and family during these two years, and work in a town where the people speak a different language (Holmes 2013:130). This drastic change in environment can be frustrating, exacerbated by local residents “clinging” to their traditional health practices and beliefs. If instead medical personnel have the choice to move to a town where the expectant mothers are disciplined to accept hospital births, this would make the job of the residents easier, and they may choose to perform their service in such places. Such disciplining and push for conformity with the norms of areas that are urban and less indigenous is made possible with the mandatory meetings municipal officials hold for expecting mothers, explaining to them that the “correct” birthing option is a hospital birth, and any other birthing option will likely cause fatalities.

In addition, a town with facilities would be appealing for visiting medical personnel, since they have to live in the clinic during their stay. Clinics are funded by the state, but municipal officials can add any modifications, which seemed to be the case in San Dionisio. When I stepped into the health clinic of San Dionisio, I felt I was in a clinic in the United States, which I did not sense in the other town clinics during my study.

The town’s municipal officials had a crucial role in providing the best quality of care, where the voices of all people in the town should be taken in consideration. San Dionisio alike other towns in the Central Valley are governed by *usos y costumbres*, customs and traditions, where the town creates their own governing laws and elect town

representatives. Unfortunately, even with this governing system, the voices of women can be limited. Women from San Dionisio were not asked if they preferred the birthing option of a home birth or any other alternative. It would have been beneficial if a relationship between municipal officials and medical personnel included the opinions of expecting mothers. However, when it came to women's perinatal care, the ones who held the cards in this situation appeared to be municipal officials.

Although the municipal officials pushed for hospital births, they made a small attempt to document traditional birthing methods. They collected the names of all the midwives of the town, and provided them to the health center. The health center kept a document listing all the known midwives of the town for historical references, which anthropologists or people doing research in women's perinatal care could easily access. However, the midwives on this list were not willing participants to my study. Many of the midwives who were listed did not want to partake in my investigation because they did not want to be associated with midwifery. It almost seemed that being a midwife was not a pleasant thing to be in this town. In the case of San Dionisio, two of the midwives I visited rejected my interview invitation telling me that they do not practice midwifery, as it is a profession of the past. The closed doors of those women left me scared that no midwife from this town wanted to participate in my investigation, but luckily the last midwife I asked, Anastasia, said yes. She also stated that she did not practice midwifery, as it was no longer needed in San Dionisio. Anastasia preferred to be known as a *curandera*, healers, rather than *partera*, midwife.

José informed me that he and other medical personnel would visit the midwives annually. I did not have the opportunity to ask him what he asked during those visits, leaving me with many questions. Were they encouraging midwives to not teach others midwifery? Were they checking up on them to see if they needed any financial assistance? Did they just want to learn more about midwifery? These questions were left unanswered.

My interviews in San Dionisio with expectant mothers, medical personnel, and midwives indicated that municipal officials were pushing women to hospital births. The possible reason for the push of this birthing option on behalf of municipal officials might have been to present San Dionisio as a modern town, to hopefully recruit medical personnel in the town. Medical personnel would prefer to be in a town where the patients come already self-disciplined to accept hospital births and other medical interventions, which municipal officials aimed to do. But, like stated I cannot make this a strong claim because I did not interview municipal officials of San Dionisio. Women from San Dionisio became second actors to the choosing of their birthing option, being a hospital birth. There might have been women who were able to extricate themselves from the monitoring of municipal officials in regards to their birthing option, but I did not have the opportunity to meet any of those women.

The Participation of Midwives

“Es un responsabilidad que tenemos las parteras para la comunidad” (It is a responsibility that we midwives have for our community) were the words of my first midwife interviewee from the town of Tlacolula de Matamoros. Rosa Garcia, age 49, has 35 years of midwifery experience. I had previously met Rosa last summer, when I spoke with midwives in Oaxaca and became familiar with the areas where I would conduct my interviews the following summer. The intention of interviewing midwives like Rosa was to hear their perspectives about hospital births and biomedical medical interventions compared to their experiences in assisting women in more traditional deliveries. Some of the questions I asked them were: How has your experience been as a midwife in this town? What training did you receive? What is the relationship between you and the medical personnel in this community? I argue in this chapter that midwives are aware of the negative implications associated with practicing midwifery, but that the response of these parteras are quite bifurcated, with some reducing the number of natural births they assist while others have become more vocal in their advocacy about their roles as midwives.

In her interview, Rosa, revealed the negative stigmas that can be placed with the profession of midwifery, being that it is an unsafe option for birth. This stigma was not only seen in Rosa’s interview but as well with the other midwives I interviewed, precisely in the case of Vanessa Ramirez. Aged 24, Vanessa was one of the recognized midwives of San Baltazar, which was a twenty-five minute taxi drive from Tlacolula de Matamoros. She became interested in midwifery at the age of 14 and leaned to that as a

profession after high school. Since her mother-in-law was a certified midwife, her training was enough to help Vanessa become certified by IMSS. Vanessa then at 18 began mentoring women in their pregnancy and assisted in few home births.

Vanessa was more of the liaison to the town's medical personnel in recommending women from San Baltazar to have hospital births. The doctor of *el centro de salud*, health center, would give Vanessa names of known pregnant women in hopes that she could help them maintain a healthy pregnancy. It was as though a pipeline of expectant mothers lined up for hospital births was being created through the efforts of medical personnel and now with the help of midwives. I felt that the funneling Vanessa was being part of was to eliminate the liabilities that she could face if a fatality occurred when assisting a woman with a home birth. She disclosed to me that she was not allowed to give anything else besides massages to the pregnant women she was mentoring, because she was afraid of being accused of any incidents during a woman's pregnancy that she could be held liable for.

Vanessa did not want to be in a position that would place her in legal problems with the state; therefore, she preferred and was told by the town's doctor to eliminate her assistance in home births only to emergencies. This was not the case for Rosa. Rosa kept assisting women in home births and suggested other traditional perinatal care, such as thermal baths. Even though Vanessa had more training by medical personnel and a longer time as a certified midwife than Rosa, her legal fears stopped her from exercising the practice of midwifery. Vanessa expressed that due to the negative remarks and constraints at the hands of medical personnel and government officials faced by some of

her midwife colleagues, she reduced her risks by limiting her services in planned home births. As a case in point, Gloria Chan from Chumbec, Yucatan faced legal complications in her participation with midwifery.⁴

Out of fear of legal consequences, Vanessa has limited herself to mainly providing massages and giving suggestions to pregnant women about a healthy pregnancy. She works closely with the town's doctor and nurse in mentoring San Baltazar's pregnant women, and only in emergencies does she assist them with a home birth. Last summer, Vanessa stated that she wanted to take science classes to strengthen her professional skills as a midwife and to avoid the negative remarks of being under-qualified, which many of her fellow colleagues received. She told me that IMSS was in the works of incorporating a science portion to their midwifery certification program, which she was planning to take, but ended up not taking them. Vanessa stated the reason why she did not continue with the science classes IMSS was providing was because it was becoming too expensive. The transportation cost to her classes was becoming out of reach and she did not have the accessibility to finish her assignments on a computer. She

⁴ Gloria did not lose her midwifery license, instead she was reduced the permission documents to be able to assist in a delivery. Without the permission documents, Gloria's patients would face problems in registering their newborns with the municipality, and have problems seeking immunization vaccines from the hospitals. This has created fear for many mothers in Chumbec to have home births, even though many desired them in this community. This information was disclosed to me the first summer I went to Oaxaca and Mayan communities in Yucatan. Gloria stated that the hospitals in Yucatan no longer wanted to work with her, resulting in her becoming an activist for the revival of midwifery in her Mayan community of Chumbec. One can attain further information on the activism Mayan midwives such as Gloria have performed to regain the authority of midwifery in Marina Gonzalez Flores (2014) senior thesis, "Resistance of Mayan Women Against Obstetric Violence."

would use the town's computer lab, but since the Internet was slow she was spending more money than she should for the time in a cyber cafe. Vanessa had the passion to become certified with a science background, but such economic obstacles have stymied these efforts.

I noticed that the possibilities for a midwife to have further training in the sciences were very limited, making it difficult to counter many of the negative comments that are said about them that imply that their lack of formal education or use of “dangerous” technique endanger women's lives. In the United States, many midwifery schools include a science course, which address such concerns. In contrast to Mexico the United States is seeing a bigger push towards midwifery. It is a paradox that a post-industrial country with the most modern medical advancements is choosing to expand offerings in natural births, whereas a less economically developed country like Mexico with fewer medical advancements and strong traditional practices in childbirth pushes for hospital births to the detriment of more natural options. It is important to note that the ones preferring and being able to access a home birth in the United States tend to have social and economic privilege, and are hardly the low-income women of color who have limited options for perinatal care.

When I told Vanessa that there are women in the United States leaning towards home births, she could not believe it, and even more incredulous when I told her that midwives here tend to earn around \$80,000-90,000 a year (Chron 2016). She asked, jokingly, if I could take her with me to the United States. Vanessa earned a small stipend for her work at San Baltazar's Clinic, but nothing even remotely approaching the \$80,000

a midwife in the United States earns. Not only are there great disparities in the value given to midwifery in the U.S. and Mexico, but also in the experiences of midwives in the same region.

With the close proximity between the towns of Tlacolula de Matamoros and San Baltazar, one would assume that Vanessa and Rosa had similar midwifery techniques and responsibilities. Although both Vanessa and Rosa are both certified and hired by IMSS, Rosa was able to be in the delivery room for cesarean operations while Vanessa was not. Rosa was the first midwife I met that had this opportunity. She told me that her participation with the doctors from IMSS happened due to her role in saving the life of a young woman about three years prior.

Rosa explained to me around midnight, a baby was born during a botched delivery that almost cost the life of the mother. This young mother had her umbilical cord cut with a machete by the baby's grandmother, who was drunk at the time. Her inebriated state caused, her to forget to remove the placenta from her daughter's uterus after it did not come down itself. In a misguided attempt to sooth her daughter's labor pains by giving her alcohol, which exacerbated the inflammation and made things worse. As soon as the young woman's uterus was becoming inflated with her placenta, her brother came running to ask Rosa for help. When Rosa arrived, the young woman was in a critical condition. Rosa attempted to reduce the inflammation and remove the placenta from the young woman with an herbal tea, but the placenta was not coming down. She told the family that they had to rush to the emergency room or else risk the life of the new mother. The family did as Rosa stated and the doctors operated on the young woman

immediately to remove the placenta from her uterus. Thankfully, she survived. The doctors were proud of Rosa for bringing the recent mother to the hospital, because it saved her life. They applauded her and told her:

Tienes un corazón muy noble y [eres] una mujer que ayuda... usted le gusta ayudar y servir en este lugar de Tlacolula. Salvaste a alguien” (You have a kind heart and are a woman that helps...you like to help and serve here in Tlacolula... you saved someone).

The doctors asked if she wanted to become a certified midwife, which meant taking a midwifery course taught by IMSS medical personnel and pass the rural midwifery exam. Rosa in a breeze passed the exam and soon began working along the doctors in the hospital.

Although Rosa was certified through IMSS for a shorter time than Vanessa, Rosa had more experience, demonstrated by her rapid response to the incident that made her recognized in the hospital of Tlacolula de Matamoros. Rosa had assisted in more than 500 home births and had other instances where she saved the lives of women during delivery. I noticed that she was not afraid of the legal consequences that can be associated with midwifery as Vanessa was; on the contrary Rosa was more vocal as a midwife than Vanessa. Aside from providing massages to pregnant women, Rosa gave herbal teas. She on two occasions allowed me to go with her and visit the pregnant women she was seeing. During our visits, some family members of expectant mothers expressed negative remarks in attempt to influence their birthing decisions. One of these remarks was that midwives were not well prepared. Rosa did not get offended with those remarks and told those individuals that she was certified and proud to be a midwife in Tlacolula de

Matamoros, because there were women that preferred home births. Rosa was a proud midwife and showed it through her actions.

Through her recognized role in saving lives and support from Tlacolula's health promoters and doctors, Rosa possessed a clear advantage compared to Vanessa that would have served for Rosa's activism towards midwifery. Rosa's recognition gave her the liberty to exercise her profession and advocate for home births. In addition, Tlacolula's population of 16,510 residents necessitates more medical personnel, whereby the use of a midwife can be helpful (Nuestro Mexico 2016). Doctors arguably considered Rosa as part of their perinatal staff, because they included her to the visits they would do to identify unrecognized midwives in rural towns.

Rosa expressed to me that she felt medical personnel valued her opinions, making her feel as an asset for Tlacolula. She also interviewed other midwives in the trips, which she tells me, "*me sentí útil en continuar con la partería,*" (I felt useful to continue with midwifery). Rosa advised midwives to become certified in order to serve better their community, as she was doing in Tlacolula. Rather than being given a script to recite by the medical personnel, Rosa was instead speaking on behalf of her experience as a certified midwife. Rosa explained to the midwives she spoke to that by becoming certified they were able to maintain their traditional perinatal practices, if the doctors felt it was safe and they passed the rural midwifery exam. Rosa from Tlacolula de Matamoros seemed to be the only midwife who was able to practice midwifery freely without any constraints from the municipal officials or medical personnel.

In San Dionisio and Santiago Matatlan, in contrast, midwives were no longer active. Midwives of these towns were elderly, without successors to continue the profession. The midwife from Santiago Matatlan, Tomasa Blas, who was 70 years old, disclosed to me that she wanted for someone to continue with her *dons*, gifts, of midwifery but none of her daughters wanted to learn. Although they valued the work of their mother, her daughters were afraid to engage in midwifery as a profession as they did not want to encounter any legal complications with the authorities, if a delivery went wrong. They preferred to be their mother's translator when outside doctors or investigators like me came to visit. *Señora* Tomasa had around 40 years of experience and a good friendship with one of the doctors of the town, but was never a registered midwife under IMSS. She tells me that she was not interested because by the time doctors became more common in Matatlan she was ready to retire from her profession. The conversation I had with *Señora* Tomasa was easily made as I had interacted with her last year as well, which was not the case with *Señora* Anastasia from San Dionisio.

Attaining an interview with *Señora* Anastasia was difficult, because as she told me “*Ya estoy cansada de hablar de partería*” (I am tired of talking about midwifery). *Señora* Anastasia did not like to be associated with midwifery, a sentiment that other midwives with whom I tried to seek interviews in this town stated. It seemed as if she was ashamed to say that she was once a midwife. She preferred to be associated with home remedies that did not deal with midwifery, such as *limpias*, spiritual cleansings. Even though it was difficult to attain an interview with *Señora* Anastasia

because of language barriers as she only spoke Zapoteco while I did not, she was the only midwife in the town willing to speak. Luckily, I was with Gabriela Garcia Santiago, my research partner, at the time of the interview request giving *Señora* Anastasia a sense of comfort and familiarity, which resulted in her agreeing to the interview.

My interviews with midwives showed me that the negative discourse about midwifery might result in a bifurcated response: on the one hand, restrict the prospects of a midwife professionally and reduce her visibility, or either close a midwife in her profession, or enhance it by being more vocal about her participation in midwifery. In addition, location and knowing how to respond fast to medical problems similar to a paramedic can play a role in being able to practice midwifery with fewer risks, but a bigger sample pool of midwives need to be interviewed to make this preliminary finding a firm one. For Rosa living in a town of around 16,510 people allowed her to work with fewer complications, whereas in a smaller town like the one Vanessa lived in did not. In a larger community it can be difficult to serve the needs of everyone; therefore, allowing midwives to help in a woman's delivery can allow time for doctors to see other patients. Rosa's ability to act fast in different medical situations added credibility to her profession as a midwife, giving her the opportunity to practice midwifery more freely.

The Participation of Medical Personnel

Medical personnel from the towns in which I conducted interviews all favored hospital births. I was able to interview doctors and perinatal promoters from each town, and from both a male and female perspective. Perinatal promoters are individuals who attain information of a healthy pregnancy from doctors and provide them to the expectant mothers of their communities. They become the liaisons between the hospital and community. The main questions that I asked doctors and medical personnel to understand whether they were pushing women to hospital births were: What recommendations do you give to your patients during their pregnancy? Do you think women prefer hospital births or natural births? The interviews with medical personnel were short and tended to be one-off conversations.

A doctor from Santiago Matatlan was the first medical personnel I interviewed. “Mariaela” had resided in the community for two years, and informed me that the last reported home birth in Santiago Matatlan was 15 years ago, showing a shift to hospital births for *Matatecos*, name used to describe people living in Matatlan. She viewed this shift as a move towards modernity, and expressed support for hospital births because in her opinion they entail fewer risks. This response was commonly seen in most interviews with medical personnel.

“José” was my second interviewee for this group. His formal title as a perinatal promoter was *tecnico de promocion de la salud*, technician for health promotion. José had been residing in San Dionisio for two years as well and was helpful in introducing me to perspective interviewees. When I asked him about the roles of midwives in San

Dionisio he informed me that midwives no longer assisted in home births, just as in Santiago Matatlan. He did tell me that medical personnel from this town kept information on midwives for historical references in a booklet and visited them annually. The reason to why José would visit the midwives of the town was unknown. José did not continue talking about the role midwives had in San Dionisio, making me sense that midwifery was a taboo subject in this town. He believed that the profession of midwifery was declining, and this was for the benefit of this town. José saw giving birth in a hospital as the “safe” birthing option. The value of the traditional knowledge that midwives had was not valued much in San Dionisio, pushing women to hospital births.

This was not the case for “Alan” in Tlacolula. Alan is also a perinatal promoter but oversees a greater number of expectant mothers than José. Alan expressed in his interview that he valued the work of midwives. The value Alan had towards midwives was seen with the invitations he would provide Rosa, one of Tlacolula’s certified midwives, to interview prospective doctors for the town’s hospital. Alan acknowledged Rosa’s midwifery profession and different medical knowledge, which he felt was helpful in such a large community. In addition, Rosa’s ability to quickly respond to medical emergencies that were not only associated with pregnancy strengthened her credibility in midwifery. One example of such medical emergency is being able to help people after a car or motorcycle accident. Rosa was of a great medical assistance when a couple had a motorcycle accident in front of her house. Unfortunately, the driver passed away instantly, but Rosa was able to save the life of the woman accompanying the male driver.

As illustrated above, not all medical personnel agreed to home births as Alan, nor had a strong relationship with midwives. But, in the case of “Laura,” San Baltazar’s doctor, a strong relationship with the town’s midwives was built even despite with a limited belief in the value of their services.

Laura, a native from Oaxaca, had five months serving as a doctor in San Baltazar. She did not consider midwives or the traditional knowledge of midwifery appropriate for assisting in a home birth. Laura informed me in the interview that one of the reasons to the partnering she did with Vanessa, the local midwife of San Baltazar, was to get women to the clinic. She said,

“Ellas son la puente entre nosotros (doctores) y las mujeres.. las parteras no están al 100% para atender a las mujeres. Yo pido a las parteras que traigan a las embarazadas a mi... ser partera no tiene conocimiento científico, que es lo que debe de ser. Las parteras dan platicas para invitar a las embarazadas a la clínica. Las mujeres confían en ellas y les pueden decir si hay problemas en su embarazo, que la partera me cuenta a mi. Las parteras nomas hablan a las mujeres sobre el control familiar porque no tiene conocimiento científico”

(They are the bridge between us (doctors) and the women... the midwives are no 100% ready to attend women. I ask the midwives to bring the pregnant women to me... being a midwife does not have scientific knowledge, which is what should be. The midwives give talks to invite the pregnant women to the clinic. The women have trust in them and they tell them if there are problems in their pregnancy, which the midwife tells me. The midwife only talks to the mothers about family control because they do not have scientific knowledge).

Laura disclosed to me that since midwives in Oaxaca do not have the scientific background like midwives in the United States, they should not help a woman plan a home birth. The only case when she found it appropriate for a midwife like Vanessa to assist in a home birth was when it was an emergency. It seemed that she did not want Vanessa or the other midwives in San Baltazar to find themselves liable if a fatality

occurred. Laura only advises Vanessa and other midwives of the town to provide massages and eating recommendations to expecting mothers, because these actions will not cause any harm to the expecting mother or fetus. She stated that if IMSS implemented a scientific background to their midwife certification program, then she would not mind midwives assisting in home births.

Most of the medical personnel I interview contributed toward the funneling of pregnant women toward hospital births, which was characterized as an expression of modernity and building ideal patients with the exception of Alan.

The Experiences of Expectant Mothers and Mother

“Voy a ir con los doctores” (I am going with the doctors) were the responses of all the pregnant women I interviewed this summer when I asked what birthing option they were seeking. I interviewed a total of 13 pregnant women, six from San Dionisio, five from Tlacolula de Matamoros and two from San Baltazar. I was unable to interview any pregnant women from Santiago Matatlan. The questions I asked these women were aimed to see what factors directed them to their birthing option from their perspective. As my previous three chapters show, municipal officials and medical personnel were the main actors involved in the birthing option of pregnant women from the Central Valley, leaving midwives with a minimal participation. Most of the women I interviewed were all very timid about disclosing much in their interviews, and this is very understandable. Disclosing information about one’s upcoming delivery to a stranger is not what an expectant mother has in mind, which led to many surprised faces when I asked what birthing option they were choosing. I was able to conduct these interviews with the help of the town’s medical personnel, local midwives, and by sitting in the town’s clinics for hours to hopefully obtain an interview with a passing pregnant woman. Interviewing pregnant women were an important category to my investigation because they obviously currently are grappling with various factors involved in making a decision about birthing options.

In the case of San Dionisio, these women did not see any other birthing option beyond a hospital birth. The possibility of having a home birth was not an option, given the inaccessibility of active midwives in this town. In addition, as mentioned earlier,

municipal officials have persuaded women to not have home births. One interviewee from this town told me that the municipal officials would tell her and other pregnant women that seeking help of a midwife was what their grandmothers used to do; it is not what pregnant women do now. These women had come to associate home births with a backward birthing practice. All of the women I interviewed from this town did not want to be considered as people from the past; therefore, they did not resist the push to hospital births municipal officials were suggesting. The interview with Teresa, an expecting mother of her third child, illustrated this acceptance to hospital births in her following statement:

We are modern now and we go to the hospital. We don't use midwives, as they are not always good. We always hear about the bad midwives who often harm the mother and the child because of their lack of knowledge of the birthing procedures. We now have the same resources as women in the United States, so why not use it?

Hospital births had come to be alluring for expecting mothers like Teresa, providing them what they believed was now the efficient and proper way of giving birth. This was made possible with the institutional power municipal officials had on conveying this message, and downgrading home births.

Drawing from Conrad's (1992) and Martin's (2011), I argue that municipal officials in the case of San Dionisio effectively medicalized the birthing process as one requiring the intervention of medical personnel. Conrad argues that medical personnel have been able to medicalize people's body by creating a "problem" (i.e. delivering a baby) that needs fixing. San Dionisio's municipal officials characterize home births as the cause of perinatal problems, whose "cure" is to have hospital births. With this

negative connotation of home births the municipal officials have easily helped replace home births with hospital births, leading to their goal of appearing as a modern town in San Dionisio. In interview with expectant mothers, San Dionisio's municipal officials kept on appearing as one of the main actors involved in a woman's birth. I imagined that when I asked the questions, What birthing option was recommended to you? Who recommended your birthing option?, the patient and medical personnel relationship would have been brought up.

Pregnant women from San Baltazar showed a different response to both midwives and medical personnel. The two pregnant women from San Baltazar I interviewed had a wonderful relationship with the town's doctor, Elizabeth Chavez, and midwife, Vanessa Ramirez. These women were asked by Dr. Chavez to seek out the assistance of Vanessa whenever they had an inquiry about their pregnancy and she was not around to answer it herself. Vanessa was the second pair of eyes in a woman's pregnancy, which my interviewees were happy to have. With Vanessa available as another care provider, interviewees expressed that they felt cared about in their town, with few worries in their pregnancy. A worry that these women did have, a recurring theme in my findings, was being told a cesarean section was needed. The women of San Baltazar feared being told this, but accepted that option because they had complete confidence in Dr. Chavez's judgment. As an Oaxaqueña, Dr. Chavez was accorded a level of trust and confidence from the women in the community, readily visible in my interviews with women of San Baltazar.

Even though Vanessa had the same close relationship with my interviewees and other expectant mothers in San Baltazar, she was encouraged by Dr. Chavez to not assist in a home birth if it was not an emergency. Dr. Chavez did not want Vanessa or any other midwife in the town to assist in a planned home birth because according to her they did not have the scientific knowledge to assist a woman in her delivery. Scientific knowledge was valued in the eyes of Dr. Chavez, which anything besides that like home remedies and healing practices were not. This has left expectant mothers of San Baltazar to mainly rely on hospital births. During my time in this town, I did not meet an expectant mother who wanted a home birth, leading me to assume that women in this town like in San Dionisio and Santiago Matatlan no longer desired home births. It was not until I reached the town of Tlacolula de Matamoros that my assumption was changed, as I met a woman who recently had a home birth.

In the town of Tlacolula de Matamoros, Rosa, the town's midwife, was able to help a woman plan a home birth. Last summer, I came to Rosa's home to continue with an earlier interview and to my surprise I met Esther and her newborn of a few hours. Esther was a young woman of 19 years of age who was expecting her first baby. This was the only time that I saw firsthand Rosa assisting a woman in her post-delivery. Rosa was going to assist other women that summer, but I was unable to accompany her because of my planned interviews in Yucatan during that period. This year around I was unable to go with her again. My interaction with Esther made me see that some women in the Central Valley did desire home births, but in many towns they

were inaccessible. In the case of Esther, the inability to have access to a midwife in her town led her to seek help outside her town, leading her to seek out Rosa.

Esther represents a subset of Oaxaqueñas in the Central Valley who still desire home births, but are challenged by the lack of accessibility. My interviews with expectant mothers make me argue that not all Oaxaqueñas in the Central Valley have the opportunity to choose a different birthing option that is not a hospital birth. The interviews with mothers showed a similar situation and how they were constructed as the ideal patients for medical personnel.

“Creo que las cesáreas son más en moda, que los doctores quieren que tengamos cesáreas para evitar que tengamos bebés” (I think that cesareans are more in fashion, that doctors want us to have cesareans to prevent us from having babies), was the response of Andrea from Santiago Matatlan. Andrea gave birth to her only child eleven years ago by a cesarean section in a private clinic. She was afraid to have her birth in a civil clinic due to the horror stories she had heard from other women. Therefore, she saved up money to give birth in a private clinic. But, her experience too became a horror story. Interviews with mothers showed how they were constructed as ideal patients, which led many mothers to perceive their cesarean section hospital births as unnecessary.

A month before her expected natural delivery, Andrea was informed by a new doctor that the fetus was tangled with the umbilical cord, which could result in a fatality if a cesarean section was not done. Andrea in terror asked the doctor if there was any form of moving the fetus to avoid a cesarean section, but unfortunately the doctor responded in the negative. Andrea left the clinic feeling defeated, but soon that same

doctor called her to inform her that they could perform one last ultrasound the week before her expected cesarean section procedure. If the ultrasound showed that the fetus was able to untangle herself from the umbilical cord, then a cesarean section would not be needed. Andrea received another call from a nurse two weeks later telling her to come into the clinic, and when she arrived, she was told that the cesarean section had to be performed that day. According to the nurse, the urgency has nothing to do with the conditions of Andrea's fetus, but rather the travel schedule of the doctors. This left Andrea feeling understandably rattled and angry. She told the doctor, who was not the same one she had seen before, that it did not make sense to operate if she was scheduled for a last ultrasound in the next two weeks. Andrea told me that having different doctors see her was upsetting, because she never knew who was in charge of her delivery.

Andrea informed me that she felt the doctors just wanted to perform a cesarean section to get her out of the hospital. She was frustrated by the medical personnel telling her that an ultrasound was no longer possible so she accepted the cesarean procedure. In the operating room she was able to witness the mistreatment of her body. Even though Andrea was on anesthesia, she was still conscious of what was happening. She told me that she could hear the doctor tell loudly to the other medical personnel *¿Como que se metió otro vez en el útero?* (What do you mean she went back in the womb?). Andrea was scared that something had gone wrong after hearing the loud discussion between the medical personnel. After the operation she asked a nurse if her baby was really tangled with the umbilical cord, and the nurse responded, "No the baby was coming just right;

that there was no need for a cesarean section.” Andrea was frustrated and stated angrily in the interview,

“Yo creo que me hicieron una cesárea para que ya no tenga más hijos, porque con un parto normal puedo tener varios pero con una cesárea nomas tres por ley y sería muy peligroso”

(I think they performed a cesarean on me so I would not have more kids, because with a natural birth I could have many but with a cesarean section by law I could only have three, and that could be very dangerous).

Andrea’s birthing experience was not what she imagined, and to make matters worse, the doctors informed her that since her baby was very strong and difficult to remove from her womb, they had to surgically cut more than needed. She felt that such a claim by medical practitioner was ridiculous, because how can an infant have more strength than the medical personnel? What upset Andrea the most were the comments she received from the nurses in the post-delivery room. The nurses told Andrea that the baby was not tangled up with the umbilical cord as the doctors informed her, meaning there was no real medical reason for a cesarean section. Andrea in her interview kept on saying, *“¿Por qué yo? Yo no más quería un parto normal”* (Why me? All I wanted was a natural birth). Almost in tears, Andrea’s last comments during the interview were:

“Yo creo que no todos los doctores son de calidad. No sé si por ganar más dinero. Aquí las cesáreas son más caras que un parto normal. Cuando mi hija nació me cobraron 13,000 pesos y un parto normal iba ser 5,000 pesos. Si iba ser niño iba ser 6,000 pesos con un parto normal. Aquí califican diferente los partos y no sé por qué”

(I believe that not all doctors are of quality. I do not know if not to make more money. Here cesareans are more expensive than a normal delivery. When my daughter was born I was charged 13,000 pesos (\$1,300) and a normal delivery would be 5,000 (\$500). If it had been a boy it would have been \$600 for a natural birth. Here they determine different deliveries and I do not know).

Andrea believes that an economic reason can be behind the high numbers of cesarean sections in Oaxaca. She informed me that she paid a fee to be attended by the medical personnel of the clinic and another for her cesarean section. Andrea had planned to only pay \$500 for her natural birth in the private clinic, but then had to plan for a cesarean section delivery cost of \$1,300, catching her emotionally and financially off guard.

Advocates against cesarean sections argue like Andrea that an economic push is being made with the increase of cesareans, which advocate Christina Galante (2013) argues, happens to benefit private clinics. Galante argues that 80 percent of the births in private clinics are cesarean sections, which both Andrea and Florina's delivery was taken place at (Cimacnoticias 2013).

Florina was another interviewee from Santiago Matatlan who felt that a cesarean section as a birthing option was not appropriate. When I interviewed Florina in August of 2015, she had recently given birth to a lovely girl. Florina is a mother of three girls; the first was born in the United States with a natural birth; the second also was born in the United States but with a cesarean section; and the last one was born in Mexico with a cesarean section. She expressed to me that she received better care from medical personnel in the United States than in Oaxaca, without mixed messages. Florina told me that at the end of her recent cesarean section procedure the nurses scolded her for allowing doctors to perform that surgical procedure. According to the nurses attending Florian's post-delivery; she was supposed to have a natural birth. According to the nurses, since Florina had her first cesarean section twelve years ago that would have been enough time for her cesarean scar to heal, leading to a natural birth with no

complications. I asked Florina why the doctors performed a cesarean section with her second child and she informed me because she had less than a year being pregnant from the oldest child, which was not the case for her third pregnancy. Florina informed me that the doctors told her that a cesarean section was needed for her third child because her body was too small, which Florina believes was a lie, leading her to distrust the medical personnel.

The mixed messages Florina received before and after the operation left her confused and frustrated. I asked Florina if she took any actions against what seemed to be an unnecessary cesarean section, and she said, *“las enfermeras nomas me estaban regañando y no me dicen que debía de hacer sobre lo sucedido, y pues no hice nada”* (The nurses were only scolding me and not telling me what to do with what just happened, and so I did not do anything). Stories like Andrea and Florina are what terrify many Oaxaqueñas in the Central Valley about having cesarean sections. Many accept hospital births only if that means a natural birth. Both Andrea and Florina stressed that they did not understand why a cesarean section was needed if they never had any complications throughout their pregnancy. Why was it that in their last month before their expected delivery, the doctor decided to change the birthing option? was a common question articulated in various interviews.

The delivery experiences of Andrea and Florina show signs of the effects of the clinical gaze performed by medical personnel who see their patients as only bodies, ignoring their social and personal realities. In the clinics of the Central Valley, women expressed concern with medical personnel not elaborating the reasoning behind their

insistence on administering cesarean sections with Oaxaqueñas. Many of the women of this area, like across all Oaxaca, have a limited educational background, making it difficult for them to understand medical reasoning for a cesarean section if they are not given a further explanation using terminology that is accessible. The lack of clear, jargon-free, and thorough explanation justifying this procedure leaves women feeling that their cesarean was unnecessary. Moreover, Oaxaqueñas of the Central Valley primarily spoke Zapoteco, and thus communication in Spanish might have not properly translated to terms they were able to understand.

Anna from San Baltazar shared a similar story as Andrea and Florina. She disclosed to me that the previous doctor attending her pregnancy told her that her delivery was going to be a natural birth, but few weeks before her expected delivery, it all changed. She was informed that she had to undergo a cesarean section because her baby was bigger than expected for her body, similar to Florina's experience. Anna was in shock when she received the news because Vanessa, the local midwife of the town and also her sister, told her that her pregnancy had no complications and gave the green light to a natural birth. Vanessa could not do much to help Anna because she was not allowed to assist in a birth if it was an emergency; since Anna sought help from medical personnel first, her pregnancy became monitored and no longer was considered an emergency delivery. Because of limited financial resources, Anna gave birth in Tlacolula's IMSS hospital. Andrea, Florina, and Anna are testimonies to the effects the medical gaze performed by medical personnel can have on Oaxaqueñas in the Central Valley; the sense of lost of control over their bodies in their delivery at a medical institution.

Out of the eight mothers I interviewed, half of them had a cesarean section, and all of them felt it was unnecessary. My interviewees believed that being told by medical personnel that having a baby too big for their bodies was a sign for a cesarean section was not sufficient enough to proceed with this medical intervention. A cesarean section might have been necessary, but by medical personnel not explaining this in a manner that my interviewees could understand, my interviewees maintained their perception that their cesarean section was not needed.

During my time in Oaxaca's Central Valley, I heard many stories and experiences that disturbed me, reflecting behavior from medical personnel that treated women with a lack of concern and compassion owed to them as people and patients. At a fundamental level, doctors and nurses should possess an understanding of the linguistic, educational, economic, and cultural background of the people they serve. They should take the time to fully explain, in accessible terms, the justification for medical procedures and decisions. The health and wishes of the woman, rather than profit or expediency, should be the paramount concern. In the Central Valley, each of these conditions were found wanting in a manner that supports the idea that medical personnel, especially seen in Santiago Matatlan, viewed their patients through the clinical gaze. Many mothers like Andrea wanted to establish a friendship with the medical personnel that was going to assist them in their delivery, but that did not occur, and with expecting mothers in San Dionisio they were being funneled to hospital births by their municipal officials.

Discussion and Conclusion

This ethnographic research in Oaxaca's Central Valley examined what actors were involved in the birthing decisions of Oaxaqueñas, to answer the research question: How are Oaxaqueñas from Oaxaca's Central Valley deciding their birthing option? My initial hypothesis to this question was: medical personnel are pushing Oaxaqueñas from the Valley to hospital births for reproductive control and to present Oaxaca as a modern town who has exchanged traditional forms of giving birth with western medical technology. Through my interviews I came to see that the medical institution was not the only actor pushing Oaxaqueñas from this region to hospital births. On a local level, municipal officials were pushing women from certain towns of the Valley to hospital births, to appear a modern town for the recruitment of medical personnel to their town. When this was not the case, medical personnel were the actors who pressured Oaxaqueñas to hospital births, and for many of these Oaxaqueñas seen through unnecessary cesarean sections under the perception of these women. This was due to the limited explanation medical personnel gave these women when suggesting a cesarean section, which was the result of the clinical gaze performed by medical personnel. Lastly, midwives had minimal participation in the birthing decision of Oaxaqueñas of Oaxaca's Central Valley, due the negative discourse that was placed on midwifery, leading many to only mentor Oaxaqueñas about a healthy pregnancy.

My interviews in the town of San Dionisio showed that municipal officials held power in a local level to medicalize a woman's birth. Both Foucault's concept of biopower and Conrad's concept of medicalization came to play in the town of San

Dionisio. Municipal officials, by holding power within the municipality were able to monitor what birthing option women were choosing in the town of San Dionisio by being able to gather all expecting mothers with mandatory meetings. This ties to Foucault's concept of biopower, where the state regulates the birth outcomes of its citizens. In these meetings municipal officials would discuss the "correct" birthing option expecting mothers should choose for their well being, which was a hospital birth according to the interviews I conducted with expecting mothers. Municipal officials were able to medicalize birthing by making it seem as a medical process that needed medical interventions to avoid any fatalities, which Conrad (1992) argues comes to be seen in previously non-medical problems, often thought to be inappropriately medicalized, to possess control of the bodies of individuals. The process of birthing has gone from a nonmedical action of life, where the primary actors assisting women in their birth were midwives, to a medicalized process with the bombing of western medical technology. Municipal officials have used the medicalization of birth as a reason to push women to hospital births.

The process of medicalization according to Conrad (1992) occurs on at least three distinct levels: the conceptual level, institutional level, and interactional level. In this investigation I was interested in the institutional level. At this level, organizations may adopt a medical approach to treat a particular non-medical problem in which the organization specializes. I argue that municipal officials were able to medicalize birthing through Conrad's institutional level, where the municipality acted as the organization of power and municipal officials as the actors enforcing it. This shows that medical

personnel are not the only actors able to medicalize a non-medical problem. Municipal officials may have not specialized in birthing but had the power to gather expecting mothers to tell them that hospital births were the only form of birthing to avoid a fatality. They also explained other medical fatalities in medical terminology that one would hear in a hospital, which made them appear as having some sort of medical knowledge, leading women to a position of acceptance of hospital births.

One possible interest for municipal officials to push women of their town to hospital births is to present a modern image of their town that appeal to medical personnel. Oaxaca being a rural and underserved state in Southern Mexico is a place where many practicing medical personnel are sent to by their medical institutions, to complete their medical service. If a town appears modern, and the construction of an ideal pregnant patient is already made, one that accepts hospital births, then that town will attract many medical personnel. This is the case because there is no need to create ideal patients, as the patients themselves are already self-disciplined to the needs of medical personnel. Gálvez (2011) argues that the self-disciplining of patients occurs through the process subjectification, involving the disciplining of expecting mothers behaviors and attitudes toward their birth through schemes of surveillance, discipline, control and administration. She argues this occurs in the medical institutions, which was not the case for women in San Dionisio.

My interviews with expecting mother of San Dionisio shows that the construction of an ideal patient is not restricted to medical institutions, it can occur in a local level by municipal officials. In addition, San Dionisio officials adding modifications to the town's

clinic to appear as a modern facility might have also contributed to the high number of medical personnel in this town. San Dionisio had a high number of medical personnel in the clinic than the other towns I visited, and had more rooms and medical equipment making me feel as I was in a clinic in the United States. A concrete explanation to why municipal officials pushed expecting mothers of their town to hospital births is not made in this investigation, because I did not have the opportunity to interview municipal officials.

In the town of Santiago Matatlan, there was no construction of ideal patients to accept hospital births by municipal officials. Medical personnel in this town seemed to control the birthing decision of expecting mothers, which two of my interviewees argue came to be possible with unnecessary medicalization of their births. Both of my interviewees disclosed to me that a month prior to their expected natural birth they were informed by a new doctor, attending them in their last checkup, that a problem arose in their pregnancy, leading to a cesarean section. The cesarean section became the medicalization to avoid a fatality. These two interviewees were Andrea and Florina.

In the case of Florina, nurses scolded her for having a cesarean section. The nurses made her feel as if it was her fault for not having the desired birth she wanted, because she did not advocate enough for a natural birth. Florina was left confused with the messages she received before and after her delivery. She did not take further actions against the unnecessary cesarean section the nurses told her about, because no one guided her in the steps to make a complaint. In Florina's birthing experience, the nurses instead

of standing up against an unnecessary section scolded Andrea for not resisting, making Florina feel as an unfit mother for not advocating for a natural birth.

Andrea on the other hand fought for a natural birth even in the last minute before her expected cesarean section, but was not listened to by medical personnel. The last doctor to see her before her expected cesarean section told her that the reason why she had to undergo a cesarean section was because her baby was supposedly tangled with the umbilical cord, but when the baby was born the nurses told Andrea that the doctor lied to her. Andrea in that moment grew furious and even more so to know that the doctor had to cut extra skin in her cesarean procedure. She told me that she believes that doctors are not of good quality, and their interest in cesareans lies in an economic motive.

Emily Martin argues otherwise; she argues that the high number of cesarean section among poor women of color like Oaxaqueñas can be due to the extra worries this group can face if they were to resist a cesarean section. These worries are mainly centered around economic reasons such as not having the financial resources to wait extra hours for their expected delivery in the hospital, and family members not having the flexibility to take days off to care for the mother and infant in the hospital (2011: 155). For Martin, the economic issue poor women of color face place them in a position to not resist medical interventions; cesareans then represent a means of control over women's bodies.

Martin argues against the idea that cesareans have increased for a source of higher physician's' fees and hospital charges, which Andrea's interview suggests otherwise. Andrea strongly believes that an economic interest lies in performing cesarean sections,

because she experienced it firsthand. She told me that the only reasons why she gave birth in a private hospital was to avoid unpleasant experiences she would have faced in a civil hospital, and because she was told that she was going to have a natural birth. Andrea was willing to pay the fee for a natural birth that could have been a smaller fee in a civil hospital or with a midwife, but to her surprise she was informed that she had to undergo a cesarean section procedure and pay that new fee. She felt that there was no need for a cesarean because she never had any complications throughout her pregnancy, and why should she only be told a month before her expected delivery that a cesarean needed to be performed. Andrea felt that her cesarean section was unnecessary and only served the economic interest of the medical personnel.

Andrea resisted the cesarean section until she found herself tired of resisting, which goes against Martin's argument of poor women of color not finding themselves in a position of resistance. My interview with Andrea showed that in towns where municipal officials did not possess local power to gather expecting mothers to tell them what birthing option to choose, women held the opportunity to choose their birthing option, mainly being a natural hospital birth, and will to resist cesarean sections. But, being able to effectively resist a cesarean hardly occurred if not ever as seen with Andrea. The medical system held more power over the birthing option of these women.

Women like Andrea felt like resisting a cesarean section because they distrusted medical personnel. They distrusted medical personnel because they did not attain further explanation to their cesarean section in terms they understand, making perceive their cesarean section as unnecessary. Many of the medical personnel from this town have

showed to view their patients through the clinical gaze, where they only view their patients as bodies and not human beings, ignoring what patients have to say about their health. They no longer find it necessary to listen to the expecting mothers and instead as stated only focus on their bodies, not taking into account social and personal realities of these expecting mothers which make it difficult for them to understand the medical reasoning to a cesarean section. Many of these women have a limited educational background, making it difficult for them to understand medical reasoning for a cesarean section if they are not given a further explanation beyond the words cesarean section; therefore, Andrea perceived that her cesarean section was unnecessary. Language as well might have played a role to the perceived unnecessary cesarean section; because being told that one needed a cesarean section in a language that one is not fluent as their primary language might make it difficult to translate. For Andrea like many of the interviewees of this investigation, Zapoteco was their first language and having to translate what medical personnel told them in Spanish might have lost some meaning in translation.

My interviews with midwives showed me that they played a minimal role in the birthing decision of Oaxaqueñas of the Valley. Many were afraid to find themselves in a legal problem; therefore, they did not practice midwifery. Rosa from Tlacolula was the only active midwife who would assist women in their pregnancy, as she had the approval of medical personnel of Tlacolula. Her case was different from other midwives, because her ability to act rapidly to medical problems like a paramedic strengthened her midwifery credibility, in the perspective of medical personnel of Tlacolula. Midwives

like Vanessa only mentored pregnant women to a healthy perinatal lifestyle, because they were aware of the negative discourse on midwifery that was placed by municipal officials and medical personnel. They saw mentoring as the way to work with expecting mothers, without getting into a legal problem with the state.

Ultimately, I argue in this thesis that many women from Oaxaca's Central Valley are pressured to have hospital births by municipal officials or medical personnel, and that makes many Oaxaqueñas secondary actors in the decision making process of their own birthing option. In the case of San Dionisio, evidence supported the claim that municipal officials pressured women of this town to have hospital births to attract medical personnel, under the premise that such personnel would prefer to work in a town where women are already self-disciplined as "ideal patients" readily accepting of hospital births. Galvez argued that the self-discipline of patients through subjectification occurs in the clinics, but women of San Dionisio showed otherwise. Many women are not given further information by medical personnel about their cesarean section, which make many women wonder if their cesarean section was really necessary. This is the product of the clinical gaze Holmes discusses, which only allows the medical personnel to see their patients as bodies rather than individuals. Lastly, midwives in this region have a limited role in the birthing decision of Oaxaqueñas because many are aware of the negative discourse of midwifery, being the legal troubles they can get into if the delivery of an expecting mother goes wrong while the mother is under their supervision. This has pushed many midwives to become mentors to expecting Oaxaqueña mothers on how to maintain a healthy pregnancy, leading them to become less active in the birthing process

of these women. Rosa from Tlacolula was the only midwife who was able to practice midwifery freely, but this was due to her ability to act as a paramedic, which was an asset for the medical personnel of Tlacolula.

“Las parteras ya no quieren atender.. ya están muy grande de edad.. ya aquí (San Dionisio) cuando sabe el municipio que estamos embarazadas no nos dejan ir con las parteras. El comité llama a las embarazadas para decirles que no vayan con las parteras. Yo no dejan. Los partos en casa están bien, pero no esa una opción. Ya no va haber partos en casa, nomas con médicos”

(The midwives do not want to assist anymore... they are very old in age... now here (San Dionisio) when the municipal officials know we are pregnant they do not allow us to go with a midwife. The municipal officials call the pregnant women to tell them to not go to a midwife. They do not allow us. The births at home are okay, but are not an option. There will no longer be births at home, only with the doctors).

This interview lays out the oppressive obstacles that women must face when choosing their ideal birthing practice. Women should have the right to choose their birthing practice regardless of their economic, social, educational or ethnic background.

Personal Significance

In returning to the country I left 19 years ago to conduct this investigation, I was not only coming back to Oaxaca's Central Valley for research motives, but motivated to answer a call for greater representation for Oaxaqueñas. My mother's birthing experience has been my inspiration to investigate what leads women of Oaxaca's Central Valley to their birthing option. My investigation reveals that to this day, not much has changed since my mother gave birth. Women from the Central Valley are still facing unpleasant, even traumatic, birthing experiences. In San Dionisio, municipal officials were pressuring women of this town to have hospital births in mandatory meetings, and in Santiago

Matatlan, cesarean sections are used as a default procedure rather than natural births, even if not medically indicated.

Being born in Oaxaca's Central Valley gave me a stepping-stone to my research, which I used to my advantage. Many of the women opened up to me in their interviews, which brought a few of them to tears as they remembered unpleasant experiences many did not talk about after their delivery. Both mothers from Santiago Matatlan who felt they had unnecessary cesarean sections were the interviewees who showed emotions of sadness and anger in their interviews. Florina told me that the negative comments the nurses made to her led to her to feel like an unfit mother after her delivery. Andrea's persistence in knowing why she had to have a cesarean section, and not obtaining this information in terms she was able to understand demonstrated the clinical gaze that medical personnel have towards their patients; the lens that does not allow medical personnel to see beyond the bodies of their patients, and the social structures affecting this community.

I had to go through immigration hurdles to conduct this investigation, which to this day I cannot believe I surpassed. One of the biggest risks of this investigation was not having the assurance of being able to come back safely to the United States. Luckily, everything turned out well and I was able bring the voices of the women I interviewed in this senior thesis. My calling to do justice to the birthing stories like my mother's was worth the risk of going to Mexico.

I hope this research will bring second thoughts to policy makers when writing perinatal policies regarding indigenous women. Indigenous communities and especially

women are groups that are often overlooked and not asked when implementing policies. I hope this research becomes a tool of advocacy for indigenous women to use when they feel they are pressured to a birthing practice they do not desire. One can learn an immense amount of information on how the Mexican medical system is run and how Oaxaqueñas view home births, simply by listening to their stories. I was able to further explore the conceptions I had on indigenous perinatal care through the stories of the remarkable and strong women who honored me by their willingness to participate in my study. Disclosing one's birthing experience is not an easy subject to talk about, and I am immensely grateful for them for opening up their lives to me.

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Appendix 1

UNIVERSITY OF CALIFORNIA, SANTA CRUZ



BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE •

OFFICE OF RESEARCH COMPLIANCE ADMINISTRATION TEL: (831) 459-
1473 orca@ucsc.edu

SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ SANTA CRUZ,
CALIFORNIA 95064

7/24/2015 RE: Conflicting Discourse Regarding Indigenous Birthing Practices of the Central
Valley of Oaxaca

UCSC IRB Protocol # 2336 UCSC Principal Investigator: Mateo, Mireya Approval Date:
7/24/2015

Dear Investigator:

The Human Subjects review committee has reviewed the proposed use of Human Subjects in the project referenced above and has determined that the project is approved for a period of three years. There is no need to submit an annual renewal form before the expiration date.

This approval will expire on 7/22/2018. You should reapply for review at least one month prior to the expiration date in order to continue conducting your research beyond that date.

Please remember that modifications to the protocol must be reviewed and approved by the IRB prior to being initiated.

Additionally, it is your responsibility to promptly notify the IRB of any unanticipated problem that occurs during the research, including any breach in confidentiality or data security that places participants or others at a greater risk of harm.

The UCSC Institutional Review Board operates under a Federal wide Assurance approved by the DHHS Office for Human Research Protections, FWA00002797. Our DHHS IRB Registration Number is IRB00000266.

Sincerely,

Caitlin Deck, Director Office of Research Compliance Administration

Appendix 2

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SANTA BARBARA • SANTA CRUZ

Name: Mireya Mateo-Gómez
 Department of: Latin American and Latino Studies
 Address: 3550 Mentone Ave #6
 Los Angeles, CA 90034
 Title of Research Project: Conflicting Discourse Regarding Indigenous Birthing Practices of the Central Valley of Oaxaca

CONSENT TO PARTICIPATE IN RESEARCH

You are being invited to take participate in a research project.

Benefits: There is direct benefit in this investigation for the researcher who will write a thesis and for interviewees who will contribute to a general understanding of how birthing practices are changing in the Central Valley of Oaxaca.

Compensation: There will be compensation after this interview in form of a fruit basket. If the interview is longer than an hour, you will be provided \$5/ 50 pesos for every additional hour spent.

Permission to record interviews: With your permission I would like to record the interview to be able to make an exact transcription of the interview. The interview will be confidential. After I transcribe your interview I will erase your interview.

You may contact **Mireya Mateo- Gómez** at **001-310-904-2881** if you have questions about the research. If you have questions about your rights as a research subject, you may contact the Office of Research Compliance Administration at **001-831- 459-1473** or **orca@ucsc.edu**.

Your participation in this research is voluntary, and you will not be penalized or lose any benefits if you refuse to participate or decide to stop.

Your signature on this document means that this research study has been explained to you, that the explanation includes the above information, and that you agree voluntarily to participate.

Signature of Participant

Signature of Witness

Typed/printed Name

Typed/printed name

Date

Date**NOTE TO RESEARCHER:**

*When the IRB has approved the use of a short form written consent document, there needs to be a **witness** to the oral presentation. Also, the IRB must approve a **written summary** of what is to be said to the subject or the representative. Only the short form itself is to be signed by the subject or the representative. However, the witness shall sign both the short form and a copy of the summary, and the person actually obtaining consent shall sign a copy of the summary. A copy of the summary shall be given to the subject or the representative, in addition to a copy of the short form.*

Appendix 3

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SANTA BARBARA • SANTA CRUZ

Nombre: Mireya Mateo-Gómez

Departamento de: Estudios Latinos y Latino América

Domicilio: 3550 Mentone Ave #6

Los Angeles, 90034

Nombre de Investigación: **“Discursos Contradictorios con respecto a Prácticas de Parto Indígenas del Valle Central de Oaxaca, México”**

CONSENTIMIENTO PARA PARTICIPAR EN INVESTIGACIÓN

Usted está invitada(o) a participar en este proyecto de investigación

Beneficios : Hay un beneficio directo en esta investigación para el investigador que va a escribir una tesis, y para los entrevistados que contribuyeran a una comprensión general de cómo las prácticas de parto están cambiando en el Valle Central de Oaxaca.

Compensación: Habrá una compensación después de esta entrevista en forma de una cesta de frutas . Si la entrevista es más de una hora , se le proveerá \$ 5/ 50 pesos por cada hora adicional gastado.

Permiso de grabar entrevistas: Con su permiso, me gustaría grabar un audio durante la entrevista para que yo pueda hacer una transcripción exacta. La entrevista será confidencial. Después de hacer la transcripción su entrevista va a ser borrada.

Puede ponerse en contacto con **Mireya Mateo- Gómez** al **001-310-904-2881** si usted tiene preguntas sobre la investigación. Si tiene preguntas sobre sus derechos como sujeto de investigación, puede comunicarse con la Oficina de Administración de Cumplimiento de Investigación al **001-831- 459-1473** o orca@ucsc.edu.

Su participación en esta investigación es voluntaria, y no será penalizado o perderá beneficios si usted se niega a participar o decide dejar de participar.

Su firma en este documento significa que este estudio de investigación se ha explicado, que la explicación incluye la información anterior, y que se compromete voluntariamente a participar.

Firma de Participante

Firma de testigo

Mecanografiado/ Nombre impreso

Mecanografiado/ Nombre impreso

Fecha

Fecha**NOTE TO RESEARCHER:**

*When the IRB has approved the use of a short form written consent document, there needs to be a **witness** to the oral presentation. Also, the IRB must approve a **written summary** of what is to be said to the subject or the representative. Only the short form itself is to be signed by the subject or the representative. However, the witness shall sign both the short form and a copy of the summary, and the person actually obtaining consent shall sign a copy of the summary. A copy of the summary shall be given to the subject or the representative, in addition to a copy of the short form.*

Appendix 4

Written summary for consent form:

This investigation in the Central Valley of Oaxaca, Mexico explores the following question, "What are the experiences and expectations of Oaxaqueña women during their pregnancy?" I will be interviewing pregnant women, mothers who have children under 15, midwives, and medical personnel. Each group will be interviewed with questions that will give me an array of information, helping me answer my research question. I will be using the information provided to me to write my senior thesis. The information that you give in the study will be handled confidentially. Your name will not be used in my report. Participation will take approximately an hour or less if translation is not needed. There might be discomfort in answering these questions for pregnant women and mothers, as the topic of birth is very sensitive to a woman. If at any time you feel uncomfortable answering a question you do not have to answer it.

Benefits: There is direct benefit in this investigation for the researcher who will write a thesis and for interviewees who will contribute to a general understanding of how birthing practices are changing in the Central Valley of Oaxaca.

Compensation: There will be compensation after this interview in form of a fruit basket. If the interview is longer than an hour, you will be provided \$5/ 50 pesos for every additional hour spent.

Permission to record interviews: With your permission I would like to record the interview to be able to make an exact transcription of the interview. The interview will be confidential. After I transcribe your interview I will erase your interview.

Resumen escrito en español del formulario de consentimiento:

La siguiente investigación, en el Valle Central de Oaxaca, México explora la pregunta ¿Cuáles son las experiencias y expectativas de las mujeres Oaxaqueñas durante sus embarazos? Voy a entrevistar a mujeres embarazadas, madres que tienen hijos menores de 15 años, parteras y personal médico. Cada grupo, tiene preguntas asignadas de la entrevista que se enfocan en sus características. La información que obtendré de estas entrevistas me ayudará a responder a mi pregunta de investigación. Voy a utilizar la información proporcionada para escribir mi tesis. Toda la información recolectada para esta investigación será utilizada de manera confidencial. Los nombres de los/las participantes no serán utilizados en mi informe. La participación en esta entrevista tomará una hora o menos, si no es necesario tener un traductor. El tema del parto y nacimiento puede resultar difícil para las mujeres embarazadas y madres, y pueden los participantes sentirse incómodos. Si en algún momento algún / alguna participante se siente incómodo en responder una pregunta no tiene que responder a ella.

Beneficios: Hay un beneficio directo en esta investigación para el investigador que va a escribir una tesis, y para los entrevistados que contribuyeran a una comprensión general de cómo las prácticas de parto están cambiando en el Valle Central de Oaxaca.

Compensación: Habrá una compensación después de esta entrevista en forma de una cesta de frutas . Si la entrevista es más de una hora , se le proveerá \$ 5/ 50 pesos por cada hora adicional gastado.

Permiso de grabar entrevistas: Con su permiso, me gustaría grabar un audio durante la entrevista para que yo pueda hacer una transcripción exacta. La entrevista será confidencial. Después de hacer la transcripción su entrevista va a ser borrada.

Appendix 5

Interview Questions for ““Conflicting Discourses Regarding Indigenous Birthing Practices of the Central Valley of Oaxaca, Mexico”

These interviews will be less of a conversation but more of a storytelling with the exception of medical personnel. The interviews can last up to an hour, giving as much time for my participants to express themselves.

Interview questions for expecting mothers:

1. How old are you? *How much schooling have you had?*
2. How long have you been residing in this community?
3. Do you have more children?
4. What birthing option was recommended to you?
5. Who recommended your birthing option?
6. Do you feel that birthing option is adequate for you?
7. Are you having any complications throughout your pregnancy?
8. How has your relationship with your doctor or midwife been?
9. What do you think of your visits to your doctor or midwife?
- 10 Do you like being pregnant? How are others treating you?
11. Do you have any fears during your pregnancy? Can you explain?
12. Are you practicing any indigenous prenatal care such as: eating certain food, getting massages, vapor baths? And if yes, which one(s) and why?
13. Does your doctor or anyone else get mad that you are using indigenous prenatal care practices?
14. How do you view natural births and its accessibility for your community?
15. How do you see the future of indigenous birthing practices?

Interview questions for mothers of children under 15 years:

1. How old are you? How much schooling have you had?

2. How long have you been residing in this community?
3. How many children do you have?
4. What birthing option was recommended for you?
5. Who recommended your birthing option?
6. Do you feel that birthing option was appropriate for you?
7. Did you have any complications throughout your pregnancy or labor?
8. How was your relationship with your doctor or midwife?
9. How were your visits to your doctor or midwife?
10. Did you like being pregnant? How did others treat you?
11. Did you have any fears during your pregnancy? Can you explain?
12. Did you practice any indigenous prenatal care such as: eating certain food, getting massages, vapor baths? And if yes, which ones and why?
13. Did your doctor or anyone else get mad that you used indigenous prenatal care practices?
14. Do you believe natural births are accessible in your community?
15. How do you see the future of indigenous birthing practices?

Interview questions for midwives:

1. How old are you? How much schooling have you had?
2. How long have you been residing in this community?
3. How has your experience been as a midwife in this town?
4. When did you start your profession as a midwife and how long you have practicing it?
5. Did you always want to become a midwife?
6. What factors contributed to your decision to become a midwife?
7. What form of training did you receive?
8. Was there difficulty in attaining training?
9. How many births have you assisted?
10. How has your relationship with your patients been so far?

11. What are the obstacles that are present in performing a natural birth?
12. If obstacles during birth are presented what resources do you have to avoid any fatalities?
13. What recommendations do you give to your patients during their pregnancy?
14. What is the relationship between you and medical personnel in this community?
15. Do you think women prefer hospital births or natural births?
16. Is it difficult for a woman to have a natural birth?
17. If yes, why do you think this is?
18. What do women tell you about their interactions with medical personnel?
19. How do you see the future of indigenous birthing practices?

Interview questions for medical personnel:

1. How much medical training have you had?
2. How long have you been residing in this community?
3. How has your experience been as medical personnel in this town?
4. When did you start your profession as a medical staff and how long have you practicing it?
5. Did you always want to become a medical staff?
6. What factors contributed to your choice of profession?
7. What form of training did you receive?
8. Was there difficulty in attaining training?
9. How has your relationship with your patients been so far?
10. What percentage of births are cesareans?
11. On what do you base your decision to perform a cesarean?
12. What recommendations do you give to your patients during their pregnancy?
13. What is your relationship to midwives in this community?
14. Do you think women prefer hospital births or natural births?
15. Is it difficult for a woman to attain permission for a natural birth?

16. If yes, why do you think this is?
17. What do women tell you about their interactions with midwives?
18. How do you see the future of indigenous birthing?

Preguntas de Entrevistas para “Discursos Contradictorios con respecto a Prácticas de parto Indígenas del Valle Central de Oaxaca, México”

Estas entrevistas serán más narraciones que conversaciones , con la excepción del personal médico. Las entrevistas pueden durar hasta una hora, dando todo el tiempo a mis participante para expresarse.

Preguntas de la entrevista para las mujeres embarazadas:

- 1 ¿Cuántos años tiene? ¿Cuánta educación ha tenido?
- 2 ¿Cuánto tiempo hace que reside en esta comunidad?
- 3 ¿Tiene más niños / niñas?
- 4 ¿Qué forma de parto / tipo de parto le recomendaron a usted?
- 5 ¿Quién le recomendó su opción de parto?
- 6 ¿Cree usted que esa opción de parto es la adecuada para usted?
- 7 ¿Está teniendo complicaciones durante su embarazo?
- 8 ¿Cómo ha sido su relación con su médico o partera/o?
- 9 ¿Qué le parecen a usted sus visitas con su médico o partero/a?
- 10 ¿Le gusta estar embarazada? ¿Cómo la tratan los demás?
- 11 ¿Qué le da miedo / le preocupa durante su embarazo? ¿ Puede explicar?
- 12 ¿Está practicando cualquier tipo de atención prenatal indígena, por ejemplo: comer ciertos alimentos, masajes, baños de vapor? ¿ En caso afirmativo, qué y por qué?
- 13 ¿Su médico o cualquier otra persona se enojan de que está utilizando el cuidado prenatal indígena?
- 14 ¿Qué piensa / cree usted sobre los nacimientos naturales y su accesibilidad para su comunidad ?
- 15 ¿Cómo ve el futuro de las prácticas de parto indígenas?

Preguntas de la entrevista para las madres con niños/as menos de 15 años:

- 1 ¿Cuántos años tienes usted? *¿Cuánta educación ha tenido?*
- 2 ¿Cuánto tiempo hace que reside en esta comunidad?
- 3 ¿Cuántos hijos tiene usted?
- 4 ¿Qué forma de parto / tipo de parto le recomendaron a usted?
- 5 ¿Quién le recomendó su opción de parto?
- 6 ¿Cree usted que esa opción de parto fue la adecuada para usted?
- 7 ¿Tuvo complicaciones durante su embarazo?
- 8 ¿Cómo fue su relación con su médico o partera/o?
- 9 ¿Cómo fueron sus visitas con su médico o partera/o?
- 10 ¿Le gustó estar embarazada? ¿Cómo la trataron los demás?
- 11 ¿Qué le dio miedo durante su embarazo? ¿Puede explicar?
- 12 ¿Ha practicado algún tipo de atención prenatal indígena como: comer ciertos alimentos, masajes, baños de vapor? ¿Y en caso afirmativo, qué y por qué?
- 13 ¿Su médico o cualquier otra persona se enojó de que usted utilizó el cuidado prenatal indígena?
- 14 ¿Cree usted que los nacimientos naturales sean accesibles en su comunidad?
- 15 ¿Cómo ve el futuro de las prácticas de parto indígenas?

Preguntas de la entrevista para parteras/os:

- 1 ¿Cuántos años tiene? ¿Cuánta educación ha tenido?
- 2 ¿Cuánto tiempo hace que reside en esta comunidad?
- 3 ¿Cómo ha sido su experiencia como partera en esta ciudad?
- 4 ¿Cuándo empezó su profesión como partera/o, y cuánto tiempo tiene practicándola?
- 5 ¿Siempre quiso ser partera/o?
- 6 ¿Qué factores contribuyeron a su elección de ser partera/o?
- 7 ¿Qué forma de entrenamiento recibió?
- 8 ¿Hubo dificultad para recibir entrenamiento?

- 9 ¿En cuántos partos ha participado?
- 10 ¿Cómo ha sido su relación con sus pacientes hasta ahora?
- 11 ¿Cuáles son los obstáculos que se presentan en la realización de un parto en casa?
- 12 ¿Si se presentan obstáculos durante el parto qué recursos tiene usted para evitar tragedias?
- 13 ¿Qué recomendaciones le da a sus pacientes durante su embarazo?
- 14 ¿Cuál es la relación entre usted y el personal médico en esta comunidad?
- 15 ¿Por qué piensa que las mujeres prefieren tener partos en casa?
- 16 ¿Crees que las mujeres prefieren los partos en hospitales o nacimientos naturales?
- 17 Es difícil que una mujer obtenga permiso para tener un nacimientos natural?
- 18 Si afirmativo, ¿por qué cree que es así?
- 19 ¿Qué le dicen las mujeres acerca de sus interacciones con el personal médico ?
- 20 ¿Cómo ve el futuro de las prácticas de parto indígenas?

Preguntas de la entrevista para el personal médico:

- 1¿Cuántos años tiene?
- 2 ¿Cuánto tiempo hace que reside en esta comunidad?
- 3 ¿Cómo ha sido su experiencia como personal médico en esta ciudad?
- 4 ¿Cuándo empezó su profesión como personal médico, y cuánto tiempo tiene practicándose?
- 5 ¿Siempre quiso ser personal médico?
- 6¿Qué factores contribuyeron a su elección de profesión?
- 7¿Qué forma de entrenamiento recibió?
- 8 ¿Hubo dificultad para recibir entrenamiento?
- 9 ¿Cómo ha sido su relación con sus pacientes hasta ahora?
- 10 ¿Cuál es su tasa de cesáreas?
- 11 ¿En qué basa su decisión de realizar una cesárea?
- 12 ¿Qué recomendaciones le da a sus pacientes durante su embarazo?

- 13 ¿Cuál es la relación entre usted y las parteras/ os en esta comunidad?
- 14 ¿Crees que las mujeres prefieren los partos en hospitales o nacimientos naturales?
- 15 ¿Es difícil que una mujer obtenga permiso para tener un parto en casa?
- 16 Si afirmativo, ¿por qué cree que es así?
- 17 ¿Qué le dicen las mujeres acerca de sus interacciones con parteras/os?
- 18 ¿Cómo ve el futuro de las prácticas de parto indígenas?

Appendix 6



My participation in a *calenda*



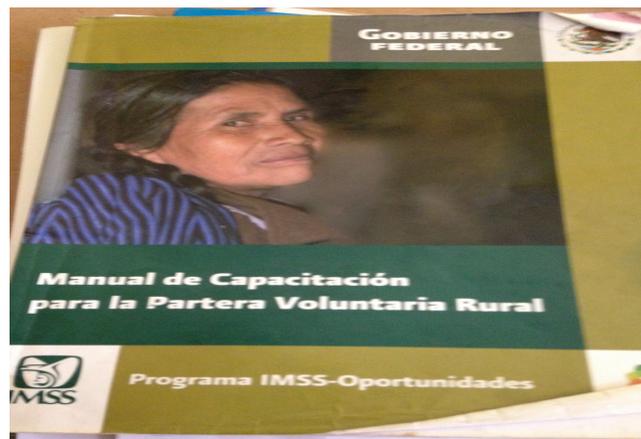
Santiago Matatlan



San Dionisio's Clinic



Emergency room in IMMS hospital in Tlacolula



Rural Midwife Handbook



San Baltazar