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Midwifery in Mexico
Bodies, policies and practices

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Disclaimer:

This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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List of Acronyms

UNFPA	United Nations Population Fund
ICM	International Confederation of Midwives
WHO	World Health Organization
INEGI	Instituto Nacional de Estadística y Geografía
INMUJERES	Instituto Nacional de las Mujeres
PND	Plan Nacional de Desarrollo
ENADID	Encuesta Nacional de la Dinámica Demográfica
ENSANUT	Encuesta Nacional de Salud y Nutrición
ENDIREH	Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares

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Abstract

This research paper will explore what are the relationships between the social policy around midwifery and the effects and practices it generates in the Mexican context. These is done by giving voice to the organizations, both national and international, that are playing a key role in challenging the dominant discourses of development, through an interview they share their different perspectives, roles and practices around midwifery. Through the exposure of their experiences and resistances, some factors determining the effects and practices of the current Mexican policy towards midwifery are identified, analysed and untangled in order to rethink on different ways of doing policy and development.

Relevance to Development Studies

This research contributes to the debates on how to understand social and development interventions differently by placing the bodies as central. I explore how development interventions, have a direct impact on the body and daily lived experiences by shaping and limiting people's agency and choice, especially women. To challenge these dominant discourses, I chose to voice the perspective of women's social movements as key actors in the long-time struggle for sexual, reproductive and health rights.

Keywords

Midwifery, bodies, childbirth, maternal mortality, development, social policy, sexual and reproductive rights

Chapter 1 . Why midwifery?[1]

Midwifery in Mexico has a long history of erasure. Until recently, midwifery had been excluded from the public health system as a viable and safe alternative for enhancing access to women's sexual, reproductive and health rights. Midwifery exists and has always existed in Mexico. It has existed on the borders of the official health system, particularly – not only- with traditional or indigenous midwives who have assisted, and continue to assist, a number of the population that either does not have access to institutional health services or they have resisted them. The last century, saw how the process of modernization forged the entrance and establishment of the contemporary medical model as we now know it, and with it the medicalization of the society, of our bodies, including pregnant bodies. In Mexico, throughout the late 1970s and 1980s, the development discourse pushed for the expansion of primary health care, emphasis in assistance during pregnancy, and this was translated into the creation of health centers and rural clinics promoting institutionalized attention and further marginalizing midwifery. In addition, in the 1990s, a risk approach to pregnancy was adopted, focusing on reducing maternal mortality rates, which only reinforced previous strategies of institutionalization.

Thirty years after the introduction of such model, Mexico still presents a gap between the needs and service provision regarding women's sexual, reproductive and health rights, including during pregnancy, labor and post-partum. Healthcare coverage has expanded in Mexico so that now 95.4% of all childbirths occur in a public health or social security institution (ENADID 2014). However, assistance during childbirth is not homogenous for women across the country, which reflects the diversity among regions of the country -and within states. Thus, allowing for different rules and operation modes according to the health institutions, which has had an impact on the effective coverage due to – but not restricted to- limited access, lack of resources, adequate infrastructure and service providers.

In this scenario, there have been documented cases, and many more continue to be invisiblized, where women have been subjected to obstetric violence due to neglect, poor services and facilities. Cases of women giving birth outside hospital premises- parking lots, courtyards and restrooms- due to the lack or absence of medical personnel and restrictions in clinics' opening hours (Briseño 2014; 2015). The pressure is for women to go to clinics or health centers in order to receive 'proper' medical assistance, even when in reality these are such poor services. Despite the urgent need for more quality attention in uncomplicated births at a primary health level, midwives only assist 2.7% of childbirth in the public health sector (ENADID 2014).

[1] This research paper follows and elaborates on previous work written on the same topic or related during my Master's program on Development Studies at the International Institute of Social Studies (ISS), Erasmus University in 2017.

This situation is not exclusive of rural indigenous areas. The medicalization of birth and obstetric violence is a global phenomenon and it is affecting women in different ways in different regions all over the world. As such, there is growing support and solidarity for the midwifery movement within the broader international movement for women's sexual and reproductive rights, promoting different ways of living the reproductive process. In Mexico as well, civil society has been active and engaged in this movement opening spaces for discussing and bring midwifery back to the public scenario.

This research comes as result of the many questions that I asked myself throughout my Master program in Development Studies. Towards the end, beyond the question of how I understood development, I started to ask questions regarding and surrounding midwifery. How are development discourses impacting/engaging in the debates around midwifery and the broader sexual and reproductive rights movement? How (women's) bodies are perceived in this context? How is childbirth perceived? How is autonomy defined? If sexual, reproductive and health rights are about reproductive freedom, how is reproductive freedom understood? What is the impact of social policy and practices? What is the role of the different actors involved? And so on.

And, in Mexico? I started questioning how it was possible that there is this wide disparity and inequality -among women's birthing experiences in Mexico. I wanted to understand how despite that some achievements have been made in the field of sexual and reproductive rights, alternatives and solutions to unnecessary medicalization of pregnancy and childbirth are still limited. I wanted to try to understand why (and how) there are still these gaps between the promises of political discourse, the legal framework on the recognition of midwifery and the reality of daily practice; as well as between the real needs of women and the provision of sexual and reproductive health services.

I am also a 30 years old Mexican woman and I have the desire of becoming a mother someday, in my country. From birth -my mother had a vaginal birth in a private hospital- I have always had access to private medical assistance, access to a private insurance and private health providers and institutions. I have never worried about having to wait for uncountable hours to receive assistance when needed. I have questioned the medical model before, yes, but I have always had the opportunity to choose how, where and by whom I wanted to be assisted. Until now, I have (almost always) felt confident about expressing discomfort and demanding respect for my rights. Or so I thought, I now wonder and reflect on my past experiences.

Today, as a Master's student in a foreign country –where I also have insurance- I could not help but wonder if I will be able –though my privileges- to act upon the actual paradigm of the Mexican medical system and defend my sexual and reproductive rights, defined as the self-determination and autonomy that each individual has to decide over their reproductive life (Laako 2015: 88) –including having children, when, where and how. Midwifery, as Bianca Vargas

from Mujeres Aliadas A.C. words it *'is not about the birth process only, we tend to obviate the structural and contextual conditions (and midwifery is about that too), and I believe these are very important, without that we cannot achieve the transformations needed to guarantee women's rights'.*

And I also think about a student colleague (mother) from a Southeastern country saying, '*even myself, I would say a modern woman, like very empowered, have a freedom of this and that, still could not insist and defend my own right to be accompanied during my child labor process'.*

I was not sure that by only analyzing the social policy, in terms of design, around midwifery I was going to be able to understand this gap. I did not want to leave out the structural power relations interplaying in the Mexican context and the actors enmeshed in them, which together help shape and drive the on-ground daily practices. So, rather I intend to answer the question: ***how can the relationship between the social policy around midwifery and the effects/practices it generates in the Mexican context be explained/understood?*** The formulation of this question echoes Mosse (2004) suggestion on paying more attention to "the relationship between these models [social policies] in development and the events that they are expected to generate or legitimize" or to open the 'black box' of unknowing between development policy and its effects" (Mosse 2004: 641).

In order to answer my question, I wanted to hear the stories of midwifery from those who think differently. I wanted to hear the voices of the civil society organizations that have been part of the global movement for sexual and reproductive rights, and in particular of the local midwifery movement in Mexico. The increasing traction that midwifery has generated, triggered the formation of a group named *Parteras de Hoy.* This group brings together a variety of actors, both national and international, to promote a midwifery model in order *to provide sexual, reproductive health care and maternal, postpartum and neonatal care to women.*

For this research, I chose to interview the head representatives of top five organizations within this group that have a very important and active role in this debate. I wanted to show not only the diversity of organizations leading the movement, but to understand the way in which their differences and commonalities (De Jong 2009) have shaped their experiences as directors/founders, as women, and some even as midwives, in this struggle.

In the next chapter, I will present the theoretical framework, or as I call it, the *lenses* through which I analysed the information gathered with the interviews that allowed me to contest the understandings of the bodies in development – including mines. After that, I will explain the methodology I used to carry them out: the *why*, *how* and *whom* -introducing who the interviewees are. Then, in order to situate the struggle, the bodies and the policies and its effect I will describe the current Mexican situation regarding midwifery. Finally, I will present the information gathered through the interviews, and the analysis that allowed me to

identify some factors that explain the relationship between the policies and the effects and practices it generates in the Mexican context, followed by some further reflection on the role of the NGOs.

In this sense, with this research I try to contribute to the debates on how to understand social and developmental interventions differently, not as isolated from history and social, economic and political realities, interests and power relations, in order to challenge the paradigms of: 'universality, neutrality, maleness, disembodiment, objectivity and with- out biases' (Kimpson 2005:74) that form the Western tradition of doing development. To start opening up spaces for new ways of thinking and doing (Escobar 2012: 2) social policy and consequently, development.

So, how do we start thinking in other ways of being and being born?

Chapter 2 . Midwifery as an entry point

Underpinning my research is how to understand the body in relation to social policy. I explore how development interventions, have a direct impact on the body and daily lived experiences by shaping and limiting people's agency and choice, especially women.

Midwifery, as concept and practice, by which I mean different understanding of the reproductive body and its care and how it is translated into practice, is both global and local, and as part of the broader movement on women's sexual and reproductive rights, has recently been subject to development interventions, directly and indirectly. I consider midwifery as an embodied experience for women both, in relation to the reproductive life process, including pregnancy, labor and puerperium, and in relation to the right to practice it. I believe that midwifery illustrates well how development is a contested domain comprised of cultural, social, economic and political factors which are embedded in a particular context.

Through the concept and practice of midwifery I attempt to deconstruct my own ideas and understandings of the body and development and how they are they intertwined in a complex set of power relations. For example, asking how does midwifery, in a developmental discourse and practice, relates to the body beyond the physical encounter during labor?

I use a feminist theoretical framework that explores the linkages among power, gender and embodiment to unpack assumptions of about the biological reproductive body and 'norms' around childbirth. I look at the way the patriarchal modern medical gaze has shaped the ways in which decisions over women's bodies are discussed, negotiated and played out. At the core of my research are the debates on body politics between the medicalization of the reproductive body and the recognition of other knowledges-. The individual body- a woman's body- cannot be delinked from the social body, meaning that it is embedded in the political, economic, social and cultural relations and context that surrounds it (Harcourt 2009). Judith Butler states: "the body has its invariably public dimension; constituted as a social phenomenon in the public sphere, my body is and is not mine" (Baksh and Harcourt 2015: 264).

Midwifery and the politics of the Body

One of the most emblematic struggles that came with the post-colonial era is that "between modernization and tradition within a nation [which] has always been written on women's bodies, for example being seen as the biological reproducers of national citizens" (Bergeron 2004: 19). This *body* is represented under a binary and heteronormative paradigm, where women are "biological determined on the basis of their reproductive capacity" (Takeshita 2017: 339). Thus,

separating them from their social and sexual body as different abstractions of their *self*.

This fragmentation of the body, often antagonizes the sexual body versus the reproductive body and the social body versus the reproductive body, whereas the integrity of women's body cannot be recognized as whole complex subject embedded in a complex system of social relations that influence its subjectivities and embodied experiences. It is important to acknowledge that the reproductive -pregnant- body is only one of the many bodies that women can, at some point in their lives, inhabit and experience.

However, while our understanding of the body does not move beyond the "conception of the body as an object [fragmented], to understanding of the body as a subject, central to power, gender and culture, [embedded in social and cultural relations], by acknowledging, through body politics, the fleshy bodies of women – in birth, breastfeeding, menstruation, their material experience of sex, pregnancy, violation, rape –the embodied experience of the female body would not become an entry point for political engagement" (Harcourt 2009).

The body constitutes "the first place where women are engaged in political struggle. These include struggles for autonomy, for reproductive and sexual integrity and rights, for safe motherhood, for freedom from violence and sexual oppression" (Harcourt and Escobar 2002:8). For this research, the body is understood -within the struggle for the recognition and redefinition of midwifery, and in broader sense for sexual, health and reproductive rights- as "a physical and cultural reality caught in the dualism of dominant scientific and medical Western knowledge systems and as a symbol of social/political projects through which individuals [women] and populations are governed" (Harcourt 2017:7).

To discuss about midwifery practices, requires us to think and reflect on the historical process that had shaped our own perceptions of what the reproductive body and childbirth practices are and on how we take the decisions over it – or how are they shaped for us. Throughout history different factors have interfered with women's choices over their bodies and their sexuality, be it cultural representations, social expectations, economic and political convenience (Baksh and Harcourt 2015: 253).

In this research, I consider midwifery as an entry for rethinking, reclaiming and respositioning the body (Harcourt 2017). Midwifery itself represents a form of resistance to neoliberal sexual and gender politics that tend to homogenize women, annihilating diversity, their voices and knowledges.

As the "embodied experience of women and men is at the core of what it means to live through what 'development' imposes on people" (Harcourt 2009: 5), the concept of body politics helps to understand the diversity of women's lived experiences within their own specific socio-economic and cultural context in order to recognize the effects of development itself but also on how to change

"the vicious cycle of social policies that silence women and perpetuate with interventions their position as objects instead of subjects owners of their bodies" (Hernández 2017).

Post-development: new ways of being born

In this research, I will also use a post-developmental theoretical approach to explore how midwifery can be understood as a form of embodied resistance to the dominant discourses of development that are rooted on the process of modernity, emphasizing the beneficial effects of science and technology (Escobar 2007). I use this framework to show how these discourses and practices are used to reinforce and perpetuate systems of domination over the bodies, like the medical Western knowledge, and thus, marginalizing other knowledges.

A post-development approach involves "rethinking radically development and move beyond the paradigm of modernity in order to open up spaces to a plural landscape of knowledges that would imply lessening the dominance of Western modern science and discourses" (Escobar 2007).

Post development theory has also been influenced by Michel Foucault view also development as a "discursive formation of power/knowledge which deploys rationalities of government (or governmentalities) in order to shape the politics of life and death (or biopolitics) in ways which are far less neutral or technical than they are sometimes presented" (Death, Gabay 2015: 600). for Foucault power is productive of new forms of knowledge, truth, and subjectivity (Death, Gabay 2015: 600). This productive conception of power will allow me to explain further in the analysis of the interviews how policies around midwifery in Mexico shape and limit women's agency.

For this research, I will use Mkandawire (2001) definition of social policy as "collective interventions directly affecting transformation in social welfare, social institutions and social relations that work in tandem with economic policy to ensure equitable and socially sustainable development".

In this sense, social policy can be considered as key instrument to achieve development. However, from a post-development critical perspective we must not forget that policies are embedded in larger social, economic and political systems of power relations. Thus, "they are the outcomes of political bargains and conflicts since they touch upon power in society -driven by the values of different social actors with different ideological positions, and invariably entailing intra- and inter-generational redistribution issues" (Mkandawire 2001: 18). Development discourses and with them social policies are a reflection of the values of the dominant economic systems and power relations.

Midwifery, as both concept and practice, challenges the understandings of development. It does it through the "change in the practices of knowing [the

body] and doing [childbirth practices]", by allowing a "multiplicity of centers and agents of knowledge production" (women and midwives), which have been long silenced, recognizing them as subjects of their own right and finally, it allows for new strategies coming from and produced by social movements to counter the Western tradition (Escobar 2007).

A post-colonial midwifery

I will use post-colonial theories to understand the history of erasure of midwifery in Mexico by "making visible the binary logic of modern thought, which operates in categorizations of sex, gender, sexuality and class" (Lugonés 2008). Through this approach is also possible to analyze the different subordination and dispossession traces that development discourses and practices have left on women's lived experiences throughout their reproductive life and particularly during childbirth.

When I refer to women in this research, I do it acknowledging that "women are constituted as women through the complex interaction between class, ethnicity, culture, religion and other ideological institutions, frameworks and locations" and not as a homogenous group, this to avoid falling into the 'women as category of analysis trap' (Mohanty 1984: 344). Because it is precisely in this process of homogenization and systematization of the oppression of women (Mohanty 1984) occurs.

In the recognition of these differences lies also the importance of having an intersectionality approach since as Ludvig (2006:250) emphasizes "differences cannot be treated as abstracted from power relations". An intersectional approach in this research will allow me to make an analysis of the relationship between the policies around midwifery and its effects through the "complex interactions of systems of oppression, including their mutual and simultaneous reinforcement and, to their impacts on [women's] lives, bodies and subjectivities" (Biekart and Harcourt 2016: 150)

From an intersectional perspective is acknowledged that different "groups in a society are affected by their position in multiple systems of power and oppression, a 'matrix of domination' that changes over time and place and in different institutional domains" (Hankivsky & Cormier 2011 cited in Pàlencia *et al.* 2014, 3). This effectively reduce gaps and achieve better results that can be translated into the protection and guarantee of women's sexual and reproductive rights.

In this sense, intersectionality theory, stresses that inequalities by race, gender, class and sexuality be considered in tandem rather than distinctly as an additive approach – for this case: women, indigenous, poor, pregnant, and so on-, but instead strives to understand what is created and experienced at the intersection of two or more axes of oppression (Hankivsky et al. 2010 cited in Pàlencia et al. 2014, 3). Indeed, the "point of intersectional analysis is not to reinscribe

the additive model of oppression rather to analyse the differential ways in which different social divisions are concretely enmeshed and constituted by each other" (Yuval-Davis 2006: 205).

The decision about the theoretical framework that I will use to analyse the information gathered had much to do with my choice of the actors I decided to interview. As mentioned before, I consider that midwifery itself questions through its practice the development regime (Harcourt and Escobar 2002) as much as the actors from civil society organizations participating in the struggle for the recognition of midwifery as a viable, current and safe option for women in order to guarantee their sexual, reproductive and health rights. In the next chapter I will describe the methodology used for this research: the *how, why* and *whom.*

Chapter 3 . Why a civil society network?

In order to understand midwifery within the Mexican context and how social policy works around it, I decided to collect the testimonies and perceptions of actors involved in the movement for the recognition and integration of midwifery. Furthermore, I wanted to look at it from a non-official –governmental perspective. I looked for an outside perspective, looking to the testimonies of non-state actors and the civil society organizations that are part of the historical and present struggle for women's sexual and reproductive rights in Mexico. It is from their experiences, that I could understand what is shaping and directing the design of government policies towards the recognition and integration of midwifery into public maternal health policy as a real alternative for women in Mexico.

First, I needed to understand where Mexico was standing. For this, I revised the current legal framework, which had been modified earlier this year. In addition, I looked into three different surveys, the National Health and Nutrition Survey (2014) and the National Demographic Dynamics Survey (2014) both were useful for identifying the current social dynamics regarding maternal health; depicting, in numbers, a big picture of the issue. The third one, the National Survey on the Dynamics of Household Relations (2016) put obstetric violence in numbers for the first time.

Then, a media review. I was impressed of how the media was taking over this topic, particularly in the last 2 years, this issue has become very relevant as cases started pouring the media, only in the last month more than 3 cases were reported, and even international media was writing about Mexico (El País, VICE News, The New York Times). At the same time, I used the results of different local reports published by the International Confederation of Midwives (ICM), the United Nations Population Fund (UNFPA), the National Commission of Human Rights (CNDH, for its Spanish acronym) and the Maternal Mortality Observatory, amongst others.

During my 'desk' research, I came to know a group of non-governmental actors that had come together in Mexico to raise awareness about the need for midwifery to be supported as a public health policy. The recently formed group *Parteras de Hoy* (Midwives Today) (May 2017), is a group of more than twenty civil society organizations, national and international, and midwives dedicated to the promotion of alternative – and traditional- childbirth practices. They jointly and individually run information campaigns to raise awareness of the benefits of midwifery for enhancing maternal health in Mexico. Furthermore, some of these organizations also practice and teach alternative – and traditional- childbirth practices.

Despite their differences, often on their approach to midwifery formation and models, the organizations in *Parteras de Hoy* have a common goal which is: *to provide sexual, reproductive health care and maternal, postpartum and neonatal care to women*. This group, comprises a variety of organizations, national and international. After identifying and mapping out the different organizations and non-state actors belonging to the group, I decided to narrow my focus on 5 organizations which are leaders in the debates around midwifery in Mexico. In order to have diverse approaches and points of view I chose the participants on the basis of their experience (years and knowledge), approach to midwifery, action lines, type of population they work with, place of work and profession.

I acknowledge that there many organizations and actors that are part of this struggle, that due to time and space constrains was not possible to include in this research. I believe the testimonies of the organizations and actors I chose have an echo, though, recognizing this is also possible from the position they occupy within this context.

Finally, I contact them through an email where I introduced myself and what I was trying to accomplish. A master student trying to understand, through their valuable experience as non-governmental actors, why is there still a gap between the provision of sexual and reproductive services and maternal health and the actual reality that many women are experiencing in Mexico. In their responses, all of them demonstrated interest in the question I was posing and thus were willing to have a conversation with me. Later, I explained that our conversations where going to be guided by a semi-structured interview because I was particularly interested in knowing their perceptions about specific topics such as midwifery but also others closely related: the body, maternal mortality, obstetric violence, social policy, childbirth, amongst others (see Annex 1). We set up the day and time. Through Skype and WhatsApp phone calls, I managed to engage in six different one-hour long conversations, as different as the participants themselves.

Who are the members of *Parteras de Hoy*?

Cristina Alonso, director and founder of *Luna Maya, A.C.* is a midwife with more than 20 years of experience. Luna Maya is formed by two birth centres, one in Chiapas and another in Mexico City, that follow and promote homebirth model and provide other sexual and reproductive services to women in urban and rural indigenous contexts. She has also been the director of the Midwifery Mexican Association.

Sharon Biessell, an expert in gender, reproductive health, population and human rights. She is director of the *MacArthur Foundation* in Mexico. In 2015, the Foundation launched a three-year strategy that seeks to improve maternal

and reproductive health through the strengthening of *professional* midwifery, becoming the largest donor supporting around 30 different projects mostly from civil society organizations.

Araceli Gil, midwife, director and co-founder of *Nueve Lunas A.C.* in Oaxaca. They provide maternal health, sexual reproductive and health services based on a traditional midwifery model. To achieve this, they created the birth centre *Luna Llena* (13 years ago), where they developed, practice and promote an educational midwifery model based on traditional midwifery. In addition, they provide different sexual and reproductive services "we have *círculos de embarazo* (pregnancy circles) and collective medical consultations based on community knowledge and accompaniment".

Bianca Vargas, is a surgeon and has an MA in Medical Anthropology. She is head of research and project consultant in *Mujeres Aliadas A.C.* an organization, based in Michoacán, that promotes sexual and reproductive rights and provides sexual and reproductive healthcare to women based on the *professional* midwifery model. This is one of the midwifery schools in Mexico that was recently officially recognized and with the ability to issue a professional license to their students as *Technician in Professional Midwifery*.

Elsa Santos, program coordinator in the office of the United Nations Population Fund (UNFPA) in Mexico. "Our mandate is that every woman can chose about their pregnancy and have access to a safe birth, furthermore, we work on sexual and reproductive rights throughout all the vital cycle". UNFPA's Country Program (2014-2018) has as one of its strategic priorities maternal and neonatal health.

The distance, in this case, did not represented an obstacle to engage in a profound conversation. All the participants talked openly and discussed very sensitive topics, I perceived this as part of their continuous struggle to visibilize what is going on in Mexico and make a statement about it. In every interview, I asked for the participants' permission to record them in order to be able to transcribe and translate their experiences. By doing this, I was able to identify the type of issues they were raising, their scope and occurrence, and to look for differences and similarities. The translation represented a challenge for me. I always kept in mind the words and meanings shared with mi in the interviews made, however, I must acknowledge that sometimes meanings are lost in translation.

Finally, through this process I was able to do an analysis, in which I must recognize my own positionality, hoping it can contribute to the discussion about changing the paradigm under which social policy is conceived and designed. Understanding and recognizing the body as the entry point (Harcourt 2009) for any potential social change to take place and to guarantee women's rights.

In the next section I will situate the bodies, the policies and practices and the struggles around midwifery, in order to recognize it as a viable and current option for women and as a valuable practice, within the Mexican context.

Chapter 4 . What is the Mexican situation?

Despite the achievements made by feminists since the International Conference of Population and Development in 1994 and onwards regarding sexual and reproductive health rights within population policies (Baksh and Harcourt 2015: 271) women all over the world continue to struggle to be recognized as subjects of development and owners of their bodies. Reports and studies show that women's sexual and reproductive health rights (SRHR), continue to be systematically and structurally violated (Maternal Mortality Observatory in Mexico). The lack of taking into account women's voice is sometimes reflected in the design of social policy and practice regarding women's SRHR, and specifically, for my research, regarding childbirth practices.

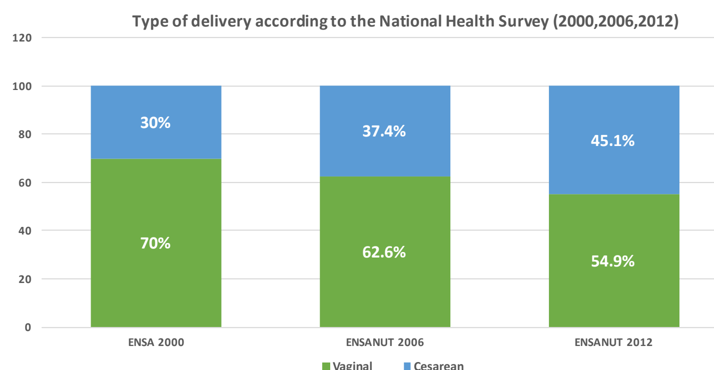
In Mexico, equality between men and women before the law and the right to health protection is established under the article 4 of the Political Constitution of the United States of Mexico (CPEUM, for its Spanish acronym). Nevertheless, at present, the reality for many women regarding the access to health services and the guarantee of their sexual and reproductive rights, especially during childbirth, is experienced very differently. In the name of development, continuous violations of women's rights occur due to the medicalization of this practice and the limited alternative solutions.

Hospitalization and medical procedures, such as cesarean sections considered as modern, have become normalized despite the World Health Organization (WHO) Statement on Cesarean Section Rates, which indicates that the ideal rate of cesarean sections should be between 10% and 15%. All over the world, but particularly in developing countries, the use of cesarean has risen notably, for example, in various countries of Latin America, the proportion of births by cesarean section is close to almost 40% at national level (Betrán et al. 2009).

In Mexico, there has been also a rise in the medicalization of pregnancy and birth in the last decade. Mexico ranks fourth in the world amongst the countries with the highest number of cesareans performed without medical emergency, after China, Brazil and the United States. Almost 50% of all childbirths are delivered by cesarean section (ENSANUT 2012).

In 2015, of an estimated total population of 119 million, 82% had health care coverage (INEGI 2015). The expansion of health care coverage, emphasis on childbirths, in the public health sector and the urgent need to reduce maternal mortality rates has been translated into the promotion of medicalized/institutionalized attention and with it the excessive use of medicalized practices amongst low risks pregnancies, such as cesareans. In the public sector, cesareans are used in one out of two births, while in the private sector this figure reaches almost 70 % (ENSANUT 2012). The indiscriminate use of such procedures can be harmful for women's health as well, since they should be practiced only under specific circumstances in order to reduce risks for women and the newborns (Hernández 2017).

Figure 1. Type of delivery according to the National Health Survey



Source: Own elaboration based on the National Health Survey Executive Summary, 2012.

However, despite the expansion of institutionalized attention, Mexico has failed to meet the target established in the Millennium Development Goals related to maternal mortality reduction –though it was reduced by 54.1% between 1990 and 2015 (PND 2013). And still, the new target set by the more recent Sustainable Development Goals (SDGs) agenda remains a challenge: reducing global maternal mortality ratio to less than 70 per 100,000 live births by the year 2030 (UN 2016).

Moreover, the recent National Survey on the Dynamics of Household Relations (ENDIREH 2016) has included information on the prevalence of obstetric violence for the first time. The results show that in the last five years 33.4% of women between 15 to 49 years old that gave birth suffered obstetric violence, 40.8% of them were assisted in a public health institution (IMSS). The survey also showed that 10.3% of the 3.7 million women that had a cesarean section were not informed of the reason and 9.7% was not asked for consent (ENDIREH 2016). Obstetric violence can take many forms, ranging from physical, psychological and verbal aggression, not allowing women to be in different positions during labor, to the use of unnecessary procedures – like episiotomy, cesarean section and forced sterilization- and also not guaranteeing an informed consent to practice such procedures.

According to the report on the State of the World's Midwifery 2014: A Universal Pathway – A Woman's Right to Health (SoWMy 2014) jointly produced by the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the International Confederation of Midwives (ICM) 96% of maternal deaths are concentrated in the 73 low and middle income, countries from Africa, Asia and Latin America that make for the 78% of world's total births per year. But in contrast, these countries have only 42% of the midwives, obstetric nurses or physicians.

In this context, the international community started promoting midwifery as a real and safe alternative in order to guarantee women equal and universal access to quality and dignified health services, comprising sexual and reproductive and health rights and services, including during pregnancy, labor and post-

partum. At the same time, this approach challenges the medicalization of childbirth and fosters the vaginal birth for low risk pregnancies at a primary health care level.

In this regard, the Mexican government, at least on paper, is trying to comply with these recommendations and to improve the situation through a series of policies. First, with a cross-cutting gender equality perspective the National Development Plan (PND) 2013-2018, aims at achieving a *México Incluyente* (Inclusive Mexico). In this line, the improvement of healthcare for population in vulnerable situations -children, women, indigenous populations- is a high priority. Women represent the 50% of the population and as such the PND recognizes that their full participation has to be guaranteed, on the other hand, for indigenous population it also recognizes that all social policies intended for them should have an intercultural perspective in order to overcome the obstacles which difficult their effective implementation (Hernández 2017).

Also, committed to enhance health care for population in vulnerable situation, such as women, and to decrease maternal and infant mortality rates the PND 2013-2018 put forward diverse strategies to guarantee a better access and quality of maternal and perinatal care. For example, the national strategy regarding prenatal, birth and postpartum care for women is contained in the *Programa de Acción Específico de Salud Materna y Perinatal* (2013-2018) (Action Specific Program for Maternal and Perinatal Health) which emphasizes the importance of providing care with a gender and intercultural perspective, the strengthening of midwifery is supposed to be articulated under this commitment. Nevertheless, midwifery is mentioned only once in all the document.

Furthermore, regarding the legal framework, the Health General Law recognizes under its articles 3 and 61 maternal health as a matter of general health and thus, a priority to guarantee women's sexual, health and reproductive rights. Maternal and child health is seen as a priority as for being the cornerstone for biological and social reproduction of human being, furthermore, as an essential condition for the well-being of families including as a key element in reducing inequalities and poverty (NOM-007-SSA2-2016, Health Ministry).

Despite this claim, it is notable that midwifery and midwives are mentioned only once in the General Law and it appears to be only to encourage the facilitation of trainings to strengthen their technical competence in pregnancy care, childbirth and puerperium (Health General Law 1984) that in addition is subject to availability and authorization of resources by the Congress in the expenditure budget for each fiscal year.

As for the specific norm for the provision of woman care during pregnancy, labor and puerperium, and of the newborn (NOM-007-SSA2-2016) it is important to mention that it has been reformed and recently republished (04/2017). Some of the most important additions to the norm are the following:

first, there is now a definition for technical[2] and traditional[3] midwives; second, it prioritizes women physical and emotional well-being through the facilitation of non-medicalized and physiological birth; third, advises against aggressive procedures for women during labor; and fourth, it emphasizes the importance of informed consent at all times during the reproductive process; amongst others. This has been key for the promotion of women's sexual and reproductive rights, for the recognition and integration of midwifery and for supporting the reduction of cesarean sections rates through the practice of "humanized labor".

According to the National Institute of Public Health (INSP) and the National Institute for Women (INMUJERES), in Mexico there has been a positive impact in the localities where professional and technical midwives as well as obstetric nurses have been integrated, these results should serve to foster and support the creation of new midwifery schools. However, in Mexico there are only three official schools with a recognized curriculum and with the ability to issue a professional license to their students as Technician in Professional Midwifery. In addition, at the moment, it is also not possible for a midwife who has studied abroad to validate her degree in Mexico. Officially, in the Mexican public health sector only 43 midwives were hired in 2016 and they were concentrated in 8 of the 32 states.

Changes to Mexican midwifery practices to guarantee and protect women's rights and health are now part of a strong debate among different actors. However, while opening the space and expanding the access to health services, the inclusion of traditional midwifery practices in the health sector has encountered some resistance. The discussion in Mexico around the recognition of alternative - traditional- childbirth practices in the public health sector has gained increasing traction in the public agenda and a variety of actors are starting to get involved while others find this revival as a continuum for a long-time fight (Maternal Mortality Observatory in Mexico).

The role that non-governmental organizations and individual advocates working on SRHR in Mexico has played and continue to play is important to understand the policy making process and its outcomes, especially from a historical perspective. The struggles that have brought together many civil society organizations have had many transformations over the last 30 years, as the organizations themselves and their agendas.

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[2] **Article 3.29** Technical midwife is the person graduated from midwifery training schools, whose degree is recognized by the competent educational authorities and corresponds to a technical level (NOM-007-SSA2-2016, Health Ministry).

[3] **Article 3.30** Traditional midwife is the person who belongs to indigenous and rural communities and who has been trained and practices the traditional model of care during pregnancy, labor, puerperium and for the newborn, and which is considered as non-professional authorized personnel to provide health care services (NOM-007-SSA2-2016, Health Ministry).

Locating the struggle

Literature has shown how transnational feminist movements have been able to "make local and cross-border connections" over shared struggles, such as reproductive freedom, possible through processes of solidarity that had enable them to organize and achieve their goals (Baksh and Harcourt 2015: 102). In Mexico, the participation of non-state actors, especially civil society organizations, in the public scenario has been key for making possible many of the transformations taken place in the last three decades regarding the promotion and protection of human rights in general, and for sexual and reproductive rights in particular. A long way has been walked from discourses to public policy that has been reflected in new norms and institutions, still the challenges are many.

I chose to refer to these actors as non-governmental in order to give space and recognition to a wide range of actions, that vary in scale, size and impact. From individual efforts to collective voices, (dis)organized civil society, international organizations and donors and academia, all of them, in their diversity, play different roles. What defines the role they play is their position, thus the power they exercise and that is exercised upon them.

Gender equality has been in Mexico's agenda ever since the First World Conference on the Status of Women held in Mexico City in 1975. From then on, Mexico, has been an active participant in the process of building a global agenda towards achieving gender equality and protecting sexual and reproductive rights. A highlight of this meeting is that women's participation was decisive for shaping the agenda, as heads of State delegations, but most importantly, as members of civil society organizations. However, the biggest challenge was, might still be, that the integration of women in these processes was subscribed under the assumptions of a patriarchal and capitalist system thus, privileging women's practical needs, particularly those that helped them to integrate in the economic system, over the strategic needs that meant a change in the power structures within their societies (Visvanathan, N. *et al.* 1997).

Despite these barriers, women's organizations, feminist organizations, from North and South, gathered together in a parallel Forum where they all had a reality check. Differences not only in ideologies but also in the concerns and struggles women were facing all over the world were varied and evident. Yet, it showed that a global dialogue was possible, a World Plan of Action was adopted and more importantly this space recognized and allowed women, from different cultures and backgrounds, to have a voice in the policy-making processes.

Another milestone for women's global movements, was the International Conference of Population and Development in 1994 (Cairo Conference). For the first time, sexual, reproductive and health rights were taken into account as a fundamental axis for the formulation of population policies. In the years to come, a lot of positive changes were achieved, in the fore of the 20th anniversary of the Cairo Conference, various regional meetings were held in order to share

some of the accomplishments as well as the challenges and backdrops that needed urgent attention.

During the year 2013, regarding sexual and reproductive rights, Mexico played an important leadership role for SRHR throughout the region and announced their intention to fight the assault on human rights and gender equality (Baksh and Harcourt 2015: 285). Civil society organizations and other non-state actors, including the actors and organizations interviewed for this research, have been committed to the follow up of these international agreements and thus have contributed to the promotion and accomplishment of sexual, reproductive and health rights in Mexico.

The role of the actors and organizations that form part of this research, alongside other non-governmental actors, has been very important in promoting a gender, intercultural and human rights approach for the protection of sexual and reproductive rights, which includes the promotion of a free and safe maternity. As reflected above, amongst their contributions, the following are worth noting: i) building a space for citizen participation and fostering a continuous dialogue between the government and non-governmental actors; ii) visibilizing how maternal mortality affects marginalized groups as well as give voice to their needs and demands; iii) creating mechanisms for monitoring and evaluating public policy; iii) promoting an intercultural and human rights approach alongside the design and use of culturally appropriate tools; iv) strengthening key actors, individual and collective, that are involved in enhancing maternal health; v) promoting professional midwifery; and, vi) systematizing information on public health, especially on sexual, reproductive and health rights. (Freyermuth 2015:18).

In Mexico, despite the accomplishments mentioned before, the implementation of this global agenda locally, aiming at the recognition and full integration of midwifery models, as I will try to show later, still encounters many obstacles, challenges and resistances -material and non-material, formal and informal, spoken and silenced, coming both from the society in general and the health sector, public and private, amongst many other actors. All these together with the advocacy role of non-governmental actors, such as NGOs, international organizations, international donors, plays a decisive role in the outcome of the political agenda, its priorities and how are they translated in to practices and the reality of 60 million women in Mexico (INEGI 2105).

It is in the understanding of these challenges and resistances and how they interplay in the Mexican context, that I have decided to focus my research. In the next chapter, I will try to explain the relationship between the policies around midwifery and their effects and practices on the ground. I will attempt to do this by critically analyzing the information the interviewees shared with me through their answers: based on their lived experiences as NGO representatives, as women, as midwives, as feminists, being one or all of them, while also occupying a place in the global and local movements promoting midwifery, in particular, and sexual and reproductive rights, in a broader sense.

Chapter 5 . The 'black box'

In this chapter, I will attempt to explain the relationship between the social policy around midwifery and the effect and practices it generates in the Mexican context using the theoretical framework to analyze the information gathered in the qualitative interviews. In this sense, I will try to open the 'black box' of unknowing between development policy and its effects" (Mosse 2004: 641).

What did I find?

From the information gathered in the interviews I identified three main factors that are determining the design of current social policy in relation to the integration of midwifery in the Mexican health system: a) International development discourses; b) the perception of midwifery; and c) invisibilization of women and diversity. Despite some progress, the current policy on the integration of midwives has not only hindered the integration of midwifery as a safe and viable model for maternal care, in order to close the gap between women's needs and service provision, but has had negative effects. As the different interviewees report, some troubling practices have become the norm in the health system: the widespread medicalization of childbirth has institutionalized birth taking control away from women to make decisions over their own bodies limiting women's reproductive freedom.

International development discourses[4]

International development discourses haven been long influencing the creation of national development plans which at the same time frame the design of social policies at a national and local level within countries (Escobar 2007). In order to comply with international standards, countries design social policies that are used as mechanisms to achieve concrete goals as well as to respond to local needs related to its population wellbeing. However, sometimes for the sake of achieving a short-term goal, social policies are designed with a short-sighted vision that ignores not only the context where they are implemented but the voices of those who are supposed to benefit from this and are unaware of the possible unintended effects this might produce.

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[4] Some of the questions from the qualitative interviews that informed this section were those about the perceptions around maternal mortality in the Mexican context, the public health sector and social policy towards midwifery.

From a critical perspective "[development] policy" driven by such development discourses is seen as "a rationalizing discourse, so the political intent of development itself is hidden behind a cloak of rational planning" this rational planning can be reflected in a trend in international development from the 1980s onward of "narrowing of the ends of development to quantified international development targets, but, on the other, a widening of its means" (Mosse 2004: 642) including maternal mortality, cesarean and obstetric violence rates.

Sustainable Development Goals (SDGs) are one illustration of international development discourses, framings and practices. SDGs are part of a historical and conceptual approach to development that was not inevitable but came from particular ideas and practices that have shaped dominant development discourses (Harcourt 2016). SDGs global agenda is grounded on the principles of universality, 'leaving no one behind'. For example, this time, the post 2015 agenda approach included a vision where every woman and girl should have "equal access to health services, including sexual and reproductive health and reproductive rights", as part of the international push to realize "universal health-care coverage, access and affordability" (United Nations General Assembly in ICM 2014).

SDGs are formed by 17 goals which are framed as explicitly 'global in nature and universally applicable' and questions, for the first time, the environmental sustainability of the current resource consumption behaviors, furthermore, they also recognize the importance of 'living in harmony' with 'Mother Earth' and 'the rights of nature' (Death and Gabay 2015: 601).

SDGs include as one of its goals to ensure healthy lives and promote well-being for all at all ages, despite the apparent shift in its discourse, the progress is again measured with indicators, establishing the target of reducing the global maternal mortality ratio to less than 70 per 100,000 live births by the year 2030 (UN 2016) and an emphasis in reaching universal access to reproductive health.

In Mexico, as with the MDGs, the SDGs agenda was adopted as a state commitment at the highest political level, as such, the different goals were translated into the priorities of the National Development Plan. This allows to understand how "the micropolitics of everyday life are linked to global processes" (Mohanty, 2003: 509). According to UNFPA, since the MDG 5, to reduce maternal mortality, the Mexican government adopted the strategy of "attending all deliveries in hospitals in order to ensure access to emergency obstetric care" (UNFPA 2017).

Here, I want to highlight, that at least in practice, three of the interviewees, still have a strong identification with MDGs, they all made reference to these - not SDGs. I see this as relevant because it shows how strong and notable was the shift on how policies started to be more and more driven by indicators such as maternal mortality.

As I will try to show along with the interviewees responses, the discourses and policies that the government has taken towards maternal health, sexual and reproductive rights and the integration of midwifery in particular, have been articulated under a rational planning approach focused on indicators such as maternal mortality –although not only- thus, linking and limiting them to the access to medical institutions.

In this context, little attention is given to how are the approaches to these indicators –established by development discourses- being adopted and translated into actions in specific local contexts. On this question, regarding maternal mortality Elsa Santos says: *'It continues to be a priority in the National Development Plan and it is also considered as a social indicator -the most terrible expression of the inequality that we live in Mexico- maternal mortality is current and that has driven decisions, like institutionalizing all childbirths, which has helped to reduce it but not as significantly as it was expected, and this happens on the expense of the quality of the attention'.*

Bianca Vargas refers to how midwifery has been related to different indicators, not only maternal mortality: *'In the beginning, they were health access and maternal mortality, by saying that with midwifery maternal mortality could be reduced. Nowadays, that we can say that Mexico is on its way to accomplish the MDGs, authorities are more and more reluctant to establish a dialogue with us about midwifery'.*

In this same line, Araceli Gil answers: '*It [midwifery] has been like a trending topic for the last 7 years, no more, because of the international pressure that has to do with the MDGs and maternal mortality goals, as well as the quality of attention -the government was very pressured and with it'.*

However, the efforts made by the government to reduce maternal mortality ratios have pushed for the institutionalization of childbirth in Mexico. Furthermore, the strategy of expanding coverage for institutional childbirth in the health sector has been translated into the excessive use of medicalized practices amongst low risks pregnancies, such as cesareans, which should be necessary only under specific circumstances in order to reduce risks for women and the newborns, but when used indiscriminately can be detrimental for their health as well.

She adds that: '*Maternal health policies have pushed for reducing maternal mortality in such a way that births are not being assisted in primary level facilities. So, women are not having birth with midwives but neither in health clinics due to the lack of resources and infrastructure, causing that the majority of women have to go to a second or third level facilities – which are not many and are far away, therefore, women do not have a first level option. Health services are being saturated which causes that true obstetric emergencies cannot be assisted'.*

In this sense, I find relevant how Bianca Vargas, also analyze the use of these indicators [maternal mortality] as a form of control: '*The discourse on maternal mortality was used to convince women that hospitals were the best option to give birth'*.

Different mechanisms of controlling women's decisions regarding birthing options have been identified and documented by diverse organizations. Control over women's bodies is being exercised directly and indirectly through different formal –structural and institutional- and informal mechanisms. These actions or omissions hinder the actual integration of midwifery as a real option.

When I asked Cristina Alonso why midwives were not assisting women anymore she answered: '*They [midwives] have been threatened with losing their economic supports from programs such as Oportunidades/Progresa. The government has been very clear, I mean, there is no written policy but it is oral. Both the woman and the midwife could lose their social support. Mexico is preparing for 100% institutionalized deliveries, so if you deliver outside the hospital the support is going to be taken away, so people is terrified'*.

Araceli Gil answer confirms this practice: '*In Oaxaca, in a lot of communities, there has been a reduction of women's options due to the use social programs [Progresa/ Oportunidades] where they give money to women in exchange for having hospital attention, and on the other side midwives are also been threatened that if they have an emergency or a complication during a birth they are not going to be assisted in the health center. They are instilling fear amongst women in order for them to decide based on fear and pressure where and with whom to have their births'*.

This kind of situations show how women's bodies and experiences are marked by structural and institutional behaviors driven by institutional discourse that end up undermining the quality of attention provided to women and seems to contradict both discourses about reducing maternal mortality and improving maternal care.

On this regard, Araceli Gil emphasizes: '*There are a lot of things that make us see that the health care vision has nothing to do with persons but with quantitative aspects like how many women are in the programs, how many women have accepted contraception. Seriously, what rules are statistics and control. This is the way women are seen. There is not a real interest in health'*.

The use of this indicators has been questioned before, arguing that beyond the lack of medical knowledge and human and economic resources it is "a complex mix of economic and socio-cultural factors which lead to gender discrimination, neglect and deprivation, and ultimately to the violation of women's rights to well-being" (de Pinho 2005; Friedman *et al.* 2005 cited in Harcourt 2009: 52). In this line, a new statement from the WHO also emphasizes the importance of "focusing on the needs of the patients, on a case by case basis, and discourages the practice of aiming for target rates".

However, I do not pretend to question here the validity of indicators as mechanisms to help measure social progress, but rather to question how are they interpreted and used for different aims in specific contexts. When used in a reductionist way, the underlying causes of the same issues they are supposed to change are invisibilized and lost in the translation of numbers. On this matter, Cristina Alonso says: 'O*ne cannot talk about public health without talking about the socio and economic context. Obstetric violence is not an arbitrary act. It happens because machismo and neo-liberal policies where the baby is considered as a product and women as a machine, so the product needs to be taken out as fast as possible'*.

Then she adds: *'There is a strong medical approach. The Ministry of Health says that they are integrating the midwifery model but what they really mean is that they are going to hire more nurses that have done a course for one year and they are going to assist deliveries inside institutions that comply with Mexican norms. The messages are contradictory. On one hand, the public health sector is trying to integrate midwifery, on the other they are looking for institutional deliveries, every pregnancy is treated as an emergency'*.

The objective of integrating midwifery models as a real alternative to guarantee women's sexual and reproductive rights, is lost when seen as a mean to achieve other goals. So, as Bianca Vargas expressed it: '*If it is not because of maternal mortality (pause) let's put it as that in the 21st century the challenge of sexual and reproductive health is not only that women do not die but also that they have access to a certain kind of attention respecting their dignity and will*'. In addition, according to the report SoWMy 2014 even if births are 100% institutionalized, maternal mortality and obstetric violence rates can continue to be high if quality in service provision is not addressed.

On the other hand, in order to focus on the recognition and legitimization of midwifery, Sharon Bissell also advises to use other kind of indicators that can show the benefits of midwifery itself: '*You have a lot of other things that you can measure about the positive impact of midwifery and midwifery itself, you can look at the accompaniment, we know that accompaniment during pregnancy and labor has better results for women and babies'*. These positive effects have been widely recognized and demonstrated by different international organization such as the UNFPA and the ICM.

A change of paradigm is needed. In order for midwifery, as a practice, can help improve women's experiences during their reproductive cycle under the broader objective of protecting their sexual and reproductive rights is necessary to see it as an end in itself not as a mean to achieve specific targets (reduce maternal mortality and/or cesarean sections), though it helps. The efforts, discourses and practices should focus on what are the obstacles and challenges midwifery is facing in the Mexican context. Midwifery is not to be put into development processes, but has to be recognized as part of it, it has always been there, and thus, concentrate on the social and cultural structures that need to be transformed. This is linked with the next factor I consider as determining the effects and practices of social policies around midwifery: the perception of midwifery.

Perception of midwifery in Mexico[5]

One of the main challenges after years of relating midwifery with the above-mentioned indicators and thus, under a rational planning paradigm, was actually to redefine what midwifery was and what is to be accomplished with its integration in the health system. In addition, also to redefine and broaden our understanding of who are the midwives and why they play an important role in enhancing access to women's sexual and reproductive rights.

Regarding the perception of midwifery in the Mexican health system, Sharon Bissell points out that there are many challenges: '*We could start with a cultural aspect, not only in organizational and labor settings, but also about gender perceptions. You have a system that gives men higher value as service providers in this area. From there, an unequal balance of power between those who are typically the doctors, which are mostly men but not always, and those who are typically midwives, here you have less men but it does not mean that they do not exist. We have a hierarchical and patriarchal system that does not have experience dealing with any women having autonomous power inside the health system, just as professional midwives tend to have if allowed'.*

Despite all the efforts each one of the interviewees is doing, as well as other actors and organizations, the integration of the midwifery model still is a challenge. Midwifery in Mexico has a long history of erasure. Until recently, midwifery had been excluded from the health scenario as a viable alternative for enhancing access to women's sexual, reproductive and health rights.

In this regard, Elsa Santos points out that: '*In Mexico, midwifery stopped being formally taught, privileging the formation of gynecologists as specialists, this happened regarding formation and in availability since you had to be a doctor, a nurse or specialist in order to provide attention. With this, midwifery competencies were lost in the health sector however, traditional midwives have been always present, and have been very important, it is not about competing but about how to recognize their knowledge and work together with them'.*

Sharon Bissell adds to this by saying that: '*Midwifery has been erased throughout the years, so nowadays it is very difficult for some people to even imagine a character like a professional midwife in the health services'.*

According to the interviewees, even if a midwifery model has been promoted, midwifery as such has been reduced to midwives' participation during labor, according to the definition once established by the Medical Subject Headings (1966) that oversimplified the role of midwifery to 'the practice of assisting

[5] Some of the questions from the qualitative interviews that informed this section were the perceptions around midwifery and midwives, traditional midwifery and childbirth in the Mexican context.

women in childbirth'. This vision has also limited the design and scope of social policy. Thus, resulting in an inefficient and isolated incorporation of midwifery.

The ICM has gone beyond this definition and emphasizes that midwifery is not only about woman's care during childbirth but rather "it promotes woman centered care and the well-being of women more generally through a supportive and preventive model of care" (ICM 2014) this includes when suitable the woman and the newborn.

In Mexico, Bianca Vargas gives an example of how Mujeres Aliadas A.C. face this challenge: '*First, we wanted to show women's reproductive process as a continuum that starts with sexuality, prevention, adolescence, accompaniment, pregnancy, labor and puerperium of course in the center, but also the post reproductive life, I can say from MA's perspective that midwifery was always seen as the ideal character for all of these. Our starting point was to think about midwifery as such'*.

More specifically, Elsa Santos says that: '*Beyond the care given during pregnancy, labor and puerperium, midwives nowadays are also trained for detecting sexual transmitted disease, HIV, menopause, etc. they are persons that are specialized in women's care and their families during the whole life cycle'*.

However, according to her, even to embrace this new understanding of midwifery is a challenge: '*There is the perception that Mexico does not need midwives because attention is already being given in hospitals, and people tend to relate midwifery only with traditional midwives, so it has been a lot of advocacy work in order to change the discourse and the perceptions to prove with evidence the benefits in women's life, in qualitative terms and in terms of their sexual and reproductive rights'*.

And when asked about the perception of traditional midwifery, she answered: '*What has most affected the perception towards traditional midwifery has been the policy in the health services in Mexico which promotes that all births have to be attended in hospitals so this policy has done that, and traditional midwives are been limited in their work (…) They are marginalized'*.

Additionally, she says that: '*They are being judged, a social judgement, they are also reprehended for not referring women on time, a lot of times without justification, in any case they should not be reprehended since they are recognized as health service providers in the official norm'*.

In this regard, Bianca Vargas also says: '*Obviously, this has happened [marginalization] after many years of threats, and of giving trainings where they were told to only count women and refer them to hospitals, otherwise they would go to jail, it was very sanctioned. And even, there are also areas, were religion, such as catholic but also protestant, have intervened and relate midwifery with witchcraft, so they do not accept it'*.

In order to support this approach, the ICM included in their definition of midwife "all health professionals who are educated to undertake the roles and

responsibilities of a midwife regardless of their educational pathway to midwifery, whether direct entry or after basic nursing". However, it recognizes that because of the diversity among countries and regions of the world, the definition of midwife is not without complexity. Hence, it does not try to promote one definition above others but recognizes that a midwife "acquires her/his knowledge and skills through different educational pathways" (ICM 2014). Yet, when needed some differentiation needs to be done in order to acknowledge this diversity and the policies necessary to protect and promote it.

In this regard, Sharon Bissell also points out that to guarantee such diversity has been a challenge for the midwifery movement: '*For example, some people [and organizations] have the perception that the development of professional midwives is an 'acto de agresión' (aggression) towards traditional midwives* and recognizes that *language do not favor in the sense because there is also discrimination against traditional midwives which has to do more with cultural aspects'*. Nevertheless, she adds that: '*Mexico, as a collective, is still working on finding a clear positioning towards midwifery, in order to able to guarantee to people, to traditional midwives and to those who advocate for them, that both models can coexist in parallelF*.

She also commented that: '*In the public health system and in general there is a reluctance to fully integrate midwives because they are linked only with traditional midwives which have been relegated with the role of making census and channel. But it is the particular profile of a professional midwife who could have a relationship with traditional midwives as well as with doctors, and acting more like a bridge and fostering the interaction of both models'*.

In this regard, Elsa Santos acknowledges: '*Of course, there is and should be interaction. If we talk about the continuum of women's health care this starts at women's homes and in the communities, is the traditional midwife who does this. This is why it is important to recover their collaboration with health services, with respect and support, and in the case of an emergency they can go to a primary care level institution without problem and being sure that there are professional midwives which will interact and continue with the attention. This will benefit midwives and women because it favors the continuum of women's attention'*.

The ICM (2014) has tried to do, and many organizations have followed, including those in Mexico, is to promote midwifery as current, as a social and cultural practice that has transformed itself in order to remain as a pillar for guaranteeing women's sexual and reproductive rights. In this line, they started also to promote different formation models and profiles such as the professional midwife. An example of this is given by Elsa Santos: '*Parteras de Hoy campaign was driven by the results of focal groups where it was identified that midwifery was related with ancient, non-cientific, and risks, but also with accompaniment, warmth and commitment, so that is why the name came up, we wanted to give the message that it was not ancient but current, something that is moving, that we are benefiting from'*.

Regarding the promotion of this new understanding of midwifery, Araceli Gil adds: '*One of the most important things has been the dissemination about midwifery being a safe, viable and current model for women's health care. What needs to be known is that*

midwifery in Mexico is current and has a long history from Mesoamerican cultures, midwifery has existed and has been present in communities for women, especially in rural and indigenous areas but also, although less visibilized, in urban areas'.

On the other hand, Cristina Alonso highlights: *'It is not only about hiring professional midwives, is about integrating the midwifery models and in order to do that you need to give voice and decision power to midwives'.*

These two last statements, help to link the first and second factors explaining the relationship of the policy models with their effects and practices -the international development discourses promoting rational planning and thus, ignoring underlying structural problems of the health system as a whole, alongside with the perception of midwifery and midwives within this system- and gives an entry to the third factor that I identified in this research: the invisibilization of women and diversity.

Invisibilization of women and diversity[6]

The lack of a participatory approach that takes into account the different voices of women in the design of social policy is a challenge that many countries face, and Mexico is no exception. One of the main critics of development discourses made by post-development theorists is that development projects always carry with them diverse forms of exclusion, "particularly the exclusion of the knowledges, voices and concerns of those whom, paradoxically, development was supposed to serve" (Escobar 2007: 20).

In this regard, the interviewees have identified that social policy, in Mexico, addressed to women in general, and in particular, regarding sexual and reproductive rights do not have a women's centered approach. On one hand, there is the persistent invisibilization of women's voices and knowledges about their own body, it is a constant in development discourses. Yet, their acknowledgement is fundamental to guarantee women's sexual and reproductive rights and the right to have a 'humanized birth'. in line with this, Araceli Gil adds that contrary to the biomedical model, midwifery is about: '*Recognizing that women and babies have their own knowledge, it is a principle. Also, a culture. We [midwives] recognize women's freedom of choice, women's freedom to give birth, women's autonomy'.*

However, within the Mexican health system, women are understood on the basis of their reproductive role. Hence, as mentioned before, attention is concentrated on the labor process itself instead of been seeing as only part of a whole reproductive life cycle process of women and how they live it. From this perspective, different questions should be asked on whether or not the principles

[6] Some of the questions from the qualitative interviews that informed this section were about the perception of women's bodies, reproductive freedom and options in the Mexican context and about whether an ideal midwifery model exists.

and interests that underlie these dominant conceptual frameworks are in harmony with those of women's lives and experiences (Butler 1993 cited in Harcourt 2009: 18).

To which Cristina Alonso answers*: 'If women were listened at all, it will be discovered that there are women who do not want to go to the hospital and need a space where they can feel safe*[7]*. But ironically, in the health sector patients are not heard and we believe that from our expertise position we know everything (…) the annihilation of women's voices is persistent in the design of policies around 'humanized birth' nothing really changes'.*

In relation to this same question, Araceli Gil says: *'Women are not seeing as women; second, they are not seen as subjects of rights. Furthermore, there is no specific attention concentrated in women, why? Because nobody has asked them what they want and need -how they want to be assisted, how do you want to deliver, how you want to be treated etc. This is an absurd but that's the way it is'.*

And she adds: '*There is no study that shows that women are taken into account to design the attention model based on what women want. Who has asked women in urban or rural areas how they want to be assisted. And this is the starting point, that women are not taken in to account at all'.*

In addition, regarding indigenous women's participation in health policy process Cristina Alonso highlights that*: 'There is a lack of basic anthropology, about asking indigenous women how they give birth. In addition to a typical post-colonial tendency of assuming that all indigenous people are the same, and it is not the same an indigenous from one region of Chiapas than another, because only in Chiapas there are more than 400 ethnic groups, languages. You cannot say that a 'delivery machine' is going to work for all women, for example, what does a tarahumara*[8] *woman has to do with a tzeltal*[9] *woman? The only thing they have in common is that they were colonized but their delivery practices are quite different'.*

When asked about if she believed that women were at all taken in to account in social policy and discourse, Elsa Santos replied: '*No. The official discourse is that all women should give birth in a hospital because like that they can control or decrease maternal mortality rates. But what happens when they arrive to the hospital where the beds need to be vacated fast because there are many women waiting, fast services, fast labor so that is what the organization of health services says. Also, now there are gynecologists in specific shifts, hence what they try to do is that in the same shift many cesareans are done, so there is no space for a safe and respected labor, there is no information of what is a cesarean. Services are organized to respond to doctors' timings and women's bodies and her reproductive freedom is not there'.*

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[8] The *tarahumara* or *rarámuris* are native indigenous people that inhabit in the north of Mexico, in the mountain range of the Sierra Madre Occidental, settled in the territory of the state of Chihuahua.

[9] The *tzeltales* are the largest ethnic group located in the mountainous region of Chiapas, southern Mexico.

Cristina Alonso emphasizes: *Women are not being respected. 'You are in a surgery room with people you don't know, without your family, you cannot choose the position you want and when the baby is born you are lucky if they give it you immediately. The surgery room is cold, with too many lights, you do not have personal objects with you and when the baby is born there's an urgency to remove the placenta quickly because "placenta kills women" finally, they stitch you, close your legs and send you to recovery, where a nurse will tell you that you have to lactate and when finished they will feed you'.*

In contrast, she adds: '*Women are looking for an experience that focuses in them, in their family and informed consent, where they can make the decisions. A non-medicalized experience inside the Mexican context'*.

The General Health Law aims to *incorporate* women *in* [emphasis added] health policy processes through the promotion of community participation in health care programs and in the provision of health services in order to strengthen the structure and functioning of the health system and to improve the health level of the population (General Health Law).

On this respect, Cristina Alonso shared a personal experience to show how women's concerns and lived experiences are invalidated by the government representatives: '*LM organized a forum with women and mothers in the Congress to talk about women's sexual and reproductive rights from women's own perspectives. From that, mothers start having meetings with the Ministry of Health to tell their experiences during pregnancy and labor in public hospitals, and what the government did was tell them that it wasn't true and that they should read the Mexican norms -NOM 007- that regulates labor in Mexico'*.

However, the way participation is framed under Mexican norms I find it somehow problematic. It shows us how development discourses and practices are still being constructed under the 'women in development' approach. Thus, assuming that women are to be incorporated into existing development processes. In this research I refer to, for example, increasing women's access to development through modern medical institutions and practices, or incorporating midwives in the same system, without challenging nor changing the systems and structures of inequality that universalize women and reproduce their oppressions.

In Mexico, because of its huge diversity, the differentiation between midwifery models has drawn a lot of attention in the current debates about how to recognize and integrate them. At present, this has been done in part by supporting a wide range of NGOs that have different approaches to midwifery. In this regard, Sharon Bissell says that: '*Taking into account the diversity of viewpoints that exist around midwifery in Mexico, a foundation like ours did not wanted to focus in one action line and leave out other options that might be more appropriate for an urban context'*. In this sense, there has been a lot of support also in the creation of midwifery schools for technical and professional midwives under specific academic plans which have validated codes.

It is important to really think on how this differentiation is done and the impact it can have such as reinforcing some of the perceptions that undervalue traditional midwifery or technical midwives. What the Mexican government has done is to recognize traditional and technical midwifery on one hand and in the other it has promoted the institutionalization of professional midwifery which is the closest to a biomedical model.

According to Araceli Gil the government: '*Has made a lot of efforts to integrate midwifery but its only option has been the institutionalized way, so from my point of view other midwifery models are not being recognized on the basis of Mexican cultural diversity. The cultural diversity, form indigenous populations and other forms of being a midwife. The government and the donors are interested only in an institutionalized model which is the closest to the biomedical model and the hierarchical way of providing health services'.*

In this case, she continues, '*traditional midwifery, despite being the origin, is being discriminated and denied. Therefore, a lot of us do not agree with the idea of a unique midwifery model and this has been a challenge, if we recognize the diversity of models then none of them could be above the others'.* On this matter Bianca Vargas says: '*This has been a chore discussion, not to obviate or annul traditional midwifery and indigenous populations, their specificities and knowledges, and to rescue all of these diversities, Mexico is like 70 different 'cosmovisiones" (world visions)'.*

These statements show the diversity of perceptions that exist around midwifery in Mexico. The aim of the government should be recognizing each model as unique and valuable taking into account the different local contexts and conditions, and at the same time guarantee that each one is accessible, safe and will protect women's sexual and reproductive rights.

Even if the ICM definition, the same as used by the Mexican Midwifery Association, is broad in order to give space to diversity. when asked about this regard, Bianca Vargas questioned if this was actually the case, especially in the Mexican context: '*Actually, under the midwifery definition used [in Mexico] the gynecologists are also recognized, if they give attention according to the competencies. Hence, within this vision, gynecologists, perinatal nurses, professional midwives, autonomous midwives, if they comply with the competencies scheme and provide assistance according to this, it can be denominated a midwifery model. For me, this is very confusing, I do not know if it really achieves their inclusion goal without invisibilizing the diversity itself'.*

Here, to have a clear differentiation is important and also the recognition of the different *ways* of being a midwife and practice midwifery in order to have specific frameworks that regulate and protect each one of them because if not both women and midwives that do not choose the institutionalized model are left unprotected.

So, when I asked about other options like homebirths which are also related to autonomous midwifery Bianca Vargas answered: '*There is an obvious rejection from the medical perspective, actually one of the violences exercised against women is related to having a home birth, when they arrive for the [birth] certificate they are sometimes subjected to a cavity inspection even when a day has passed and the cervix is not open and they do this without anesthesia, it is like a punishment for choosing home birth and as a condition to have the [birth] certificate'*. Hence, what happens is that the place you are born, since it is not prohibited in the law [homebirth], should not be an element of discrimination in order to have a birth certificate, it is a violation of the right to be registered.

The medicalization of childbirth and the use of informal strategies controlling women's decisions are just one part of a system that does not recognize as a priority nor guarantees women's reproductive freedom. The reality is that for guaranteeing women's reproductive freedom as conceived by Petchesky: "all women, regardless of class, race, ethnicity, sexual orientation, or physical ability, should the right to have, or not to have, children with dignity and with all the necessary material conditions to make raising children a sustainable life choice" (Baksh and Harcourt 2015: 255) women's agency and ownership of their bodies must be recognized, as the interviewees have pointed out. Also in order to guarantee the women have freedom of choice, options must exist and be accessible to every woman according to their preferences, needs and context.

Discussing about the access, Bianca Vargas makes an important remark: '*In Mexico City if you do not have a certain economic level you cannot access to midwifery because it is expensive -sometimes at same cost of a hospital. It is a place where midwifery it is more a private thing and not a real possibility for women's choice and access (…) there are few of them* [midwives] *who would say I'll go wherever or if you want to pay with guajolotes (turkey) it's fine'*. So, who has the access, that is the main question.

Therefore, on one hand, women are not being asked about how they want to give birth –where and with whom- they are oppressed and excluded, and neither their different lived experiences are taken into consideration. On the other, as I will show below, midwives are not recognized in all of their diversity, respecting their voice and knowledge as care providers. Therefore, the options available for women are going to be rather limited.

When I asked Bianca Vargas about women's options and if she considered there was an ideal midwifery model, she answered: '*So, for me the idea, or the ideal model of midwifery is diverse, as diverse as women's options. I do not know if I would put it as an alternative, saying that you have biomedicine and the other alternative, but at the end I do believe that the decision regarding sexual and reproductive health, being able to choose, depends on having the options to choose, if you do not have them you could not think this way'*.

She continued by saying that she believed in the interaction of different midwifery models: '*I believe that allowing the interaction of different models of midwifery, traditional and professional, understanding that both can change and are in constant transfor-*

mation, is possible and can be very useful. I believe that something very important is the articulation, because that would help to make it safer is that the reference models actually work in coordination with hospitals instead of them being an obstacle'.

For Araceli Gil: *'There is not such a thing as an ideal situation. Therefore, more than asking which midwifery model I would ask what kind of women exist in our society and what does they want'.*

In this line, she then emphasized again the importance of taking into account women's voices and their diversity: '*I believe not only in one model but rather on the basis of what women want, where and with whom, what kind of model and context, home, birth center, hospital, and having the information about advantages and disadvantages of each model. I believe that the ideal model is that women have information and options to know in which kind of midwifery she identifies'.*

Finally, Araceli Gil reflects on the question regarding social policy around midwifery in Mexico, to which she answers: *'What is happening is that social policies are not looking at women and babies in the center. Authorities are looking at an emergency situation because of the context: 'a collapsed health system and international pressure to achieve the MDGs', hence the incorporation of midwives to this system makes no sense for us. The situation won't change unless the system that is assisting women changes its paradigm, to one where women are at the center and have the lead role during their childbirth'.*

I find this last intervention very useful to illustrate my argument about the three factors that I present as determining the relationship between the policy models around midwifery and the effects and practices it generates in the Mexican context: development discourses, perception of midwifery and the invisibilization of women and diversity. It exemplifies how it is not a matter of designing the 'right' policy but about changing the paradigms, and in order to change them we need first to understand them. In this sense, policy models are poor guides (Mosse 2004) to understanding effects and practices of development interventions which are also shaped by different relationships and interests but also cultural, social and political characteristics in a specific context.

As Mosse notes (2004:665) "the coherence attributed to a successful –or not- development project is never a priori, never a matter of design" -I would say not only about the design- since it will be ignoring that policies are not isolated but created, driven and implemented within specific systems of power relations. which can be challenged or reinforced by these, through encounters and dis-encounters, resistances, interests and lived experiences. Again, if we want to think and do policies differently there is a need to open and detangle what is inside the 'black box' of unknowing between development policy and its effects (Mosse 2004: 641).

Building on the results of the analysis of the interview is evident how the organizations of Parteras de Hoy have managed to start changing the discourse on midwifery and its relationship with development. In the next chapter I will reflect more on the important role that these organizations have played in redefining the politics of being born in Mexico.

Chapter 6. Midwifery: A solidarity network

I confirmed, during the interviews and after the analysis, in listening to the interviewees several times, that these organizations and persons who represent them, are creating and pushing for new alternatives to resist and challenge, together in solidarity, the effects of the development interventions. With their actions, with the consolidation of the movements, they are raising an "awareness that reality can be redefined in terms other than those of development and that, consequently, people and social groups can act otherwise on the basis of those different definitions" (Escobar 2007: 21).

Changing the paradigms

Mexico, as mentioned before, has a long tradition of NGOs doing advocacy and monitoring activities that are needed in a country with the kind of cultural, social, economic and political conditions that were described earlier, specially regarding sexual and reproductive rights. However, more than ever, today civil society organizations understood the importance of acting together in solidarity as *Parteras de Hoy* shows. They have understood the political importance of "recognizing the enormous diversity of stories, memories, situated knowledges speaking from different realities as fundamental since these diversitites enrich and help creating new and different perspectives of social change" (Biekart and Harcourt 2016: 154).

However, besides willingness and the civic drive of organizations to make change happen, the formation and cohesion of this group would not have been possible without the large funding coming from international donors. The "global connections forged by women's rights movements to promote sexual and reproductive rights" is also helping to build solidarity (Biekart and Harcourt 2016).

As Sharon Bissell puts it in her own words: '*The international movement supporting midwifery globally has been very favorable for midwifery because it was recognized first that macro development policy was not paying enough attention to this topic before, thus resulting in problems in different regions, whether it is the over medicalization or the lack of qualified attention'*.

In this sense, Elsa Santos show us with her answer how this change is happening and how dominant development discourses and practices can be challenged: *'We are facilitating dialogue and South-South cooperation, with countries like Chili and Peru which have already worked on the integration of midwifery in their public health sectors. Knowledge sharing'*.

This kind of international involvement is challenging the dominant ways of doing international development and cooperation. The midwifery movement in Mexico, and globally, embodies that challenge. Throughout this research, it has been shown how the role of the global movement for sexual and reproductive rights, and particularly for midwifery has changed the relationships between the North and South, questioning and challenging the previous development discourses and practices Laako (2015: 91).

Sharon Bissell highlights that one of the strengths of the movement: *'Coordination amongst organizations stands out'*. She adds that this has been possible also due to the commitment to share knowledge: '*To share that kind information [of every project funded] with the other organizations (…) Now has become one [obligation], just as we did with the collective strategy design [of the movement/group], it is very important that everybody has the information of what everybody else is doing'*.

On this respect, Araceli Gil says about the movement: '*Right now, is very good because we have managed to visibilize midwifery and I think that is very important. Talking about midwives 10 years ago was completely different, you had to spend long time just explaining what a midwife was. We have managed to close the information gap through dissemination, this has been possible also because the organizations are very diverse and have different approaches and roles'*.

To which she adds*: 'This has had interesting results like how different midwifery models and visons are interacting, you have traditional midwives, professional midwives, nurses, so you have different ways of being a midwife and be formed as one'*.

The local politics of this movement is "allowing new imaginaries of well-being and the possibility to flourish potential for bigger social change". (Biekart and Harcourt 2016: 155). I believe that a bridge is being built, by this movement, that through its diversity has been able to "defend other ways of being in the world, or what some call 'traditions' in a colonial relation with the 'modern' ways of being" (Biekart and Harcourt 2016: 156).

The ways in which the movement has been portrayed by the different actors shows how by sharing and co-creating knowledge, not only transparency and accountability is guaranteed, but it fosters the trust and collaboration spirit needed to consolidate solidarity within the movement, needed to achieve real changes.

Bianca Vargas shares her perspective on the movement in Mexico: *'I think that this interdisciplinary vision, looking at the topic from different perspectives, for example, there are approaches the topic from a budgetary perspective, others from a human rights perspective, others from autonomous perspective -indigenous people autonomy- women's rights, etc.'*.

The aim of this paper is not to antagonize and create an opposition between midwifery and biomedical models, but rather it shows how the normalization of the use of biomedical models in addition to the lack of information or misleading information undermines women's agency and capacity to make an autonomous choice. As Cornwall suggests, an "effort is needed to bridge the gap between biomedical messages, popular knowledge and lived experience" (Cornwall and Welbourne 2002: 220). This approach will not only enhance the access to information that will enable women to make autonomous decisions over their bodies, it will also allow women to use this awareness in creative ways to push for the creation of such spaces that will allow this experience to take place in a safe environment, with the proper infrastructure and care.

The women working together in the different organizations that form *Parteras de Hoy* are part of and follow "complex patterns of simultaneous identification and differentiation" (de Jong 2009:13). Yet, I believe that their success has despite their differences they build on their common goal to *provide sexual, reproductive health care and maternal, postpartum and neonatal care to women through midwifery practice.* Thus, demanding for more attention to be paid in the structural barriers that constrain women's options and midwives' capacity to practice.

Challenges and further questions

The way in which women, midwives and midwifery are represented has implications in terms of the policies and practices it produces (Cornwall 2008). In this sense, what will continue to be a challenge for the organizations to change the current interpretations and representations of midwifery and other concepts related to it.

What is usually "more urgent and practical is the control over the interpretation of a problem" (Mosse 2004: 641). The examples given throughout this research, I believe illustrate how the use of different concepts –maternal mortality, childbirth, midwifery- lays on how they have been interpreted, constructed and represented as a different set of problems, like about access to institutionalized attention. In a Foucauldian perspective, in this sense "power lies in the narratives that maintain an organization [state] definition of the problem" (Roe 1994 in Mosse 2004: 646).

As Elsa Santos recognizes when asked about the challenges: '*A lot. First, we have presidential elections next year and the campaigns are almost starting –I do not know which is worst (laughs)- also Mac Arthur foundation funding comes to an end (…) we will have to do advocacy with the new government, new alliances with our local partners and look for more funding.*

However, this might come as one of the challenges but also as an opportunity for the organizations to forge new relationships with the new actors in

order to build from the start synergies and shape their political discourse towards midwifery differently.

In this line, about changing interpretations and paradigms, another important question that remains for further reflection is *where are the men? Why aren't they participating in this struggle?* These considerations were highlighted by Cristina Alonso: '*How is it possible that in 2017 some men cannot be present during labor and that men do not do something about it is frankly quite shocking. I believe there is an absence of men in this political struggle and is… (sighs)*'.

This situation brings more questions for me that need to be explored: *are not men in a way part of the reproductive process? Do they not have a reproductive body? Are not their lived experiences as fathers and partners also imprinted by these interventions? Even if they are lived and experienced differently?* For this matter, I will just say that I believe that midwifery can also challenge the gender asymmetries and roles present in the social relations of reproduction which are reinforced by the Western medical system of knowledge.

My journey through midwifery

At the start of this research few months ago, in the process of selecting a research question I first thought about the *institutionalization* of midwifery *in* the public health system. I was not aware that I, myself, was falling into the trap of development discourses. By *incorporating* midwives *in* the public health institutions, I was obviating the underlying structural problems that midwifery by itself as an isolated practice cannot solve.

I remember Bianca Vargas saying about obstetric violence: '*Of course, there are cases where this happens [individual exercise of violence], I have seen it, so it is real, but it leaves outside all the part of the structural and institutional problems that have to do with public policy and the formation, I mean the more collective and social aspects that are not the face to face relation, for me those are part in obstetric violence*'.

And when I asked her about the institutionalization of midwifery, she responded: '*For me, any person that works in this kind of institutional context, I mean I see violence as a mix of gender violence, yes, with its particularities, but also of institutional and structural violence (…) they are trying to be integrated where their capacity of action and agency is limited, where the challenges faced by them and doctors are shared. So, whoever pretends to provide sexual and reproductive assistance within this context and conditions, would be part of this complex frame of exercising obstetric violence*'.

In this sense, the members of *Parteras de Hoy* are calling for attention to be given to the structural and institutional barriers that are shaping women's lived

experiences during childbirth, they are in a way identity, ethnicity, race and gender not be read as determining universally the experiences of all women (de Jong 2009).

After the interviews, and the more I was familiarizing with midwifery in the Mexican context, I reflected on my position. Being a Mexican young woman, I have experienced structural violence in different spaces. However, I realized that for this particular scenario I had not reflected on the implications of the words I was using and how they were also part of –and reinforcing- the same discourse [developmental] I was trying now to challenge in this research. So, in the way they are deconstructing the understanding in the public arena of policy making I found myself also continuing to deconstruct my own ideas about development, women, violence and so on.

Midwifery, as an option and as practice, represents the struggle for sexual and reproductive rights, these organizations embody this struggle, our struggle, my struggle, because beyond 'childbirth' and 'maternity', is about our bodies being once more controlled, oppressed and violated through the interventions made in the name of development. As such, a lot of feminist activists and organization have embraced also the topic, as Cristina Alonso remarks: *'It is being clear that when we talk about women's sexual and reproductive rights we talk about obstetric rights, these are going to be on the table alongside abortion, general violence, feminicides. These are all issues that we need to work for. I hope that we can be united'.*

Finally, part of the positive impact that the movement and the members of *Parteras de Hoy* have been able to achieve in recently lays largely on the recognition of the "incompleteness of any political proposal that does not incorporate dialogue with diversity, building identities and creating knowledge" (Biekart and Harcourt 2016: 155). So, will this solidarity remain? Will it be able to adapt and renew in order to face the changing reality? Will it grow and strengthen in such a way that continues to challenge the current discourses on midwifery and development thus, changing its policies and practices? From what I have seen and heard during the course of my research, I think I feel confident about it.

Appendix 1. General interview guide

- Opening questions

1. Can you tell me about the organization? About your work?
2. What is your position within the organization? Your background?
3. What are the main activities of the organization?
4. Do you work with a specific group of people? Why?

- Chore questions

5. How do you understand reproductive freedom?
6. What is your perception on midwifery?
7. How do you relate midwifery and reproductive freedom? And SRHR?
8. How do you perceive obstetric violence in Mexico?
9. What is your perception on maternal mortality?
10. What is your perception of childbirth in Mexico?
11. How do you perceive women's body in the Mexican context?
12. What is your perception of the health sector in Mexico?
13. How is your perception on current policy towards midwifery?
14. What is your perception on the work of NGOs?
15. Is there an ideal model of midwifery?

- Closing questions

16. Do you think men have a role to play?
17. How do you see the future of midwifery and childbirth in Mexico?

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