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La Partera Profesional: Articulating Identity and Cultural Space for a New Kind of Midwife in Mexico

Robbie Davis-Floyd

This article documents the emergence of a new kind of midwife in Mexico, the thoroughly postmodern *partera profesional*. It traces the transnational conjunctures that facilitated her creation, illustrates aspects of her philosophy and praxis, and probes her ongoing articulations of identity. These women, who are of diverse sociocultural backgrounds, initially sought training from American direct-entry midwives in the independent out-of-hospital midwifery model; now, they are adapting that model to the situation in Mexico. Through their own practices, through intensive liaison work with traditional midwives, and through organizing national midwifery conferences and meetings, they are creating midwifery as both incipient profession and nascent social movement. Some of them operate outside the medical system while others are carving a niche within it. The mere existence of these self-consciously activist midwives constitutes a critique of monological Mexican medicine and its high cesarean rates; however, these women face a long struggle to define their identities, legalize their practices, and generate a sustainable space within the emergent Mexican technocracy. To their intense dismay, this struggle must take place within the context of the escalating disappearance of the traditional midwives whom they seek to support. The tension they feel between their desire to

ROBBIE DAVIS-FLOYD, Ph.D., a Research Fellow in the Department of Anthropology, University of Texas (Austin), is an internationally known cultural anthropologist specializing in medical, ritual, and gender studies, and the anthropology of reproduction. She is the author of numerous articles and of *Birth as an American Rite of Passage* (1992); co-author of *From Doctor to Healer: The Transformative Journey*, and *The Power of Ritual* (forthcoming), and coeditor of eight collections, including *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (1997); *Cyborg Babies: From Techno-Sex to Techno-Tots* (1998); *Reconceiving Midwives: The New Canadian Model of Care* (forthcoming); and *Midwives in Mexico: Continuity, Controversy, and Change* (forthcoming). Funded by the Wenner-Gren Foundation for Anthropological Research, she has recently completed a major research project on the development of direct-entry midwifery in the United States, the results of which will appear in *Mainstreaming Midwives: The Politics of Change*. Her studies of contemporary transformations in Mexican midwifery are ongoing.

Address correspondence to Robbie Davis-Floyd, 804 Crystal Creek Dr, Austin, TX 78746.

preserve traditional midwifery and their desire to create professional midwifery is a recurrent theme. These goals alternately complement and conflict with one another, yet both are central to the *partera profesional's* ongoing efforts at identity articulation.

Key Words: midwives, childbirth, Mexico

I was really proud and happy to be learning midwifery, and when people asked me what I did, I would say, "I am studying to be a *partera*." And my husband used to elbow me and go, "Shh, you don't understand, don't say you are a *partera*! We don't think it's cool here, like you guys think it is in the States. What *partera* means to us – it means scraggy old women in *rebozos*." And I said, "Well, I want to throw that in people's faces. They think it's scraggy old women in shawls – well, *it's me too!*" And at first he was uncomfortable with that, and now after attending lots of births with me he's the first to go up to somebody and say, "My wife is a *partera*, and the *parteras* are the greatest thing!"

– Alison Bastien, Certified Professional Midwife, 1997

A new kind of midwife is being born in Mexico. In Spanish, she calls herself a *partera profesional*, and in English (many of her number do speak English) she calls herself a "professional midwife." This article seeks to document the emergence of this new Mexican midwife, to trace the pattern of the transnational conjunctures that facilitated her creation, to illustrate certain aspects of her philosophy and praxis, and to probe her ongoing articulations of identity. Although their numbers are few, these midwives are engaged both in their own professionalization process and in spearheading a nascent social movement around the reformation of childbirth and the preservation of traditional midwifery. The contradictions inherent within these objectives challenge their feminist and inclusive ideology as they struggle with the exclusive demands of professionalization, seeking to negotiate their emergent and thoroughly postmodern identities in a country where traditional midwives are a vital but vanishing force, and where biomedicalization has come to dominate birth.

A WORD ABOUT WORDS: "TRADITIONAL," "PROFESSIONAL," AND THE "POSTMODERN MIDWIFE"

The cultural analyst...must be able to identify those sites, those moments, when people struggle to win a bit of space for themselves in the world.

– Lawrence Grossberg

This article is about the bit of space that Mexico's professional midwives are struggling to win for themselves. Their struggle necessarily encounters and interpenetrates the larger bit of space inhabited by Mexico's traditional midwives. Given the strong critique within anthropology of the term "traditional" and its potentially denigrating juxtaposition with the term "professional," I must explain at the outset that my use of both of these terms is purely ethnographic: I am calling the subjects of my study what they call themselves. In the five years that I have been working with the midwives who form the main subject of this article, I have watched them struggle with labels and finally settle on the term *partera profesional*, for reasons that will become clear later on. And at conferences put on by the *parteras profesionales*, as well as in rural villages in various Mexican states, I have formally interviewed and/or casually spoken with hundreds of indigenous community midwives, asking them (among other things) what they call themselves. A few use the term *comadrona*, and a few call themselves *parteras empíricas* (practical midwives),¹ but the vast majority use the term *partera tradicional*. They do not articulate the reasons why; when I ask them, they just say "because that's what we are." It seems to me that, in identifying themselves as "traditional," these women are embodying their own felt sense of the contingent cultural space within which they dwell. I see their use of this term as an act that signifies their engagement in an identity-making struggle with the legacies of colonialism and the forces of modernization and class stratification in contemporary Mexico. The *parteras tradicionales* I have met seem to position themselves as indigenous practitioners in uncomfortable juxtaposition with "modern" biomedical practitioners. For them, the word "traditional" appears to simultaneously encode pride in a heritage they seek to celebrate and preserve, and unease at the cultural and medical marginality that heritage presently entails. Exactly how these women perceive the meaning of *partera tradicional* remains an open question (but see Good Maust, Güémez Piñeda, and Davis-Floyd, forthcoming) – one that invites a micronarrative parallel to the one I present here for the women who call themselves *parteras profesionales*.

Following the usage of my Mexican interviewees who speak English, I will translate *partera tradicional* as "traditional midwife." That translation is subject to challenge. According to the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF), the appropriate official

terminology for those who call themselves *parteras tradicionales* is “traditional birth attendant” (TBA).² This terminology is supported by the fact that the word *parto* means “birth,” and so a *partera*, most literally, would be “one who attends birth” (just as a *curandera* is “one who cures,” a *yerbera* is “one who uses herbs,” and a *huesera* is “one who sets bones”). But there is a great deal in a name, especially in the name “midwife,” which comes from Old English and means “with woman.” This word’s encapsulation of a core midwifery value – being “with woman” during pregnancy and childbirth – ensures that it will not be readily given up by those who can lay claim to it.³ The professional direct-entry midwives I have been studying in the United States, and the *parteras profesionales* in Mexico, insist on using the word “midwife” to define themselves in English. They take great offense at the TBA acronym, believing that it both deprives those to whom it is assigned of core aspects of their identity and relegates them to second-class status in the midwifery world: they perceive it as a most unwelcome reproductive stratification (Ginsburg and Rapp 1995). Some of them are at present taking part in an international effort to agree on an alternative to the international definition of a midwife (see Introduction in this special issue) – one that is more inclusive and more respectful of the valuable role so-called TBAs play in their communities. These TBAs do not speak English and thus are not engaged in this debate. But they certainly experience its consequences, which, in most Mexican states, have kept them in a subordinate and marginalized position relative to the official health care system.

Those same consequences keep some American direct-entry midwives and some of Mexico’s new *parteras profesionales* outside that system too. The WHO-approved definition limits the term “midwife” to those who have graduated from formal government-approved educational programs. Increasing numbers of American direct-entry midwives do graduate from such programs, but many choose to gain their training through apprenticeship (see Benoit et al., forthcoming; Davis-Floyd 1998a, 1998b), as have some of the Mexican *parteras profesionales*. These American and Mexican professional midwives are solidly in favor of preserving apprenticeship as a valid educational route; they form part of an international movement to expand the international definition to include as “midwives” individuals who are locally recognized as experts in childbirth by their communities and who become such by *any* educational route, from formal government-approved programs to apprenticeship and self-

study (see Introduction). This discussion is central to an understanding of the *parteras profesionales* who are the subject of this article; some of them meet the international definition of a midwife, and some do not, yet they all support the effort to expand that definition to include themselves and the *parteras tradicionales* of Mexico, whose work they deeply respect and whose existence they wish to preserve along with their own. That those who write and speak about *parteras profesionales* accept their translation of *partera* as "midwife" and not as "birth attendant" is critical to their political and moral agenda. Thus my usage of their translation constitutes a de facto political act of support for that agenda and of resistance to the agenda of those public health officials and leaders of the International Confederation of Midwives who created and wish to perpetuate the international definition in its present form; there is no way to remain neutral in this debate.

One final word about words: when I refer to any midwives in this article as "postmodern," I am using that term as an ideal type (see Introduction in this special issue). To recap, a postmodern midwife

takes a relativistic approach to various ways of knowing about birth. . .[and] can articulate ways of making discrepant systems complementary. Recognizing the limitations and strengths of both the biomedical system and her own system, the postmodern midwife moves fluidly between them in order to serve the women she attends. Lacking or actively rejecting a sense of her practice as structurally inferior to that of biomedicine, she is free to observe the benefits of traditional midwifery practices common in many cultures (e.g., massage, external version, eating and drinking during labor, birthing in upright positions, birthing at home, and uninterrupted contact between mother and baby). She compares these with what she sees in the hospital and with what she learns about scientific evidence. . .; she concludes that biomedicine does not recognize the value of the midwifery approach; and she develops a sense of mission around preserving midwifery in the face of biomedical encroachment. In this way she constitutes her alternative praxis as a form of critique. At the same time, she does not hesitate to appropriate the authoritative lexicon, the trappings, and the technologies of biomedicine when she finds them of either instrumental or symbolic value. . .When possible, she attends conferences and meetings, making connections with other midwives in other parts of the world, increasing her ability to translate between systems, and gaining consciousness of midwifery as a global movement.

Describing the *parteras profesionales* I write about in this article as "postmodern" in no way implies that they are the only postmodern

midwives in Mexico. Indeed, I have been studying a group of Mexican traditional midwives who are very busy constructing hybrid identities in urban areas where they must constantly engage in strategic negotiations with physicians (Dietiker forthcoming; Davis-Floyd, 2001); forming regional and state associations and lobbying health agencies and authorities, as I have personally observed; and, in a few cases, attending international conferences and cultivating access to e-mail (Davis-Floyd, 2001; Good Maust et al., forthcoming). I thus intend my use of the term "postmodern midwife" to elide the distinctions between Mexico's traditional and professional midwives; the boundary between them is not firm but fluid and permeable. These issues of terminology, definition, and the anthropologist's role in the identity construction of the midwives about whom we write form critical threads in the fabric of international midwifery politics and, thus, will weave themselves throughout this article.

METHODOLOGY

Between 1997 and 2000, I conducted a series of in-depth interviews with 20 of these new midwives (and with some of their supporters) in the places where they live and practice – Mexico City, Cuernavaca, and Tepoztlán in Morelos; San Miguel de Allende in Guanajuato; and Xalapa, in Vera Cruz. I also attended national midwifery conferences that they held in Puebla (1997); Oaxaca (1998); Oaxtepec, Morelos (1999); and San Luís Potosí (2000). I continued my work with them at various conferences in the United States and abroad: I spent time with them and conducted follow-up interviews in 1999 and 2000 at Midwifery Today conferences in London, Japan, and New York City; at conferences held by the Midwives' Alliance of North America in Lake Tahoe and Orlando; at a home birth conference in Spain; and at an International Conference on Humanizing Childbirth in Fortaleza, Ceará, Brazil. Our most recent meeting was at a planning session for a conference on professional midwifery and international certification in San Miguel, Guanajuato, in February 2001. In other words, my fieldwork with these midwives has mirrored the multi-sited and transnational nature of their praxis, which is constituted not only in attending to women, but also in the political activities through which they seek to legitimate themselves in the eyes of Mexican health care authorities, to generate a new sense

of legitimacy for traditional midwives, and to articulate with the international midwifery community on their own behalf and on behalf of the those they are trying to represent (i.e., traditional midwives).

During this period, I complemented my work with the *parteras profesionales* with research on *parteras tradicionales*. At conferences in Mexico, as I mentioned above, I conducted brief interviews with hundreds of traditional midwives from all over Mexico, which I have augmented through intensive in-depth interviews with a group of seven highly urbanized *parteras tradicionales* in Cuernavaca, Morelos. These are the traditional midwives who work most closely with the professional midwives I have been studying; through this second set of interviews, I was able to learn a great deal about the complex interface between these groups in Morelos and to better understand the emergent nature of the type of midwifery being practiced by members of both. These urbanized traditional midwives (they include Doña Facunda, whose creative use of the IV pole is described in the Introduction in this special issue) are manipulating multiple knowledge systems and creatively combining biomedical and traditional practices. They, and many of their midwifery colleagues in Cuernavaca, instantiate the postmodern midwife as thoroughly as do the *parteras profesionales* under discussion here. This unusual group of *parteras tradicionales* will form the subject of further research and future articles (see Davis-Floyd, forthcoming).

BACKGROUND AND CONTEXT

Articulation offers a theory of contexts. It dictates that one can only deal with, and from within, specific contexts, for it is only there that...identities and relations exist. Understanding a practice involves historically and theoretically (re)-constructing its context...Too much of contemporary theory treats contexts as the beginning of analysis, as a background which exists independently of the context being studied...But the practice of articulation does not separate the focus from the background; instead, it is the background that actually articulates the focus.

—Lawrence Grossberg

As Grossberg suggests, the focus of professional midwifery in Mexico is articulated by the context within which it is arising. That context includes a developing society experiencing the intense biomedicalization of birth and the concomitant gradual demise of

traditional midwifery, which is widely regarded by members of the growing middle and upper classes as a "premodern" vestige of a more backward time that must necessarily vanish as "modernization" (e.g., education, technologization, economic growth) progresses. For centuries the primary birth practitioners in Mexico, traditional midwives were, by the early 1970s, attending 43 percent of Mexican births (Secretaría de Programación y Presupuesto 1979:237) – a percentage that declined precipitously over the next two decades. Between 1995 and 1996, traditional midwives attended less than 17 percent of births in Mexico (INEGI 1999).⁵ The majority of these women are over 65 years of age (SSA 1994); many are dying without having trained replacements. In general, young people in Mexico today seek a formal education and want to enter a profession; they see the hospital as the progressive place to go for birth (see also Fraser 1995). Biomedicine has not only taken over childbirth, it is also redefining its very nature. In vaginal deliveries extreme interventions like fundal pressure (*Kristeller*) and manual extraction of the placenta are common, and Mexico's 40 percent cesarean section rate is one of the highest in the world (Belizán et al. 1999). In public hospitals the rate increased from 13 percent in 1990 to 25 percent in 1997, and in Mexico City it increased from 25 percent to 37 percent (Secretaría de Salud 1998). In private hospitals, the 1997 cesarean section rate was 52 percent (Comité Promotor por una Maternidad sin Riesgos 1997; Fernández de Castillo 1997). Recent research indicates the doctor-driven nature of this excess of cesareans, which social scientists are now referring to as an "iatrogenic epidemic" (Castro, Heimbürger, and Langer n.d.).

A less interventive approach characterized the care given by an earlier generation of professional nurse-midwives. These women were known as *parteras tituladas*. They attended the majority of hospital births throughout the 1950s, and their presence was instrumental in convincing women to go to the hospital to give birth. However, in the early 1960s, in response to pressure from the growing numbers of gynecologists, anesthesiologists, and pediatricians eager to take over their role, the social security hospitals (and later others) prohibited these "titled midwives" from attending births (Carrillo 1999). As a result, around the country these *parteras tituladas*, many of whom had practiced in hospitals with relative autonomy for years, were told that they were not allowed to catch babies any more but should confine their activities to obeying doctor's orders, cutting the cord, and catching the placenta (Angeles

Camacho Rodriguez, former *partera titulada*, personal communication). They were not organized and saw no means of fighting back; angry and bitter, many of them left nursing practice for jobs in administration or elsewhere.⁶ They were replaced by nurses who do not undergo midwifery training but who do study nursing for three years, with an additional one-year specialization in obstetrical nursing. Officially titled *Licenciadas en Enfermería y Obstetría* (colloquially known as LEOs), these women mostly work as high-tech labor and delivery nurses in addition to performing administrative work and teaching.

Thus, in Mexican midwifery there exists a huge and growing gap between (1) the apprentice-, self-, and/or government-trained (in two-week courses) traditional midwives who attend births in their communities and (2) the university-trained LEOs – obstetrical nurses who work only in hospitals and, in most places, are not allowed to be the primary attendants at birth.⁷ It is this gap, which leaves both working-class and middle-class women (especially in urban areas) without midwifery care and without the option of out-of-hospital birth, that the new *partera profesional* seeks to fill. In this endeavor she is supported by a few physicians and opposed by a few others; most Mexican physicians are still unaware of her existence.

Commonly, government officials and MDs dismiss midwifery by arguing that there are plenty of doctors and nurses in Mexico; that the poor are entitled to the same care as the middle class; and that, therefore, progress in maternal health care does not mean either preserving traditional midwifery or creating a new kind of midwifery but, rather, giving everyone access to hospitals and doctors. This argument is representative of what has been called the “megarhetoric of developmental modernization” (Appadurai 1996:10), which identifies a single point in a given area toward which development should be progressing (Appiah 1997:425): in health care, that single point is Western biomedicine. In urban areas, hospitals abound. In rural areas, a wide-ranging net of biomedical health care clinics has been extended; this, say government officials, is the way to bring health and maternity care to the rural poor. But very few physicians want to work in such clinics beyond their year of mandatory social service, so the clinics are often under-staffed and many areas remain under-served. More fundamentally, in both countryside and city a profoundly medicalized mentality characterizes Mexican physicians’ views about birth. As Marcia Good Maust (2000) has shown, many Mexican physicians genuinely believe that birth is a dangerous process that can cause harm

to mothers and babies; that technological interventions like cesarean sections are the best way to ensure the safety and well-being of mother and child; and that midwives, a hangover from the undeveloped past, are a temporary evil that must be replaced as quickly as possible with the vanguard of the future – modern health care.

In the United States and in the international midwifery community, a postmodern discourse (one that stems from multiple points of reference and that does not assume the superiority of any one method) around the benefits of professional midwifery care and certain indigenous approaches – such as walking during labor, upright positions, and herbal remedies – punctuates the cultural dialogue about birth (Arms 1975; Ashford 1988; DeVries et al. 2001). Outside of some branches of the public health sector, this discourse is barely heard in high places in today's Mexico. In the United States, both nurse- and direct-entry midwives are engaged in active campaigns to increase government and public awareness of the multiple benefits of midwifery care. In Mexico there are no midwifery lobbyists to disturb legislative halls. Implicit and pervasive assumptions dominate national middle-class opinion: at worst, midwives are "scraggy old women" – backwards, illiterate, ignorant, a danger to mothers and babies but a necessary evil until they can be replaced with physicians; at best, they are colorful folkloric hangovers from Mexico's past who, like the black granny midwives of the American South, should be nostalgically honored for services rendered and phased out as soon as possible.

Deploying such stereotypes, US doctors had effectively eliminated midwifery by the mid-1950s, making the United States one of only two industrialized nations (the other is Canada) in which physicians are the primary attendants for the majority of births. In contrast, in most European countries midwives, who have long since been professionalized, attend the majority of normal births (DeVries et al. 2001). With regard to the United States, countless studies show that midwives not only give women more individualized and nurturant care than do most physicians, but that they also, in general, use fewer interventions, are more cost-effective, and often have better outcomes because they are less likely than MDs to create problems by intervening unnecessarily (see Rooks 1997; MacDorman and Singh 1998). But in the United States, after a century of being repressed by physicians, nurse- and direct-entry midwives still attend just under 10 percent of births (Ventura et al. 2001). Their contemporary American renaissance is a recent phenomenon, and it is

driven by consumer demand, growing awareness of the multiple benefits of midwifery care, cost-cutting initiatives, and the flight of obstetricians due to the high cost of malpractice insurance (which midwives can obtain much more cheaply than can MDs). American midwives are growing in numbers, as are the births they cumulatively attend. In 1979, the percentage of midwife-attended births in the United States stood at 2 percent; in 1996, 5 percent; in 1998, 6 percent; in 1999, 7 percent (Ventura et al. 2001). It now seems to be rising by 1 percent every year—a gain mostly attributable to nurse-midwives. Likewise, midwifery is presently being legalized in all Canadian provinces; as Canadian midwives gain legal status, the percentage of births they attend rises (Bourgeault, Benoit, and Davis-Floyd, forthcoming). In Mexico, in dramatic contrast, the percentage of midwife-attended births is still dropping, from 43 percent in 1976 to 16 percent in 1996 (INEGI 1999). As professional midwifery takes deeper root in Canada and the United States, in Mexico traditional midwifery continues to disappear.

The American direct-entry midwives with whom these new Mexican midwives choose to affiliate used to be referred to as “lay midwives”; however, for the past 20 years they have been engaged in a process of professionalization that has led to the development of a new direct-entry certification – the Certified Professional Midwife (CPM) (Davis-Floyd 1998a; Rooks 1997). At the time of this writing, two of the new midwives in Mexico have obtained CPM certification and three others are in the process doing so – an indication of (1) their desire for a professional credential that validates their knowledge, skills, and experience, and (2) the transnationally shared nature of their knowledge base.

However, unlike the direct-entry midwives to the North, who began their rise in the 1970s when traditional midwifery had almost completely disappeared, Mexico’s professional midwives are beginning their work within the context of a still vital, albeit vanishing, traditional midwifery system around which they are seeking to generate what Arjun Appadurai (1996:10) would term a “subversive micronarrative” of opposition to biomedical hegemony. Their relationships with traditional midwives are complex: on the one hand, they assume the near-inevitability of the demise of traditional midwives; on the other, they seek to use their class status and privilege to support traditional midwives in multiple ways. This support has included backing up traditional midwives in birth emergencies; helping them to organize their own local and regional associations;⁸

creating joint skills-sharing workshops for those associations; raising money for scholarships to enable dozens, sometimes hundreds, of traditional midwives to attend the MANA Mexico conferences (see below); and generating international awareness about the value of traditional midwifery through conference speeches, videos, and publications. Through such work, the *parteras profesionales* attempt to counteract the ongoing obliteration of traditional midwifery even as they struggle to define their own identities and to negotiate their paths through a health care system that might at any moment attempt to obliterate *them*.

It is against a general cultural background of silence concerning the benefits of midwifery care, and much talk about the importance of expanding the reach of biomedicine, that the new *parteras profesionales* must struggle both to speak for themselves and to give traditional midwives a louder voice. At the time of this writing (June 2001), they number just over 30,⁹ but, like the mouse who roared, they make a great deal of cultural noise. Their influence extends widely because of the conferences they put on, the speeches they give, the networking they do, the schools and foundations they create, and the bridges they build, not only with traditional midwives, but also with certain physicians and health care authorities. Some of these have begun not only to support them, but also to serve, on occasion, as activists in their cause.

THE STORIES: LAURA CAO ROMERO, PATRICIA KAY,
LUCILA GARCIA, ALISON BASTIEN, PAULINA
FERNANDEZ, ANTONIA CÓRDOVA, AND THE
CASA SCHOOL OF PROFESSIONAL MIDWIFERY

Articulation is the production of identity on top of difference, of unities out of fragments, of structures across practices. Articulation links this practice to that effect, this text to that meaning, this meaning to that reality, this experience to those politics... And these links are themselves articulated into larger structures.

– Lawrence Grossberg

In the next sections, through telling the stories of individuals engaged in “producing identity out of difference,” I describe how midwifery in Mexico is developing into both an incipient social movement and a nascent profession. At first I contemplated presenting these women as a group, but I found their diversities too

compelling for such elision: some of the *parteras profesionales* are urban upper or middle class, others are from the urban or rural poor; some are older, with grown children, others are younger, with no children; some have college educations and master's degrees, others have graduated from middle school (*secundaria*), and one received no formal schooling at all during her childhood. Some are politically engaged and active, others just want to care for their clients and build their practices in their locales. Such differences are sometimes a source of fission and sometimes a source of strength; in either case, these differences are essential to these women's identity as professional midwives, and they need to be understood.

So in what follows I will describe some of the "contingent places and historical conjunctures" (Grossberg 1992) that led to these women independently forming themselves as professional midwives and, then, finding each other and gradually developing an understanding of themselves as a (variably) cohesive group with a common agenda and purpose. As Grossberg points out, "There are no necessary correspondences in history, but history is always the production of such connections and correspondences" (1992:53). I want to write history here, or "herstory," as some of my English-speaking interviewees would say. I want to look at these women in their particularities in order to understand how they are individually and jointly generating a previously non-existent cultural and political space within which a new kind of midwifery can grow. This herstory is both local and transnational in character – both embedded within large traditional cultural processes and generative of little new ones. It is the hybrid product of individual, inter-ethnic, and international conjoinings – a "bushy" (Ferguson 1999:42) set of overlapping events and experiences rather than a clear-cut linear account. Thus my task requires me to become both storyteller and Levi-Straussian bricoleur, describing one at a time the tiny tiles imbricated within this emergent midwifery mosaic. As the lives of these midwives are at once separate and complexly interrelated, both to each other and to wider transnational events, I must present their stories so as to reveal their separateness, their layered articulations, and their embeddedness within the postmodern phenomenon of what, in Canada and the United States, has been referred to as "the midwifery renaissance" – a social movement that these new midwives are now creatively generating in Mexico. I wish I had space to describe them all, and I can only assure my readers that the

stories I left out are no less illuminating than are the ones I have chosen to include.¹⁰

From Frustration to Action: Laura Cao Romero and Patricia Kay

The story of the new professional midwifery in Mexico has its beginnings among a disgruntled group of childbirth educators who, throughout the 1980s, were growing increasingly frustrated with their inability to offer women real options in childbirth. One of them was Laura Cao Romero, an upper-middle-class woman from Mexico City. Laura took Lamaze classes during her first pregnancy and, as a result, had what she describes as a "very pleasant birth" experience. Wanting to offer such options to others, she decided to become a childbirth educator and received her certification in Lamaze in 1974. When the last of her three children entered kindergarten, she went back to school and completed an undergraduate degree in English and a master's degree in applied linguistics. All the while, she kept on teaching childbirth education classes,

but I got very, very frustrated whenever I accompanied the mothers to the hospital and saw the way they were treated. So with time I realized that I was being part of that training that we are receiving to behave like good women in labor. I realized I was helping doctors teach women to let them do episiotomies, to accept enemas and shaving of the pubis and unnecessary cesareans – all the things. . . I felt very frustrated whenever I went to a birth and saw these women screaming and the doctors conducting their births in a way I didn't like for the woman, so I felt very helpless – impotent and dependent on doctors – and something within me told me that wasn't the right way.

During a 1987 sojourn in Austria, Laura met professional Austrian midwives and realized that they attended the majority of women throughout pregnancy and birth, were trained in formal programs that were completely separate from nursing programs, and "worked in the same buildings as lawyers and engineers," enjoying the prestige and cultural status of the professional realm. Laura remembered that, when she was nine years old and growing up in Veracruz, the mother of one of her classmates had been a *partera* who ran her own birth center. Laura thought that she wanted to be like her friend's mother, and she began to wonder, "Where are the schools for Mexican professional midwives?"

Around the same time, an American woman named Patricia Kay, who was married to a Mexican physician and living in Mexico City, began to think along similar lines. Having heard horror stories about childbirth in Mexican hospitals, Patricia decided to birth her first and only child at home, relying on a strong intuitive sense that this was the right choice. After becoming pregnant, she searched for months before she finally located a homeopath who agreed to attend her. Describing the birth as one of the most transformational experiences of her life, Patricia noted that, afterwards,

people just started flocking to me: "how did you do it?" So I innocently started sharing, you know, the diet that I was on, and exercise and the things I had learned, and the demand became greater and greater, and I saw that there was this need in Mexico for women of my class to have information and empowering experiences in birth.

During a severe bout of pneumonia two years later, Patricia, who had a bachelor's degree in anthropology and a master's degree in curriculum instruction, realized that midwifery was to be one of her major life paths. Within six weeks of having made the decision, she and her husband traveled to Albuquerque, New Mexico, where she enrolled in a training institute run by midwife Pam England. She said, "It was like the sky opened, the Red Sea parted and Patricia goes to midwifery school! On what we sold our belongings for, plus a house I had sold previously in the States, we were able to live for three years while I was studying and apprenticing." On completing England's program, Patricia became a licensed midwife in New Mexico and practiced independently for six months, attending out-of-hospital births.

At that time, in the late 1980s, such practitioners were still known as "lay midwives." But they did have a national organization, the Midwives' Alliance of North America (MANA), which had been formed in 1982 by some of the pioneers of the American home birth midwifery movement. During the 1980s the members of MANA grew in number, established national core competencies and standards for out-of-hospital midwifery practice, and wrote a powerful statement of values and ethics describing their holistic philosophy and woman-centered midwifery model of care.¹¹ Preparation of these documents at the national level paralleled the dynamism of a number of state-level midwifery associations whose members, during the 1980s, successfully lobbied for laws that legalized, licensed, and regulated them. New Mexico was one of the first states in which midwives achieved these goals. In each of these states, lay midwives

set their own standards of practice and wrote their own licensing examinations; thus they were able to preserve their holistic and independent style of out-of-hospital midwifery even as they formalized and legalized it (Davis-Floyd 1998a, forthcoming a, forthcoming c).

Patricia Kay understood that this kind of midwifery was well suited to Mexico's situation, as it fosters independence of thought and action: midwives like Patricia are educated to screen their clients for risk, to accept only low-risk clients, and to transport women to the hospital in the face of certain indicators. However, they also acquire the skills to handle almost any unexpected emergency that may arise. In rural Mexico, where hospital transport is often unavailable and hospital care itself is fraught with dangers (Castro, Heimburger, and Langer n.d.), such lifesaving skills can prove especially valuable. Thus it was clear to Patricia that the model of midwifery she learned in New Mexico would be of great value to the rural Mexican poor. Furthermore, she knew from experience that there were almost no options for middle-class women in Mexico who wanted to avoid the interventionist hospital approach to childbirth. So from the very beginning, Patricia and those who came after her conceptualized the *partera profesional* as one who could and should be able to meet the needs of all women. According to Patricia, "We saw birth as a women's issue, an issue about respecting feminine energy, and we saw birth as a place where that respect was much more important than social class."

Returning to Mexico, Patricia and her husband discovered that a friend of theirs was opening a health clinic, called the Clínica Popular Tlapahtialcalli, in the village of Tepoztlán near Mexico City and Cuernavaca. They moved to Tepoztlán and both began working in the clinic. Her husband took charge of the medical department and Patricia opened a maternity department, where she worked as a professional midwife and homeopath. She had no legal status in Mexico, only her New Mexico license; nevertheless, because of the respect she earned from her patients and from the medical community, she was able to build a thriving practice. She sustained that practice over the next ten years – six in the clinic and four in private practice.

One day in the late 1980s, Laura Cao Romero was lunching with a friend in Tepoztlán who happened to mention that a woman there had recently had a waterbirth at home, attended by an American midwife named Patricia Kay. Excitedly, Laura located Patricia, and, over time, they became friends. Their long discussions cemented in

both of them an understanding of the need in Mexico for professional midwives (the term they used at the time). During one conversation in 1988, Laura said to Patricia, "Well, I would like to become a midwife, what about you teaching?" And Patricia answered, "Well, if you get a group of people together, I will agree to teach you." Knowing that there were many other childbirth educators in Mexico City and Cuernavaca who shared her frustration and sense of impotence with regard to offering women real options in birth, Laura called a number of them and told them about Patricia's offer. Twenty-six responded to her call and signed up for the course.

Thus began a three-year series of classes (1989–1991). These classes were held every two weeks, and students interspersed them with large amounts of reading and self-study. Of the original 26 students, nine completed the three-year program. Five of them (including Laura Cao Romero) were long-time childbirth educators. The graduates also included an acupuncturist; a Spanish expatriate who had given birth in the water with Patricia attending; an obstetrical nurse, Lucila Garcia, whose story I tell below; and an MD from Mexico City who took Patricia's training because she wanted to attend out-of-hospital births "like a midwife, and not like a doctor."¹² These students supplemented Patricia's bi-monthly classes and occasional weekend seminars with the intense study of obstetrical textbooks and other materials. They created a carefully thought out set of protocols for practice (that are still in use today) and gained their initial clinical skills by working side-by-side with Patricia. Needing to augment their training with more clinical experience than Patricia alone could provide, some of these women, after completing Patricia's course, worked with various doctors or went to El Paso to attend women at Casa de Nacimiento or Maternidad La Luz¹³ (long-standing midwifery clinics serving a primarily Hispanic population). Both of these clinics offer their own training programs, but they created streamlined routes for Patricia's graduates, allowing them to focus on clinical experience. Lucila Garcia, however, remained in Tepoztlán and gained all her clinical experience as Patricia's apprentice. Her story constitutes the next set of tiles in our midwifery mosaic.

Lucila Garcia: From Nursing to Midwifery

Unlike Patricia's other students, Lucila was not of the urban middle class but, rather, was born and raised in rural Tepoztlán; her parents

were peasants (*campesinos*). Lucila sought a professional education at the university in Mexico City, from which she graduated as a Licenciada en Enfermería y Obstetricia (LEO) – a licensed obstetrical nurse. Her intent had been to attend births, but throughout her training she had to deal with the frustration of never having an opportunity to do so. Not wanting to work in hospitals, Lucila considered community nursing. However, soon after graduation she met Patricia, who, at that time, was looking for someone whom she could train to work with her as a midwife in the clinic in Tepoztlán. Lucila immediately went to work as Patricia's assistant, also becoming part of Patricia's first midwifery class. Finding Patricia's woman-centered approach to birth (see Davis-Floyd 1992, 1998a; Davis-Floyd and Davis 1997 for descriptions of this holistic midwifery approach) to be much more rewarding than the medical approach, Lucila left nursing behind and devoted herself to the study and practice of out-of-hospital midwifery. As Patricia phased out of active midwifery practice, Lucila gradually took her place, serving both poor and middle-class women in Tepoztlán and Cuernavaca. At the time of our interview in summer 1997, Lucila was attending approximately six births a month in homes and private clinics, including her own. From Patricia she also learned homeopathy, which she incorporated as part of her midwifery care. When I asked her to describe her approach to birth, Lucila responded as follows:

We are with the woman from when she does not want to be alone anymore. That can be at 2 centimeters or at 5 to 7. Usually from 4 centimeters on we are cheering her up, we give her massage, we do homeopathy, encourage her to rest, to relax. We ask somebody to be with her, her mother or a friend, but there are also women who don't want anybody – that's fine if that's what they want. The majority of the women want to have their partner or their mother. We let the woman take the position she wants to give birth – that can be on a chair, on the bed, sitting, kneeling, squatting, half lying down. What we never use is a delivery table, never.

In the moment the baby comes out, we hand it over to the mother right away if everything is fine. There is no reason to do any manipulation and the father is in charge of cutting the cord. And we try to respect the first two hours, not to interfere a lot. We are checking on the baby, if it breathes normally, and more or less an hour later we start preparing the bath for the baby, in order to do its physical exam. That's when we separate the baby from the mother. And also as soon as the baby comes out we try to have the mother breastfeed, immediately. There are babies that won't accept the breast yet and we are checking on them for two or three hours, or more time,

according to their condition. And logically, if they give birth in the clinic, if it's raining or if it's at night, we won't send them home. But if everything is well four hours after the birth, or six hours, we send them home.

Lucila's straightforward account describes the midwifery model of care as it has been practiced by direct-entry midwives in Canada and the United States since the 1970s (Rothman 1982), and it clearly shows that this model has now taken root in Mexico. In addition to normal births, Lucila handles many complications that occur out-of-hospital, including postpartum hemorrhage, with great success. She is skilled at external version and the use of water for labor and birth. She does not attend breech births or the births of twins, referring those women to physicians whom she respects.

In the United States, professional midwives like Lucila, who work out-of-hospital, can undertake a three-year apprenticeship with one or two practicing midwives, and/or can enroll in a formal vocational program (usually also three years) in an independent midwifery school (Davis-Floyd 1998a, 1998b; Benoit et al. 2000). Vocational training, like the kind Lucila received from Patricia, combines didactic teaching and learning with an apprenticeship component. Pure apprenticeship, on the other hand, includes no formal didactic training but does involve a great deal of reading and studying on one's own and with one's mentor, usually in response to situations that arise during pregnancy and birth. Apprenticeship learning is thus fully hands-on and retains an immediacy and focus that can be lost when didactics are separated from experience. Both of these models are also at play in Mexican professional midwifery. Patricia was educated – and educated her students – in the vocational model. In contrast, Alison Bastien, an American woman who was practicing midwifery in Guanajuato while Patricia was practicing in Morelos, learned midwifery by apprenticing with a traditional Mexican midwife. Her story, which requires us to jump 400 miles from Lucila's clinic in beautiful Tepoztlán to the equally beautiful tourist town of San Miguel de Allende, lays the next set of tiles in our *expanding midwifery mosaic*.

Alison Bastien: Apprenticeship and Vision

Like Patricia Kay, Alison Bastien gave birth to her first child at home with a midwife, an act she attributes to reading Suzanne Arms' *Immaculate Deception* during her teenage years. From that book she gained a sense of how profoundly hospitals and physicians often

misunderstand birth and how much damage their overly interventionist treatment can cause. She was confirmed in that understanding during the years she spent studying childbirth education and serving as a doula (a labor support professional) in northern California. By the time she moved to San Miguel in 1982 she was in her early 20s; she realized that she wanted to become a midwife and began to search for a mentor. At first unsuccessful, she started to stop pregnant women on the street to ask who was going to attend them during birth; this is how she eventually found Doña Maria Jesusa Arvisu Gonzalez, better known as Doña Chucha. But when Alison asked if she could study with her, Doña Chucha did not take the young *gringa* seriously and, for many months, ignored her request.

Originally trained as a nurse, in the 1950s Doña Chucha started to work with a doctor who attended home births. By the time Alison met Chucha in 1986, she had been in practice for 35 years and was beginning to experience a postmodernism of her own: like a few of the surviving black granny midwives of the American South (Susie 1988; Bovard and Milton 1993), she was occasionally being asked to attend the births of middle-class women who wanted to avoid the hospital. But she did not provide the kind of prenatal care such American women expected; she did not ask to see pregnant women until their seventh or eighth month, at which time she began the *sobada*, or traditional massage.¹⁴ Shortly after making Doña Chucha's acquaintance, Alison met Chris Nieto, an American woman living in San Miguel who also wanted to become a midwife. Realizing that American women were accustomed to earlier and more regular prenatal care, Alison and Chris gathered supplies and equipment, read extensively, and gradually began doing prenatal care for American expatriates, recommending that they choose Doña Chucha as their primary birth attendant:

Instead of her taking us on, we took her on, yeah! Not on purpose. . . it was just like this was the only way I could get at her. I started bringing her clients, and by sheer coincidence, there I was too! And there I was again! And there I was again! And she started kind of liking me, because I didn't butt in, and I was bringing her customers, and in fact we grew quite fond of each other. . . We hung out for a fair amount of time, but never in that way of, like, "Let's go over lesson three now – shoulder dystocia," "Let's process our experiences," "Let's look up what Varney says," you know? No, this is a whole other model of learning, which is just *do* and *be*. I did a lot of *doing* and *being*, and I would do a lot of obsessing and reading on my own at home or with Chris.

Alison describes Doña Chucha's practice as follows:

She was not traditional in the sense that she didn't use, for example, herbs. She was traditional in the sense that she did the *sobada* – faithfully, this was the mainstay of her care. She was very non-interventive in every way. She didn't use traditional interventions or medical interventions or any interventions, really, and she really didn't need them. . . Her interventions were much more subtle preventions, and for me that was a very beautiful gift. She was never a person who would say, "Now, look out, this one might be a dystocia, you can tell by the way the head is turning" – no, it would always be resolved before it got to that point. . . she was very good. She also had a backup doctor who eventually became my backup doctor when I began practicing on my own.

Commenting further, Alison noted: "Every neighborhood here has a woman like Doña Chucha, although they are not always nurses. To her it was not a big deal, it was not a 'cool' thing, it was just what she does." (In contrast, of course, postmodern midwives do think that what they do is "cool"; midwifery for them is not just a service, it's a hip political and [counter-] cultural statement.) After several years of working together, one day Doña Chucha called Alison to report that she was not going to attend births at night any more for any reason. That night, three of their clients went into labor, and Alison, by herself, was catapulted into attending all three births in rapid succession. She took this remarkable circumstance as a sign of passage and initiation, a message that she was finally and fully a midwife ready to practice on her own. For a year Alison continued to attend all the nighttime births alone. But toward the end of her second pregnancy, she started to worry that Doña Chucha would not be there for her if she gave birth at night.

One night a few days before my due date she called me up and said, "Alison, I'm done not being available at night, just thought you'd like to know. If you have your baby at night, I'll be there." And I said, "Well, can you tell me now, what it was?" There was always this mystery thing about it, like I couldn't ask and she wasn't into telling me. And she said, "I've been helping my midwife, Señora Barajas, die. She's been dying and I've been doing the night shift to care for her. She delivered all my children, she was a committed midwife for me." She had passed her mantle on to Chucha way back when, and Chucha felt, you know – she wanted to be there for her. And Senora Barajas had died a few nights before. The whole thing made me feel really special. She couldn't go to births at night, because she had to be there for her own midwife, and I could be there for people because Chucha was there for me.

For the moment, we will leave Alison practicing midwifery in San Miguel, only a few blocks away from the home of Antonia Córdova, a traditional midwife about whose existence Alison did not know. Although Antonia, like Alison, was to become one of the central figures in the development of professional midwifery in Mexico, she and Alison did not meet until the following November. And then they did not meet in Mexico but in El Paso, Texas, at a MANA conference, for such is the transnational nature of this midwifery renaissance story.

Antonia Córdova: From Traditional to Professional Midwifery

The child of a family with nine brothers and sisters, Antonia Córdova Morales grew up taking care of the cows and working with her parents and siblings in the fields around her hometown of San Miguel. Receiving no formal schooling, at the age of 12 she went to work as a maid. She married young and gave birth to six children, all of whom were born in her home with a traditional midwife in attendance. Although there were hospitals, she told me she was afraid to go to them because she knew how badly poor women were treated there, and, since her mother had successfully birthed all her children at home, Antonia saw no reason not to do the same. She added that, since she became a midwife, in addition to all her other clients she has attended every family member who has given birth (19 in all at the time of our 1997 interview) – a fact of which she is very proud. Antonia said she became a midwife “by accident”:

I was not even fifteen years old when I had my first child, and at the time I said consciously to myself, “I would like to become a midwife.” I was attended by a midwife, but I don’t know why I wanted to be one. But then the other children were born, I was very poor, and the idea to become a midwife was forgotten. Then there was a woman whose husband had abandoned her, and she was going to have her baby with a midwife. But when the midwife was attending her, she gave her several injections of pitocin... I did not know anything really. But I saw that the girl was not doing well and she was swollen, [what I now can call] very edematous in her vagina, and I said to her to get up and that I was going to bathe her with warm water so she could rest a bit. But then when I got her up and bathed her, the contractions went away. And so the midwife was very mad at me, because she said I had stopped her labor... So the midwife got angry and left, but then she came back at night in order to give the woman another

injection. But the woman did not want that again. So for a whole month she did not have any sign of labor anymore.

[Robbie:] So that baby would have been born prematurely?

[Antonia:] Yes. So exactly one month later, the seventeenth of May of 1985, her contractions started. And I told her that I was going to get the midwife, and she said, "I don't want that old witch. I want to be right here." And I told her, "You can't be alone, something can happen to you, let's go to the hospital." "No, I won't go to the hospital." So, well, the woman stayed right there. She was very stubborn, and so I told her that somebody had to attend her, but she said, "I won't leave my house. I die here, whatever, but I will have my baby here." So when I saw her stubbornness, what I did was to put a piece of plastic over the bed, because she did not even want to move from there. I put a plastic sheet down and a blanket, there it was the baby was born. It was a little girl. And I have thought about that birth many times, and now that I am a midwife, I know that it was a very difficult birth. But at the time I did not think of the risk or of a problem.

...But this woman passed out and she had a big hemorrhage. I had heard from a woman who was a *curandera*... that a handful of chewed cumin seeds (*cominos*) stops a hemorrhage, so I gave her a handful of cumin seeds and told her to chew them. Then the woman started to react and I put cold compresses on her face. . . When I cut the cord, I did not think of anything, so when I saw that the baby girl started to bleed, what I did was to squeeze, and I talked to somebody else who was outside, some relative, to come in, and when she saw all this, instead of helping me she started to cry, and I said, "Don't cry, give me a string, something, to tie the cord," and she gave me a string that I tied the cord of the baby with and the baby was all right. But then I had to keep working on the mother. It was very difficult, I mean in that moment this is what I did, without knowing practically, but fortunately the woman and the baby are alive. . . Now when I think of it, sometimes it gives me goosebumps! To think, to relive everything that happened and I know that it was a very dangerous birth. The woman as well as the baby was in danger.

Once the baby started to nurse, the hemorrhage stopped, and mother and baby did well from then on. In this story we have a unique opportunity to look back, through the eyes of a midwife now professionally trained, at the first birth she ever attended, when she had no training at all. The details in her story enable us to note the differences between her intuitive reactions at the time, when she "did not think of risk," and her informed reactions now, when she knows the mother or baby could have died. She tells this story with a dual consciousness, noting her naïve lack of awareness of the risks she faced but also appreciating her intuitive reactions – preventing a premature birth, stopping a hemorrhage, tying the cord when it

started to bleed, handing the baby to the mother to nurse. Her story simultaneously honors her spiritual calling to midwifery – her visceral, instinctual response to birth – and the professional knowledge she has since acquired. Because she tells her history without self-denigration, by implication she also avoids denigrating other “midwives without training” (Lefebvre 1994). In so doing, she demonstrates a keen awareness of the delicacy of her political position in Mexican midwifery. Because she is Mexico’s first traditional midwife to complete a three-year-long formal professional educational program and enter hospital practice, she spans the boundaries between the traditional and the professional and between the indigenous and cosmopolitan worlds. Even as she embodies and expresses their differences, she represents and remains responsible to all.

But we are getting ahead of our story. After this first birth, as women increasingly began to seek her out, Antonia realized that

I could not keep attending women this way, without having anything and without knowing anything. So I looked for help in the Social Security because I was told that that is where the midwives go... I was there for two years, where I learned everything *except* to be a midwife... I learned to vaccinate, to make a cancer test, to check an IUD, to take out an IUD. I went to rural areas to give vaccinations. Two years later they finally gave me the training as a midwife, for two weeks. It was one week of theory and the second week of practice. The week of theory, well, to listen to the blablabla and to be sitting there – [sighs]. The week of practice, that was one day in family medicine, another day where you see the pregnant women, another day in family planning, another day where you see how they bathe the babies, and another day where the women recuperate from a cesarean. That was my training as a midwife. After these two weeks, they gave us a paper that accredited us as midwives, with a bag that contained scissors, a bulb syringe, five syringes, some face masks, two or three pairs of throw-away gloves, and a Pinard horn.

Unsatisfied with the limited information she received during this “training”¹⁵ and with “being taught that midwives should imitate doctors,” Antonia heard about a course in women’s sexuality and reproductive health being offered at the Centro de Adolescentes de San Miguel de Allende, better known as CASA, a non-profit health and social service agency (which includes a hospital) located in San Miguel. Nadine Goodman, an American woman who is the founder and director of CASA, has long placed primary emphasis on helping young adolescent women gain access to health education, birth control, and family planning. Knowing Antonia was a practicing

midwife, Nadine inquired as to whether she had found the course useful. Antonia replied that she had learned a great deal that she had never known, especially about the reproductive tract, and told Nadine that she wanted to learn a great deal more, specifically about midwifery. Nadine said she would keep that in mind. Antonia joined the CASA staff as a health promoter teaching about birth control and family planning in rural areas around San Miguel.

And now the pattern expands to encompass a pre-existing tile. One day Nadine told Antonia that she had found a possible teacher for a midwifery course, a midwife in Tepoztlán named Patricia Kay, and she asked her if she could find women who would be interested in taking the course. Thrilled, Antonia located 26 practicing traditional midwives, all of whom signed up for the course. In July 1991, Patricia began teaching at CASA for one weekend every month. By the end of September, Patricia had fallen ill and could no longer make the four-hour drive to San Miguel, so she requested that the CASA students come to her in Tepoztlán. Most of the midwives in the class were unable to make the commute, but four of them did begin making regular trips to Tepoztlán. They usually went every two or three months and stayed with Patricia for two weeks at a time. Three midwives – Antonia, Leonor Cervantes, and Esther Lara Castillo – finished the course in 1993. Leonor and Esther went back to practice midwifery in their communities, while Antonia remained at CASA, eventually becoming the director of midwifery services there. Before beginning her training with Patricia, Antonia had attended 70 births as a traditional or, more precisely, “empirical” (see Endnote 1) midwife: she did not learn through a traditional apprenticeship but, rather, simply from attending births and then from the short course in the *Seguro Social*. When I asked Antonia to describe the differences in her philosophy and practice before and after her time with Patricia, she said:

The difference, I think, is a big one. It is often said that midwives catch babies. I believe it is not the same to catch a baby and to receive a baby. And many midwives, that’s what we do, we catch babies. The woman is about to give birth – “Push!” and then I clean it, I tie it, I wrap it – “Here it is, you gave birth,” and that’s it. Now there is a lot of difference in the humanness, the warmth and the respect that I give to the woman, as much in their pregnancy and their labor as during their births... Here in San Miguel, I think I would never have learned that. Before I studied with Patricia, I felt that I was respecting the women, but the respect – I gave it to them silently, I did not talk. I watched the woman suffer, that she screamed and cried, that

she got mad and that she became desperate – what I did was to be silent, not saying anything. But now, the pain, the crying, the desperation – I have an appropriate word to say.

[Robbie:] What do you say?

[Antonia:] There are times when the women, almost the majority, say, “I can’t do it.” I tell them, “You *can* do it, you can. . . Breathe, breathe in deeply, concentrate and focus your energy.” I touch their perineum – “focus your energy here, and push there where you feel my fingers. . . Breathe in, and push, push down here, and the baby will be born” . . . I tell them a lot of times that their uterus is a rose, why? Because a rose will open petal by petal, exactly the way the uterus opens. . . And the women practically don’t complain anymore, don’t get desperate anymore. They are happy to wait for the rose to finish opening.

[Robbie:] How did you think of using this image?

[Antonia:] When I was with Patricia, she had us do visualizations. And I liked that a lot. For me it was like a fairy tale, I closed my eyes and I heard her voice, but I was inside what she was saying, you see?

Through Antonia’s participation in Patricia’s course, the New Age met the traditional midwife, and they clicked. Antonia also described a number of technical skills she learned from Patricia, but she continued to stress that, more than anything, Patricia had taught her not to stop at obtaining technical information but to deal with the woman’s emotional and practical needs in a holistic way:

The midwife is like a big tree, because the midwife isn’t just good for attending a birth: many people come to her for advice, for emotional counseling, for family planning advice, for health things, for everything, you see? . . . We are a big tree, and it depends on the tree, on the shade the tree gives, to do the women good.

This expanded role, which Antonia encapsulated in the metaphor of the midwife as a “big tree,” became foundational for the approach to midwifery education that CASA ultimately adopted, which now includes training midwives in all the skills Antonia mentions. Antonia herself has been instrumental in the development of this approach. After she started practicing midwifery in the CASA hospital, Antonia taught a class of seven traditional community midwives, beginning in November 1994 and ending in April 1997:

I taught them what I had learned, what I had written down – what life had shown me and what Patricia had shown me – and what they themselves had shown me. We all learned: I learned from them, they learned from me. From there I got Belén and Manuela. There were other midwives in that group with very much wisdom, but they were from rural areas and, unfortunately,

they couldn't come to work here in the hospital because they don't know how to read and write. But they have a lot of wisdom as midwives.

After the course, Belén and Manuela joined Antonia at CASA, where they still practice (as of June 2001). When I asked Antonia to describe how the CASA midwives attend births, she responded that, first of all, they try to send first-time mothers home if they arrive in early labor because, from the time of admission, the mother and her relatives start counting the hours and get increasingly anxious if labor does not progress. Then they want the midwives to intervene: "They think that it depends on us that the baby is born. And that is not true. It depends on the mother, it depends on the baby." If the woman who arrives in early labor is from a rural area far from the city, then they admit her but frequently remind her that the labor may take a long time:

First we ask her all the questions: what time did she start? did she eat? did she sleep? has she been walking? is she tired? If she is very tired, well, then she should rest. We give her something to eat, not like in other hospitals that say "No more food, no more nothing." They eat what they want. Of course in heavy labor they don't really want to eat anymore, but yes, they can drink. Sometimes we listen to the fetal heart rate with the Pinard, but if the woman is very sensitive, and it bothers her to have us push into her belly with the Pinard horn, then we listen with the Doppler. But the Doppler often transmits a lot of noise: it gets confusing. So better with the Pinard. We don't shave, we don't do episiotomies, and we don't use the *Kristeller* (fundal pressure). Most women don't get IVs. They give birth upright most of the time – sitting, squatting, or on their hands and knees (*hincada*) – in that position, they don't complain about back pain any more.

Antonia, Belén, and Manuela attend breech births when necessary, but, like traditional midwives, they prefer to perform external versions during the prenatal period. Antonia says they have good success turning babies who are breech or transverse into vertex (head-down) positions; according to Sandra Morningstar, an American midwife who often works with Antonia, she successfully turns babies "nine times out of ten." She encourages the baby to turn by talking to it, by getting the mother to lie with her head down and her hips elevated several times a day, and by applying cold compresses to the top of the uterus and hot compresses to the pelvic region where she wants the head to go, for, she says, "The head of the baby always seeks the warmest spot." She does not perform versions if she hears variations in the fetal heart rate because of the

danger that the cord may be too short or may be wrapped around the neck. At the time of our interview, out of the 700 births Antonia had attended in the CASA hospital, she had never lost a baby during labor. According to Antonia, the CASA midwives do have to deal with death but very rarely is it the death of a baby they have been attending: most of the perinatal deaths in the CASA hospital are in the form of babies who die in utero from congenital anomalies (see Endnote 20).

I asked Antonia for her opinion of traditional midwives, and she replied that she has “enormous respect for their wisdom.” I said, “But what about the midwife who gave the pitocin injections to the very first woman you attended in labor?” She explained that, yes, that woman was a traditional midwife, but she had been taught to give pitocin injections by the *Seguro Social*. In other words, Antonia, once again demonstrating her continued responsiveness to both worlds, blamed the midwife’s inappropriate use of those injections not on the traditional system but on the inappropriate and limited information given by the *Seguro*. Asked if she performs the traditional *sobada* when women come for prenatal care, Antonia replied that she does if she feels the woman needs it: if the woman says, “My baby has fallen” because she feels she is carrying the baby too low, then Antonia will do massage to push the baby up; or if the woman has back pain, she may turn her on her side to rub her back. In a speech Antonia gave at a Lamaze International convention in Mexico City (Córdova Morales 1997), she described the hostility and opposition she encountered from the CASA doctors during her first years of practice there, and how, over time, she gradually earned their respect. She knew a threshold had been crossed the day the doctor in charge asked her to be the one to attend his wife in childbirth, kicked all the other doctors out of the room at her request, and from then on stuck to his role of husband and father, trusting his wife and Antonia to handle the rest.

Didactic Versus Experiential Learning

While Antonia’s experience of offering professional training to traditional community midwives was a positive one (resulting in two of the members of her class, Belén and Manuela, being hired to work permanently at CASA), Patricia’s experience of offering professional training to traditional midwives was somewhat different. Out of her original CASA class of four traditional midwives, Patricia noted that

Antonia had the least difficulty with didactics, and she attributed this to the fact that Antonia's earliest midwifery training did not involve hands-on apprenticeship but, rather, didactic training offered through the *Seguro Social*. Patricia concluded that this didactic training had predisposed Antonia to be comfortable with didactic learning and to be open to accepting new information. The other three traditional midwives who had taken the same course were not only older than Antonia, but they had also been practicing for many years before they came to study with Patricia. She noted that they had grown accustomed to doing birth in particular ways and, thus, seemed to find it difficult to incorporate new information. Their approach to birth was infused with beliefs and rituals grounded in their particular cultures; and it was upon these that they tended to rely in problematic cases. For example, Patricia described her experience with Esther, the most experienced of her group of four, as follows:

Esther had already been working for 25 years as a midwife and a traditional herbalist, and her grandmother had been the one she learned from. Esther had worked way more than I had when I was training her...I'm really convinced because of the traditional midwives that I've known here, it's almost as if the Creator puts these outstanding women in certain places on the earth where there is no one else, and they are given these amazing intuitive skills and they take women through the door and they do it. And they have amazingly good records, you know. They live out in the middle of nowhere, they have no medical backup, they work with very poor populations, and yet they have this power about them – a few of them, not all of them, I'm not romanticizing it either – that is steeped in wisdom, deep common sense and a deep connection with something else. And Esther's grandmother and Esther herself is one of these women.

Esther probably had a third grade education. So I developed all these ways of – we did hands-on teaching all the time, but, you know, Esther already had in her mind a way of approaching Mystery this way, so that the Western world doesn't really make sense to her, it never really made too much sense – although she got a commendation because she was able to recognize placenta previa one time. She had never heard of placenta previa before, didn't know it was even a possibility, but in the month after we learned about it of course it comes to her, she recognizes it, she goes with the woman to the hospital, saves her life and they give her a special commendation.

But, just an example of the difficulty, I took her to a home birth one time, and she had been a janitrix in the *Seguro*, which is where she learned to do IVs because she watched the nurses do them and she figured out how to put in IVs just by watching – I mean, that's how brilliant she is, you know. So I

took her to this home birth because I thought there would be a good match between her and this woman I was attending, who was a middle-class intellectual, but who had this kind of back-to-nature attitude and thought that herbs and midwives were a good idea.

And it was a long birth, it was a difficult birth. And I thought that things were going along pretty well, and, after about seven hours of being there, Esther says she is really worried. "What's the matter, Esther? The birth is going slowly, but there is definite progress, and the baby is fine, the mom is fine." Esther said, "Yes, but it seems as if it's really slow." "So what would you do?" "What I would do is put aloe vera (*sávila*) on her – put it on her sacrum and it's going to make her sweat and she is going to dilate like that and you'll see, the baby will be here in an hour." I thought, "Fine, if you can make this baby come within the next hour" – because I was thinking at least another seven hours, you know – "I'm going to put a monument to you and to *sávila*," you know?

So she goes and finds a plant, and she gets the *comal* out, which is a Mexican round plate that we make tortillas on, and she is roasting the *sávila* and she is getting it nice and warm, and then she takes it and opens it and starts putting crosses all over this woman's body. The woman had agreed to the herb part of it, but she wasn't into magic and she wasn't into the religious part of it, you know? But Esther is invoking this saint and that saint and putting crosses all over her, and she finally puts it on her sacrum and she kind of winks at me and she said, "You'll see, within an hour she is ready and she'll have this baby."

Great – an hour came and went and there was now sweat but there was no baby and we go on with this long labor. Esther is beside herself. So she goes out of the room and later, when she comes, back she says, "I just don't know what's happening. I have been praying to San Martín, and praying and praying and he's ignoring me."

So about seven hours later, when dilation is complete and this woman had chosen to squat – well, Esther didn't think she should squat, because the uterus was going to fall out. And the pushing of course is equally as long as the rest of the birth, so we are waiting and waiting, and Esther is like beside herself again. She said, "What she needs to do is to offer everyone something," so she runs into the kitchen and gets some cookies or something, wanting this woman in the middle of pushing to be offering cookies to everyone! I said, "Esther, relax, put the cookies away, sit down next to me, she is doing fine," you know? So the baby came out, it was a little depressed, and then she proceeds to have a massive hemorrhage.

So, since I had to revive the baby, I tell Esther to get an IV in the woman *now*. And I'm working on the baby and I look over and I see that Esther is about to put a solution in her without draining the line, and I realized that she didn't have this part of it down, that she had never used a butterfly cath, and so I kind of – by then the baby was doing fine, so I go and put in the IV

and you know – I thought, by the grace of God this woman has not killed someone, because she never understood the part about draining the line first. So we got the hemorrhage under control and we wrapped the baby and everyone is fine and we go home. And Esther is just really upset that San Martín has failed her.

And I realized – I have thought a lot about this birth, because the cultural match that goes on, you know, of us who have a cultural background that has included school and doctors and nurses – you can't take that part of yourself out, it's there. So this woman, the intellectual woman who was giving birth, had that. But Esther didn't, and I don't doubt that if we had been in Dolores, where Esther is from – I visited her house and stayed in her birthing room, and there is a little statue with a little plug-in flashing light for San Martín – and you know, I have no doubt that within that whole milieu the *sávida* and the prayers would have worked.

This story resonates with the tensions between folk and professional systems of practice and belief, and between the culture of the *campesino* and the middle class. Patricia speaks to the difference site of care and cultural milieu can make in the experience of birth, acknowledging that, within Esther's accustomed cultural space, where she shared a mutual belief system with her clients, her approach would most likely have yielded results. The lesson Patricia took away was that the cultural gulf between her system of midwifery and Esther's was, in most cases, too wide to be effectively bridged. This experience, and many others like it, in tandem with Antonia's completion of Patricia's training and her successful career as a professional midwife at CASA, suggested to Patricia Kay and Laura Cao Romero that the group to whom they could most productively offer their professional midwifery training might not be older traditional midwives but, rather, their daughters. The daughters, they reasoned, would have grown up with midwifery and birth all around them but would be of a generation that is accustomed to receiving formal schooling. Thus they would be more open to the kind of information that Patricia had to offer – information which, no matter how hands-on she tried to make it, still had to be absorbed through didactic teaching and memorization. Reasoning that younger women with some formal schooling would be more open to this approach, Patricia and Laura were also aware that training the daughters of traditional midwives would be a way of avoiding medical opposition. They reasoned that such women are more likely to stay in their communities, where they are most needed, than to move to cities and compete with doctors. Thus Patricia's vision for

the future of Mexican midwifery began to crystallize around founding a school in the Morelos area for the daughters (and other interested young women) of some of the hundreds of traditional midwives who live and practice in that state.

In this vision she was and is supported by her other students, most especially by Laura Cao Romero and Lucila Garcia, as well as by Lucila's former apprentice, Paulina Fernandez (whose story I tell below). Wanting to preserve traditional midwifery and apprenticeship training, these women are all too painfully aware of the rapidity with which the numbers of *parteras tradicionales* are diminishing and of the fact that much of their knowledge is dying with them. Most young people in Mexico today desire formal, socially valued education and professional training that will guarantee them a good income. So the *parteras profesionales* of Morelos and Mexico City divide their time between practicing midwifery, working to support and preserve traditional midwifery, and holding to the vision of creating a professional midwifery school or training program.

In 1991 Laura Cao Romero founded a non-profit association, Ticime, to support midwifery in Mexico. For its first few years Ticime was housed in a small apartment on the third floor of a building near the highway to Cuernavaca (the same place where the first midwifery classes were held); this apartment served as a clearinghouse for information on midwifery and birth. Back and current issues of Ticime's journal, *Conversando Entre Parteras*, as well as multiple issues of many other birth periodicals (in English and other languages) were available there, neatly displayed on magazine racks. The lending library contained hundreds of books available for checkout. A spare bedroom or two often housed student interns who would come to Mexico from the United States or elsewhere to staff Ticime's business office and to work with the traditional midwives Ticime supports. *Ticime* is the plural of the Nahuatl word *ticitl*, meaning "midwife." Through choosing to use an indigenous word as her organization's name, Laura and her colleagues intended to display their ideological alignment with traditional midwives and their commitment to the preservation and perpetuation of traditional as well as professional midwifery.¹⁶ Ticime's principal objectives include fostering the midwifery model of care in Mexico, lobbying about midwifery issues in health care forums, developing a network among midwives in Latin America and in Hispanic communities in the North, and informing the public about new findings and relevant publications. Working side by side with Laura in Ti-

cime's endeavors is Paulina Fernandez, whose story forms an essential part of the pattern of our transnational midwifery mosaic.

Paulina Fernandez: Becoming a Midwife, Transnationally

A middle-class woman in her early 30s, with residences in both Cuernavaca and Mexico City, Paulina believes babies should be born at home. She had wanted to be a midwife from the time she was nine years old. As she grew up she learned that Mexico's midwifery schools had long been closed, and she accepted, "with resentment," the idea that she would have to attend medical school instead. But a weekend workshop for birth assistants, which she attended at the Seattle Midwifery School in 1994, presented other options. She bought some books and began to read up and, in 1996, spent seven months in the intensive midwifery education program at Maternidad La Luz in El Paso (see Endnote 13). She returned to Mexico and spent a year and a half apprenticing with Lucila in Tepoztlán, attending three or four births a month, most of which occurred normally. Feeling the need for more experience with complications, Paulina returned to the intense learning environment of La Luz, where the high volume ensures that midwifery students will gain exposure to a wide range of problems and complications. Another eight months at La Luz gave her the skills and the self-confidence she felt she needed to handle any emergency; her time with Lucila had already imbued her with the spirit and the rhythms of community midwifery. It was an ideal combination of teaching environments: in El Paso she learned to deal with whatever showed up; in Tepoztlán she learned the full meaning of continuity of care. And in El Paso she also learned to teach: toward the end of her second stay there, she became the senior midwife and was in charge of supervising the students – a skill she would someday like to employ in a Mexican midwifery school in Morelos.

On her return to Mexico, she teamed up with Laura and Lucila to move Ticime to larger and more accessible quarters, which they found by expanding Lucila's clinic in Tepoztlán (Patricia Kay's original site of practice). Laura and Paulina have joined Lucila in offering a full range of midwifery services; they also work to design community education programs on reproductive issues and to obtain funding to support the formation and success of organizations created by traditional midwives. Like Laura, Lucila and Paulina have also attended one of the two-week training courses offered by a

government agency in order to obtain legal status and to be able to sign birth certificates; their three certificates from those courses hang together on Ticime's foyer wall. Paulina also played a key role in the creation of professional midwifery in Mexico by replacing Naolí Vinaver (see Endnote 11) as the fifth MANA representative to Mexico. But in order to tell that story, we have to go back to its beginning.

MANA in Mexico

The close and nurturant relationship I described above between Alison and Doña Chucha not only served them and the women they attended, but also ultimately led to the beginnings of MANA's presence in Mexico. Alison's "eternal gratitude" to Chucha led her to write an article about Doña Chucha and her practice for *Midwifery Today* (Parra 1987).

And I thought she was so wonderful that I...asked MANA if they wouldn't like her to go up to Colorado to their conference and be a guest speaker. I wanted her to be honored in a much bigger milieu than just me. She didn't seem to get it that she was something really special and that what she did was really special.

Alison had just given birth and could not accompany Doña Chucha, so one of Alison's friends served as companion and translator, reporting that Chucha's reception at the 1987 MANA conference was warm and enthusiastic. As time went by, Doña Chucha gradually phased out of midwifery and into hospice care; eventually, worn out, she moved to the United States to live with relatives there. Alison, assisted by Chris, took over where Doña Chucha left off. However, as Alison continued to attend home births, she felt increasingly isolated and longed for contact with other midwives. Paula Tipton, a renowned direct-entry midwife from San Diego, visited San Miguel and shared many of her skills with Alison and Chris, thus reminding Alison of the value of regular contact with other midwives.

I wanted contact and I didn't want to have to go all the way to the U.S. every time I wanted to hear birth stories, you know? So, once again, I wrote to the MANA people...and asked if we couldn't become a region here in Mexico, and volunteered myself to help get it started, with the idea that a Mexican woman would eventually take it over...While [Chucha] was at MANA, the friend who went with her came back and said, "I met this really neat

midwife, she is an American married to a Mexican, they say they are going to come back down to Tepoztlán and open up a clinic." It was Patricia Kay. And Patricia Kay did do just that about a year or two after. At that time she was up in the States dreaming of this idea...I just love how things begin, when you never know it!

Receiving a positive response, Alison became the first MANA representative in Mexico. She began to attend MANA board meetings, looking for ways to get Mexico on the agenda. She said,

It was a struggle convincing the board that they should put time and money into making Mexico a region: they kept asking questions like, 'Who's going to translate the newsletter?' And it was also a struggle contacting midwives here in Mexico, who all had the same skeptical attitude: 'Why do we want to go with the *gringas*? What do you mean, we have to pay dues?' Originally, we had only five people in the region.

One day in 1987 Alison got a phone call from Guadalupe Trueba,¹⁷ a childbirth educator who later became one of Patricia Kay's students but who, at that time, was serving as director of ASPO/Lamaze in Mexico. Lupe had read Alison's article about Doña Chucha in *Midwifery Today*, and she invited Alison and Chris to come to Mexico City to give a talk to childbirth educators about home birth. This they proceeded to do, and they "were amazed" at the reception they received from the 35 people in the room. "They really thought that it was wonderful that we were doing home births. They all wanted to know where they could study...and within six to eight months they got hold of Patricia Kay and that first class began." The 35 people in the room included Laura Cao Romero, who had also read Alison's article in *Midwifery Today* and had called her one day later on to chat. Discovering that Alison was about to leave to attend a MANA board meeting, Laura offered to pick her up at the train station in Mexico City and drive her to the airport so that they could have some time to visit. Their discussion led them to share a vision of Mexico as an active MANA region, and Laura promised to help make that vision a reality. By the time Alison's three-year tenure as MANA representative for Mexico ended, Laura and Lupe Trueba were ready to jointly take her place. As Alison had hoped, Mexico would now be represented by Mexicans.¹⁸

These two "maniac networkers," as Alison called them, brought new members into MANA and worked hard to bridge the gap, of which they were keenly aware, between themselves as relatively

affluent middle-class midwives and the thousands of traditional midwives in Mexico. As Alison put it to the MANA board:

They are there, they need representation, they have a lot to teach us. Just be patient, they'll be right behind us! All you've got to do is to keep that door open, and they are going to come though. And then Laura, bless her, networking hard, managed to get a bunch of grants and we all flew up to El Paso together on a plane, with 15 or 20 Mexican traditional midwives in their shawls, from all kinds of little *pueblitos* all over the place.

For these women and others who would come, the experience of being included in what could have been an exclusively American organization was, by their own account, transformative. It was at that 1991 MANA conference in El Paso that some of the new Mexican midwives found each other and met some of their traditional counterparts for the first time. Before she went to El Paso Alison had never met or heard of Antonia, who lived only ten blocks from Alison in San Miguel.

I didn't know she existed! I didn't meet her until we both turned up in El Paso – at which time I became aware that there were over 27 midwives in my personal community! Rural midwives, in rural areas, plus in the different barrios, but nobody there ever told me about them. I didn't know who they were! I met Antonia and Doña Leonor and Doña Esther from Dolores Hidalgo, who had all been Patricia's students, and I went, "I can't believe I had to come to Texas to meet you guys!" Even though then I felt a little like, "Oh my God, why didn't I know them before?" it also confirmed for me how important it was for us to be a part of MANA, and even if it brought together three women from the same goddamn town in Mexico, to me, that was really important – I hadn't met them before!

I was present at that 1991 MANA convention in El Paso, and I vividly remember what an impression the Mexican traditional midwives made in their beautifully embroidered *huipiles* (blouses) and long braids. Appearing sometimes in traditional dress, and sometimes in regular Western apparel, they illustrated the hybridity of contemporary Mexican indigenous identity. (Since then I have seen them at several such conferences and have learned that these apparel shifts are generally intentional: they pack both kinds of clothes, in part, to show that they live in both kinds of worlds.) With Laura translating, they attended workshops and gave workshops themselves, during which they overcame the language barrier by acting out labor and birth in fine dramatic fashion so they could demonstrate to the American midwives their traditional techniques.

And Alison rejoiced: "I remember sitting on that plane and just crying with joy. I knew it, goddammit, I knew we could do it! I knew some day there[d] be a planeload of women in *huipiles* coming to the States. . . It wasn't about me, it was a collective vision my tuning fork was tapping into. . . And each year after that, more Mexican midwives joined MANA."

In 1994 the growing group of MANA members in Mexico¹⁹ held its first meeting, hosted in Cuernavaca by Laura Cao Romero and Naolí Vinaver and attended by about 30 people. Since then MANA Mexico conferences have been held annually around the country.²⁰ Attendance has grown every year. At the 1999 Oaxtepec conference, for example, there were over 300 registrants; 150 of them were traditional midwives, most of whom had been able to come because MANA had given them scholarships. And the 2000 San Luis conference was attended by over 500 people, approximately 350 of whom were traditional midwives. And Alison continues to rejoice: "It's just been a beautiful thing. . . And it's everybody's thing, and everybody thinks it's normal, and they look forward to coming, and you know, now they are fighting over whose town gets to sponsor it!"

A full treatment of what goes on at these conferences would take another article. However, because they are such important sites of action for the *parteras profesionales* – and of interaction between them, traditional midwives, and the many interested others who attend – I want to give my readers a taste of the eclectic, transnational, and transcultural flavor of these conferences as well as of the spirit of social activism that pervades them. The following description is excerpted from the fieldnotes I wrote during the most recent MANA conference, which was held in San Luís Potosí in June 2000 and was coordinated by Paulina Fernandez:

We are in a giant auditorium attached to a huge, attractive, middle-price-range hotel. It is the opening general session of the conference. Over 500 people fill the auditorium. Some are men and women in business suits or luncheon dresses – doctors, chiropractors, health officials, obstetrical nurses, alternative practitioners; a few are American midwives in long dresses and skirts. The most conspicuous group are the traditional midwives from the Huasteca in San Luis, with their brightly colored headdresses, white *huipiles*, and bare feet. Adding to the color are other traditional midwives from all over Mexico, most of whom are wearing their own distinctive native dress. I am struck by the sight of a physician in a suit and tie in the front row chatting animatedly with the wizened, barefoot, and almost toothless

traditional midwife seated next to him. Her name is Doña Micaela, from a remote rural area of Puebla... Burning copal at the podium, a group of traditional midwives from San Luis wait to conduct the opening ceremony, after an introduction by Paulina Fernandez and Laura Cao and welcoming remarks from the Governor of San Luis.

The first presentation is by Naolí Vinaver, who describes her practice and discusses the safety of home birth. Antonia Córdova follows her, using overhead transparencies to describe the various conditions of risk that indicate that one should transport a woman to the hospital. Next comes a presentation on "Maternal Mortality in Mexico," given by Dr. Adriana Chacón, head of the Department of Reproductive Health for the State of San Luis Potosí, followed by a discussion of "Care of the Newborn," jointly given by Laura Cao Romero and American midwife Diane Holzer (in previous conferences, Diane offered workshops using cows' hearts to teach midwives how to suture perineal tears). Over the course of the next two days, traditional midwives from Oaxaca and Chiapas offer workshops on how they practice and the problems they confront; other traditional midwives teach about the use of herbs for menopause, for vaginal infections, and for hemorrhage. Nurses teach about family planning, detecting uterine cancers, and post-miscarriage treatment; a psychologist discusses "*Enlace entre la Medicina Tradicional y la Medicina Moderna*;" anthropologist Janneli Miller describes birth among the Tarahumara; a doula and two physicians from Guadalajara describe their team approach to birth; a physician and nurse team describe sterilization techniques; another physician discusses his experience with water birth; and the CASA students give a workshop about their school, which is forming an ever-larger part of the pattern in our growing midwifery mosaic.

CASA and the First Professional Midwifery School In Contemporary Mexico

The 1996 MANA conference in San Miguel was hosted by CASA, and the CASA midwives, in their brightly colored T-shirts displaying the CASA logo, have been a visible presence at every MANA Mexico conference since then. Antonia's success in Patricia's program and in training Manuela and Belén, combined with the good outcomes these professional midwives have achieved in a high-volume practice with a high-risk rural population, intensified Nadine's commitment to midwifery and inspired in her the desire

to create a stable and ongoing professional midwifery school, which she named the CASA School of Professional Midwives. Its first directors, Anne Davenport and Gloria Metcalfe, developed a solid curriculum and, in 1997, managed to get it formally accredited by the Ministry of Education of the State of Guanajuato, which approved the CASA school as a technical terminal-level career in the specialty of professional midwifery.²¹ Subsequent directors Rosa Hidalgo and Jennifer Goldberg have both expanded the curriculum and preserved the school's state accreditation. The first nine students entered the school in 1997; four of them – Carolina Alcocer Bolanos, Maricruz Coronado Saldierna, Maria Eugenia (Maru) Torres Ortíz, and Rosa Maria Arriaga Soria – completed that first three-year program and graduated in August 2000. At the time of this writing, these first four graduates are carrying out the mandatory year of social service work required of all Mexican professionals before they can begin autonomous practice. Their education, like the school, is funded through grants obtained by Nadine Goodman. Because CASA contains both a hospital and a school, students are able to begin clinical work with pregnant women from the first day of their educational program. In fact, according to Nadine, the hospital was built, in part, because it would create a training site for midwifery students and, in part, because the cultural acceptability of the hospital setting would help to legitimate midwives in the public eye. So innovative is the CASA program that an article about it recently appeared in the *Wall Street Journal* (Friedland 2000). Entitled "American Woman Seeks Official Role in Health Care for Mexico's Midwives," this article begins:

Esperanza Martínez is a vanishing archetype. She is elderly and poor, and has only a primary-school education, but she has skill enough to have coaxed more than 1,500 babies into the world. To Nadine Goodman, an American-born public-health specialist, Mrs. Martínez – known locally as Doña Esperanza – is part of a tradition that offers Mexico a humane and cost-effective model for maternity care in thousands of remote communities. In 1997, Ms. Goodman opened Mexico's first school of midwifery here in this town 180 miles northeast of Mexico City. Now, nine young women are getting more than three years of clinical training in delivering babies, combined with apprenticeships under *parteras* such as Mrs. Martínez who work with little more than scissors and a bag of herbs. The school expects to graduate its first class this fall. "The professional midwife is the best option for accompanying women in their reproductive cycle," says Ms. Goodman,

a 43-year-old Columbia University graduate who settled here 20 years ago. "But the idea that good, low-cost service can be provided" by indigenous women "without a college education really shakes things up here."

In fact, it shakes things up so much that the CASA midwifery school, and Nadine, have experienced a good deal of opposition from some government officials and physicians. While the state education ministry has been supportive, the state health ministry, which is run by physicians, has been anything but. At one point in 1998, the health ministry threatened to shut down the CASA hospital by refusing to renew its license if the midwives were not removed. CASA and its many supporters gathered more than 10,000 signatures from people in San Miguel and the rural communities served by CASA workers, as well as 200 letters of support from CASA donors, and delivered them to then governor Vicente Fox (Friedland 2000). Shortly thereafter, CASA's license was renewed. Part of CASA's ability to garner such widespread grassroots support stems from the multiple services it provides to women, which include not only midwifery, but also obstetrics, neonatology, basic gynecology, and family planning. CASA's family planning and reproductive education services reach over 50,000 people per year in San Miguel and surrounding regions.

The renewal of the hospital's license was a victory, to be sure, but much work remained. Nadine was determined to ensure that the CASA graduates would obtain the federal professional seal (*cedula profesional*) that recognizes them as independent health professionals qualified to practice in any state. In this quest she was opposed by those who want to equate "professional" with at least a high school and, ideally, a university education as well as by various physicians and state government officials who dislike the idea of autonomous midwives. According to the *Wall Street Journal* article cited above:

Carlos Tena, the secretary of health of Guanajuato state, where both the school and hospital are located, says that while he is all for giving existing midwives the training necessary to do their jobs better, he sees no point in creating new ones. "I don't think Nadine's vision is workable," says Dr. Tena, a cardiologist. "And I will continue fighting with her as long as she demands that parteras be recognized as professionals"...Roberto Uribe, a professor at the National Autonomous University of Mexico and an officer of the National Federation of Gynecologists and Obstetricians, says the idea of reviving the partera, even with clinical training, "is a tremendous step backward." "It doesn't matter if the parteras all die off," Dr. Uribe says.

"The real issue is: How do you get rural women to the hospital on time?"
(Friedland 2000, 1)

With these words Dr. Uribe obscures two fundamental realities of Mexican life. First, transport to the hospital in many rural areas is often simply not a viable option; many rural women cannot afford and/or do not have access to transportation. Professional midwives who can screen women for risk and (if necessary) bring them to the hospital in advance, who have the skills and equipment to handle sudden emergencies at home, and who live and work in the communities where women live and give birth – and where they can provide backup services to traditional midwives – constitute a far more viable alternative (Davis-Floyd, forthcoming b). Second, the care many women, especially members of the working class, receive when they do go to hospital is often rude, disrespectful, insensitive, and unnecessarily interventionist, as is evidenced by Mexico's 40 percent cesarean rate and by the routine application of many unnecessary and damaging procedures during labor and birth (Castro 1998, 1999a, 1999b; Castro, Heimburger, and Langer n.d.). In keeping with Patricia Kay's philosophy, which has been shared by subsequent teachers and directors, the CASA midwives are imbued with the woman-centered philosophy known internationally as the "midwifery model of care" (see Rothman 1982; Davis-Floyd 1998a); and the CASA educational model ensures that their care will be not only woman-centered, but also culturally appropriate.

Even though CASA's midwifery students do gain a good bit of their clinical experience in the CASA hospital, the intent of the school is not to groom them for hospital practice but, rather, to enable them to live and practice in their home communities. Thus CASA's educational requirement is that the student must have completed Grade 9; students with high school and university degrees tend to be unwilling to remain in rural areas (and, in a region where the average person completes only Grade 4, a higher requirement would drastically limit the applicant pool). Understanding that the graduate midwives would not be well equipped to practice in rural communities unless they had also trained in such communities, and wanting them to develop as much cultural literacy as medical literacy, the CASA program includes in its three-year curriculum five two- to three-week rotations (one per semester) during which the students live with and learn from a community midwife. And, in addition to their private hospital, CASA also has a

home birth service for women who live in San Miguel, so the students have plenty of opportunities to attend in-hospital births as well as to attend out-of-hospital births in both rural and urban environments. In creating both the home birth service and the community apprenticeship program, CASA has been assisted by Sandra Morningstar, a CPM from Missouri, who moved to San Miguel in the mid-1990s to help make Nadine's vision a reality. Sandra also works in the CASA hospital as a professional midwife, alongside Antonia, Manuela, Belén, and the CASA students.

In May 2000, Sandra Morningstar, with the help of the CASA staff, organized a "herstorical event" in San Miguel called *Cultura Viviente* (Living Culture) – "a gathering of hundreds of regional village midwives from Guanajuato to document their birthways, traditional ceremonies, and visions for the future" (personal communication). At this gathering, a new *Asociación de Parteras de Guanajuato* (APGAR) was formed, with Antonia Córdova Morales as its first president. In such ways, even as CASA proceeds with its professionalizing enterprise, its members continue to demonstrate support for, and philosophical and political solidarity with, traditional midwives.

The CASA model (formal vocational training for both in- and out-of-hospital birth, combined with intensive apprenticeships with community midwives in rural areas and urban home birth experience) is unique in Latin America, perhaps in the world. Its simple, concrete practicality and combination of science and caring, along with the cost-effectiveness and reductions in maternal and infant mortality that result from it,²² should mean that it is lauded, supported, and welcomed with open arms in government and development circles. However, these objectives do not match the present modernist goals of Mexico's health officials, who still see the expansion of medical services as being all that is essential in the struggle to decrease maternal/infant mortality. So even for a school as well established as CASA – which is housed in a beautiful colonial building in San Miguel, is accredited by the education department of the State of Guanajuato, is solidly funded, has an excellent staff, has a hospital in which its students can gain clinical experience, and has a community-based apprenticeship program – the battle for cultural legitimacy is far from won.

But another major step has just been taken, for Nadine Goodman's efforts to obtain the federal *cedula profesional* for CASA's students have been successful; it will be awarded to the students from the first

graduating class in summer 2001, when they complete their year of social service.²³ Future challenges include generating legal status for them in the State of Guanajuato and, perhaps, nationwide, which will necessitate the passage of new legislation; and, of course, finding employment for them. These first four graduates can probably work in the CASA hospital, but the ultimate goal of the school is to graduate students from rural communities who will return to practice in those communities. The problem with this lofty ideal is that there is absolutely no guarantee that these women will be able to make a living if they do return home. Most traditional midwives are poor because, often, they are not paid for their services or are paid very little. Graduates of a rigorous three-year professional program are going to expect a more substantial and steady income. Nadine and her colleagues are keenly aware of this problem; they are also aware that the Secretaria de Salud (SSA) and the health ministry (IMSS) have built thousands of rural clinics that are drastically understaffed, and they hope to convince these agencies to offer permanent, government-funded posts to the CASA grads. At these clinics, CASA graduates could serve as primary health care workers, interfacing with traditional midwives, attending births, and providing well-woman and reproductive care under government auspices. Whether this is a real possibility or a pipe dream remains to be seen; meanwhile the three students in CASA's second class will graduate on September 1, with two other classes of eight each behind them and no clear guidelines for what these students will be able to do with their professional midwifery educations.

National Certification For Mexico: Whose Knowledge Counts?

At the 1997 MANA Mexico conference in Puebla, for which she served as conference director, *partera profesional* Naolí Vinaver spoke the following words on a panel that included the directors of the CASA midwifery school:

I congratulate you on opening the first school for professional midwives. At the same time I'm afraid. I'm afraid because I would not want that a few years from now, the government will just recognize you, the people who graduate from this school, and mandate that people who have worked as midwives have to pass through your school in order to be recognized. So I simply ask you, when you talk to the Secretary of Health...to put emphasis on the important points of this school, but please be very careful not to put

emphasis on "How good that now the quality of care will be so much better, empirical midwives don't give this kind of care." If we differentiate a lot between the empirical midwives, the traditional midwives, or the midwives without official training – well, I would like us to stay united, from now and for many years to come, and not allow that in the next conventions, the professionals are sitting here, the empiricals there, and that the empiricals are not recognized, and they will feel bad because they are not as professional as the professionals. This is just the thing I'm scared of and I want to make it public. But I congratulate you and keep moving!

Here Naolí expresses both her support for CASA and her fear that the vocational model of formal training in schools will end up as the standard for professional midwifery education in Mexico. She is aware that government recognition of the vocational model might preclude acceptance of apprenticeship as a valid educational route. Her fears here are for future professional midwives, who, she believes, should have the right to learn through apprenticeship, for future traditional midwives who should continue to have that right, and for the thousands of practicing traditional midwives who might be excluded from potential government recognition because of their lack of formal training. For a time, such fears were the subject of intense discussion among the Mexican *parteras profesionales*. The outcome of these discussions was agreement that they should do everything in their power to ensure that all routes to midwifery education will remain open in Mexico, including self-study and apprenticeship.

American direct-entry midwives have long debated the relative merits of formal vocational programs versus apprenticeship. Formal programs set clear standards and have clear, written criteria and goals, while apprenticeships often appear more diffuse. How to evaluate the competence of apprentice-trained midwives was a thorny issue among American midwives from the time of MANA's inception until it was resolved through MANA's creation of the North American Registry of Midwives (NARM), which proceeded to develop CPM certification (see Davis-Floyd 1998a). NARM designed its certification process to evaluate the competence of midwives trained by any route; thus the CPM is often described as a "competency-based" credential: what matters is what you know – not how or where you learned it. Once this credential was created in 1994, midwives across the country began the long fight to legalize it in all 50 states. At the time of this writing (July 2001), there are over 700 CPMs, and the CPM credential is legally recognized in 17 American states.

Aware of the development of NARM certification and the out-of-hospital knowledge base it is designed to preserve, CASA designed its educational program to meet NARM's educational requirements and to qualify its students to become CPMs. CASA's support of the CPM reflects its commitment to keeping open all routes of midwifery education, including apprenticeship, and it creates the possibility of unified standards among Mexico's *parteras profesionales*. Naolí Vinaver is already a CPM, as is Alison Bastien. Laura Cao Romero and Marian Tudela (see Endnotes 10 and 12) have passed the CPM written exam and will soon take the skills exam; Paulina is planning to take both. The CASA students have stated that they would like to become CPMs, and NARM is hoping eventually to facilitate that process. Thus there is a possibility that the CPM, which is the only international midwifery certification that validates all educational routes, might become the standard for Mexico's professional midwives. If it does, then they will gain the advantages of clear educational standards and of the status granted by an international certification. But few *parteras tradicionales* will have the resources to obtain CPM certification, which requires extensive written documentation of experience and the passing of both a written exam and a skills test.

As I write, a new possibility has opened up for Mexican midwives to create their own national certification through the national Council on Normalization and Certification of Labor Competency (CONOCER), which specializes in helping members of many professions, from architects to mango packers, create federally recognized professional certification. CONOCER's certification processes are voluntary and do not equate with licensure or guarantee the right to practice. But they do empower members of a group to define their own standards and, thus, their professional identities. In other words, they serve to articulate official cultural space.

The creation of national certification is an important step in any group's professionalization project (Torstendahl and Burrage 1990) – one that is complicated for these women by the gender and class stratifications inherent within the current health care system (Witz 1992). For Mexico's *parteras profesionales*, the process of developing national certification is likely to intensify the constant tension they experience between their impulse toward professionalization and their impulse toward the larger social movement they wish to create around preserving traditional midwifery. Social movements are, by

nature, inclusive of all who wish to participate; professionalization projects are always exclusive of some (see Daviss 2001).

At a conference on certification held at CASA in San Miguel in February 2001, Laura Cao Romero stated:

I need to say that I knew traditional midwives when I became a midwife and I am not a traditional midwife. I founded an organization to help them. I think for this conference we should be very reductionist, considering all the problems the traditional midwives face: they are taken to the police, there is no real protection for them, no juridical protection. What do those who wish to found a profession need? What do we need from society in order to build this model of midwifery with certification and licensing and employment in the hospitals or studying in schools? What does this model of professional midwifery that is new in Mexico need in these senses?

But in an e-mail she sent to me a few days later Laura expressed deep reservations about creating a national certification because such a move "might be pushing a very elitist group, that of *parteras certificadas*, which the *parteras tradicionales* will find hard to access."

Laura's struggles with the conflicting needs of professional and traditional midwives mirror those of her professional colleagues, who have the same sorts of discussions with themselves and each other. And, in so doing, the *parteras profesionales* are not unaware of the power differential that enables them to be the ones having such discussions. The possibility of creating a national midwifery certification through CONOCER arose during a meeting sponsored by CASA in February 2001, the purpose of which was to plan a large conference on international certification. No traditional midwives were present. The CONOCER representatives attending this meeting issued the invitation directly to the *parteras profesionales*, who found it instantly appealing because of its potential for inclusivity. CONOCER's process is open and flexible. It emphasizes competence, not educational route, and so does not require any kind of formal education for certification, and the applicant may take an oral rather than a written certifying exam. CONOCER proceeds by asking an expert committee of approximately ten members to identify the knowledge and skills they believe should be required. This list is then presented to practitioners around the country, who review it, provide comments, and suggest modifications. CONOCER also works to create an education process whereby applicants who initially do not pass the exam are helped to gain the knowledge that will eventually enable them to do so. These characteristics have the

potential to keep the CONOCER process open to traditional midwives, thereby avoiding the pitfalls the NARM process presents.

But, as we have seen, the knowledge bases of professional and traditional midwives are not the same. So their acceptance of the CONOCER invitation confronted the *parteras profesionales* with a choice between: (1) pushing CONOCER to adopt the professional direct-entry standards they have worked hard to learn and to practice by (a move that would exclude most traditional midwives from access to certification), and (2) supporting inclusive standards most midwives can reach, which will prevent the *parteras profesionales* from defining themselves through the knowledge base of professional midwifery.

As of the time of this writing (July 2001), their commitment to inclusivity has remained central. The professional midwives present at the initial meeting with CONOCER issued invitations to participate on the certification committee to equal numbers of professional and traditional midwives. The expert committee of midwives, whose members have agreed to work by consensus, started the CONOCER process in April 2001, assisted by a representative from NARM.²⁴ One of the first decisions committee members made was to accept NARM skills lists and other documents as resources, but not to adapt the CPM for Mexico. Rather, they will create a certification that is uniquely Mexican. These women of disparate backgrounds and practice styles have taken up the challenge of trying to set standards for a national certification that demonstrates competence to the public, is accessible to all midwives who want to obtain it, and honors the skills and knowledge bases of Mexico's traditional *and* professional midwives. Preliminary reports on this ongoing process indicate that these are both daunting and stimulating tasks (Sandra Morningstar and Laura Cao Romero, personal communication, 2001).

CONCLUSION: PROFESSIONAL AND TRADITIONAL MIDWIVES

[Articulation] involves real historical individuals and groups, sometimes consciously, sometimes unconsciously or unintentionally, sometimes by their activity, sometimes by their inactivity, sometimes victoriously, sometimes with disastrous consequences, and sometimes with no visible results... The notion of articulation prevents us from postulating either too simple a beginning or too neat an end to our story.

– Lawrence Grossberg

And, indeed, there is no neat end to this story. The *partera profesional* is building fragile bridges across the restless and permeable boundaries dividing the developed from the developing worlds, professional from traditional knowledge systems, and Mexico's middle and upper classes from its rural and urban poor. She supports, honors, and works in alliance with her traditional counterparts, and she enjoys educational advantages that they do not. But she is not separate from them in any easily definable way: although some of the professional midwives I discuss here are highly educated middle-class women (Patricia Kay, Laura Cao Romero, Naolí Vinaver, Paulina Fernandez, Alison Bastien), others are from agricultural/working-class backgrounds and have not completed high school (Antonia Córdova, the other CASA midwives Belén and Manuela, and some of the current CASA students). Even this educational divide is spanned by Lucila Garcia and other CASA students from poor, rural families who did go on to obtain higher education. What all of the *parteras profesionales* have in common is: (1) a professional knowledge base regarding out-of-hospital midwifery practice (although the CASA midwives also train and work in CASA's hospital) that overlaps significantly with (or may be the same as) the knowledge base developed by the independent direct-entry midwives of the United States;²⁵ (2) an independent, autonomous mentality; (3) a nurturant, woman-centered philosophy of care known transnationally as "the midwifery model" (Rothman 1982); (4) conceptual and/or actual affiliations with MANA and with its holistic principles of care and inclusive ideology, which regards midwifery not only as a health care profession, but also as an international sisterhood and a transnational social movement; and (5) a respect and appreciation for traditional culture and traditional midwifery knowledge and techniques, which most of them, at least to some extent, incorporate into their practices.

In other parts of the developing world, the relationships between traditional and professional midwives are often fraught with bitterness and tension: lack of what I have come to think of as a "postmodern consciousness" keeps many professional midwives locked into the hierarchical and relatively univariate (i.e., "modernist") medical system (Davis-Floyd 2000). Wearing white coats and an air of authority, they tend to look down on traditional midwives, or TBAs. In contrast, the thoroughly postmodern consciousness of Mexico's *parteras profesionales* leads them to reach around the notion of modernism to place their style of midwifery on a conceptual

continuum with that of traditional midwives. Honoring the past and present knowledge and practice of their traditional colleagues, they seek both to support them as they are and to transform them into mentors for professional midwifery students while that is still possible. They want to synthesize tradition and science in order to create a new and, they hope, more sustainable future for Mexican midwifery.

In this effort they are driven by a strong sense of mission and urgency due to the escalating disappearance of the traditional midwives. In a moment of despair, during lunch after a CASA meeting concerning international certification, Nadine Goodman said, "I'm afraid this is going to end in failure, we will lose traditional midwifery in Mexico and the hospitals and doctors will entirely take over birth." The professional midwives at the table, who included members of the NARM Board from the United States, responded in unison: "Well, that's why we're sitting here, to prevent that!" These midwives (and myself, the anthropologist who was both observing them and participating in their efforts) were painfully aware that the national certification they were discussing at that moment might further de-legitimize traditional midwives and, thus, hasten their disappearance; however, they also knew that, without it, Mexico's fledgling professional midwives might also disappear. The task of creating a certification that sustains both professional and traditional midwives will challenge all participants to define their values at the core. And, as they work, they will know that such a certification, even if federally recognized, will not guarantee them legal status or licensure: those battles will still have to be fought in political arenas dominated by physicians and other representatives of the biomedical health care system.

The professional midwives I treat in this article inhabit a tiny cultural space perched precariously on the shifting ground between the disappearing traditional midwives and the expanding biomedical system. I intend their individual stories, as I have recounted them here, to illuminate the shape of this new space they are creating, the local conjunctural surprises and resulting transnational alliances that facilitate its emergence, and its complex articulations with the space already inhabited by Mexico's traditional midwives. I have sought to describe the efforts of the *parteras profesionales* to generate, from their individual experiences, the "subversive micro-narrative" of a nascent social movement in uneasy dialogue with an incipient professionalization project. And I have tried to show how

this micro-narrative, a mosaic made up of many overlapping stories, constitutes a site for the enactment of necessary struggles between the values, knowledge systems, and structures of power that impinge upon the identity articulation of Mexico's new "daughters of time."

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NOTES

1. The term "empirical midwife" is sometimes used to distinguish those who learned midwifery through attending women in childbirth or through short training courses from those who learned it through a long tradition of apprenticeship. However, most often the terms *partera tradicional* and *partera empírica* are used interchangeably. In this article, for the sake of simplicity, I will confine myself to *partera tradicional*.
2. For a discussion of the problematics encapsulated in the term "traditional birth attendant," see Pigg (1997), Davis-Floyd (2000), and the Introduction in this special issue.
3. For both the Mexican and the American professional midwives I have interviewed, the mystique and appeal of the word "midwife" are enhanced by the fact that many professional midwives experience a spiritual calling similar to those that have been documented for traditional midwives around the world (Paul and Paul 1975; Vincent-Priya 1991). In the over 300 interviews I have carried out with American midwives since 1995, almost all the direct-entry midwives, and two-thirds of the nurse-midwives, reported experiencing a spiritual calling that drew them to midwifery.
4. "Direct-entry" is a term that was adopted in the early 1990s by American midwives who were formerly known as "lay midwives." This change in terminology reflects their growing sense of themselves as fully qualified professionals.

Technically, the term indicates that they do not pass through nursing but, rather, enter directly into midwifery education. See Davis-Floyd (1998a, 1998b) for more detail.

5. The 1997 Encuesta Nacional de la Dinámica Demográfica (INEGI 1999) shows 16.41 percent of Mexican births delivered in *otro lugar* (another place), which, for the most part, would be births at home attended by a *partera*. This number breaks down to 5.48 percent in places with 15,000 or more inhabitants, and it breaks down to 31.17 percent in places with fewer than 15,000 people. (My thanks to demographer Joe Potter at the University of Texas for this information.)
6. Laura Cao Romero, a professional midwife who is one of my interviewees for this article, once told me: "I met an old *partera titulada* in Oaxaca who came to our MANA convention in 1998 because she was very happy to see the rebirth of a profession that her generation of professional midwives allowed to miscarry." It is a historical irony that, as Ana María Carillo (1999) points out, the *parteras tituladas*, who were Mexico's first professional midwives, were created in the 19th century to replace and eliminate traditional midwives, but in the 20th century, the *tituladas* were eliminated by physicians who did not want the in-hospital competition.
7. An exception to this rule is the private clinic in Mexico City known as CIMIGEN. See Endnote 17.
8. For example, in the mid-1990s the *parteras profesionales* helped the traditional midwives of central Oaxaca to form their own regional association, which they call *Guillis* (pronounced *guizees*, Zapotec for "midwives"). In May 2000 they spearheaded the creation of a state association in Guanajuato – Asociación de Parteras de Guanajuato (APGAR) – that offers membership to all midwives. And they are currently assisting the *parteras tradicionales* of Morelos to form a state association.
9. How many there are depends on whom one decides to count. Taking active practice or political or educational involvement as the primary criterion, I am counting: the six midwives whose stories are told in this article (Laura Cao Romero, Patricia Kay, Alison Bastien, Antonia Córdova, Lucila García, and Paulina Fernández), five of the still-engaged midwives described in Endnote 9 (Guadalupe, Cristina, Pia, Lourdes, and Naoli), the four graduates of the CASA School of Professional Midwives (see below), and the 19 students currently enrolled at CASA. This number will shrink if some of the students drop out; it will grow when the next class enters CASA in September 2001.
10. Stories not told in this article due to space limitations and/or my inability to reach these women for interviews include those of Guadalupe Trueba (see Endnote 17); Marian Tudela, who practices professional midwifery in Cuernavaca; Mary Ellen Galante, an American nurse-midwife who worked in Oaxaca for a number of years but has since returned to the United States; Cristina Galante, a midwife professionally trained in Italy who has lived and practiced in Oaxaca for about ten years; Pia Scogniglio, a professional midwife from Switzerland who has also been practicing in Oaxaca for many years; Gloria Olympia Rivas, who learned midwifery in El Paso and went on to medical school; Lourdes Bravo, who completed midwifery training but concentrates on childbirth education in Cuernavaca; and Barbara Wishingrad in San Miguel, an American midwife who, in recent years, has concentrated her energies on documenting the myriad uses of the Mexican *rebozo* (shawl) (she calls her project "The Rebozo Way").

Isabel Martínez's story is a telling one: she was a childbirth educator in Mexico City who entered midwifery studies at Maternidad La Luz at the same time that

Laura Cao Romero began to study with Patricia Kay. Isabel completed the one-year intensive program at La Luz, then returned to Mexico and joined Patricia's class for a time. Later she opened a birth center in Ciudad Satélite, north of Mexico City, and took on an apprentice, Carolina Alcocer, who later became one of the first students in the CASA School of Professional Midwifery. Isabel ran a large and successful practice until the death of a baby during a home birth she attended. The relatives of the mother threatened to put Isabel in prison, so she precipitously left the country and has not been heard from since. Isabel's experience provided powerful motivation for her apprentice, Carolina, to enter CASA and to obtain a state-accredited formal education.

Also not included here is the story of Naolí Vinaver, a Mexican professional midwife born and raised in Xalapa, Veracruz, who was trained in the United States and returned to Xalapa, where she attends the home births of middle-class couples, backs up traditional midwives, and, for several years, appeared on statewide television every Tuesday morning at 10:00 AM showing birth videos and discussing the advantages of natural birth. In addition, Naolí often travels to various countries discussing home birth and demonstrating traditional Mexican birthing techniques (such as the multiple uses of the *rebozo* during labor) at international conferences. Naolí is central to the development of the *partera profesional*; however, as she has eloquently told her own story (Vinaver 1999, forthcoming), I have mostly left her out of these pages. (She can be reached at <kalimba@prodigy.net.mx>). Also not included due to space limitations are the fascinating stories of the students at the CASA School of Professional Midwives in San Miguel. I have conducted extensive interviews with the four members of the first graduating class. I plan to interview future graduates as part of my ongoing research. I recommend the CASA School to future researchers as a rich ethnographic site.

11. To view these documents and for up-to-date information about MANA, see <www.mana.org>.
12. The nine graduates of Patricia's original group included childbirth educators Laura Cao Romero, Guadalupe Trueba (see Endnote 17), Lourdes Bravo Garza, Isabel Montes de Oca, and Gina Bisognio; acupuncturist Melissa Nussbaum; Marian Tudela, a mother whose interest in midwifery began with a water birth at home attended by Patricia Kay; physician Angeles Guerrero; and obstetrical nurse Lucila García. Alina Bishop completed the first half of Patricia's training and has worked as a member of Ticime.
13. The majority of *parteras profesionales* who traveled to the United States for training participated in the program at Maternidad La Luz, which was created in 1987. By 2000, around 6,000 births had taken place there, and over 3,000 students from many countries had obtained midwifery training. Most formal direct-entry midwifery programs are three years in duration, but, because of the high volume of births at La Luz (about 600 per year), its program is especially intensive and so is only one year long. After that time, La Luz students are able to apply for CPM certification. La Luz's training program combines didactic classes with hands-on learning; from the day of their arrival, students working directly with their mentors participate in prenatal exams and postpartum care and soon begin attending births. Per week, students work two 24-hour shifts, attend nine hours of classes, are assigned a great deal of homework, carry out research projects, and take a series of examinations, gaining a strong combination of theory and ex-

perience. Once a week, the students gather for a "birth chat" so that by the time they graduate, they have attended 80 or 90 births and listened to the stories of hundreds more. Maternidad La Luz was the first program to achieve accreditation by the Midwifery Education and Accreditation Council (MEAC), a partner organization of MANA. In November 2001, MEAC received recognition as an accrediting body from the US Department of Education.

14. For discussions of the central role of *sobada* in traditional midwifery care, see Sesia (1997) and Jenkins (in Part II of this special issue). Unlike traditional midwives, few of Mexico's new professional midwives perform *sobadas* (traditional massage) as a regular part of their prenatal care.
15. Antonia's description of her training course echoes descriptions of equally inadequate TBA training described by Jordan (1993) and, more recently, by various authors in the new collection *Midwives in Mexico: Continuity, Controversy, and Change* (Good Maust, Güémez Piñeda, and Davis-Floyd, forthcoming).
16. Laura Cao Romero and her colleagues in Ticime have given speeches in many countries about traditional Mexican midwifery, have worked with the Safe Motherhood Initiative in Mexico to encourage efforts to preserve traditional midwifery, and have traveled extensively in Mexico locating and interviewing traditional midwives. They have helped groups of traditional midwives in Oaxaca and elsewhere create local organizations and hold monthly meetings for skills sharing and for discussing issues of mutual interests (often bringing or sending speakers from Cuernavaca to give workshops at these local meetings), and they have made a video, *Sobada and Manteada: Massages Practiced by Mexican Midwives* (Grupo Ticime n.d.), that discusses traditional birth techniques. Ticime also publishes a quarterly magazine, *Conversando entre Parteras*. To reach the midwives of Ticime, contact Laura Cao Romero at Cerrada Flor de Agua No. 11, Col. Florida, Mexico DF CP 01030. Tel. 011-525-661-6832. E-mail: <ticime@laneta.apc.org>; Paulina Fernandez at Alvaro Obregon No. 103, Colonia Centro, junto a la Clínica Borda, Cuernavaca, Morelos, CP 62000. Tel: 011-52-731-21836, <paulinafp@infosel.net.mx>; Lucila Garcia and the Ticime clinic at Camino a Meztitla No. 4, Valle de Atongo, Tepoztlán, Morelos, C.P. 62520, 011-52-73-9-50750 <parteras@laneta.apc.org>. The Ticime website is <www.parteras.org>.
17. Due to space limitations, I could not include Guadalupe Trueba's story, but it is a fascinating one that reveals the extreme legal and political marginality of the *partera profesional*. In brief, Lupe studied with Patricia Kay in El Paso, then returned to Mexico and initiated a home birth practice under the auspices of CIMIGEN, a maternity clinic in a poor southern district of Mexico City. It is the only place in Mexico City where the LEOs actually function as midwives, attending births and giving full spectrum perinatal care. For years, due to the support of CIMIGEN's medical director, Dr. Carlos Vargas, Lupe was able to transport her home birth clients there in case of need. This arrangement could have continued indefinitely, except for the threats Lupe began to receive from other physicians in Mexico City, who assured her they would put her in jail if she had a bad outcome. Her lack of legal status made her doubt her ability to defend herself in court, and, eventually, she stopped practicing. At the time of writing, she attends home births in the capacity of doula with two of the nurse-midwives from CIMIGEN, who were inspired by her holistic ideology to expand into home birth practice.
18. The professional midwives who have served as MANA representatives from Mexico are: Alison Bastien, Laura Cao Romero and Guadalupe Trueba (who

- served together), Naolí Vinaver, and Paulina Fernandez. Beginning in 2001, the next MANA representative will be CASA graduate Carolina Alcocer.
19. As of the time of writing (June 2001), there were around 70 dues-paying MANA members in Mexico.
 20. MANA conferences have been held in Xalapa, Vera Cruz (1995), San Miguel de Allende (1996), Puebla (1997), Oaxaca City (1998), Oaxtepec (near Cuernavaca) (1999), and San Luís Potosí (2000). Edith Medina Mejia, a LEO from San Luis, was one of the attendees at the 1996 MANA conference in San Miguel. She was so impressed with the spirit of sisterhood and cooperation between professional and traditional midwives that she went home to San Luís and began to organize conferences, which she now puts on every December for all the midwives of her state. These conferences are entitled *De Partera a Partera* (From Midwife to Midwife). Four hundred midwives or more pour out of the mountains of San Luís to attend these conferences and obtain the benefits of the skills-sharing workshops and the interchanges with other midwives they provide. These conferences, like the annual MANA conferences, constitute rich sites for anthropological investigation.
 21. The CASA School of Professional Midwifery is accredited by the Guanajuato State Department of Education, Accord No. 176-97, 4 July 1997, Registration No. 11PETO143N. For more information, write to the CASA School of Professional Midwives, Santa Julia No. 15, Col. Santa Julia, San Miguel de Allende, GTO, Mexico 37700. <casa@unisono.net.mx>
 22. Statistics from births attended in the CASA hospital between May and October of 1999 show a total of 249 births, 207 attended by midwives and 12 by physicians. Thirty cesareans were performed, yielding a cesarean rate of 11.5 percent (Goodman 2000). In 2000, CASA's cesarean rate was 13 percent.
 23. Upon completion of their social service, CASA graduates will be eligible to apply for their nationally recognized professional licenses (*cedula profesional*) from the Department of Professions, Ministry of Public Education (File # 11-00043).
 24. The participants on the CONOCER Expert Committee include, among others: Arturo Hernandez of CONOCER; professional midwives Antonia Córdova, Alison Bastien, Laura Cao Romero, Maricruz Coronado Saldierna (a CASA graduate), and Sandra Morningstar (a consultant from NARM); and traditional midwives Manuela Mendoza and Cirila Sanchez (both from small towns near San Miguel), Carmen Quevedo and Irene Sotelo (from Cuernavaca), and Hermila Diego (from Oaxaca City) (Sandra Morningstar and Laura Cao Romero, personal communication, July 2001).
 25. This knowledge base of course also overlaps to a great extent with that of obstetrics, but there are fundamental differences. Obstetrics tends to assume that births are disasters waiting to happen, and, consequently, its knowledge system is filled with information about technological interventions that generate a sense of control for both the physician and the woman over the process of birth. But these interventions often cause problems, which then must be corrected with more interventions. In contrast, midwives tend to assume that birth will proceed well in the vast majority of cases (as is, in fact, what happens), and, consequently, their knowledge systems tend to be filled with techniques for facilitating women's ability to give birth on their own, with minimal intervention. The difference between these two knowledge systems is most clearly illustrated in the positions they prescribe for birth. Obstetric textbooks generally mandate that women

should lie down flat with their feet in stirrups to give birth; this position allows the obstetrician a clear field for maneuvering the baby down the birth canal, applying forceps, and cutting episiotomies. Midwives insist that the most physiologically efficacious positions for birth are upright – standing, kneeling, sitting, squatting, or on hands and knees – so that the woman can work most effectively with gravity and with her own muscles to push the baby out. For over 20 years, a huge and growing pile of scientific evidence has proven the multiple benefits of upright positions and the many detriments of the lithotomy position, which include reduction of the flow of blood and oxygen to the baby (often resulting in fetal distress), a decrease in women's ability to push effectively, a narrowing of the pelvic outlet (and thus more difficult births and more dystocia), and increased perineal tears (see Enkin et al. 2000; Rooks 1997). This is but one example out of dozens I could give. The point is that the differences between these ways of knowing about birth are not superficial but fundamental (Davis-Floyd 1992): their assumptions about the nature of women's bodies and birth diverge at the core. Physicians who do not understand these fundamental differences are unlikely to be able to perceive the value of the midwifery approach, in spite of the large body of science that supports it.

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