Traditional Midwives in Tamaulipas: The Difficult Negotiation Between Traditional Child-birth Knowledge & the Biomedical System in Mexico

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Since the 1970’s, the government in Mexico has started encouraging medical staff to work closely with traditional midwives by using training programs. As a consequence, midwifery identity and practice in Mexico is constantly being transformed. This negotiation process is not easy, as the focus of the majority of the training programs for midwives is to change midwifery practice.

The article analyzes biomedical and local practices of midwives in Tamaulipas, Mexico, with respect to training programs. The way in which training programs have possibly changed the perceptions of traditional midwifery identity and the negotiation between traditional midwifery practices and biomedicine will also be examined. The paper concludes by presenting the challenges represented by the creation of a model of intercultural health and the utilization of traditional medical resources within the national health system.

Worldwide, 34% of infant deliveries have no skilled attendant. This means that each year, 45 million births occur at home without the help of a skilled health personnel. Skilled attendants assist in more than 99% of births in more developed countries, versus 62% in developing countries (WHO, 2008).

In many Latin American countries, traditional midwives (parteras) continue to deliver the majority of babies. Currently, a total of roughly 35,000 midwives are registered in Mexico. While in the underprivileged states of Chiapas and Oaxaca 60% of births are attended by traditional midwives with little or no professional training, in the rest of the country, only 10% of births are attended by a midwife as opposed to a doctor (WHO, 2008, CNP, 2009).

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In many rural and pre-urban communities, the kind of perinatal care that midwives provide is usually deeply embedded within its own explanatory model and collectively valuated as the result of accurate hand-on experience.

The recent international attention to incorporating traditional midwives into national healthcare systems to address the high rates of maternal and infant mortality has exacerbated the pressures of medicalization and biomedical control over midwifery practices at the local level in numerous developing countries (Allen, 2002, Walsh & Downe, 2004).

By addressing the interplay between the hands-on knowledge of traditional midwives and the biomedical system, this article examines biomedical and local beliefs and practices surrounding births in Tamaulipas, Mexico, paying particular attention to the issue of training programs. It also aims to analyze the challenges present in the utilization of traditional medical resources within the national health system in relation to birth and women’s health.

At this point, I would like to clarify the rationale for the choice of the term ‘traditional midwife’ that will be used in this paper. The terminology used by different parties and individuals is extremely important in understanding the sense of authority that both midwives and health service professionals hold as well as the perceived hierarchy and control that health officials attempt to create over midwives. One term used with frequency is ‘traditional birth attendant’ or TBA.

Bailey and colleagues (2002, p.15) define a TBA as “an older woman, often with minimal schooling, who lives in the community and is recognized for her experience attending pregnant women, the birth itself, and caring for the mother and newborn immediately after the birth… providing certain services that the formal health system does not.” While used widely in the literature on the subject, the TBA term may carry a derogatory connotation of ignorance and incompetence on the part of midwives, thus imposing a narrow biomedical definition on the midwife’s role (Cosminsky 2001).

A term that has often been used in place of TBA is ‘traditional midwife.’ According to Foster and colleagues (2004), this term attempts to find a balance between acknowledging a midwife’s extensive skills and still distinguishing her from individuals with higher training. Traditional midwife ‘respectfully’ recognizes the work of these practitioners as midwifery work. The term also acknowledges the self-identity of these practitioners, while differentiating their training from a midwife who has undergone higher levels of education (Foster et al., 2004). In this article, I refer to the Mexican traditional practitioners who attend births as traditional midwives, or TMs, to distinguish them from the professional midwives. Professional midwives have formal
education in western biomedical sciences and licensure in their respective countries, either as certified nurse-midwives or certified professional midwives. WHO categorizes professional midwives as skilled birth attendants.

From the point of view of this terminology, it is also important to make a distinction between non-skilled birth attendants and skilled birth attendants. The term ‘skilled attendant’ refers exclusively to people with midwifery skills (for example, doctors, midwives, and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. They must be able to recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence, or are not possible in the particular setting (UFRA, 2011).

**Intercultural Practices & Changes in Traditional Midwifery in Mexico**

Today, in many societies, various healing systems exist in parallel with biomedicine. Where biomedicine and alternative medicine are supposed to coexist, efforts made to create so-called holistic or integrative medicine have often resulted in an unequal relationship (Baer & Davis-Floyd 2005; Langwick, 2008; Calvet-Mir et al., 2008). Biomedical practitioners have selectively integrated certain alternative practices and, at the same time, forced alternative medicine to adapt to the biomedical system (Fadlon 2004; Koss-Chioino et al. 2003).

These concerns come out of a long tradition of studies in medical anthropology focusing on medical pluralism. Kleinman (1980) distinguishes overlapping sectors of healthcare while Janzen (1978) focuses on how people resort to various medical systems using a network of family members, colleagues and friends (also see Van Wolputte et al., 2002). Finkler (1991) focus on medical encounters and Whitaker (2003) on how individuals combine explanatory models and treatments.

The present paper draws from studies that have focused upon the ways in which power relations shape medical systems through training programmes (Baer 2005; Bailey et al., 2002; DeVries et al. 2004, Geurts, 2001; Reis, 2002). The anthropological debate on traditional medicines has started assessing in a critical way the policies of integration between traditional medicine and biomedicine (Helman, 2007).

Rance Lee (1982), recognizing the unequal relationship that generally characterizes the coexistence of various therapeutic traditions in a society, has studied the ‘therapeutic pluralism’ in terms of ‘domination’ of a medical tradition over another, introducing the concept of ‘hierarchical pluralism’ in the field of medical care.
Ethnographies of pregnancy and delivery often point out the divergence that exists between the biomedical model that dominates the provision of formal healthcare and local beliefs and practices surrounding birth (Bailey et al., 2005; Bloom et al., 2001; Castaieda et al., 1992; Lorentzen, 2008). This discrepancy is a matter of concern for public health professionals who fear that ‘traditional culture’ may represent an ‘obstacle to health’ and for those who advocate interventions to replace existing beliefs with more accurate information derived from biomedicine (Brodwin, 1996; Greene, 1998; Reis, 2002).

**Mainstreaming of Midwifery in South America**

In these last few years, there have been efforts from several governments in South America to enhance a closer collaboration between physicians and traditional practitioners—midwives included—through training programs (Frenk et al., 2003, Jordan, 1993). This has created a shift in the traditional health practices and determined a process of renegotiation and adaption to the formal healthcare system (Davis-Floyd, 2001; Glei & Goldman, 2000; Sesia, 1996).

Internationally, the broad lines of a policy has already been formally expressed by the World Health Organization (WHO, 2000) in 1978 with the Declaration of Alma Ata (Kazakhstan). This declaration was centered around the concept of primary healthcare, which was considered a tool to achieve the objective of ‘health for all by 2000’. In this respect the governments have been encouraged to involve the traditional healers in the national health system, who, when duly trained, could team up with doctors. In addition, efforts to reduce maternal and perinatal mortality in the Third World by UNICEF and WHO, and those engaged in implementing the Safe Motherhood Initiative have for three decades at an international level, have been centered around TBA training. The training mostly consists of short courses taught by biomedical personnel, usually doctors, nurses, or professional midwives to community midwives (Pigg, 1997). These courses has as objectives to ‘enhance’ the midwives with additional skills in perinatal care. Particular attention has been paid to the identification of pregnancies presenting a higher risk and the enrolment of pregnant women in family planning campaigns. The underlying logic of training programs is that maternal and infant mortality rates can be reduced by improving obstetric care and referring women with complications to emergency care in a timely manner. Training programs focus on changing those practices that are deemed to be dangerous for the mother and baby while at the same time teaching midwives basic biomedical obstetrics to recognize risk signs and to know when to refer women to a higher level of care (Davis-Floyd, 2003; Feldhusen, 2000; PAHO, 2005).
As Goodmaust (2000) has shown, Mexico’s high Cesarean rates stem in large part from physicians’ deeply diffused idea that birth is a dangerous process that can cause harm to mothers and babies and that technological interventions like Cesarean sections are the best way to ensure the safety and well-being of mother and child.

**Traditional Midwifery in Mexico: from Rejection to Inclusion Through Professional Training Courses**

In Mexico traditional medical practices such as midwifery, have been often disregarded by the health policy makers till the early 1970s. Till the 70’s the main preoccupation was indeed to attain a rapid and pervasive process of ‘modernization’ of the healthcare system that had to be achieved through a form of reliance on biomedicine and modern technology (DeVries et al., 2004; Geurts, 2001, Torres & De Vries, 2009). A common argument against midwifery made by government officials was that there were plenty of doctors and nurses in Mexico, that the poor were entitled to the same care as the middle class, and therefore, the progress in maternal healthcare should entail giving everyone access to hospitals and doctors. This argument is representative of what has been called the ‘megaheretic of developmental modernization’ (Appadurai, 1996), which identifies a single point in a given area toward which all development should progress (Appiah, 1997). In healthcare, that single point is usually defined as Western biomedicine.

Having outlined the general approach of the biomedical staff towards traditional midwifery, it is important to highlight how it is not accurate to affirm that all the health providers have rejected the traditional midwives and their practices. Many doctors and nurses have clearly worked and accepted traditional midwives and made efforts to engage them in clinics and regional hospitals. This embrace has made a difference in the quality of the training of traditional midwives. There have been attempts to make training less rigidly medicalized, by focusing on ways to improve the trainee’s skills regarding hygienic conditions and the recognition of signs of high-risk births. Nevertheless, issues of class, schooling, and race shaped the interactions between those trained under the medical model and those who learned by practice, midwives included.

In 1972, the government started the first training programs for ‘traditional midwives’ to improve maternal and childcare. By 1977, the training included a section on family planning. Two factors fed the interest for supporting and expanding midwife training. First, since the system has not been able to provide quality care in all rural areas, the main objective of the initial training programs was to upgrade hygienic practices and awareness. It was also geared to the recognition of symptoms of high-risk cases and encouragement of referral of risk cases.
Second, rapid population growth required a successful implementation of family planning in rural areas where midwives were traditionally recognized and respected caregivers in their communities. They had an easy access to women in reproductive age (Parra, 1993).

The necessity to enhance maternal and child health services and coverage were the highest priorities of the primary healthcare approach adopted by Mexico in the late 1970s. They also made traditional midwives the natural focus of institutional interest. In the process of incorporation of midwives by the Mexican government into the institutional healthcare services, more than 15,000 parteras have been trained between 1974 and the beginning of the 1980s (Malvarez & Castrillon, 2005; WHO, 1999). As a result of these changes, it has become both easier and bureaucratically beneficial for parteras to attend training classes and receive licensing. In fact, only licensed parteras can register a newborn, the government requires a licensed midwife’s signature and official seal on the birth registration form if a baby is not born in the hospital.

Other measures for mainstreaming traditional medicine into the biomedical systems consisted in the implementation of a series of projects designed to create regionally based health centers as well as hospitals where both modern and traditional medicine could be practiced. This organizational movement among traditional practitioners started publicly in Chiapas over a decade ago. It has culminated in the creation of over 57 organizations, representing over 30 different indigenous groups and 18 states of Mexico, which delivered in 1992, the first National Plan for Indigenous Traditional Medicine (WHO, 2008). However, efforts toward legitimization and utilization of traditional medical resources within the national health system have proceeded in a very selective manner. Since the biomedical approach has always kept its hegemonic role in the domain of care, the only areas of traditional medicine that have been recognized are those having a greater ‘potential’ for being successfully ‘incorporated’ within the national health system. Examples are herbalism and midwifery. The fact that these domains of traditional medicine have been accepted by the biomedical system has to do with the empirical and technical nature of these practices, which health authorities often see as easily reducible to the scientific rationale. Consequently, these traditional practices have been considered to potentially support the biomedical model without substantially questioning the hegemonic medicinal system (Sesia, 1996).

Incorporating Traditional Midwives in Biomedicine through Training Courses

Training programs are generally designed to teach traditional midwives about general hygiene and preventive care. This includes
encouraging midwives to send all pregnant women to the health center/post for tetanus vaccination, prenatal examinations, and postpartum follow-up. Moreover, they are designed to instruct midwives to recognize and refer high-risk women and those with complications to a doctor or hospital (Huber & Sandstrom, 2001; Hurtado & Saenz de Tejada, 2001).

However, the training programs organized by the Mexican government which aim to reinforce the collaboration between traditional midwifery practices and biomedical medicine, have been object of criticisms (Bailey et al., 2002; Cosminsky, 2001; Goldman & Glei, 2003). The programs have been considered didactic, tedious, unnecessarily complicated, and inappropriate for older, frequently illiterate, rural women. In addition, the nurses teaching the material are often considered inadequately trained themselves, are typically unable to speak indigenous languages, and are frequently condescending to the midwives. Observers of these programs also lament the training programs’ reliance on Western, urban models of training that 1) use culturally inappropriate teaching methods; 2) advocate the use of procedures that are impractical in the midwives’ environment, particularly for home deliveries (e.g., sterilization of scissors via boiling); and 3) discourage, or sometimes condemn, traditional practices that are unlikely to have negative effects and may even have beneficial ones (e.g., delivery in an upright rather than supine position and cauterization of the umbilical cord in lieu of sterilization of scissors). Houston (2000) argues that the training programmes often fail to take account of the cultural aspects of the traditional midwives’ knowledge and practices. They also fail to create good working relations, or a willingness to learn how traditional midwives operate as a basis for developing training material.

As part of the medicalization efforts, training programs frequently condemn traditional practices (such as use of the sweat-bath, massage, and herbal remedies), and may encourage the adoption of biomedical ones in their place (Foster et al., 2004; Jordan, 1997). It has been argued that the central focus of all training programs has been to change midwifery practice, either by supplanting traditional practices with biomedical models or through delimiting traditional capabilities (Bailey et al., 2005; Feldhusen, 2000). Cosminsky (2001) states that the enterprise of teaching and learning is always an enterprise in the service of multiple agendas. Although it is ostensibly about the transmission of knowledge and skills, in a hierarchically organized society, it is also about the imposition, extension, and reproduction of lines of power and authority (Schaider et al., 1999; Sibley & Sipe, 2002). According to Davis-Floyd (2003, p. 1916):
Almost always, these courses are extensions of biopower, fingers of articulation reaching from biomedicine into indigenous communities designed not to clasp hands in mutual accommodation but to alter what they encounter. Very seldom do the ‘trainers’ enter a community and spend time there learning about indigenous birthways before they try to intervene. Rather, they attempt to educate traditional midwives in biomedical ways of thinking, most especially about conditions of risk that are deemed to necessitate transport.

The effectiveness of the retraining sessions has also been brought into question (Kumar et al., 2000). Whereas some studies find that training has an impact on knowledge, practices, or referrals (Akpala, 1994; Islam & Malik, 2001), others find little or no effect (Lynch & Derveeuw, 1994; Smith et al., 2000). Moreover, even when training appears to influence practices, researchers seldom are able to identify a positive effect on maternal outcomes (Goodburn et al., 2000; Smith et al., 2000). Studies of traditional midwives have shown that the past midwifery training programs have little or no ability to change how the midwives attend to women. When surveyed on their practices, trained midwives frequently display almost identical scores to untrained midwives in terms of what researchers deem both ‘beneficial’ and ‘harmful’ practices (Glei & Goldman, 2000; Huber & Sandstrom, 2001).

Understanding the local knowledge and practices is considered central for incorporating the traditional midwives into evidence-based care (Davis-Floyd, 2002; Houston, 2000; Smith et al., 2000). Other critics (Davis-Floyd, 2002) highlight the fact that expert knowledge transfer ignores the fact that social actors, including in this case the traditional midwives, make sense of their world as they interact with others, within a social landscape with multiple realities (Guba & Lincoln, 1989). As meaning is deeply shaped by cultural context and personal perception, knowledge transfer would need to take into account people’s sense of meaning and visions of reality. When this is not the case, knowledge transfer may reinforce hierarchies of knowledge and practices, and in some cases promote competing forms of conflicting knowledge.

Although training is now much more widespread, it is unclear how effective these institutions are and whether they truly benefit parteras in their paramedical practices and sense of identity (Bailey et al., 2005; Davis-Floyd, 2003; Feldhusen, 2000; Foster et al., 2004). This study aims to contribute to this research gap by analyzing the ways in which training programs have possibly changed the perceptions of traditional midwifery identity and the negotiation between traditional midwifery practices and biomedicine. This article explores the views on the training they receive and the applicability of knowledge they gain.
METHODOLOGY

The data presented in this paper are based on a fieldwork I carried out in the state of Tamaulipas, in the town of Tula, between February and March 2009. I conducted thirty-two interviews, 17 with traditional midwives (parteras) and 15 with pregnant women or with women who already delivered babies. I collected the data through semi-structured and open-ended interviews and with two focus groups.

I recruited traditional midwives with the assistance of healthcare providers at the local hospital and through personal acquaintances. The remaining midwives were accessed through referrals. The criteria used for selection were their work experience, number of deliveries, and attendance of a training program. The age of the parteras ranged between 48 and 68 years. The traditional midwives varied in terms of schooling: two/thirds of the parteras interviewed had between four to five years of schooling and the remaining number of the interviewees had been educated beyond the primary school level. The majority of the parteras (10 of 17) attended the training courses organized at the hospital on a regular basis (every month or every other month).

I selected the participants through personal acquaintances and by referral. I made the selection based on the parameters such as age, education and economic condition, this last element being measured on the basis of the average income available at the household level. The interviews (45 to 60 minutes each) with traditional midwives consisted of structured and semi-structured components. The structured questions aimed to collect data such as age, education, household income, number and frequency of deliveries and number of training courses attended. The semi-structured questions aimed to assess the point of view of the interviewees about the efficacy of biomedical and traditional health practices in midwifery, and to gather perceptions on intercultural health practices with a special focus on training programs for midwives.

After obtaining consent, I tape-recorded the interviews and subsequently translated them into English. In order to assure the privacy of the interviewees, I omitted the names of the interviewees or used pseudonyms.

I complemented the data obtained from individual parteras interviews, and augmented their validity of my observations by carrying out two group interviews. The groups consisted of six participants each, which were selected from women who were not previously interviewed. I purposefully selected the twelve traditional midwives who participated in the focus groups from among those who participated in the individual interviews, the criteria for the selection being their work experience,
number of deliveries and the frequency with which they participated in the governmental training programmes. I stopped the focus discussion groups when it was clear that the traditional midwives were describing similar experiences and when no new information was obtained, a stage described by Morse (1996) as saturation.

I developed primary thematic categories, such as sharing of knowledge process, types of knowledge, participation in training sessions etc., followed by codes for subthemes. Independent coders established reliability in the use of the coding system before all excerpts were formally analyzed. I refined overlaps or distortions of data, thematic categories and merged or subdivided in an iterative process. I summarized the data thematically and with illustrative quotes to capture the range of perspectives represented in the interviews.

**RESULTS & DISCUSSION**

Ten of the seventeen parteras interviewed had undergone training recently. The other seven midwives had not received any formal training and the majority of them expressed lack of interest in institutional courses.

Maria, a 39-year-old licensed partera and Clara, a 45-year-old unlicensed partera, began their profession through a religious calling from an ancestor who used to practice midwifery activities before them. The majority of the other midwives, especially the older ones whose age ranged between 52 to 64 years, acquired their expertise as apprentices to senior parteras. At the time of the study, four midwives were under 50, eight were between 55 and 60, and five were over 60 years of age. Each had at least 15 years of midwifery experience.

The total number of the midwives interviewed were charging a fee for their services, which covered attending a birth and providing postnatal care to the mother. The fee ranged from $30 to $80 USD, depending on the services provided and by the experience of the midwife. Those women that could not afford the fee, usually paid the midwife in several smaller payments or gave her gifts in exchange.

All but one of the midwives interviewed had attended a training course at some point in their careers. The implementation of the midwifery program in Tamaulipas has produced some important repercussions in the education of midwives and in the way they perceive ‘expertise’. This change in authority and perceptions from traditional knowledge and instruction to biomedical models is reflected in the forms of education among experienced and new midwives.

More than half of the midwives who have more than 20 years of experience affirmed that they learned their skills and expertise from older midwives. None of them stated that they learned the practice from
training programs. These data should be contrasted with the midwives having five or fewer years of experience. Only 15% of midwives included in the latter category affirmed that they directly learned from other experienced midwives.

In Tula, despite the increasing dominance of the biomedical healthcare system, older midwives emphasized the importance and the significance of their own knowledge and experience. They only contextualized the relevance of training programs within their own experiential knowledge and abilities. Although experienced midwives recognized the value of the training courses, the majority of older midwives affirmed that they already possessed a sufficient understanding of the midwifery practice. A middle-aged midwife who attended two training courses in the previous year stated:

*Taking part in a training course is a good experience: I got to know other people and I can discuss with doctors and other midwives. Despite this, these courses do not really add further knowledge and new information to me… I have gained a lot of experience in all these years and I already know many of the things explained in these courses…*

The interviews with the *parteras* in Tula show how, in some cases, training settings in which the transmission of knowledge and skills takes place, are instrumental in extending and further legitimizing biomedical obstetrics. With a few exceptions, trainers make no real effort to value the previous knowledge of the *partera* attending the course. For example, most *Partera’s* were not asked questions about their practice or past experience in the domain of deliveries and post-natal care. However, biomedical training courses are the primary means that allow the new midwives to gain their expertise. The new midwives who were selected to participate in the available training courses in Tula attribute their knowledge, ability, and legitimacy to their participation in these training programs. Thus, the new midwives are highly influenced by the training programs and the biomedical model serves as the template for their own stated practice. Recently trained and inexperienced midwives reflected the biomedical practices which they learned in training courses in reference with the delivery positions and the reasons for and timing of referrals to the hospital.

Interviews with new midwives shows how the construction of biomedical training also shapes the value and relevance the trainees attribute to traditional midwifery practices. Young and recently trained midwives constantly attributed their capacity and expertise in midwifery to their participation in training programs and minimized the relevance
of the experiential knowledge of older midwives. This attitude is reflected in the statement of a 32-year-old midwife:

When I started my practice as a midwife I was very preoccupied as I was not sure of myself and I did not know much about this profession. Luckily I attended some training courses organized at the Tula hospital and now I have learnt how to do the work.

The ways in which the export of Western biomedical/obstetrical knowledge devalues local forms of knowledge and perpetuates hierarchies among birth attendants is clearly exemplified in Tula. Talking about their experience with biomedical professionals during the training sessions, nine out of 17 traditional midwives interviewed affirmed that they often felt not at ease in the company of doctors, and declared that they felt nervous that the doctors would undermine their knowledge in front of the patients. This illustrates that the sense of identity of the parteras was affected by their interactions with biomedical professionals. While they felt good that they were helping their patients to get quality biomedical care, their training resulted in diminished self-esteem because the interactions often made the traditional midwives feel unqualified or ashamed. A traditional midwife in her late fifties affirms:

in the training sessions organized at the hospital the doctors tell us that we need to send women to them and try to convince the women to give birth in the hospital... There was a doctor who told us once that we are not capable of attending effectively the women and that our intervention often expose them and their babies to several risks... I have been a partera for many years, but I feel like my knowledge is inferior to Western medicine.”

When asked what they learned from the overall training experience, ten out of seventeen midwives replied that they learned about the risks before, during, and after childbirth and that they had to bring the women to the hospital if there is any sign of risks. The training programs that the traditional midwives interviewed attended seem to focus on convincing parteras that most risks and complications are beyond their control and that they need the assistance of biomedical professionals. From the interviews, it seems as though that the traditional midwives learned very few skills that could help them avoid or alleviate these risks on their own.

It is true that many of the complications that arise during pregnancy and birth are extremely dangerous and require advanced medical technology. However, parteras should be trained to approach these situations with confidence in their actions, whether those actions
are treating the woman to the best of their ability or bringing her to a hospital. Instead, what they are taught is a complete fear of anything out of the ordinary occurring.

Midwifery training programs often attempt to rebuild traditional knowledge of childbirth. However, this does not mean that the new model of midwifery is always replacing the authority of experienced midwives among women. This idea is well illustrated by the practice of prenatal massage therapy, a relevant practice which has been emphasized in numerous ethnographic studies of midwives in Mexico and Latin America. It is through the prenatal message that it is believed that the midwives are able to verify the size and age of the fetus (Paine et al. 1999). Most significantly, this type of massage is considered to be important to reposition the fetus if it has assumed an incorrect position before the delivery. Yet, during training, doctors and trained nurses place no importance on the massage therapy, and often neglect to mention it. Often, trainers talk about the massage in a negative way. Midwives are continually told that they should not attempt it, as it can damage the fetus.

Despite these warnings, more than half of the parteras interviewed perform massages. The desirability of the massage lies in the fact that the midwives traditionally consider it the most significant preventive and curative prenatal strategy that they have at their disposal. In this way, the massage becomes a sensible, rational and effective strategy among the limited technical resources that are available to the midwives.

According to the midwives interviewed, some of the functions attributed to the prenatal massage are: to estimate gestation time, relocate the baby in the head-down position, relieve and soothe the pain and detect when the time and childbirth approaches. Midwives tend to stress the massage’s potential as a diagnostic and a corrective tool in case of a transverse or breech fetal position:

> the massage is very important as it helps relocate the baby… if the massage is not done properly, the baby can come in the wrong position and this will cause major complications during the delivery… when a woman comes for a massage, I check with my hand to see how the baby is located. If the baby is positioned wrongly I have to relocate it.

Midwives & the Construction of Cultural Models in Health

The interviews with women at the hospital in Tula emphasized how there is a generally shared construction of delivery as a condition requiring the supervision of a medical expert. Although these women did not consider pregnancy to be a pathological state and many of them
did not regularly had prenatal visits, they emphasized the importance of having a knowledgeable assistant at delivery, preferably at the hospital. The efficacy of a formal health institution was explained through the fact that the practitioners at the hospital are able to utilize technologies that are inaccessible to those who are not ‘experts’. Nevertheless, while urban women of the upper strata receive care comparable to that offered in modern care centers in developed countries and may feel comfortable with the technological and social context of hospital birth, this is not the same for many lower-class Mexican women. For those women, the hospital is an unfamiliar place where decisions about their care are made according to criteria that they are often unable to understand. A traditional midwife declares:

One girl told me that she did not want to go to the hospital for her delivery because she said that she heard that doctors were not kind and that they insulted the women. She said that sometimes they also neglected the patients, who are left on their own. There have been some cases when the women went to urinate and the babies were born in the washrooms. Or it may happen that if a woman screams a lot and she is very agitated before giving birth, the doctors without hesitation make a cesarean section.

Two-thirds of the women interviewed who delivered at the hospital, expressed strong dissatisfaction with their birthing experiences. This negative judgment mainly resulted from the inadequate and negative interactions they had with nurses and doctors. More than half of the women who delivered, especially the older ones, affirmed that they were unattended at the time of the birth. These women emphasized how they labored alone in the rooms of the hospital, without the moral support of relatives or friends who were not allowed to stay with them during the labor. In addition, young women, especially those with a low education, perceived that the nurses with whom they interacted treated them without much respect. According to these women, the ill-treatment they suffered resulted from their unfavourable status as low-income patients.

Despite these negative perceptions of biomedical healthcare services, a quarter of the women interviewed at the hospital clinic, especially the younger ones, were concerned about their safety in the case of a home birth.

The point of view of women of reproductive age with respect to home delivery is well illustrated in the remarks of one woman in her early 20s to whom hospital delivery seemed a necessity: “You could risk to die if you make a delivery at home”, she affirmed. The sense of dependency on the hospital is evident in the following account of how the women in
a poor neighbourhood of Tula responded to an unexpected home birth. When one woman delivered at home following an abrupt labor, she and the other women involved were distressed at the idea that the delivery would occur at home, without the supervision of a physician. On the advice of the neighbour across from the street, the mother of this woman who was very close to delivery called the community clinic nurse, who arrived shortly after the delivery.

The midwives interviewed, especially the older ones, affirmed that the fear of a possible risk for the health of the delivering mother and the baby is the major reason that could explain why women sometimes seek hospital childbirth.

*if women were told what to expect, they most probably would not rush to the hospital. The role of midwives is to help the women to understand that they can tolerate and endure the pain… There is a natural reflex that helps get the baby out. If the woman is relaxed and if there is no form of interference, the delivery generally goes well.*

A midwife stated that of the approximately 150 births she assisted, not one woman required a caesarean. Yet she was aware that many indicators of problems change or disappear over the course of pregnancy and that unforeseen events can always happen.

Midwives’ views on childbirth and its social context are not homogeneous. Despite these differences of opinion, all of them consider the broader social context and quality of life for women and children beyond birth itself. Some of their key concerns are that ‘doctors are robbing power of women at childbirth’. As Sandra, a middle-aged traditional midwife affirmed: “*It is necessary to regain power back from the biomedical system… In the same moment when we ask the advice of a doctor about birth, we lose our power.*” The midwives aim for giving women confidence in their own body’s capacity for childbirth. The centrality of midwives as providers of alternative birthing services, is an important counterbalance to the autocracy of doctors. The midwives point out that “*doctors with their technology, take power away from women at childbirth*” by defining them at risk, and fuelling their fears of pain and imperfect children. They state that they educate and support women to allay and cope with their fears about pain and giving birth to imperfect children. Although midwives work on a small scale, many are successfully recuperating formerly used birthing methods and alternative practices.
Biomedical Approach & Traditional Midwifery: What are Some Possible Synergies?

Despite many unresolved issues, some synergies could be built between the biomedical and traditional system. Some possible advantages of biomedical approach over traditional midwifery is located in the capacity to identify the risk factors in pregnancies, and to deal with situations of emergency if it arises. This aspect is crucial as it can considerably reduce maternal morbidity and mortality. The problem of the inadequacy of primary healthcare in numerous rural regions in Tamaulipas is aggravated by the incapacity of the health services to deal with serious obstetrical complications. In other words, many women have very limited access from a geographic and financial point of view to specialized obstetrical services. Even when their midwives wish to transport them to local hospitals, in many places, there is simply nowhere to go (Nigenda et al., 2005).

The frequently experienced economic crises in Mexico and the strict budgetary restrictions of the public sector cast major doubts on the capacity of the government to enhance the presence of the primary healthcare facilities in the rural areas. Some of the principal obstacles to increasing the coverage and the performance of the local health facilities are represented by problems of understaffing, funding cuts, decreasing wages and shortage of medical supplies (ICM, 2007, Sesia, 1996). These obstacles cannot be solved within the near future. In the light of these considerations, the role played by midwifery, especially in rural and peri-urban regions will most probably be maintained in the near future.

Although training courses have often been criticized in the literature (Bloom et al., 2001; Jordan 1993), their principal pitfalls have not effectively been addressed. Efforts for implementing training courses for midwives is appropriate, although the content, methodology and underlying ideology of these courses should be revised. In this respect, particular attention should be paid to the detection of risk and referral of gestating women at risk is important. However, it is also important to teach specific techniques of intervention to the midwives, when complications arise and when medical help may not be readily available.

It is also important that the training programmes do not just include midwives but that they are also extended to the medical personnel operating at the primary and secondary level of care. The latter should also familiarize themselves with the principal methods and beliefs of traditional midwifery, especially in rural regions. These courses will be necessary to increase the respect of the medical staff towards midwives and will help to improve communication with all empirical providers of care. The relevance for maternal health of establishing a good relationship with traditional midwives is shown by this case study: the parteras who referred women with severe complications were the
ones who managed to find physicians willing to support them and stand up for them in case of emergencies.

**CONCLUSION**

Despite the current challenges, traditional midwives are important actors in local healthcare strategies. They have great potential to effectively provide for women, especially those belonging to low-income groups, a timely and culturally appropriate health service before and during the delivery. Although training courses have been organized for midwives in several countries, Mexico included, most of these efforts were not specifically designed to meet local needs and capabilities. As the current work shows, the training programs have many challenges. Some challenges are in tailoring educational modules to take into account the previous education and experience of local health promoters and midwives. Other challenges are due to the limits of the existing health system, and the practice of assessing educational needs in conjunction with local health promoters and midwives.

Although this work analyzed some of the challenges in the integration between traditional midwives and biomedical system, the positive outcomes of the collaboration between *parteras* and biomedicine cannot be underestimated. Awareness about the importance of increasing the participation of *parteras* in local health services and hospitals, both in rural and urban areas in Mexico, should be increased. Such efforts should include medical as well as nonmedical aspects of care, and therefore, should be interdisciplinary in their nature. Besides midwives, medical personnel operating at the primary and secondary levels of care should also receive training regarding ethno-obstetric practices, their benefits, and their underlying rationales. Only in this way, the cooperation and the respect that comes from a mutual understanding of different visions and practices of health can be enhanced.

It is crucial to keep in mind that the processes, methods of communication, and individual responsibilities are still being developed and refined. It is important to set up training programs as well as strategies for creating healthy relationships between the *parteras* and the formal healthcare system. Within this evolving system, it is vital that traditional midwives continue to receive support needed, and respect most deserve.

Mexico’s morbidity rate during pregnancy, delivery, and the immediate postnatal period (up to eight weeks post-partum) is nearly 50%, and the neonatal mortality rate (deaths of infants under 28 days of age) is 22 per 1,000 live births, according to official figures (WHO, 2008). The maternal mortality rate is 52 per 100,000 live births. The
professionalization of midwifery involves systematising traditional knowledge and complementing it with medical approaches, in order to reduce the risks of childbirth and better guard the health of mothers and their newborn infants. Although training for traditional midwives has a potential to positively effect the quality of healthcare system for birth and deliveries, this important goal should be approached and accomplished by fully respecting the local cultural values.

REFERENCES


Sesia, P. M. (1996). Women Come Here on Their Own When They Need to: Prenatal Care, Authoritative Knowledge, and Maternal Health in Oaxaca, *Medical Anthropology Quarterly*, 10(2), 121-140.


