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Key dimensions and ideological implications of safe motherhood discourse in a rural indigenous community in Mexico

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Thesis submitted to the Faculty of Graduate and Postdoctoral Studies in partial fulfillment of the requirements for the PhD degree in Spanish

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Abstract

Over the decade of 2000, the Mexican government defined maternal health as a political priority and put pressure on key stakeholders to institutionalize pregnancy and childbirth in rural communities with indigenous population, through coercive use of poverty relief programs and surveillance policies involving health staff, community leaders, neighbours and families in close maternal control from pregnancy to newborn care. Safe motherhood campaigns addressed pregnant women and recent mothers, making them responsible for their own health and for the health of their unborns and newborns. As a result, most pregnant women went for prenatal chats and check-ups and a growing proportion turned away from homebirth assisted by traditional birth attendants. However, most also kept combining traditional and biomedical care and many felt safer delivering in their homes.

This study was nested within a community-led research effort to narrow the distance between biomedically-oriented government policies and indigenous views and practices of maternal and newborn care, aiming to reduce maternal mortality and morbidity among aboriginal populations, without marginalizing indigenous cultures.

I explore the connections and interactions between health risk discourse –the dominant paradigm in contemporary public health communication-, safe motherhood discourse, and indigenous discourses about maternal care in Xochistlahuaca, a rural community in Guerrero State, Mexico. I show how institutions and individuals draw from existing discourses, adopt them, reject them, and reshape them to make meaning according to their own needs, circumstances, and aspirations. I discuss how these interactions explain and affect maternal and perinatal care among the majority Amuzgo population. I also analyze the ideological implications of government and indigenous discourses in a context of unequal power relations. In particular, the study reveals how different sources construe the roles of key stakeholders, such as indigenous women and men, and how indigenous women handle and reshape multiple discursive pressures from government and community sources concerning maternal health and their role in society.

I analyze data from government health promotion materials and interviews with health officials, government health staff, and men and women in the communities, using a theoretical and methodological framework based on critical discourse analysis, social semiotics, systemic functional linguistics, and multimodal approaches. The findings reveal "discursive synergies" and contradictions between government safe motherhood discourse and traditional orders of discourse. They also shed light on how people make coherent –and rational- construals of risk blending their own experiences and multiple, often conflicting discourses in an unequal multiethnic environment with competing authority claims. These findings should be of interest to a range of stakeholders working to prevent maternal and perinatal death in intercultural contexts.

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Chapter 1: Introduction

1.1. Context and rationale for the proposed research

1.1.1. Maternal mortality in indigenous communities

Lying in the bed of her small hut in Guadalupe Victoria, her eyes brimming with spite, the young woman lashed at the doctors who stood, baffled, a few feet away: "I'm sick of you! Go out of my house and never come back! Don't you understand? I'm not going to have my children in the hospital, even if the President of Mexico himself comes knocking on my door. Every woman that goes there comes out dead."

The doctors, some of them government health authorities engaged in an all-out effort to prevent maternal deaths, had tried everything. They asked, begged, threatened, cajoled, talked to the woman's husband, her parents, and her parents-in-law, to no avail. They offered to cover all her expenses and those of her family if she would have her twins in Ometepec, where the district health facilities are, two hours down the mountain road in rural Guerrero, one of Mexico's poorest states.[1] They thought the small, defiant 18-year-old Amuzgo woman, was putting her own life and the life of her children at risk, and they told her so. "If I wanted to die, then I would have the right to die", she said, unmoved. Faced with her flat-out rejection, the doctors offered to help her deliver at home. "I will have no doctors by my side!" she cut them short. When they came back, a month later, the doctors found the woman lying on a mat, and two healthy babies on a hammock. This time around, other family members asked them to leave.

"It happened a couple of months ago, a few blocks from here," Celestino Gómez Vázquez, an Amuzgo community health promoter, told me as we walked through the red-soil streets of Guadalupe Victoria, in late April 2008. "The doctors think she was lucky, but she and her family think otherwise. People here have a proud tradition of giving birth at home, and they've had bad experiences with hospitals in the past," he explained.

[1] See characterization of Guerrero in terms of poverty and marginalization on 1.1.4.1, on p.18-22.

This real-life story embodies the challenges –and conflicting views- of maternal and newborn health in remote indigenous communities throughout the Americas. Judging from global figures of maternal death, one could say –like the Mexican doctors did- that this defiant woman and her children were lucky. Each year, worldwide, more than half a million women die and a great many more suffer from ill health and disability as a result of complications from pregnancy, childbirth, and the immediate postpartum period. Often in close relation with these circumstances, some four million neonates die before their first month of life and an equal number are stillborn. The vast majority of these tragedies take place in developing countries, where rural populations, ethnic minorities and the poor suffer higher death rates than urban dwellers, dominant ethnic groups and the well off.[2] [3] International health and development agencies and maternal health experts contend that many –if not most- of these deaths could be prevented through better knowledge of health and hygiene issues and better and timelier access to adequate health care[4] [5] [6] Latin America is no exception to these trends: In 2000, there were 190 maternal deaths per 100,000 live births in the region, compared to 20 per 100,000 in developed countries.[7] [8]

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[2] World Health Organization. *The World Health Report 2005: Make every mother and child count*, p. xiv. Geneva: WHO, 2005. Available at http://www.who.int/whr/2005/whr2005_en.pdf. Accessed September 25, 2006. The most common causes of maternal death worldwide are haemorrhage, infections, pregnancy-induced hypertension –also known as eclampsia in medical terms-, obstructed labour, and unsafe abortion. There are also indirect causes of maternal death: these are pre-existing conditions, such as anaemia, malaria, HIV/AIDS, or heart disease, which can complicate pregnancy or be complicated by it. (See pages 62-64 of the same report.)

[3] Sibley L, Sipe TA, Koblinsky M. Does traditional birth attendant training improve referral of women with obstetric complications: a review of the evidence. *Social Science & Medicine* 59(8):1757-68, 2004.

[4] WHO 2005, p.1.

[5] Lule E, Ramana GNV, Ooman N, Epp J, Huntington D, Rosen J. *Achieving the Millennium Development Goal of Improving Maternal Health: Determinants, Interventions, and Challenges*. Washington, DC: World Bank, 2005.

[6] Acosta AA, Cabezas E, Chaparro JC. Present and future of maternal mortality in Latin America. *International Journal of Gynecology & Obstetrics* 70:125-131, 2000.

[7] *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA. World Health Organization*. Geneva: WHO, 2004, p. 11.

[8] One quarter of maternal deaths in the region are due to haemorrhage, 15% to complications from abortions, 13% to pregnancy-induced hypertension, 7% to obstructed labour, 8% to other obstetric complications, and 20% to indirect causes. For each woman that dies, 135 suffer injuries and permanent disabilities. *Estrategia regional para la reducción de la mortalidad y la morbilidad maternas,* 26th Pan-American Sanitary Conference, 54th Session of the Regional Committee, Washington DC, 23-27 September, 2002. Washington, DC: Pan American Health Organization, 2003. Available at http://www.paho.org/Spanish/GOV/CSP/csp26-14-s.pdf. Accessed May 18, 2010.

Indigenous[9] peoples are particularly challenged in this regard. Maternal mortality in indigenous communities in the Americas –especially in remote areas- may be twice or three times higher than national averages.[10] [11] Poverty, lack of timely access to essential services, low quality of care, fear of discrimination, language barriers, and cultural misunderstanding, all play a role in this outcome.[12] [13] [14]As the opening story suggests, indigenous stakes are not confined to disproportionate numbers of death and disability. In the last of a 2007 series of *Lancet* articles on indigenous health, Stephens *et al* express their concern that major international policies such as the Millennium Development Goals might further marginalize indigenous communities through their top-down, utilitarian approach to health policy, which encourages national governments to maximize health benefits for the majority, while potentially demoting minorities.[15] This has led national governments to impose global safe motherhood guidelines,[16] based on western biomedical views and practices,[17] without regard to indigenous concerns and

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[9] I use the expression "indigenous" as defined by the United Nations: "Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them." In United Nations, *The concept of indigenous peoples: background paper prepared by the Secretariat of the Permanent Forum on Indigenous Issues.* Document PFII/2004/WS.1/3, Department of Economic and Social Affairs, Workshop on Data Collection and Disaggregation for Indigenous Peoples, New York, 2004. Available at http://www.un.org/esa/socdev/unpfii/documents/workshop_data_background.doc. Accessed May 18, 2010. I do not use the expression "aboriginal", because it is less extended across the Americas –and it could also carry pejorative overtones in certain places.

[10] Montenegro R, Stephens C. Indigenous health in Latin America and the Caribbean. *Lancet* 367:1859-69, 2006, p. 1863.

[11] *Healing Our Spirit Worldwide* (Newsletter for Indigenous People), No 2. Washington DC: Pan American Health Organization, 2004, p. 1-3.

[12] Castañeda M, Díaz D, Espinosa G, Sánchez-Hidalgo D, de la Torre C. *La mortalidad materna en México: cuatro visiones críticas*. México, DF: Fundar, Centro de Análisis e Investigación, A.C.; K'inal Antzetik, A.C.; Foro Nacional de Mujeres y Políticas de Población; Universidad Autónoma Metropolitana, Unidad Xochimilco; Coordinadota Nacional de Mujeres Indígenas, 2004.

[13] Montenegro R, Stephens C 2006, p. 1865.

[14] Freedman L. Maternal mortality and poverty reduction: a rights-based approach. In *Exclusión y derecho a la salud: La función de los profesionales de la salud. Conferencia IFHHRO-EDHUCASALUD 2006.* Lima, Perú, and Utrecht, Netherlands: Educación en Derechos Humanos con Aplicación en Salud-Edhucasalud, and Federación Internacional de Organizaciones de Derechos Humanos y Salud-IFHHRO, 2006, p.45-60.

[15] Stephens C, Porter J, Nettleton C, Willis R. Indigenous Health 4: Disappearing, displaced and undervalued – a call to action for Indigenous health worldwide. *Lancet* 367:2019-28, 2006, p.2025.

[16] See chapter 2.2, p. 64-82, for a definition of safe motherhood and a detailed discussion on mainstream safe motherhood concepts and guidelines.

[17] See chapter 2.1.3, p. 56, for a definition of biomedicine.

cultures, further alienating indigenous peoples.[18] [19] [20] Pressure to institutionalize pregnancy and childbirth are key indigenous concerns, since place of birth and community participation in childbirth are deeply rooted in indigenous cultures[21] [22] [23] [24] and play an important role in the way indigenous peoples see themselves and engage in health planning, policy-making, and community health care.[25] [26] [27] Indigenous peoples link the imposition of hospital births and the evacuation of women from remote communities for childbirth to the marginalization of indigenous knowledge and practice, with serious social and cultural consequences.[28] [29] [30]

To ensure the viability of local birthing traditions and indigenous cultures, many researchers and indigenous peoples are calling for a new relationship between biomedical views and policies and indigenous knowledge and practice.[31] [32] Advocates of this

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[18] *Surviving Pregnancy and Childbirth: An International Human Right.* Center for Reproductive Rights; briefing paper, 2005, p. 6. Available at www.reproductiverights.org. Accessed November 7, 2006.
[19] Kruske S, Kildea S, Barclay L. Cultural Safety and Maternity Care for Aboriginal and Torres Strait Islander Australians. *Women and Birth* 19:73-77, 2006.
[20] MotherCare's Community Assessments: Understanding Family and Community Behaviours and Practices. *MotherCare Matters* 8(3-4):1-24, 2000, p.6. Available online from www.mothercare.jsi.com. Accessed October 13, 2006.
[21] Begay, RC. Changes in Childbirth Knowledge. *American Indian Quarterly* 1(24):550-565, 2004.
[22] Davis-Floyd R, Sargent, CF. Introduction – The anthropology of birth. In: *Childbirth and Authoritative Knowledge – Cross-cultural Perspectives*, R.E. Davis-Floyd and C. Sargent (Eds). Berkeley: University of California Press, 1997, pp 1-53.
[23] Sesia, P.M. "Women come here on their own when they need to": Prenatal care, authoritative knowledge and maternal health in Oaxaca. In *Childbirth and Authoritative Knowledge – Cross-cultural Perspectives*, R.E. Davis-Floyd and C. Sargent (Eds). Berkeley: University of California Press, 1997, p. 397-420.
[24] Adetunji, J. Preserving the pot and water: A traditional concept of reproductive health in a Yoruba community, Nigeria. *Social Science & Medicine* 43(11), 1561-1567, 1996.
[25] Tedford Gold S. Techniques of Citizenship: Health and Subjectivity in a New and Predominantly Inuit Territory. *Citizenship Studies* 11(4):349-365, 2007.
[26] Douglas VK. Childbirth among the Canadian Inuit: A review of the clinical and cultural literature. *International Journal of Circumpolar Health* 65(2):117-132, 2006.
[27] Berry, NS. Kaqchikel midwives, home births, and emergency obstetric referrals in Guatemala: Contextualizing the choice to stay at home. *Social Science &Medicine* 62(8):1958-1969, 2006.
[28] Chapman RR. Endangering safe motherhood in Mozambique: Prenatal care as pregnancy risk. *Social Science & Medicine* 57(2): 355-374, 2003.
[29] Jasen P. Race, Culture, and the Colonization of Childbirth in Northern Canada. *Social History of Medicine* 10(3): 383-400, 1997.
[30] Kaufert P, O'Neil J. Cooptation and control: the reconstruction of Inuit birth. *Medical Anthropology Quarterly* 4(4), 427-442, 1990.
[31] Jordan, B. Authoritative knowledge and its construction. In *Childbirth and Authoritative Knowledge – Cross-cultural Perspectives*, R.E. Davis-Floyd and C. Sargent (Eds). Berkeley: University of California Press, 1997, p. 55-79.

approach contend that mutual respect and understanding would contribute to the sustainability of new programs by strengthening community capacity and ensuring local participation in health planning and provision.[33] [34] [35]

1.1.2. A discursive approach to safe motherhood in indigenous communities

These conflicting views and practices of pregnancy and childbirth, their interactions and potential implications, are both reflected and played out in discourse –understood both in a general way, as the production of meaning through language and other semiotic resources[36] [37], and in a more restrictive manner, as a particular way of constructing a subject-matter or an area of knowledge,[38] like safe motherhood is a particular construction of maternal and perinatal health. Discourse has both symbolic and material effects, as it contributes to the construction of social identities, subject positions and social relationships.[39] Pregnancy and childbirth also have discursive dimensions and implications, as individuals, institutions and communities make meaning about them.[40]

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[32] Brady, M., Kunitz, S., and Nash, D. Who's definition? Australian aborigines, conceptualizations of health and the World Health Organization. In Lara Marks and Michael Worboys (Eds.), *Migrants, minorities and health: Historical and contemporary studies*. New York: Routledge, 1997, p. 272-288.
[33] Lavoie, J.G. The decolonization of the self and the recolonization of knowledge: The politics of Nunavik health care. In: Colin Scott (Ed.), *Aboriginal autonomy and development in Northern Quebec and Labrador*. Vancouver: UBC Press, 2001, 332-356.
[34] Kumar, R. Thakur, JS, Aggarwal, AK. Effect of continuing training on knowledge and practices of traditional birth attendants about maternal and newborn care. *Indian Journal of Public Health* 44(4):118-23, 2004.
[35] Caudill, DM. The door of the tomb is open: Participatory action research to assess the impact of strengthened community capacity on maternal health care in rural Mali. *Dissertation Abstracts International*. 58-12B, 6516, 1997.
[36] Hodge R, Kress G. *Social Semiotics*. Cambridge: Polity Press, 1988, p. 6.
[37] Lemke J. *Textual Politics: Discourse and Social Dynamics*. London: Taylor & Francis, 1995, p. 6.
[38] Fairclough N. *Discourse and Social Change*. Cambridge, UK: Polity Press, 1992, p. 128.
[39] Ibid, p. 64.
[40] According to Treichler, who studied the communicational dimensions of mounting challenges to medicalized birthing from feminists, midwives, and women's health movements in the United Status during the 1970s and 1980s, "the crux of the problem is that childbirth is not a uniform event whose true meaning and real nature are universal and potentially accesible to everyone. Childbirth is what it means, and its meanings are so diverse as to be virtually infinite." Treichler P. What Definitions Do: Childbirth, Cultural Crisis, and the Challenge to Medical Discourse. In Brenda Dervin, Lawrence Grossberg, Barbara J. O' Keefe, and Ellen Wartella (Eds.) *Rethinking Communication, Volume 2*. Chapter 27, p. 424-453. Newbury Park, CA: Sage Publications, 1989, quote on p. 427.

Health problems certainly exist in a non-discursive dimension: people *actually* die or fall seriously ill in the process of being born and of giving birth. But illness and death *take on meaning in language*, as soon as we attempt to explain what happened and why, or when someone tries to bring the *issue* of maternal death to the attention of individuals, communities, population groups, and governments, and they strive to engage the whole world into doing something about it. Once in the domain of language and discourse, death and disease acquire a malleable, at times elusive quality: No language used to talk about them will be definitive, unquestioned, and unambiguous -in other words, a final word. In fact, death and disease are questioned, challenged, and explained *in* and *through* language. And each question, each challenge, and each explanation is questioned in turn.

A few paragraphs above, I mentioned the main causes of maternal death as they emerge from mainstream public health literature. These causes are established through the epidemiological study of many episodes of maternal death. Epidemiological analysis of health issues lies at the foundation of contemporary health risk discourse.[41] In particular, the notion of population health risks dominates the public agenda,[42] cutting across countries, cultures, social and ethnic groups[43]. Risk estimates and definitions are produced by public health experts and channelled through academic publications, calls to action, and public health interventions from international health organizations such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO), development agencies, national governments, public health services, medical organizations, and NGOs. Health risk discourse defines public health risks, their scope and importance, and is meant to shape clinical practice and people's behaviours in contemporary societies.[44] In other words, discourses on risk contribute to shape the way we perceive, understand, and deal with risk.[45] These issues loom large in public health, where life events –such as pregnancy and childbirth- are presented in terms of risk, and

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[41] See chapter 2.1.1, on p. 48 for a discussion on the concepts and the semantics of risk.
[42] Petersen A, Lupton D. *The New Public Health: Health and self in the age of risk*. London, Thousand Oaks, and New Delhi: Sage Publications, 1996, p. 48.
[43] Førde OH. Is imposing risk awareness cultural imperialism? *Social Science and Medicine* 47(9):1155-1159, 1998.
[44] Petersen A, Lupton D. 1996, p. 47-60.
[45] Lupton D. *Risk*. London and New York: Routledge; 1999, p. 15

individuals, groups and communities are labelled at risk and expected, persuaded or even coerced to keep these risks under control.[46] [47]

But even though many risks are real, people's views and behaviours often do not match expert and government expectations, mostly based on numerical evidence and policy needs[48] [49]. A host of emotional, cultural, economic, and social factors, as well as a string of competing risks, play a role in people's decisions[50] [51]. Safe motherhood is no exception, particularly where cultures and languages collide, and people live in dire conditions, as it happens in indigenous Mexico. Identifying different construals[52] of maternal risk under these circumstances can contribute to build cultural bridges, avert the deepening of unequal power relations, and prevent illness, disability, and death.

1.1.3. Looking for key dimensions of safe motherhood discourse

In this work, I intend to demonstrate that health risk discourse has been at the heart of safe motherhood discourse, which was the institutional label for an overarching set of policies and guidelines that have shaped the prevention of maternal mortality and morbidity on a global scale since 1987. In Latin America, safe motherhood was translated and adopted as *maternidad sin riesgo* (literally, maternity *without* risk).[53] In Mexico, as I will show here, risk-informed safe motherhood discourse is embedded in public health

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[46] Lupton D. Introduction: risk and sociocultural theory. In Deborah Lupton (ed.) *Risk and sociocultural theory: new directions and perspectives*. Cambridge: Cambridge University Press, 1999b, p. 1-11.
[47] Guttman N. *Public Health Communication Interventions. Values and Ethical Dilemmas*. Thousand Oaks: Sage Publications, 2000, p. 29-30.
[48] Douglas M. *Risk and blame: Essays in cultural theory*. London & New York: Routledge; 1992.
[49] Kasperson R, Renn O, Slovic P, Brown HS, Emel J, Goble R, Kasperson JX, Ratick S. The social amplification of risk: a conceptual framework. In Lofstedt R and Frewer L, eds. *The Earthcan Reader in Risk & Modern Society*. London: Earthcan Publications; 1998, p. 149-162.
[50] Adams V, Miller S, Chertow J, Craig S, Samen A, Varner M. Having a "safe delivery": conflicting views from Tibet. *Health Care for Women International 26:821-851*; 2005.
[51] Chapman RR. Endangering safe motherhood in Mozambique: prenatal care as pregnancy risk. *Social Science & Medicine 57:335-374*; 2003.
[52] By "construe" and "construal" I refer, throughout this text, to the semiotic construction of life experiences, social events, and whatever happens in the "real" world. I take this definition from Halliday MAK. *The Language of Science*. London and New York: Continuum, 2004, p. 9. We construe texts both as producers and interpreters.
[53] See chapter 2.2.3 (p. 71-75) and 2.2.4 (p. 75-79) for an in-depth discussion on the connections between health risk discourse and safe motherhood discourse.

campaigns to promote *embarazo saludable* (healthy pregnancy) nationwide, from Mexico City to remote indigenous villages across the country.

I will try to identify how key components or dimensions of health risk discourses from different theoretical frameworks,[54] such as risk awareness[55]; calculation and choice,[56] responsibility[57 58]; blame[59 60 61]; danger/threat[62 63]; trust[64 65 66 67], and control/self-control[68 69 70], as well as key dimensions of mainstream safe motherhood discourse, such as pregnancy risks, safe childbirth, skilled assistance at birth, and the wellbeing of the foetus and the newborn,[71] feature in safe motherhood discourse in communities with a majority of indigenous population, who are also among the poorest and most marginalized in Mexico,[72 73] and how these elements interact with other discourses about risks in pregnancy and childbirth at the community level.

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[54] See chapter 2.1, p. 47-64.
[55] Førde OH 1998, p. 1158.
[56] Norman P, Conner M. The Role of Social Cognition Models in Predicting Health Behaviours: Future Directions. In M Conner and P Norman (eds), *Predicting Health Behaviour*. Philadelphia, PA: Open University Press, 2001 reprint, p. 197-225.
[57] Douglas M 1992, p. 14 and 24-25.
[58] Guttman N, Salmon CT Guilt, fear, stigma and knowledge gaps: ethical issues in public health communication interventions. *Bioethics* 18(6):531-552, 2004.
[59] Douglas M 1992.
[60] Joffe H. *Risk and "the Other"*. Cambridge: Cambridge University Press, 1999.
[61] Kirkham M. The culture of midwifery in the National Health Service in England. *Journal of Advanced Nursing* 30:732-739, 1999.
[62] Douglas M 1992.
[63] Burgess A. The making of the risk-centred society and the limits of social risk research. *Health, Risk & Society* 8(4):329-342, 2006.
[64] Slovic P. Perceived risk, trust, and democracy. In Connolly T, Arkes H, Hammond K (eds), *Judgement and Decision Making: An Interdisciplinary Reader.* Cambridge: Cambridge University Press, 2000, p. 500-513.
[65] Lofstedt R, Frewer L. Introduction. In Ragnar Lofsted and Lynn Frewer (eds.), *The Earthcan Reader in Risk & Modern Society*. London: Earthcan Publications Ltd, 1998, p. 3-27.
[66] Frewer LJ, Hedderley D, Shepherd R. What determines trust in information about food-related risks? Underlying psychological constructs. In *The Earthcan Reader in Risk & Modern Society*. London: Earthcan Publications Ltd., 1998, p. 193-212.
[67] Alaszewski A. Risk, Trust and Health. *Health, Risk & Society* 5(3):235-239, 2003.
[68] Petts J, Niemeyer S. Health risk communication and amplification: learning from the MMR vaccination controversy. *Health, Risk & Society* 6(1):7-23, 2004.
[69] Foucault M. Governmentality. In Burchell G, Gordon C, Miller P (eds), *The Foucault Effect*. Chicago: University of Chicago Press, 1991, p. 87-104.
[70] Schehr, RC. Conventional Risk Discourse and the Proliferation of Fear. *Criminal Justice Policy Review* 16(1):38-58, 2005.
[71] See chapter 2.2, p. 64-82.
[72] *Índices de Marginación 2005*. México, DF: Consejo Nacional de Población, 2007. p. 49-51. Available at http://www.conapo.gob.mx/publicaciones/margina2005/01_b.pdf. Accessed May 9, 2009.

Previous ethnographic research –referenced throughout this text- has identified cultural values and practices related to motherhood and childbirth among indigenous peoples in Mexico and other Latin American countries. There is, also, a well-established body of work around discourses on pregnancy[74 75 76], childbirth[77 78], motherhood[79 80 81 82 83], and reproductive health[84 85 86 87 88], and the relationship between women and medical practitioners[89 90]. In-depth analysis on the construal and interaction of biomedical safe motherhood discourse and indigenous discourses about pregnancy and childbirth has

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[73] Carrasco T, Davis SH, Valdés ME, Wodon Q, Humphrey C, Siaens C (eds.) Indigenous Peoples in the States of Chiapas, Guerrero and Oaxaca. *In Development Strategy for the Mexican Southern States.* Washington, DC: The World Bank, 2003, p. vi. The authors contend that southern indigenous communities "are the poorest of the poor and should be considered a priority population in any efforts to reduce poverty."

[74] Root R, Browner CH. Practices of the pregnant self; compliance with and resistance to prenatal norms. *Culture, Medicine and Psychiatry* 25(2):195-223, 2001.

[75] Lupton D 1999c, p. 59-85.

[76] Weir L. Recent developments in the government of pregnancy. *Economy and Society* 25(3):372-392, 1996.

[77] Johns JS. *The curse of Eve: A genealogical analysis of the discursive practice of contemporary childbirth.* Master's thesis, submitted to the University of Manitoba, 1996.

[78] Crouch M, Manderson L. Parturition as social metaphor. *Australian and New Zealand Journal of Sociology* 29(1):55-72, 1993.

[79] Schwarz P. *Influencia de las representaciones sociales de la maternidad en la construcción de la identidad femenina en mujeres jóvenes de clase media urbana.* Buenos Aires: Instituto de Investigaciones Gino Germani, Facultad de Ciencias Sociales, Universidad de Buenos Aires, 2005. Available at http://www.iigg.fsoc.uba.ar/Jovenes_investigadores/3JornadasJovenes/Templates/Eje%20identidad-alteridad/Schwarz-identidad.pdf. Accessed February 23, 2007.

[80] Stanworth M (ed). *Reproductive Technologies: Gender, Motherhood and Medicine.* Cambridge: Polity Press, 1987.

[81] Wilson H, Huntington A. Deviant (M)others: The Construction of Teenage Motherhood in Contemporary Discourse. *Journal of Social Policy* 31(1):59-76, 2005.

[82] Wall G. Moral constructions of motherhood in breastfeeding discourse. *Gender & Society* 15(4):592-610, 2001.

[83] Marshall H. The Social Construction of Motherhood: An Analysis of Childcare and Parenting Manuals. In Phoenix A, Woollett A, Lloyd E (eds), *Motherhood: Meanings, Practices and Ideologies.* London: Sage Publications, 1991, p. 66-85.

[84] Hayter M. The social construction of 'reproductive vulnerability' in family planning clinics. *Journal of Advanced Nursing* 51(1):46-54, 2005.

[85] Howson A. Embodied obligations: the female body and health surveillance. In Nettleton S, Watson J (eds), *The Body in Everyday Life.* London: Routledge, 1998, p. 218-240.

[86] Howson A. Cervical screening, compliance and moral obligation. *Sociology of Health & Illness* 21(4):401-425, 1999.

[87] Brook B. *Feminist Perspectives on the Body.* London: Longman, 1999.

[88] Bush J. 'It's just part of being a woman': cervical screening, the body and femininity. *Social Science and Medicine* 50(3):429-444, 2000.

[89] Arney WR. *Power and the Profession of Obstetrics.* Chicaco, IL: University of Chicago Press, 1982.

[90] Baraitser P. Power and knowledge in family planning consultations; can a reanalysis of doctor-patient interaction improve client satisfaction? *British Journal of Family Planning* 21(1):18-19, 1995.

considerably less space in the literature. [91] [92] [93] [94] This is the approach I take here, looking for connections and disconnections that may foster or hinder healthy maternal outcomes among indigenous peoples of Guerrero state.

Health risk discourse may also have ideological implications, in terms of power relations within indigenous groups and between these groups and non-indigenous stakeholders. As Martin and Stenner point out, "discursive activities are inseparable from relations of power" and have practical effects in everyday life.[95] Guttman points to the "privileging dilemma" in health communication and he asks: "By focusing on specific health problems or particular ways to address them, does the intervention privilege certain stakeholders or dominant ideologies?"[96] This has direct bearing on the central research problem and the general objective of this work, insofar as "any policy intervention is also always an intervention into these complex dynamics of discursively mediated mutual recognition."[97]

Looking in this direction, I intend to explore potential power effects stemming from government safe motherhood discourse –and from its interaction with local discourses. There is a longstanding tradition of social critique focused on discourse analysis that harks back to the work of Althusser[98], Barthes[99], and Foucault[100] [101] [102], and has been

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[91] Adams V, Miller S, Chertow J, Craig S, Samen A, Varner M. Having a "safe delivery": Conflicting views from Tibet. *Health Care for Women International* 26:821-851, 2005.
[92] Litt JS. *Medicalized Motherhood: Perspectives from the Lives of African-American and Jewish Women.* New Brunswick: Rutgers University Press, 2000.
[93] Kaufert P, O'Neil J. Analysis of a dialogue on risks in childbirth: Clinicians, epidemiologists, and Inuit women. In S. Lindenbaum and M. Lock (Eds), *Knowedge, Power, and Practice.* Berkeley: University of California Press, 1993, p. 32-54.
[94] Roth Allen D. *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania.* Ann Arbor: The University of Michigan Press, 2002.
[95] Martin A, Stenner P. Talking about drug use: what are we (and our participants) doing in qualitative research? *International Journal of Drug Policy* 15:395-405, 2004, p. 403.
[96] Guttman N 2000, p. 194.
[97] Ibid, p. 403.
[98] Althusser L. *Lenin and Philosophy and Other Essays.* (B. Brewster, Trans.) New York and London: Monthly Review Press, 1971, p. 170-176. Available at http://www.marx2mao.com/Other/LPOE70NB.html. Posted May 2002. Accessed November 12, 2008.
[99] Barthes R. *Mitologías.* Madrid: Siglo XXI, 1980.
[100] Foucault M. *El orden del discurso.* Barcelona: Tusquet Editores, 1987.
[101] Petersen A, Bunton R (eds.) *Foucault, Health and Medicine.* London and New York: Routledge, 1997.

fully developed in terms of social semiotics by Hodge and Kress[103 104], van Leeuwen[105], Kress and van Leeuwen[106] and others, and as critical discourse analysis (CDA) by Fairclough[107 108 109], Wodak[110 111 112], and Van Dijk[113 114 115 116], among others. I will use elements from social semiotics and CDA here.[117] In particular, CDA links discourse and power through the key notion of "ideology", which all authors working within this tradition make operational through the analysis of actual texts. CDA tends to see ideologies as "systems of ideas of any social group or class", learned through discourse and social practice, which promote the interests of that group or class -whether for 'dominating' or 'dominated' groups, or whether as means of domination or resistance.[118] Lupton, whose work I have drawn from, has used a similar approach for sociocultural analysis of health risk discourse in contemporary Western societies. [119 120 121 122 123 124 125 126]

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[102] Foucault M. *The archaeology of knowledge*. London: Routledge, 1972, chapters 1-3. Available at http://www.marxists.org/reference/subject/philosophy/works/fr/foucault.htm.
[103] Hodge R, Kress G. *Language as Ideology, 2nd edition*. London: Routledge, 1993.
[104] Hodge R, Kress G. *Social Semiotics*. Cambridge: Polity Press, 1988.
[105] Van Leeuwen T. *Introducing social semiotics*. London and New York: Routledge, 2005.
[106] Kress G, van Leeuwen T. *Multimodal Discourse: The Modes and Media of Contemporary Communication*. London: Arnold, 2001.
[107] Fairclough N. *Language and power*, 2nd edition. Harlow, UK: Pearson Education Limited, 2001.
[108] Fairclough N 1992.
[109] Fairclough N. *Media Discourse*. London: Edward Arnold, 1995.
[110] Wodak R, de Cillia R, Reisigl M, Liebhart K (eds). *The discursive construction of national identity*. Edinburgh: Edinburgh University Press, 2000.
[111] Wodak R (ed). *Gender and discourse*. London: Sage Publications Ltd., 1998.
[112] Wodak R. Critical Linguistics and Critical Discourse Analysis. In Verschueren J, Ola Östman J (eds), *Handbook of Pragmatics*. Amsterdam/Philadelphia: John Benjamins Publ. Co., 2006, p. 1-24. Available at http://www.ling.lancs.ac.uk/staff/wodak/papers/06hbprag.pdf. Accessed March 3, 2007.
[113] Van Dijk TA. Discourse semantics and ideology. *Discourse & Society* 6(2):243-289, 1995.
[114] Van Dijk TA. *News as Discourse*. Hillsdale, NJ: Lawrence Erlbaum, 1988.
[115] Van Dijk, TA. *Communicating Racism: Ethnic Prejudice in Thought and Talk*. Newbury Park, CA: Sage, 1987.
[116] Van Dijk TA. *Texto y contexto. Semántica y pragmática del discurso*. Translation: Juan Domingo Moyano. Madrid: Cátedra, 1980.
[117] See chapter 3 for a detailed discussion of the theoretical and methodological framework.
[118] Van Dijk T, Neff-van Aertselaer J, Pütz M. Introduction: Language, discourse and ideology. In M Pütz, J Neff-van Aertselaer, T van Dijk (eds.). *Communicating ideologies: Multidisciplinary Perspectives on Language, Discourse, and Social Practice*. Frankfurt: Peter Lang, 2004, p. vii-xxx.
[119] Lupton D. Risk as moral danger: the social and political functions of risk discourse in public health. *International Journal of Health Services, 23(3):425-35*, 1993.
[120] Lupton D. *Moral threats and dangerous desires: AIDS in the News Media*. London: Taylor & Francis, 1994.
[121] Lupton D. *The Imperative of Health. Public Health and the Regulated Body*. Sage: London, 1995.
[122] Lupton D, Barclay L. *Constructing Fatherhood: discourses and experiences*. London, Thousand Oaks, and New Delhi: Sage Publications, 1997.

Working along these lines, I will try to determine if and to what extent government discourse on safe motherhood places the onus on individuals and subordinate groups which are labelled "at-risk", ignores the collective dimensions of public health problems, contributes to reproduce unequal power relations, and plays down or leaves out economic, political, and access barriers that hamper maternal and child health. I will also look into core elements of government safe motherhood discourse, such as prenatal care, safe delivery, and the wellbeing of the foetus[127] [128], and I will analyze the interactions between these "official" discourses and different discourses from within the community and the traditional order of discourse, such as prenatal control, self-care, spousal solidarity, ethnic identity, and more specific discourses from traditional health care, as discussed in chapters 6 and 7.

1.1.4. Research topic and immediate context

In line with the above framework, this thesis looks into key dimensions and ideological implications of safe motherhood discourse in Xochistlahuaca, a remote rural community with majority of indigenous population in the *Costa Chica* region of Guerrero, one of Mexico's poorest and most violent states[129] [130].

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[123] Lupton D. *Risk*. London and New York: Routledge, 1999a.
[124] Lupton D 1999b.
[125] Lupton D. Risk and the ontology of pregnant embodiment. In Lupton D (ed.), *Risk and sociocultural theory: new directions and perspectives*. Cambridge, UK, and New York : Cambridge University Press, 1999c, p. 59-85.
[126] Tulloch J, Lupton D. *Risk and Everyday Life*. London, Thousand Oaks, New Delhi, Sage Publications, 2003.
[127] Weir L 1996.
[128] Lupton D 1999c, p. 62.
[129] According to the Consejo Nacional de Población (CONAPO), a government agency, Guerrero has the highest levels of marginalization in Mexico. *Indices de Marginación 2005*. México, DF: Consejo Nacional de Población, 2007, Annex A, p. 55. Available at http://www.conapo.gob.mx/publicaciones/margina2005/AnexoA.pdf. Accessed May 9, 2009. The index of marginalization is a composite of socioeconomic indicators, including household income, educational level, illiteracy, and housing conditions, based on Mexico's 2005 Second Population and Household Census and the 2005 Fourth Quarter Occupation and Employment Survey. (Ibid, Annex C, p. 309-310.) Available at http://www.conapo.gob.mx/publicaciones/margina2005/AnexoC.pdf. Accessed May 9, 2009.
[130] Guerrero is besieged by drug trafficking and militarization. As the prices of traditional crops fall, many farmers have turned to cultivating poppies for heroin production. The state has become the primary producer of opium poppies in the country, with 60% of the national output. At the same time, rival drug

The project is nested within a multi-stakeholder international research initiative that aims to bridge traditional and biomedical approaches in order to improve maternal and newborn health in remote indigenous communities in a context of cultural safety -that is, protecting and promoting indigenous cultures.[131] [132] The first stage of this program takes place in rural areas of Guerrero. The initiative also seeks to build capacities for intercultural health research and policy-making, and to help revert health inequalities resulting from cultural and environmental marginalization of indigenous communities.

Frontline research users -Amuzgo health promoters in Xochistlahuaca- gave birth to the overall research initiative.[133] They experienced first-hand community resistance to government policies, which try to impose institutionalized pregnancy and childbirth, following western biomedical views and practices, in order to revert excessive rates of maternal mortality among indigenous populations –a common trend in Mexico[134] and all

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cartels are engaged in an ongoing turf war over drug routes and consumption hubs like Acapulco. The government has deployed 1/6th of all troops assigned to combat drug trafficking in Guerrero, but human rights organizations contend that the government uses the army to harass indigenous communities instead of fighting poverty, which is the underlying cause of the farming shift towards opiates. *Facts About Guerrero*. S!Paz.org. San Cristóbal de las Casas, Chipas: S!Paz. 2009. Available at http://www.sipaz.org/data/gro_en_03.htm#MILITARIZACION. Accessed May 9, 2009.

[131] The concept of "cultural safety" has been proposed in opposition to colonialist approaches to health research and interventions, which impose the values of one cultural group over another. Kruske S, Kildea S, Barclay L. 2006. Eckermann et al define cultural safety as "an environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening." Eckermann A, Dowd T, Chong E, Nixon L, Gray R, and Johnson S. *Binang Goonj: Bridging cultures in Aboriginal health.* Armidale (NSW): University of New England, 1994, p. 165.

[132] This research initiative is based on the assumption that indigenous and biomedical approaches to women's health care are not incompatible, following, among others: Davis-Floyd R. and Sargent CF Introduction – The anthropology of birth. In: *Childbirth and Authoritative Knowledge – Cross-cultural Perspectives*, R.E. Davis-Floyd and C. Sargent (Eds). Berkeley: University of California Press, 1997, pp 1-53. Drejer R. "Mcunga wa Jadi": Working with traditional midwives in Tanzania. *International Midwifery* 2001; 14(5)6-7. Kruske S, Barclay L. Effect of Shifting Policies on Traditional Birth Attendant Training. *Journal of Midwifery and Women's Health* 49:306-311, 2004.

[133] See letter from the Amuzgo Indigenous Health Promoters Network to Ascencio Villegas Arrizón, director of CIETmexico –Annex I, 508.

[134] Luna Gordillo R. *Eslabones críticos en las defunciones maternas de Chiapas, Oaxaca y Guerrero a partir de los estudios de caso.* Power Point presentation. San Cristóbal de las Casas, Chiapas: Dirección de Atención a la Salud Materna y Perinatal, Centro Nacional de Equidad de Género y Salud Reproductiva, February 2009. Available from http://maternidadsinriesgos.org.mx/web/wp-content/uploads/2009/03/presentacion-aidem-chis-gro-oax-2008v21.ppt. Accessed on May 20, 2009. In Mexico, the highest MMRs are in Oaxada (102/100,000 in 2007, 103/100,000 in 2008) Guerrero (98/100,000 in 2007, down to 84/100,000 in 2008), far above the national average of 53.6/100,000 for

across the Americas[135] [136]. In search of an option that would take into account social and cultural traditions, they teamed up with CIETmexico, the Tropical Disease Research Centre at the University of Guerrero, in Mexico; CIETcanada, an academic NGO that carries out public health research in several countries; Guerrero State's Health Secretariat, and other key partners/users from government and civil society.[137]

Two research proposals resulted from this collaboration. One of them competed for funding in the final round of the 2006 Global Health Research Initiative Teasdale-Corti Team Grants, a joint program of the International Development Research Centre (IDRC) the Canadian Institutes of Health Research (CIHR), the Canadian International Development Agency (CIDA) and Health Canada. This proposal was not funded. The research partners made a second submission, in response to the UBS Optimus Foundation 2007 call for research proposals on child survival in Latin America.[138] The foundation selected this proposal for one-year funding, starting in August 2007, and then renewed financial support for 2008-2010. Working as a communications consultant for CIETcanada, I was invited to link my doctoral research with this overarching initiative

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2008. These two states are among the poorest and most populated by indigenous peoples. Nationwide, predominantly indigenous municipalities have much higher MMRs than municipalities with a moderate indigenous population. For this analysis, see Mojarro O, Tapia Colocia G, Hernández López MF, Macín Pérez I. Mortalidad Materna y Marginación Municipal. In *Situación Demográfica de México 2003*. Mexico City: Consejo Nacional de Población, 2003. Available at http://www.conapo.gob.mx/publicaciones/2003/09.pdf. Accessed February 6, 2007.

[135] *Healing Our Spirit Worldwide*. PAHO newsletter, edition No 2, May 2004. Washington: PAHO. Available at http://www.paho.org/English/DD/PIN/Boletin_ENG.pdf. Accessed November 13, 2006. Maternal mortality is higher for indigenous groups in the Americas, where national averages often mask great disparities and inequities within countries. In Bolivia, the national rate stands at an already high 390/100,000, spiking at 496 in Potosí, with a larger indigenous population. In Honduras, where the national average is 147, the numbers range from 190 to 255 in departments with significant indigenous population. In Guatemala, the MMR among indigenous women is 83% than the national rate.

[136] Ramos S, Romero M, Karolinski A, Mercer RG, Insúa ID, del Río Fortuna CA. *Para que cada muerte materna importe*. Buenos Aires: CEDES, Ministerio de Salud de la Nación, 2004, p. 35, 53. In Argentina, where the average MMR was 43/100,000 in 2002, the province of Formosa had an MMR of 166/100,000. Here, 35.8% of all maternal deaths happened in indigenous communities, when indigenous peoples are only 7% of the overall provincial population.

[137] See letters from Guerrero State Secretary of Health, Guerrero State Secretary of Indigenous Affairs, Guerrero State Secretary of the Woman, Guerrero State Population Council, Autonomous University of Guerrero, municipalities of Xochistlahuaca and Tlacoachistlahuaca, , Kinal Antzetik, Fundación Justicia y Amor, and Iniciativa por una Maternidad sin Riesgos en México, to Ascencio Villegas Arrizón, director of CIETmexico –see Annex I, p. 509-519.

[138] Andersson N, Villegas Arrizón A. *Mexican Canadian cooperation to build capacity for multi-centred implementation research on newborn survival among Indigenous populations*. Research proposal submitted to UBS Optimus Foundation on April 30, 2007.

for maternal and newborn health (from now on, the MNH Project). In a letter to the Research Ethics Board at the University of Ottawa, Ascencio Villegas, director of CIETmexico, highlights the importance of research on safe motherhood risk discourse as "a valuable new angle to CIET's usual epidemiological approach."[139]

I saw this as a great opportunity to look into some issues that have puzzled me as a professional working in the field of communication for health and development. Over the last few years, I have been involved in health-related projects in Argentina, Canada, Pakistan, southern Africa, Mexico and Nicaragua. In all this time, I have witnessed how development agencies, academic units from developed nations, international health organizations and national governments in the developing world try to impose mainstream health risk discourse, based on biomedical criteria, epidemiological risk estimates, and cognitive behavioural models, through an increasingly globalized health agenda. The results are not always convincing[140], particularly among ethnic minorities and disadvantaged populations, as values within mainstream risk discourse are taken for granted and people's views and experiences often collide with public health imperatives.[141] Ideological implications are mostly ignored or brushed aside in these development-oriented initiatives.

1.4.1.1. Xochistlahuaca and the Amuzgo people

The municipality of Xochistlahuaca (from now on Xochis, as it is known in the region) is nested at the foothills of the Sierra Madre del Sur, the mountains of the *Costa Chica* region of Guerrero State, in southwestern Mexico.[142] It borders the neighbouring state of

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[139] See Annex I, p. 519.

[140] Seale points to evaluations that show mixed effects of mass media health education campaigns, and says that "for conveying complex health information, for teaching skills (such as the negotiation of safer sex) or for challenging strongly held beliefs, they are more likely to be ineffective." Seale C. *Media & Health.* London, New Delhi, and Thousand Oaks, CA: Sage Publications, 2002, p. 4-5.

[141] Referring to challenges to medicalized childbirth in the United Status during the 1970s and 1980s, Treichler states: "As these challenges play out in language, they embody the tensions and contradictions of the health care system and the cultura in which they occur." Treichler P 1989, p. 425.

[142] Xochis became a municipality in 1850, at the end of the war of independence, when the state of Guerrero was created. It was canceled and incorporated to Ometepec in 1932, and reinstated on September 6, 1934. See López Guzmán B. *Los amuzgos y el municipio de Xochistlahuaca, Guerrero.* Xochistlahuaca,

Oaxaca and the municipalities of Tlacoachistlahuaca (from now on Tlacoachis) and Ometepec in Guerrero. Some 25,200 people lived in Xochis in 2005, of whom approximately 93% (23,500) were indigenous and 7% (1,700) mestizo.[143] [144] The make-up of the indigenous population is roughly 93% Amuzgo, 4% Mixteco and 3% Nahua.[145] For this thesis, I have focused on the majority Amuzgo population.[146]

There are 103 localities in Xochis, including the city of Xochis, which is the seat of the municipal government (*la Cabecera*), the neighbouring town of Cozoyoapan,[147] the mid-size village of Guadalupe Victoria and 100 other small villages, ranging from nearby hamlets to remote settlements in the mountains. Most Amuzgo houses are made of adobe (clay and straw baked into hard bricks) and have dirt floors, though some in the main towns are using non-traditional materials such as cement blocks and iron beams; dozens of tile-roofed adobe houses line up along the gravel roads in the countryside.[148] A majority of houses in the main towns have either toilets or latrines for excreta disposal, but many rural households only have squat holes in the floor.[149]

México: Programa de Apoyo a las Culturas Municipales y Comunitarias-Dirección General de Culturas Populares, Unidad Regional Guerrero, Programa de Apoyo a las Culturas Municipales y Comunitarias (PACMYC)-CADCAC, 1997, p. 32-37.

[143] *Censo de Población y Vivienda 2005*. Instituto Nacional de Información Estadística y Geográfica, México. Available at http://www.inegi.org.mx/inegi/default.aspx?s=est&c=10202. Accessed May 4, 2009.

[144] By "Mestizo" I refer to people of mixed European and indigenous descent. This expression was common in the Spanish empire and its colonies, and it is currently used in Mexico. Coronado points out that, in social practice, the term *mestizo* is used by all ethnic groups to refer to "non indigenous" people, particularly in places with a majority of indigenous population. Coronado Suzán G. *Las voces silenciadas de la cultura mexicana. Identidad, resistencia y creatividad en el diálogo interétnico*. Mexico, DF: Centro de Investigaciones y Estudios Superiores en Antropología Social, 2003, p. 48. Data from chapter 6 and my own observation during fieldwork indicate this is what happens in Xochis.

[145] López Guzmán B 1997, p. 60.

[146] López Guzmán B 1997, p. 70. Approximately half of all Amuzgos live in Xochis, which is still considered the heart of the Amuzgo culture. Most other Amuzgos live in Tlacoachis, Ometepec, and San Luis Amuzgos and Santa María Ipalapa in Oaxaca. From an intra-ethnic perspective, the Amuzgos from Xochistlahuaca have a higher status than other Amuzgo groups in Guerrero and Oaxaca.

[147] Xochis Cabecera and Cozoyoapan are physically separated from each other by a narrow street, but they have been historically distanced by issues of land tenure, endogamic marriage, and other inter-community grievances. See Gutiérrez Ávila MA (coordinator). *Derecho consuetudinario y derecho positivo entre los mixtecos, amuzgos y afromestizos de la Costa Chica de Guerrero*. Chilpancingo, Mexico: Universidad Autónoma de Guerrero-Comisión Nacional de Derechos Humanos, 1997, p. 75.

[148] A yet unpublished CIET baseline household survey carried out in April-May 2008 for the maternal and perinatal health research initiative where my own research project was nested (from now on MNH Project 2008 baseline) defines more than half of the houses in the sample as "precarious" constructions.

[149] MNH Project 2008 baseline

Paved roads now connect Xochis and Cozoyoapan with Guadalupe Victoria and the nearest hamlets -and with the health district second-level hospital in Ometepec. Dirt and gravel roads are the only means to reach the Cabecera and the Ometepec hospital from most small villages. Very few people have automobiles and the majority use public transportation such as taxis and vans when they need to cover long distances. Many people walk to their daily activities in the countryside. Traveling to and from remote villages all but stops when the rain season arrives, usually in June.

There are 37 preschools, 50 elementary schools, four high schools (two of them in the Cabecera, one in Cozoyoapan, another one in Guadalupe Victoria) and a pre-university establishment (*preparatoria*) in Xochis.[150] Two types of elementary schools operate there: Spanish monolingual schools of the national educational system and Amuzgo-Spanish bilingual schools of the indigenous educational subsystem.[151] A growing cadre of male and female bilingual Amuzgo teachers has increasingly taken on leadership roles in the communities.[152] Health services consist of five primary care centres with recent medical graduates doing obligatory social service, and a 24-hour first-level hospital with a gynaecologist, anaesthesiologist, and general practitioners in the Cabecera. Most nurses are women who live in the communities. As of May 2008, only the Xochis hospital had an available vehicle for transporting pregnant women in emergencies. There is a second-level hospital in Ometepec, one hour from Xochis Cabecera.[153]

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[150] Gobierno del Estado de Guerrero. *Municipios del Estado: Xochistlahuaca*. Available at http://www.guerrero.gob.mx/?P=xochistlahuaca. Accessed May 8, 2009.

[151] López Guzmán B 1997, p. 81. From interviews with key informants from bilingual schools it became clear that curricular contents were very similar to those in the monolingual system. In addition, textbooks and class materials were all in Spanish. In January 2009, bilingual Amuzgo teachers agreed that "the education imparted in indigenous communities is neither intercultural nor bilingual", and demanded profound changes in the bilingual system. See Jáuregui F. Se organizan maestros amuzgos: inician un proyecto para fortalecer la educación intercultural bilingüe. *El Faro de la Costa Chica*, January 15, 2009. Posted on Guerrero Cultural. Chilpancingo, Mexico: Fundación Académica Guerrerense. Available at http://guerrerocultural.blogspot.com/2009/01/sobre-educacin-intercultural-bilinge-en.html. Accessed May 14, 2009.

[152] Aguirre Pérez IG. Pueblos Indígenas del México Contemporáneo: Amuzgos de Guerrero. Mexico, DF: Comisión Nacional para el Desarrollo de los Pueblos Indígenas, 2007, p. 26. Available at http://www.cdi.gob.mx/index.php?option=com_docman&task=cat_view&gid=16&Itemid=24&mosmsg=Est%E1+intentando+acceder+desde+un+dominio+no+autorizado.+%28www.google.com%29. Accessed May 8, 2009. Some 4% of the economically active population works in the school system. This proportion is equally divided between men and women.

[153] Data on health services comes from the MNH Project 2008 baseline survey. Hospital structural level refers to available services, infrastructure, and complexity of care. Smaller, first-level community hospitals

Near-subsistence economy

Xochis, which was an important cultural and spiritual Amuzgo centre at the end of the 15th Century, and a Spanish administrative focal point for the southern coastal region since 1563, [154] [155] is now among the 25 most marginalized municipalities in all of Mexico -a textbook case of economic, social, and educational underdevelopment.[156] Malnutrition is high, poverty endemic, and sustainable development a very long shot. The average family income is very low by Mexican standards and most peasants live a hand-to-mouth existence.[157] This leads to ever-growing labour migration, particularly among young men.[158] [159] As a result of these circumstances, it is not unusual for women, children and the elderly to work in the countryside.

The majority of the Amuzgo population practices subsistence agriculture in less than optimal conditions on collectively owned property. Most agricultural lands are located on steep mountainsides, where low-quality soils are hit by heavy though uneven rainfall between June and October –which makes the local economy greatly dependent on rain patterns. To make matters worse, the region suffers from deforestation, little credit availability, low capital investment, and frequent conflicts over land. As a result, indigenous agriculture has very low levels of productivity, even in the disadvantaged

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are referral hubs for primary care centres. Second level hospitals are medium-size teaching institutions that can deal with more complicated cases. For instance, the Xochis hospital can stabilize patients suffering from certain pregnancy-related complications, such as pre-eclampsia, but it cannot safely treat these conditions and their eventual aggravation, and must refer them to Ometepec or, in life-threating emergencies, to a third-level hospital in large urban centres, like Acapulco, the largest city in Guerrero, or Chilpancingo, the state capital, both located 4 to 5 hours from Xochis. In practice, many women are referred directly from primary health care units to Ometepec's regional hospital.

[154] Valdez N. *Ethnicity, class, and the indigenous struggle for land in Guerrero*, Mexico. New York and London: Garland Publishing, 1998, p. 27.

[155] Aguirre Pérez IG 2007, p. 13-15.

[156] According to CONAPO, 53% of the population of Xochis over 14 years of age is illiterate and 70% has not completed elementary school. Some 70% of all households are overcrowded, almost half do not have sewers or drainage, and 82% have dirt floors. CONAPO 2007, Annex B, p. 124. Available at http://www.conapo.gob.mx/publicaciones/margina2005/AnexoB.pdf. Accessed May 9, 2009.

[157] One third of the population makes less than a minimum wage. Aguirre Pérez IG 2007, p. 29.

[158] Valdez N. Land Reform and the Two Faces of Development in Rural Mexico. *Political and Legal Anthopology Review* 19(2):109-120, 1996.

[159] Aguirre Pérez IG 2007, p.7.

context of southern Mexico.[160] The sustainability of this agricultural activity is further hampered by traditional slash-and-burn techniques.[161]

Land tenure follows the ejidal system of collective ownership, based on customary rural law.[162] In essence, *ejidos* are communal lands structured as communities or townships with their own governing bodies for decisions concerning the common property.[163] [164] Traditionally, male indigenous and mestizo members of the ejido (*ejidatarios*) had small plots averaging two hectares of communal land (*parcelas*) for private family use. They could live, farm, and build a homestead on their plots, but they could not rent or sell them. In other words, they had the use and benefit of the land, but they did not own it. Parts of the ejido cannot be parceled and are collectively used by the community.[165] [166] Since the enactment of the New Farm Act in 1992, the Mexican government has tried to reduce or eliminate ejidos and communal lands, mostly through privatization and concentration in fewer hands, arguing that traditional land tenure is inefficient and unproductive.[167] The New Farm Act allows buying, selling, and leasing ejido land.[168]

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[160] Carrasco T, Davis SH, Valdés ME, Wodon Q, Humphrey C, Siaens C 2003, p. ii.
[161] Valdez 1996, p.110-112.
[162] Dunn M. Privatization, Land Reform, and Property Rights: The Mexican Experience. *Constitutional Political Economy* 11:215-230, 2000, reference on p. 215. The ejidal system was established in Mexico in 1917 by the government of the revolution.
[163] García-Garza JB, Vázquez-Silveyra JS. *Mining Law in Mexico: An Overview*. Mexico DF: Baker & McKenzie S.C., 2006, p.10. Available at http://www.bakernet.com/NR/rdonlyres/9D4AA2AF-D856-4ECC-828A-D306D05A2564/40322/MiningLawinMexBro1.pdf. Accessed May 7, 2009.
[164] Each ejido has a board of directors (*comisariado ejidal*) from the farming community and each director is known as *comisario ejidal*. The president of the comisariado is the maximum authority of the board.
[165] García-Garza JB, Vázquez-Silveyra JS 2006, p. 10. There are three types of land in each ejido: land for human settlement (towns and villages with their homes, streets, parks, schools, etc.), *ejido colectivo* (common ejido property that cannot be parceled), and *ejido parcelario* (land parcels for exclusive use of individual beneficiaries).
[166] Franco Pellotier VM. *Monografía y diagnóstico del Distrito Electoral Federal 08, con cabecera en Ometepec, Guerrero*. México, DF: Centro de Investigación y Estudios Superiores en Antropología Social, 2004, p. 11. Available at http://www.mexicantextiles.com/library/mixtecquerrero/Ometepec_guerrero.pdf. Accessed May 17, 2009. Xochis obtained the first ejido grant from the federal government in August 1933 and is now comprised of seven ejidos, two of which belong to ethnic Mixteco and Nahua minorities.
[167] Valdez N 1998, p. 38. The commercial and economic assessment of ejido viability does not take into account indigenous views of land as both sacred and collective resource.
[168] García-Garza JB, Vázquez-Silveyra JS 2006, p. 10. Buying or selling does not imply full private property, as parcels remain within the ejido. Private ownership requires freeing land from the ejido through a lengthy procedure.

Ejido lands have been the source of frequent violence in Xochis. Lack of survey records and legal documents to prove rights of usufruct have led to clashes between *ejidatarios* and between communities.[169] [170] Rancheros from wealthy Mestizo families and political *caciques* have secured ejido land at the expense of small indigenous farmers.[171] [172] Some communities have questioned the very nature of the ejido grant as a travesty of historical indigenous rights to the land.[173] These circumstances have made local people sensitive to policies and programs regarding land rights, to the point that Amuzgo ejidatarios from Xochis and Cozoyoapan have consistently rejected the privatization of the ejidos, including government offers to grant individual property titles for agricultural land and urban spaces, even when they came with free technical advice, agricultural inputs (fertilizers, pesticides, herbicides), low-interest credits to make purchases, and even cash benefits to participating farmers.[174] [175]

Maize is the staple crop in Xochis, although farmers also sow beans, chilli peppers, tomatoes, squash, *jamaica* (hibiscus) and *ajonjolí* (sesame).[176] But even though local farmers produce enough corn to meet their own needs, they have to sell part of that production to purchase other goods –including imported corn at a higher price in times of

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[169] In Mexico, the people of rural Guerrero have a reputation of being *bravos* –tough- and even violent. Valdez (1998, p. 128) argues that this is not an inherent characteristic of indigenous peoples living in the region, but rather "outward manifestations of deeply seated problems related to a system of social inequality."

[170] Gutiérrez Ávila MA 1997, p. 75-76 .

[171] Valdez N 1998, p. 127-128.

[172] Gutiérrez Ávila MA 1997, p. 76.

[173] Valdez N 1998, p. 102-116. There are indigenous communities in Mexico that own their lands outright and did not acquire them as a result of government ejido grants. They refer to these lands as *terrenos comunales* (communal lands). Although ejidos parcels and *terrenos comunales* are used in similar ways, they are technically different types of properties and have different political connotations. Claiming the "restitution" of indigenous communal land, as opposed to ejido grants, was at the heart of an indigenous political movement that sought to regain indigenous control of common land from wealthy mestizo landowners and Amuzgo elites in the 1960s.

[174] Valdez N 1996, p. 113. This was a fundamental reason for not requesting signed authorization from local dwellers for face-to-face interviews and subsequent use of the written transcripts. Many people are reluctant to sign any documents for fear of losing their land rights.

[175] Ibid, p. 117-118. To emphasize the central role of the ejidos in the Amuzgo culture, the author contends that privatized ejidos in Xochistlahuaca are not owned by Amuzgo people; they belong to descendants of Nahuas who settled in the area in the late 19th Century, who represent an ethnic minority, and who live on the fringes of Amuzgo communities.

[176] Aguirre Pérez IG 2007, p. 23. These local products, together with poultry and billy goat, are essential components of the traditional Amuzgo diet (ibid, p. 38).

increased demand.[177] [178]According to Valdez, the survival of the indigenous communities under these conditions can only be explained through a mix of superexploitation[179] of family labour and ejido-based cultural resilience.[180] The ejido system, which allows for communal forms of livelihood and social organization, becomes "a multipurpose institution that reproduces sociocultural aspects of indigenous communities, thereby contributing to identity formation and survival."[181] [182]

Some local farmers also sell fruits and beef and pork on the hoof in small volumes, while few bigger but still small-scale ranchers have a more profitable activity as buyers and sellers of livestock.[183] [184] Men work as labour in farming and construction, and women in domestic service. In the last few years, many in Xochis have opened small family shops, usually in their own homes, where they sell manufactured goods from urban centres, such as groceries, clothes, and a variety of household and school supplies.[185] Favoured by the construction in 1995 of paved roads between Ometepec, Xochis and Tlacoachis, public transportation has emerged as a profitable, up-and-coming line of business, though concentrated in the hand of few, mostly Mestizo *transportistas* who have the means to buy vehicles and the contacts to get operating licenses.[186]

Textile weaving, a traditional craft of great cultural relevance, allows women to supplement their household income.[187] Xochistlahuaca is a prestigious textile hub, where various groups and cooperatives try to preserve the art of weaving tablecloths, *huipiles* – stitch-decorated tunics worn by indigenous women in Mexico and Central America-and

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[177] Valdez N 1996, p. 111-112.
[178] López Guzmán B 1997, p. 71.
[179] Unusually severe exploitation, in classical Marxist theory.
[180] Valdez N 1996, p. 112.
[181] Ibid, p. 109. Despite the egalitarian tradition of communal land in Xochis, the author points out that "colonial legacies are readily apparent in the formation of regional class structures and social organization".
[182] During fieldwork, I could personally corroborate the importance of the ejido authorities (*comisarios ejidales*) in different aspects of community life.
[183] López Guzmán B 1997, p. 72.
[184] Aguirre Pérez IG 2007, p. 7.
[185] Ibid, p. 23.
[186] Ibid, p.7.
[187] Ibid, p. 26. Some 16% of the economically active population is comprised of artisans (13% are women and 3% are men).

other traditional textiles.[188] [189] As is the case with agricultural products, Amuzgo women sell their handicrafts to indigenous and non-indigenous traders who pay much less than the retail prices they later charge in urban markets, like Ometepec, Chilpancingo and Acapulco, where the artisans have no direct access.[190] [191]

Because most economic activities are family-centred, Amuzgo children have an early induction into labouring through apprenticeship, the preferred learning method among indigenous cultures: while boys begin working in the countryside alongside their fathers and are ready to farm the land at age 12, girls perform household duties and start developing weaving skills at a very young age.[192]

Social life and customs

The Amuzgos live in a patrivirilocal[193] pattern of nuclear and extended families. For centuries, marriages were customarily arranged between families; boys and girls were betrothed to each other from as early as childhood, and this is still the case in many villages[194]. Matrimonial arrangements, which amount to inter-family alliances, are mostly endogamous to the same ethnic group, but can happen between families from different villages, since they aim to build social networks between communities.[195] [196] However, this trend is changing, especially among people with more education (*los más educados*), according to local sources.[197] People also talk of young men who "stole" the woman they

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[188] See, for instance, Freund B. *Cozoyoapan: an Amuzgo town next to Xochistlahuaca, near Ometepec, Guerrero: hand woven textiles are made on back strap looms.* Mexican Indigenous Textiles Project. 2005. Available at http://www.mexicantextiles.com/grouppages/groups/amusgos/cozoyoapan1/index.htm

[189] According to the Centro de Desarrollo Municipal (CEDEMUN), almost 40% of Amuzgos work in the manufacturing sector, which can only be explained by women's work as textile weavers. See Aguirre Pérez IG 2007, p. 23.

[190] López Guzmán B 1997, p. 73.

[191] Gutiérrez Ávila MA 1997, p. 85.

[192] Aguirre Pérez IG 2007, p. 42-43.

[193] When a newly married couple initially moves in with the husband's parents and later settles in a house of their own.

[194] Aguirre Pérez IG 2007, p. 41.

[195] Ibid, p. 41.

[196] Valdez N 1998, p. 137. The author analyzes these familial arrangements "as part of the survival strategies of the campesinos under the existing socioeconomic conditions." (p. 132)

[197] This would make sense from an economic perspective, because the more educated would likely be less dependent on survival strategies linked to the traditional subsistence economy.

wanted from her household –usually not against her will- and later settled scores with the family of the "bride". The Amuzgos marry at a young age and mostly among themselves, because there are sexual taboos against interethnic marriage between Amuzgos, Mixtecos, and Tlapanecos.[198] Families resort to traditional community authorities when they cannot solve internal conflicts by themselves.[199]

Most people in Xochis communicate in the local variant of Amuzgo language.[200] This fact seems to reflect a close connection between language and ethnicity common to all Amuzgo peoples.[201] The Mixteco language has no bearing in Xochis, because the Mixtecos live in remote villages and feel more connected with neighbouring Tlacoachis, while Nahuas have lost their language and speak Spanish.[202] Mestizos, too, are Spanish speakers, but some of them are bilingual in Amuzgo. Although Amuzgo is the dominant language in everyday use, Spanish is the official language of government and has wide currency in Xochis.

Clothing is another marker of ethnic identity. Women usually wear huipiles, while men's traditional outfit is a combination of *cotón* and *calzón* (white cotton shirt and pants). There are outfit variations among men from different villages, and clothing styles can also point to socioeconomic status, age, and language proficiency. The combination of clothing and language can connote ethnic identity and assimilation.[203]

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[198] Gutiérrez Ávila MA 1997, p. 83.
[199] Ibid, p. 84.
[200] People used Amuzgo for everyday communication in 80% of households surveyed during the MNH Project 2008 baseline. Bilingual Amuzgo-Spanish education has somehow consolidated the dominant status of the Amuzgo language in everyday life –even though very few people can read or write in Amuzgo.
[201] Linguists and anthropologists contend that the use of Amuzgo language in everyday life is an accurate indicator of ethnicity, as compared to other indigenous peoples in Mexico. However, Amuzgo is a complex tonal language with regional variations, which makes it hard for Amuzgos from different regions to understand each other. See, for instance, Guerrero: Indigenous Peoples' Profiles. Centro de Investigación y Estudios Superiores en Antropología Social. México, DF: CIESAS. 2008. Available at http://pacificosur.ciesas.edu.mx/diagnosticoestatal/guerrero/conte13.html. Accessed May 8, 2009.
[202] López Guzmán B 1997, p. 77.
[203] Valdez N 1998, p. 29. The author gives the following example: "An Amuzgo man who does not speak Spanish will most often wear the traditional cotton apparel, while someone with some ability to communicate in Spanish would be more likely to wear traditional pants with a western style shirt. An Amuzgo proficient in Spanish might choose to wear only western style clothing." My own experience in the field ratifies this observation. Preference for Spanish and western clothing also indicate higher levels of education, greater proximity to the Mestizo population, and, in general, higher socioeconomic status.

As elsewhere in Mexico, the vast majority of people in Xochis have strong religious feelings and identify themselves as Catholics.[204] Protestants are a distant second largest group in terms of religious affiliation.[205] Like many other indigenous cultures, the Amuzgo blend their Catholic faith, including adherence to a busy ritual calendar and the cult of many saints, with Amuzgo origin myths, animistic beliefs and practices.[206] [207] They also believe that all natural elements –the earth, the hills, the water, the animals, the crops- have a spirit of their own.[208] This syncretism may be instrumental to the maintenance of Amuzgo identity and sense of community:

> The syncretic character of religious practices, and its reconstruction of lived history, are indicators of the creative agency of people who innovate and adapt their daily lives to the exigencies of the historic moment. These examples of adaptive strategies show that in every instance of domination and subordination (and Christianity in indigenous communities is an historical example), there is fertile ground in which alternative strategies of resistance and survival are cultivated.[209]

There is yet another type of syncretism that links religious and civil administrative duties within a civil-religious hierarchy known as cargo system or *mayordomía*. The system, common to indigenous communities across Mexico and Central America, gives social recognition to men and households who are elected to perform some civil and religious

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[204] According to the MNH Project 2008 baseline, 90% of women of reproductive age identified themselves as Catholic and 10% as belonging to other religious denominations. Most people in Xochis give allegiance to the official line of the Catholic Church, but a few side with the traditionalist branch founded by French archbishop Marcel Lefebvre, who led the opposition to the changes that resulted from the Second Vatican Council.

[205] Protestants are in turn comprised of Evangelists; Pentecostals; Luz del Mundo, a Christian denomination with international headquarters in Guadalajara, Mexico; and Jehovah's Witnesses, also called *Atalayas* after the Spanish name of their periodic publication.

[206] Valdez N 1998, p. 30-31.

[207] Hochstein G. *Behind God's Back: Reconciling Sex and Sin in an Amuzgo Community*. San Luis Obispo, CA: Central Coast Press, 2000, p. 43. The author makes a point of the self-contained practice of Catholicism in Xochis: "Among Xochistlahuacans there is only some awareness that which is practiced as 'Catholicism' by the majority of their population is not the same as that of urban Mexico and the Vatican."

[208] Aguirre Pérez IG 2007, p. 43.

[209] Valdez N 1998, p. 34. I will return to this hypothesis in the discussion of my own findings, where I suggest the blending of biomedical risk discourse and practices with traditional health views and practices may have a similar function.

tasks for the community, which in Xochis includes mobilizing communal labour.[210] Elder councils like the Consejo Supremo Amuzgo usually appoint cargo holders, trying to respect consensual views in the community,[211] even though political parties and caciques have had greater bearing on these processes, with disruptive effects.[212]

Anthropologists have documented the practice of retributional killing among the Amuzgos, either openly, in the shape of interpersonal or inter-family violence and communal justice, or in a hidden manner, mostly through sorcery. Gutiérrez Ávila observes that some Amuzgo communities tolerate and practice the killing of those deemed violent or dangerous to the common good. This happens, for instance, when there is not enough evidence to judge trespassers according to Mexican criminal laws or when the community considers that court sentences are not harsh enough.[213] Franco Pellotier offers a systemic explanation involving the assignment of guilt and the expectation of retributional justice as a collective mechanism to explain and control violence through nahualism.[214] Nahualism is the common belief among indigenous Mesoamerican cultures that human beings have an animal counterpart with whom they share soul matter –some even have the magical power to take the shape of that animal.[215] The Amuzgos associate physical violence, resulting in ill health or death, with attacks on the victim's *nahual* (also called *tono*), and communities engage in a silent search for signs of culpability that leads, sooner or later, to socially sanctioned vendettas seeking to restore the lost social balance.[216] [217]Another study also reveals the acceptance of homosexual relations and

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[210] Ibid, p. 33-34.
[211] Ibid, p. 69.
[212] Franco Pellotier VM 2004, p. 12.
[213] Gutiérrez Ávila MA 1997, p. 85-86.
[214] Franco Pellotier VM. Violencia y control social: la lógica de la culpabilidad en un grupo indígena. *Desacatos* 13:152-160, 2003. Available at http://www.ciesas.edu.mx/Desacatos/13%20Indexado/2%20Esquinas%204.pdf. Accessed May 17, 2009. This theory is relevant to my research, because nahualism is seen as one of the main causes of ill health among the Amuzgos, including complications during pregnancy and childbirth.
[215] Ibid, p. 154. The author points out that the relationship between a person and his or her nahual is social in nature, insofar as nahualism is a means of social control.
[216] Retributional murder based on nahualism does not explain or lead to violence between Amuzgos and Mestizos, because this systemic explanation is only part of the indigenous worldview (ibid, p. 156).
[217] There are other anthropological definitions of nahualism and tonalism, but I will focus on those related to indigenous beliefs and social practices in Xochis. Hochstein, for instance, observes that the words *tonal* and *nahual* used to designate two different concepts among the Amuzgos: "the familiar animal spirit and the alien animal spirit," but they have eventually "coalesced to mean roughly the same thing, a benign

suggests that the malleable, dynamic nature of a multi-faceted religious syncretism allows for the reconciliation of sin, sex, and retributional murder in the Amuzgo culture.[218]

The role of women

Health staff often describe indigenous women in the Costa Chica as *chaparritas*, because they are shorter, smaller, and slimmer than mestizo women. This description bears upon the very topic of my research, since being chaparritas is very frequently listed as a risk criterion for pregnancy and childbirth in indigenous communities. There is no agreement on why the Amuzgos and other indigenous groups have these characteristics. While some authors point to inherent ethnic traits,[219] most others focus on chronic malnutrition coupled with poverty and hard living conditions in the countryside.[220] [221] [222] By and large, women's demeanour goes with their physical appearance: they are quiet, softly spoken, and shy by mestizo standards.

Household life and family reproduction revolve around women. Girls have to perform household duties at a very young age. They look after their younger siblings, run errands, prepare meals, bring lunch to their male relatives tending to the farm, help out with the

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familiar animal." The author contends that the relationship between a person and his or her *tono* helps explain the Amuzgo view of individual responsibility as limited by "the hidden and therefore unknown behavior" of the familiar animal. Hochstein G 2000, p. 33-38. I will return to this idea in the final chapter.

[218] Hockstein G, 2000.

[219] López Guzmán B 1997, p. 14. According to the author, the Amuzgos migrated from the Pacific Coast "because they inhabited an inhospitable place, where animals would make prey of them because of their short height."

[220] Avila-Curiel A, Shamah-Levy T, Galindo-Gómez C, Rodríguez-Hernández G, Barragán-Heredia LM. La desnutrición infantil en el medio rural mexicano. *Salud Pública de México* 40(2):150-160, 1998, quote from page 159. Available at http://www.scielosp.org/pdf/spm/v40n2/Y0400207.pdf. Accessed May 14, 2009. The authors state that "height growth deficiency consistently correlates with cumulative effects of chronic malnutrition," which the authors link with serious social disadvantages in rural Mexico.

[221] Bustos P, Amigo H, Muñoz SR, Martorell R. Growth in Indigenous and Nonindigenous Schoolchildren From Three Poverty Strata. *American Journal of Public Health* 91:1645-1649, 2001. Available at http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1446847&blobtype=pdf. Accessed May 14, 2009.

[222] *La desnutrición crónica en América Latina y el Caribe*. El Dorado, Panamá: Oficina Regional del Programa Mundial de Alimentos (World Food Programme), 2007, p. 2. Available at http://www.onu.org.pe/upload/infocus/pma_desnutricioninfantil.pdf. Accessed May 14, 2009. "Chronic child malnutrition is concentrated among indigenous populations and the poor, who live in the more isolated rural communities or in the outskirts of urban centres, and most of whom have inherited unfavourable socio-economic conditions. In these populations, prevalence of chronic malnutrition is higher than 70%. Most of these children are victims of an inter-generational cycle of poverty and malnutrition."

harvest, and start weaving under their mother's guidance; by doing all this, they learn how to be a woman in the Amuzgo society.[223] This early commitment and manifold contribution to their household's economy seems to develop a strong family-oriented work ethic among women, which is reflected in community expectations and may have implications for maternal health.[224]

Women's participation in public life is heavily conditioned by the social, economic, and educational circumstances of Amuzgo women.[225] In Xochis, female illiteracy and lack of schooling are rampant. Most women are monolingual, even though many have some passive knowledge of Spanish.[226] [227] Women are particularly constrained through kinship rules in a patriarchal society, since most of their social relations, including networks of ritual kinship that extend natural kinship and foster mutual help (like being *comadres,* or co-mothers of a child), are established in a subordinate position, as daughters, sisters, and wives of men.[228] Machismo patterns are present in gender relations across different social spaces, and men are seen as the "natural" leaders of the households. Women are expected to remain virginal until they get married, which usually occurs in their teenage years;[229] they also begin bearing children at this age. A woman in her twenties who is either single or childless is still a rare sight in Xochis.

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[223] Aguirre Pérez IG 2007, p. 30-35, 43. Although a growing number of female children and teenagers may be attending elementary, middle and even high school, they have to juggle their educational obligations with household chores and farm work.

[224] In the MNH Project 2008 baseline survey, almost half of elderly women perceived that townspeople expected pregnant women to work as much as usual, compared to 14% of husbands who perceived the same. And while 75% of men thought people expected pregnant women to work less than usual, only 50% of elderly women had this perception. One possible explanation for these gender differences is that elderly women have internalized familial –and community- expectations to the point where they sustain these unwritten norms more so than men do.

[225] Aguirre Pérez, IG. Participación política y social de mujeres indígenas: el caso de una lideresa tradicional. *Cuicuilco* 10(27):1-26, 2003. I follow the author in her description of women's role and social participation among the Amuzgo of Xochis.

[226] According to the MNH Project 2008 baseline survey, one-third of all women 15-49 years had no formal education and half of all women had not attended school beyond third grade. Only 18% had studied beyond elementary school.

[227] The proportion of men who speak and understand Spanish is larger than the proportion of women who are bilingual, particularly among older generations. Some 60% did not have any knowledge of Spanish. This is also a reflection of unequal gender relations, insofar as men have traditionally had more access to formal education and have had more contact with mestizos for doing business and engaging in social and political participation.

[228] Aguirre Pérez IG 2003, p. 11.

[229] Gutiérrez Ávila MA 1997, p. 83.

In spite of these limitations, most women in Xochis have some sort of work-related income, usually as textile weavers, potters, needlewomen, bakers, and sellers of *tacos* and *tortillas* (maize pancakes), sometimes supported by national and international anti-poverty and micro-regional development programs.[230] [231] This contribution is essential to the household economy.[232] Women are also gaining autonomy and participation in community life through both traditional means, such as groups of back-strap loom weavers, and non-traditional organizations of bilingual elementary and high school teachers who support the autonomist Frente Cívico Indígena de Xochistlahuaca. Some authors see cooperative back-strap weaving as an identity-affirming practice in a context of social, political, and economic threats to Amuzgo culture and traditional community ways.[233] Some observers say the status of Amuzgo women in Xochis compares favourably to gender relations among the Mestizo majority in Mexico as a whole. A Catholic priest who had been living in the area for many years at the time of our interview was of this view:

> **Q:** Do women have a say here? Do they have the same power of decision that a man has in these communities?
>
> **A:** Well... I would say that the women here, the Indian woman, have probably more say than they do in general, than women do generally in Mexican society. [...] But still... the men rule the roost. In certain communities, for example, it's not looked upon favourably that women are in charge of government. But there's always been a tradition here that women are accepted as part of the social fabric, you know, governing. However, usually, the ones who pick who they want to govern are men. But they pick women sometimes. So, it's... I would not say there's full equality, but there's more of a... The women have more rights here in the... in the Amuzgo culture than they do, say, in the general mestizo culture in Mexico. More machismo... There's more machismo in the mestizo culture.

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[230] Aguirre Pérez IG 2003, p. 4.
[231] According to the MNH Project 2008 baseline, 66% of all women in Xochis have some work-related income, compared to 34% in neighbouring Tlacoachis, which has a majority of Mixteco population and a larger proportion of Mestizo inhabitants than Xochis.
[232] Gutiérrez Ávila MA 1997, p. 73.
[233] Ibid, p. 23.

However important, this trend happens in the context of a still heavily male-dominated society. Not all communities will be equally open to women's participation in the public sphere. Rigidly hierarchical authority structures have not made room for women leadership.[234] Socioeconomic status, educational level, and kin are all important factors that bear upon women's participation in the public sphere.[235] Lack of time due to the heavy burden of household chores and income-generating activities; lack of information about community issues; feelings of fear and insecurity; and perceptions of community rejection to female involvement in traditional male affairs are other powerful barriers for women to access the public sphere.[236]

The division of labour also reflects traditional gender roles: 73% of men and 2% of women work in farming and cattle raising, although women's contribution to these activities –preparing the land, harvesting, taking the man's place when he migrates- seems to be underrepresented in government statistics. On the other hand, 13% of women and 3% of men work as artisans, mostly doing handicrafts.[237]

Interethnic relations

Clear differences in social status and unequal appropriation of resources characterize interethnic relations in Xochis.[238] The Amuzgo majority has better access to public services, economic resources, and power positions than the indigenous Mixteco minority

[234] Aguirre Pérez IG 2007, p. 50.
[235] Aguirre Pérez IG 2003, p. 4-5.
[236] Greater access to formal (western-oriented) education for women may have a disruptive effect on these traditional patterns.
[237] Aguirre Pérez IG 2007, p. 29.
[238] I understand ethnicity in terms of kinship, group solidarity, common cultural ground (dress, language, value system), a common proper name, a myth of common ancestry, and a subjective component of perceived ethnic identity. See, for instance, Hutchinson J, Smith AD. Introduction. In John Hutchinson and Anthony D. Smith (eds.). *Ethnicity*. Oxford and New York: Oxford University Press, 1996, p. 3-14. Based on this understanding, I consider Amuzgos, Mixtecos, Nahuas, and Mestizos (from indigenous and non-indigenous descent) to be different ethnic groups.

dwelling in far-flung villages in the higher mountain.[239] Mixteco and Nahua minorities have no participation in traditional decision-making bodies.[240]

On the other hand, the Mestizo population –a minority in Xochis, but a dominant majority in Mexico- has historically had the upper hand in almost all aspects of community life.[241] Mestizo caciques and appointees have run the "official" municipal government over the last two decades; Mestizo *rancheros* have the largest land holdings;[242] and Mestizo traders buy maize crops from Amuzgo farmers at low prices and provide them with other essential products at market prices.[243] The same interethnic imbalance prevails within the health system, where most doctors are Mestizo, although there are several Amuzgo nurses who graduate from the University of Guerrero's Nursing School in Ometepec, and Amuzgo primary health care technicians (better known as TAPS, from the Spanish acronym for *técnicos en atención primaria de la salud*).

Political institutions and dynamics

The political structures and dynamics of Xochis are very complex, because they combine and superimpose the institutions of the Mexican government, indigenous decision-making bodies, deep-seated political *caciquismo*,[244] and local indigenous movements vying for municipal autonomy, which are loosely linked with regional autonomist movements, such as the Zapatista coalition in Chiapas. At the level of the municipal government, the ruling Institutional Revolutionary Party (PRI) has been in power since the 1970s. Other political forces have emerged in recent years, such as the centre-left

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[239] Aguirre Pérez IG 2007, p. 53.
[240] López Guzmán B 1997, p. 75. According to the author, there are historical reasons for these unequal power relations among indigenous groups. The Amuzgos resent the Nahuas because the latter settled in Xochis and seized Amuzgo lands after de 1910 revolution, and they discriminate the Mixtecos because they held sway over the Amuzgos in pre-Colombian times.
[241] Aguirre Pérez IG 2007, p. 53.
[242] Valdez N 1998, p. 42.
[243] López Guzmán B 1997, p. 71-72. The author points out that interethnic trade with Nahuas and Mixtecos is not driven by only profit, but rather follows a barter-like pattern –though money is often involved- that is functional to the survival of indigenous communities.
[244] In most of rural Guerrero, as elsewhere in Mexico, political parties have long relied on local self-appointed political bosses, usually wealthy landowners or business entrepreneurs, known as *caciques* or *caudillos*, who in turn depend on the loyalty and support of the peasantry.

Democratic Revolutionary Party (PRD), which currently governs the state of Guerrero, and the centre-right National Action Party (PAN), which is in control of the federal government and also runs neighbouring Tlacoachis.[245] [246]

Social scientists and community sources agree that party politics have had a negative impact on the Amuzgo society, deepening old rifts and creating new ones within and between communities. Political parties have weakened traditional authorities by appointing local leaders from outside the communities and disregarding centuries-old consensus building procedures.[247] Historically, community leaders were chosen because they were seen as honest and hard working people and because they had a track record of both civic and religious service to the community.[248] The traditional Amuzgo political system has relied on the Council of Elders or *Consejo Supremo Amuzgo* for community guidance ranging from political leadership to the rule of customary law. However, the Council has lost some of its power and moral authority in recent times, and many in Xochis do not see it as representative enough to act on behalf of the indigenous population.[249] Alliances with Mestizo caciques and party allegiance now carry equal or greater weight than these ancestral institutions.

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[245] Tlacoachis is the only municipality with majority of indigenous population run by the PAN in the whole of Mexico. As such, it has received an inordinate amount of funds and institutional support from the federal government over the last decade.

[246] The last municipal elections were held on October 5, 2008. The incumbent PRI obtained 40% of the votes; another 30% went to PAN, 20% to PRD, and 10% to the *Partido del Trabajo* (PT). Tribunal Electoral del Estado de Guerrero, Quinta Sala Unitaria. *Juicio de Inconformidad, Expediente TEE/QSU/JIN/007/2008*, October 22, 2008. Available at http://www.teegro.gob.mx/consultas/sentencias/ano-2008/quinta/tee-qsu-jin-007-2008.pdf. Accessed May 8, 2009. This is a judiciary resolution to an adversary process initiated by PRI after the elections.

[247] Aguirre Pérez IG. Participación política y social de mujeres indígenas: el caso de una lideresa tradicional. *Cuicuilco* 10(27):1-26, 2003, reference on p. 22.

[248] López Guzmán B 1997, p. 74. As a result of capitalistic developments and "modernizing" influences from political parties and academically trained professionals, many in Xochis now feel that only *personas preparadas* (people with educational background and professional titles) should hold government posts and have leadership roles, even if they have no history of community service or moral authority in a traditional sense.

[249] Gutiérrez MA. *Déspotas y caciques: Una antropología política de los amuzgos de Guerrero.* Chilpancingo, México: Universidad Autónoma de Guerrero, 2001, p. 63. I reached similar conclusions from observation and interviews during fieldwork in Xochis.

Organized indigenous resistance to official authorities erupted in 1979 and has rocked the political dynamics in Xochis over the last two decades.[250] Amuzgo and Nahua communities have claimed their right to self-determination and to elect their leaders according to their customs. In 2000, the then president of the municipal government, local PRI cacique Aceadeth Rocha Ramírez[251], refused to recognize *comisarios* (municipal commissioners or delegates) elected by the communities following traditional ways.[252] On March 16, 2001, the autonomist *Frente Cívico Indígena de Xochistlahuaca* (Indigenous Civic Front of Xochistlahuaca) seized the seat of the municipal government, which has been operating in a different building ever since. On November 20 of the same year, the Amuzgo people, gathered in a community assembly, chose a collective body of indigenous authorities, "in accordance with Amuzgo consuetudinary law, of their own accord and at odds with caciques, political parties, and state electoral laws".[253] Women, particularly artisans and teachers, have been key players in the autonomist movement.[254]

In practice, the "evicted" government has continued to operate as the "official" government within Mexico's legal and political structure. The indigenous autonomous government has symbolic power, but no management of resources. Supporters of indigenous autonomy have grouped in grassroots organizations and voice their cause

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[250] Gutiérrez MA 2001, p. 64-70.

[251] Aceadeth Rocha Ramírez, local PRI cacique who headed the local government twice between 1999-2002 and 2005-2008, and is currently a member of the Guerrero State Legislature, stands out as a particularly polarizing figure in municipal and regional politics and a key anti-autonomist figure. See, for instance, *Comunicado desde Xochistlahuaca*. Kaosenlared.net. March 30, 2009. Available at http://www.kaosenlared.net/noticia/comunicado-desde-xochistlahuaca. Accessed May 7, 2009. Also see *Broadcaster from Ñomndaa Radio demonstrates that the State Department of Justice fabricated the case for which he was imprisoned in 2007*. Tlachinollan: Centro de Derechos Humanos de La Montaña. October 3, 2008. Available at http://www.tlachinollan.org/english/notbp/notbp081030_win.html. Accessed May 7, 2009. A human rights civil society organization operating in Guerrero demanded the State Attorney General's Office investigate Rocha Ramírez in connection with the assassination of anthropologist Miguel Ángel Gutiérrez Ávila. See Castro M. La PGJE debe investigar a Aceadeth Rocha por el asesinato del universitario: FGRI. *La Jornada Guerrero*, August 7, 2008. Acapulco, Guerrero: Editora de Medios de Guerrero S.A. de C.V. Available at http://www.lajornadaguerrero.com.mx/2008/08/07/index.php?section=sociedad&article=008n1soc. Accessed May 7, 2009.

[252] Aguirre Pérez IG 2007, p. 47.

[253] González García C. El camino de abajo: autonomía del pueblo Amuzgo. *La Jornada* 69, Hojarasca monthly supplement, January 2003. Quoted in Aguirre Pérez IG 2003, p. 24.

[254] Aguirre Pérez IG 2007, p. 48. Three of the initial 24 members of the Frente Cívico and half of the 250 bilingual teachers who took part in the movement were women. The magnitude and intensity of women's participation in these political events was unprecedented in Xochis and rarely heard of among indigenous peoples in Mexico.

through *Radio Ñomndaa* (The Word of the Water), an Amuzgo-only community broadcast service that went on the air on December 2004 and has been under mounting pressure from the official government to shut down.[255] [256] [257] In May 2009, the autonomists denounced negotiations between traditional indigenous leaders and municipal authorities aiming to return the city hall to the "official" government. [258]

Political and crime-related violence are commonplace in Guerrero, including political and drug-related killings and kidnappings. In early 2009, the autonomist movement of Xochis demanded an investigation into the assassinations of indigenous autonomy advocates, including anthropologist Miguel Ángel Gutiérrez Ávila, who participated in the intercultural design sessions for the MNH Project and was a well-known specialist in the Amuzgo culture.[259] [260] Political tensions and divisions are evident in the communities, and this requires a delicate balancing act when doing fieldwork –it is not unusual for people to ask whom the researchers are working for, and doors can as quickly open as they can close according to the response. There is a widespread perception that political allegiances determine every aspect of community life, including education and health care. This pervasive view is reflected in the words of a villager from Llano del Carmen, who was talking about a community health centre in early 2010:

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[255] Servicio International para la Paz (SIPAZ). Civil Society Section. *Report on Xochistlahuaca*. Available at http://www.sipaz.org/gro_scivil/scivil_idxe.htm. San Cristóbal de las Casas, Chiapas: SIPAZ, 2009. Accessed May 4, 2009.

[256] Schneider C. Guerrero: Marginalization and Repression. *Task Force on the Americas Report*. Larkspur, CA: Marin Interfaith Task Force on the Americas, Summer 2008, p. 2. Available at http://www.mitfamericas.org/Newsletter-2008-Summer.pdf. Accessed May 9, 2009.

[257] According to the MNH Project 2008 baseline, almost half of all households listened to Radio Ñomndaa, while only 16% listened to another local FM broadcast station that was identified as "the radio of the (municipal) president", because it was created to counteract the influence of the autonomist broadcast.

[258] Labastida M. México: Grupos de Xochistlahuaca llaman a la unión indígena para defender sus derechos. *Argentina-IndyMedia.org*, Marc h 31, 2009. Buenos Aires: Centro de Medios Independiente. Available at http://argentina.indymedia.org/news/2009/03/662600.php. Accessed May 4, 2009.

[259] Ocampo S. Piden parar represión en Xochistlahuaca. *La Jornada*, March 30, 2009. Mexico DF: DEMOS Desarrollo de Medios Sociedad Anónima. Available at http://www.jornada.unam.mx/2009/03/30/index.php?section=estados&article=034n5est. Accessed May 4, 2009.

[260] Gutiérrez Ávila studied the political, legal, and social structures and dynamics of the Amuzgo societies and other ethnic groups in the Costa Chica of Guerrero. He was the author of *Derecho consuetudinario y derecho positivo entre los mixtecos, amuzgos y afromestizos de la Costa Chica de Guerrero*. Chilpancingo, México: Universidad Autónoma de Guerrero y Comisión Nacional de Derechos Humanos, 1997, and *Déspotas y caciques: Una antropología política de los amuzgos de Guerrero*. Chilpancingo, México: Universidad Autónoma de Guerrero, 2001.

> Lo que sabemos es que en ese centro de salud no atienden a toda la gente; sólo a priistas, y no siempre está abierto. Es como todo en este pueblo, la gente está dividida. Hay dos escuelas primarias, una de priistas y la otra de gente que no simpatiza con ellos.[261]

Health practices

Like other indigenous groups in Mesoamerica, the Amuzgos have a complex ancestral structure of social control, religion, and sickness, which frequently links ill health with external forces (e.g. spirits) and breaching of social norms, and they have mostly relied on *curanderos* (healers) and *brujos* (witches) to interpret, understand, and restore health and social balance through traditional medicine and rituals.[262]

The Amuzgos have traditionally identified several causes of ill health, including *espanto* or *susto* (fright), *coraje* (anger), *antojo* (craving, particularly for food), *males* or *daños* (evil spells), loss of one's *sombra* (literally, loss of one's shadow, a metaphorical reference to soul loss), and loss of the *nahual* or *tono*.[263] Espanto usually stems from enduring or witnessing violence or distress, particularly in the household or among close acquaintances –though one can get a fright just from walking by the house of someone who recently died. Coraje is equally stressful and dangerous, and it can be contagious, even at a certain distance from an angry person. Most incidents of anger and fright arise from conflict or changes in social relations, which require that balance be restored in this sphere.[264] The antojo is a very common belief across the Americas –and very relevant to maternal health, since antojos are usually seen as desires of the unborn child expressed

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[261] Unpublished fieldwork notes from Geovani Valtierra Gil, an Amuzgo anthropologist working for the MNH Project, January 2010. Reproduced with the author's permission.
[262] Franco Pellotier VM 2004, p. 13.
[263] For this section, I follow different sources, including López Guzmán B 1997, p. 54-55; Aguirre Pérez IG, 2007, p. 44; Franco Pellotier VM 2004, p. 13; interviews with key informants in Xochis, and an unpublished analysis of interviews with TBAs (*parteras)* by Geovani Valtierra, an Amuzgo anthropologist from Xochis who is also a member of the MNH Project team.
[264] Cosminsky S. Tradicional birth practices and pregnancy avoidance in the Americas. In A. Mangay Maglacas, John Simons (eds). *The potential of the traditional birth attendant. WHO offset publication 0303-7878, 95:75-89*, 1986, reference on p. 76.

through her mother. Unsatisfied cravings provoke a sharp unbalance that needs to be restored before it causes harm to the child.[265]

A much-feared state is the loss of the *nahual* or *tono*. In most Mesoamerican indigenous cultures, the nahual is the soul of an animal that becomes a person's alter ego. Each person has his or her *nahual/tono*. When people have physical or emotional ailments, one possible explanation from within the culture is that their *nahual* has taken ill. As explained above, nahualism also entails a strong belief in the powers of certain people, particularly witches, to harm others through their animal or nahual.[266] [267]

Traditional healers diagnose the underlying cause of ill health by using a basket or a set of cards, or through pulse reading. Healers treat their patients with a combination of traditional medicine –usually preparations from plants, herbs, and meat from medicinal animals, such as hens, guajolotes, armadillos, rattlesnakes, and billy goats- and prescribed prayers to invoke spirits, cast off spells, and help restore a natural state of balance to the body and the mind.[268] [269] [270] In 1986, with support from UNICEF and the *Instituto Nacional Indigenista*, the Amuzgo traditional healers created a local organization to assist the indigenous population. With funding from the Mexican government, they built the *Centro de Desarrollo Regional de Medicina Indígenas* (Indigenous Medicine Regional Development Centre), which has been operating in Cozoyoapan since 1989. Healers working at this centre carried out consultation, prepared traditional medicines, and coordinated their activities with a similar centre in Llano del Carmen.[271] At the time of

[265] A majority of parteras in Xochis said an unsatisfied craving could either "affect the child" or make the woman "lose her child". Data obtained from the MNH Project 2008 baseline survey in Xochistlahuaca.
[266] Franco Pellotier VM 2003, p. 154.
[267] CIESAS 2008.
[268] López Guzmán B 1997, p. 54 and 58.
[269] Robinson GG, Barcimeo López C. *Medicinal Plants Use Pattern Among the Amuzgos of Guerrero, Mexico.* Tampa, Florida: Instituto Lingüístico de Verano, 1999. The authors observe that Knowledge and use of traditional plants coexists with, and has given ground to, use of chemical western drugs. Available at http://www.sil.org/mexico/amuzga/guerrero/A006i-MedicinalPlants-amu.pdf. Accessed January 20, 2010.
[270] Fieldwork notes from Geovani Valtierra Gil. Reproduced with the author's permission.
[271] Franco Pellotier VM 2004, p. 13.

fieldwork, the Cozoyoapan had little operational capacity, while the centre in Llano del Carmen had been transformed into a municipal health unit.[272]

From an epidemiological perspective, the population of Xochis suffers frequently from gastrointestinal diseases, such as dysentery, parasites, and diarrhoea; and there are many cases of malaria, flu, and pneumonia, particularly during the rain season.[273] [274] Rural dwellers are exposed to scorpion sting, which happens both in the countryside and inside the home.[275] Malnutrition is endemic among indigenous populations in Guerrero.[276] Maternal mortality is higher in Costa Chica and the mountains than in any other region of Guerrero state, which in turn has the highest maternal mortality rate in Mexico.[277] The state government links this situation to long distances from remote villages to health units, lack of transportation, untrained parteras, and "lack of cohesion of the social network with authorities and civil society".[278] As data from this thesis shows, government officials and health staff also blame what they see as inherent cultural traits and ethnically bounded views among indigenous peoples.

Traditional birth attendants (TBAs, or *parteras* in Spanish[279]) provide essential care during pregnancy, childbirth, and the immediate postpartum period. They treat different conditions of the pregnant woman –from antojo to swollen feet and bleeding- using a

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[272] I confirmed these observations through an e-mail exchange with Geovani Valtierra Gil, May 20, 2010.
[273] Ibid, p. 64.
[274] Villegas Arrizón A. *Impacto del proyecto Planificación Microrregional en cinco municipios pobres del estado de Guerrero.* Master's thesis. Acapulco, Mexico: Universidad Autónoma de Guerrero, 1999.
[275] Villegas A, Andersson N, Martinez E, Rodriguez I, Lagunas A. Alacranismo en Guerrero: un estudio epidemiológico en 20 comunidades. *Salud Pública de México 30(2): 233-239,* 1988.
[276] Legorreta-Soberanis J. Identificación de factores de riesgo que influyen en la desnutrición crónica medida por talla baja, en niños menores de dos años, en cinco municipios pobres, indígenas y mestizos, en el estado de Guerrero, México. Master's thesis. Acapulco, México: Universidad Autónoma de Guerrero, 1999.
[277] *Reforzamiento de la Vigilancia Epidemiológica de la Mortalidad Materna y el Embarazo de Alto Riesgo.* Power Point presentation. Chilpancingo, Guerrero, Mexico: Secretaría de Salud, 2006.
[278] González Benicio C. La muerte materna en La Montaña se debe en parte a la falta de cohesión social, según la Secretaría de Salud. *El Sur*, March 6, 2009. Available at http://www.suracapulco.com.mx/nota1e.php?id_nota=54287. Accessed May 19, 2009.
[279] In Amuzgo, parteras are known as *ts'a^{n}nanto' yu namatseincuii*, which literally means "the person who assists the woman who gives birth", and also as *ts'a^{n}nan'ncja yundyaa* or "the person who catches the baby". These names follow a common pattern of action-oriented wording in the Amuzgo language, since they refer to specific activities carried out by the partera during childbirth. I have taken these translations from an analysis of in-depth interviews with parteras by Geovani Valtierra, an Amuzgo anthropologist who collaborates with the MNH Project.

variety of traditional resources and, in some cases, biomedical teachings and western medicines. Historically, most Amuzgo women have given birth at home, assisted by parteras.[280] [281] This situation has personal as well as economic[282], social and cultural roots,[283] [284], which have also been observed in other regions of Mexico.[285] [286]

However, government pressure through health services, biomedical TBA training,[287] safe motherhood discourse, and conditional cash-transfers through poverty-reduction programs has managed to change these practices, and now a growing number of women are turning to institutionalized delivery.[288] Currently, the most frequently rendered service by parteras is the positioning of the foetus in the woman's womb to enable a natural delivery and reduce the likelihood of c-section. This is an action requested by

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[280] Loza Hidalgo T, Ortega Medina G. Atención de la mujer en Guerrero: Programa Alimentario y Nutrición Familiar. In Comité Promotor por una Maternidad sin Riesgos (ed.), *Maternidad sin riesgos en Guerrero*. México DF: Comité Promotor por una Maternidad sin Riesgos en Guerrero, 1996, p. 128-135. According to this study, only 2 out of 10 women gave birth in hospitals and other government health units in rural Guerrero in the mid 1990s.

[281] Andersson N, Martínez E, Villegas A, Rodriguez I. Vigilancia epidemiológica y planificación descentralizada: el uso de sitios centinela en Guerrero. *Salud Pública de México* 31:493-502, 1989. According to this publication, less than 20% of women in Xochis delivered their babies in health units in the late 1980s. An unpublished CIET study from 1998 found that 80% still delivered in their homes at the time, most of them assisted by parteras.

[282] The income of indigenous people in Guerrero is 36 percent the income of non-indigenous population. Carrasco T, Davis SH, Valdés ME, Wodon Q, Humphrey C, Siaens C. *Indigenous Peoples in the States of Chiapas, Guerrero and Oaxaca*. Washington, DC: World Bank, 2003, p. 1. Available at http://wbln0018.worldbank.org/lac/lacinfoclient.nsf/d29684951174975c85256735007fef12/63a3f4e71ce14d2385256dc500661aaf/$FILE/Mexico%20SouthStates%20Indigenous%20Peoples.pdf. Accessed on July 25, 2007.

[283] Rodriguez Juárez ML. La necesidad de la conciencia y la socioculturización de la práctica médica. In Comité Promotor por una Maternidad sin Riesgos (ed.), *Maternidad sin riesgos en Guerrero*. México DF: Comité Promotor por una Maternidad sin Riesgos en Guerrero, 1996, p. 144-148.

[284] Ortiz Montealegre R, Mateos Díaz A. La maternidad en las mujeres indígenas de la montaña de Guerrero. In Comité Promotor por una Maternidad sin Riesgos (ed.), *Maternidad sin riesgos en Guerrero*. México DF: Comité Promotor por una Maternidad sin Riesgos en Guerrero, 1996, p. 154-158.

[285] Castañeda M, Díaz D, Espinosa G, Sánchez-Hidalgo D, de la Torre C. *La mortalidad materna en México: cuatro visiones críticas*. México, DF: Fundar, Centro de Análisis e Investigación, A.C.; K'inal Antzetik, A.C.; Foro Nacional de Mujeres y Políticas de Población; Universidad Autónoma Metropolitana, Unidad Xochimilco; Coordinadota Nacional de Mujeres Indígenas, 2004.

[286] Módena ME. *Madres, médicos y curanderos: diferencia cultural e identidad ideológica*. México, DF: Ediciones de la Casa Chata, 1990, p. 148.

[287] According to official data, of some 70 active parteras in Xochis, 43 had received biomedical training from government health staff as of October 2007. This information comes from *Censo de Parteras Tradicionales*. Secretaría de Salud del Estado de Guerrero, Subsecretaría de Prevención y Control de Enfermedades, Departamento de Salud Reproductiva, Jurisdicción Ometepec, October, 2007.

[288] According to a 1998 unpublished CIET study, 8 out of 10 women in Xochis delivered their children at home at the time, most of them assisted by a partera. Data from the MNH Project 2008 baseline shows that 6 out of 10 women had delivered their last baby at home.

many women, including those who prefer to deliver in health facilities, against the objections of most clinical practitioners, who consider it dangerous to the foetus, particularly in the last weeks before delivery.[289] In chapter 6, I discuss how people make sense about these practices and what discourses they draw from in the process.

1.1.4.2. Safe motherhood discourse in rural Mexico

Global safe motherhood discourse considers that a safe pregnancy is a closely monitored one, and that the only safe delivery is the one taking place in medical facilities with biomedically-trained staff.[290] And although there are discursive nods to women's birthing culture, this cultural component is overridden by "optimum safety" concerns.[291] Experts routinely link home deliveries assisted by TBAs -a core component of indigenous birthing cultures in the Americas- with unsafe practices and poor birth outcomes.[292]

From my first visits to communities with majority of indigenous population, in July 2006, it became apparent that institutionalization of pregnancy and childbirth is commonplace in health staff discourse in rural Guerrero.[293] Doctors and nurses request indigenous women to deliver in hospitals and health centres, where they are usually alone, without material and emotional support, leaving a disrupted family behind –sometimes for many days. They must expose themselves and allow men to touch them, coming from a culture with little physical contact between mothers and sons, fathers and daughters, brothers and sisters. They must deliver while lying in bed, legs spread open, exposed to strangers, and let practitioners penetrate them with their hands. They are bathed after delivery, when

[289] Data from the SM 2008 Project baseline survey.
[290] WHO 2005, p. 68-71. For a detailed discussion on this topic, see chapter 2.2.3 (p. 71-75) and 2.2.4 (p. 75-79).
[291] Ibid, p. xv.
[292] In March 2009, the Secretary of Health of Guerrero State went on the record saying that most maternal deaths in the mountains of Guerrero happened when women delivered assisted by untrained parteras. See Rodriguez Montes J. Muertes Maternas en La Montaña, por intervención de parteras, achaca Barrera. *La Jornada Guerrero*, March 6, 2009. Acapulco, Guerrero: Editora de Medios de Guerrero S.A. Available at http://www.lajornadaguerrero.com.mx/2009/03/06/index.php?section=sociedad&article=010n1soc. Accessed on May 4, 2009.
[293] In July-August 2006, I personally interviewed CIET colleagues, Amuzgo community health promoters, traditional birth attendants, nurses, primary care technicians, social workers, medical practitioners, and government health officials in Xochis, Ometepec, Acapulco, and Chilpancingo, the capital of Guerrero state. I have kept the anonymity of most of these sources.

they believe bathing can bring them harm. Health personnel do not give them back the placenta and the umbilical cord for burial, a centuries-old custom shared by many indigenous peoples, which helps them through postpartum stress, as they believe it is tied to the wellbeing of their children[294]. Key informants in the communities explained that many women are also reluctant to go to hospitals for fear of episiotomies and c-sections.

Language barriers are a strong deterrent against the use of government health centres, and no less of a problem when people get there. Most indigenous patients have little if any knowledge of Spanish, which makes it difficult for them both to express themselves –if they do at all- and to understand what doctors and nurses tell them. Even when they know some Spanish, this means little in terms of true mutual understanding. Health staff are mostly ignorant of indigenous terms and cultural meanings related to health and illness. In this context, doctor-patient interaction is extremely one-sided. At the time of fieldwork, ad-hoc translators, ranging from untrained health personnel to other patients and neighbours of health centres, mediated communication during clinical consultation.[295] The director of the hospital in San Luis Acatlán, a nearby district with the highest maternal mortality rate in Guerrero at the time[296], summed up the situation: "People from around here can translate better than our health staff." The permanent rotation of medical practitioners in community health centres further blocks any deep communication, in sharp contrast with the close, long-term relationship between women and *parteras*. All health workers interviewed in Xochis and Ometepec, where the government district headquarters are located, brought up these obstacles to their work.

Meanwhile, poor women must attend prenatal screening and health chats to keep social benefits and scholarships, as part of government programs, like the nationwide *Programa*

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[294] This particular concern is also linked to women's unwillingness to give birth in medical facilities in Mexico, Peru, and Colombia. Cosminsky S 1986, p. 81.

[295] According to the MNH Project 2008 baseline, only two government health workers delivered group prenatal chats in Amuzgo language in health care units at the time; two other workers gave these chats in Spanish, and four used translators. By late 2008, there were trained translators in some health services.

[296] Secretaría de Salud del Estado de Guerrero-Programa Arranque Parejo en la Vida. *Reforzamiento de la Vigilancia Epidemiológica de la Mortalidad Materna y el Embarazo de Alto Riesgo*. Power point presentation, 2006.

Oportunidades, the main anti-poverty program of the Mexican government[297]. Government health centres hand out standard safe motherhood leaflets in Spanish, when many patients are illiterate. As I will show in chapter 4, these materials reveal the influence of biomedical thinking, mainstream safe motherhood discourse, and cognitive behavioural approaches to health risk. These models address individuals as rational decision-makers, in full command of their lifestyle choices, who are ultimately responsible for their own bodies and wellbeing, as well as those of their children –a prevailing public health ideology in most Western countries[298] [299]. This focus on lifestyles and people's behaviour tends to blur social, cultural, and community dimensions of health and disease. They also perpetuate inequalities by casting blame on subordinate and stigmatized groups[300] [301], such as indigenous peoples, while "drawing attention away from the structural causes of ill health".[302]

1.2. Central research problem

The Guerrero MNH Project was an excellent opportunity to explore two closely interconnected issues. On the one hand, I sought to understand how *maternidad sin riesgo* –the very core of government discourse- reflected key dimensions of public health risk discourse (detailed and discussed in chapter 2) and how these components interact with indigenous discursive construals at the community level, in an intercultural context. On the other hand, I have explored how these dimensions and interactions reflect, challenge or reproduce power structures and relations in this same context. Focusing on the first of these two issues may contribute to healthy maternal outcomes that take into account indigenous views and practices. Emphasis on ideological implications can reveal how discursive constructions bear upon power relations between dominant and dominated groups -women in particular.

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[297] For details on this program, see Oportunidades. México, D.F.: Secretaría de Desarrollo Social. 2010. Available at http://www.oportunidades.gob.mx
[298] Joffe H 1999.
[299] Lupton D 1999, p. 17-24.
[300] Douglas M 1992.
[301] Joffe H 1999.
[302] Lupton D 1993, p. 433.

1.3. Research objectives

1.3.1. General objective

To explore key dimensions and ideological implications of safe motherhood discourse (*maternidad sin riesgo*, in Spanish) and related discourses in government communication products targeting pregnant women, and in transcriptions of interviews with a sample of pregnant women, recent mothers, and men[303], and with other relevant stakeholders in the municipality of Xochistlahuaca, Guerrero state, Mexico.

1.3.2. Specific objectives

I have tried to answer the following research questions:

-How do key dimensions of health risk discourse and safe motherhood discourse, as discussed in chapter 2, feature in government maternal health communication and in transcriptions from interviews with pregnant women, recent mothers, and men in Xochis?

-Which other relevant discourses do our sources use to make meaning about maternal and perinatal health?

-What intertextualities and interactions can be traced between the different discourses?

-What are the ideological implications of these discourses and interactions (i.e., are power relations between the different stakeholders challenged or reproduced)?

-In particular, how do our sources construe the role of indigenous women based on these discourses?

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[303] Pregnant women and recent mothers are key subjects in the definition of safe motherhood (see 2.2.1 and 2.2.2 below, p. 64-71, for a detailed discussion on this topic) and the main target audience of government safe motherhood discourse in Mexico. Their husbands are also targeted through communication products and campaigns, as well as government health services, as I show in chapters 5 and 6.

1.4. Methods

I have explored different texts –a perinatal card, an educational video, and interviews with men and women from the communities and with other stakeholders- looking for key dimensions of health risk discourse and safe motherhood discourse, as identified in the literature (see chapter 2), as well as other discursive dimensions and categories related to risk in pregnancy, childbirth and the immediate postpartum period, as they emerged from the literature on indigenous views and practices in Guerrero[304] [305] [306] [307] and other regions of Mexico[308] [309] [310] [311] [312] [313], and from interviews with key informants from relevant orders of discourse –e.g., religion, education, traditional community health care, etc.

I worked from an integrative critical discourse analysis (CDA) approach, articulating the theoretical and methodological framework around Fairclough's three-dimensional view of discursive events as texts, discursive practices, and sociocultural practices, which I found particularly useful to account for the dynamic interaction between language and other aspects of social life.[314] [315] I also drew from Hodge and Kress' reworking of

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[304] Flores Arellano AN. Salud reproductiva de las mujeres indígenas: Los saberes de las Amuzgas en Guerrero. In Comité Promotor por una Maternidad sin Riesgos (ed.), *Maternidad sin riesgos en Guerrero.* México DF: Comité Promotor por una Maternidad sin Riesgos en Guerrero, 1996, p. 96-102.
[305] Ortiz Montealegre R, Mateos Díaz A 1996.
[306] Gutiérrez Ávila MA 1997.
[307] López Guzmán B 1997.
[308] Molina Rosales DO. *Percepción del riesgo durante el parto en los Altos de Chiapas.* Tapachula, Mexico: El Colegio de la Frontera Sur (Ecosur), 2002. Available at http://www.ecosur.mx/Difusi%F3n/ecofronteras/ecofrontera/ecofront15/pdf/percepcion-riesgo.pdf. Accessed February 25, 2007.
[309] Módena ME 1990.
[310] García-Barrios C, Castañeda-Camey X, Romero-Guerrero X, González-Hernández D, Langer-Glas A. Percepción de las parteras sobre factores de riesgo reproductivo. *Salud Pública de México* 35(1):74-84, 1993. Available online at http://www.insp.mx/salud/35/351-8s.html. Accessed July 23, 2006.
[311] Espinosa Damián G. Doscientas trece voces contra la muerte: mortalidad materna en zonas indígenas. In Castañeda M, Díaz D, Espinosa G, Sánchez-Hidalgo D, de la Torre C. *La mortalidad materna en México: cuatro visiones críticas.* México, DF: Fundar, Centro de Análisis e Investigación, A.C.; K'inal Antzetik, A.C.; Foro Nacional de Mujeres y Políticas de Población; Universidad Autónoma Metropolitana, Unidad Xochimilco; Coordinadota Nacional de Mujeres Indígenas, 2004, p. 161-238.
[312] López Austin A. *Cuerpo humano e ideología: las concepciones de los antiguos nahuas.* México, D.F.: Universidad Nacional Autónoma de México, 1980.
[313] Coronado G. Competing Health Models in Mexico: An Ideological Dialogue between Indian and Hegemonic Views. *Anthropology & Medicine* 12(2):165-177, 2005.
[314] Fairclough N 1992. I discuss these and all other theoretical and methodological concepts in detail in chapter 3.

hegemony and ideological complexes, which allowed for a nuanced articulation and re-articulation of power relations.[316] [317] Lupton's work on contemporary health risk discourse –and pregnancy risk- further anchored CDA theory within a solid body of research. I provide a detailed discussion of the theoretical and methodological framework in chapter 3.[318]

1.5. Contents

In this Introduction, I have discussed the context and rationale for the proposed research, including reasons for using discourse analysis to look into safe motherhood in an intercultural context. I have also analyzed the disproportionate impact of maternal mortality among indigenous populations, and the implications of mainstream safe motherhood discourse and policies to prevent maternal deaths and disabilities. Drawing from the literature, key informant interviews, personal observations, and data from the MNH Project, I have described the main social, economic, political, and health circumstances in the municipality of Xochis, and I have discussed core traits of the Amuzgo culture. I have also laid out the central research problem and the research objectives.

In chapter 2, I explore the connections between health risk discourse and safe motherhood discourse from a global perspective, as well as their potential interactions with indigenous views and practices of pregnancy and childbirth. For this, I draw on literature from different disciplines, including sociology, anthropology, epidemiology, medical sciences, and health communication. I analyze health risk discourse as a core component of contemporary public health communication, including safe motherhood discourse. I outline the emergence, development, and consolidation of safe motherhood

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[315] Outside the order of discourse of public health, there are many other orders of discourse and discourse types challenging the hegemonic pretensions of government and biomedical views of health, disease, safety, risk, life and death. This state of discursive collision and collusion opens many opportunities for change within and between different domains of social life.
[316] Hodge R, Kress G 1988.
[317] Hodge R, Kress G 1993.
[318] See chapter 3.5 and 3.6, p. 112-137.

discourse and policies as the main drivers behind global and national initiatives to curb maternal mortality and improve maternal health over the last two and a half decades.

To better articulate key dimensions of safe motherhood discourse with indigenous views in Xochis, I discuss indigenous traditions regarding motherhood and maternal health in Mesoamerica, including the knowledge and practices of the Amuzgo people. I pay special attention to ideological implications of public health risk discourse, safe motherhood discourse, and pre-Columbian views of the human body in Mesoamerica, as they emerge from the literature. In particular, I point to the profound consequences that maternal health discourses have always had for the production and reproduction of power relations in both indigenous and western societies. This chapter concludes with a brief summary of key dimensions of public health risk discourse and global safe motherhood discourse that feature prominently in the analysis of safe motherhood materials and interviews with government health staff, pregnant women, and other social actors in Xochis.

Chapter 3 contains a detailed discussion of the theoretical and methodological framework, including definitions of key concepts and components. I start with an overview of discourse analysis as a specific approach to qualitative research and I argue for its relevance to address the main research problem. I then outline an analytical framework that links discourse analysis with social critique, drawing from key tenets of CDA and social semiotics, such as the notions of ideology, hegemony and ideological complexes, with an emphasis on the uneasy balance between stability and change. More to the point of my research subject, I explain how I have used these core concepts to delve in the ideological effects of health risk discourse and safe motherhood discourse in an intercultural context.

In the same chapter, I elaborate on the interactions between different components of the theoretical framework and between theory, methodology, and data. In particular, I summarize Fairclough's three-dimensional model for the analysis of discursive events as texts, discursive practices, and sociocultural practices. I discuss how this model accounts

for the dynamic interaction between language and other aspects of social life, and how I have used it in my work.

The chapter includes an overview of the research process and the links between this doctoral dissertation and the overarching CIET safe motherhood and newborn health research initiative where it is framed. I provide a detailed account of my activities as member of the CIET research team and I explain how my own research drew from and contributed to this multi-stakeholder effort. Finally, I discuss the selection of the corpus, including government health promotion materials and interviews with community participants and key informants. I describe the process of questionnaire design, fieldwork, translation, and transcription of interviews, and I go over some specifics of textual analysis for different kinds of texts.

In chapters 4 and 5, I use the theoretical and methodological framework to make a detailed analysis of two representative texts –a perinatal health card and a video film for the prevention of pre-eclampsia and eclampsia- that were part of government safe motherhood communication campaigns in Xochis between September 2006 and April 2008. These texts targeted pregnant women and, to a lesser extent, other key actors –such as husbands- and the general population. Both of them have circulated widely and are equally illustrative of government discourse in Xochis, the Ometepec health district, and Guerrero state at large. I will show how these texts display key dimensions of safe motherhood discourse -and health risk discourse as an overarching category- and other dimensions related to health and social equity, which are specific to maternal health discourse in Mexico, as well as co-opted elements from traditional orders of discourse.

In chapter 6, I explore how indigenous women and men use key dimensions of government safe motherhood discourse, as well as elements from different orders of discourse (e.g., family, community, religion, traditional health care) to make meaning in relation to pregnancy, childbirth, and puerperal and newborn care. I also analyze selected segments from interviews with other stakeholders, such as government health officials, government health staff, and religious leaders, to stress certain discursive influences and

articulations, and to fill out the overall discursive picture that feeds into the ideological complex of maternal health and motherhood. In chapter 7, I discuss the evidence from chapters 4-6 with regard to the theoretical framework, key elements from the literature, and the objectives of my research. I also cast a reflexive look on the project, with a focus on successes, shortcomings, and suggestions for further research.

1.6. Conclusion

This is a study of government and indigenous discourses on safe motherhood and maternal health in a remote rural community, with majority of indigenous population. The project is part of a community-led research effort to narrow the distance between indigenous and government views of safe motherhood, and thus help to reduce maternal mortality and morbidity without marginalizing indigenous cultures.

I have looked into the use of safe motherhood discourse and other discourses related to maternal and perinatal health by government sources, pregnant women, and men from the communities, trying to understand their interactions and how they can foster or hinder healthy maternal outcomes. I have also analyzed the ideological implications of these discourses –in terms of their potential impact on power relationships and the situation of indigenous women.

Addressing the proposed research problem in this way should help to elaborate intercultural safe motherhood initiatives to reduce maternal mortality and morbidity rates that take into account the views and priorities of indigenous populations, do not impose interests and criteria from dominant groups, and do not contribute to reproduce unequal power relations in Guerrero state, Mexico. The findings should also be of use to better address these issues with indigenous populations across Latin America.

Finally, data from this study should also reveal how indigenous women and men handle and reshape multiple discursive pressures from government and community sources, concerning maternal health and their role in society.

Chapter 2: Literature review

In this chapter, I will explore the connections between health risk discourse and safe motherhood discourse, as well as their interaction with indigenous views and practices of pregnancy and childbirth, drawing on literature from different disciplines, including sociology, anthropology, epidemiology, medical sciences, and health communication.

I will start by analyzing health risk discourse as the most salient trait in contemporary public health communication. I will also explore the connections between risk discourse and safe motherhood discourse, which have been at the very heart of global safe motherhood initiatives and national policies to curb maternal mortality and improve maternal health.

To facilitate a better understanding of these articulations and their impact on public health communication worldwide, I will discuss how maternal health and maternal mortality took centre stage as international public health issues in the late 1980s, and how safe motherhood discourse gained global status and became the overarching semantic field for maternal health policies at global, regional, and national levels for two decades.

In Mexico, the federal government put into practice top-down safe motherhood policies across the country since the early 1990s, reaching as far as remote rural villages with majority of indigenous population. This process provides an excellent opportunity to look into the impact of global and national safe motherhood discourse on the views, practices, and social relations of indigenous minorities. For this purpose, I will give an overview of indigenous traditions regarding motherhood and maternal health in Mesoamerica, including the knowledge and practices of the Amuzgo people. In particular, I will consider potential connections between key dimensions of health risk discourse and safe motherhood discourse on the one hand and indigenous views of pregnancy and childbirth on the other.

I will pay special attention to ideological implications of public health risk discourse, safe motherhood discourse, and pre-Columbian views of the human body in Mesoamerica. As a result of this analysis, I will show that maternal health discourses and policies have always had profound consequences for the production and reproduction of power relations, and I will set the stage for the specific analysis of these effects as safe motherhood discourse interacts with indigenous views and practices in Xochis.

The chapter will conclude with a brief summary of key dimensions of public health risk discourse and global safe motherhood discourse that feature prominently in the analysis of safe motherhood materials and interviews with government health staff, pregnant women, and other social actors in Xochis.

2.1. Why health risk discourse

2.1.1. The semantic worlds of risk

Risk discourse in the public sphere is one of the defining traits of our times.[1] [2] [3]. Risks are assessed, framed and labelled by experts, and then magnified or minimized by mass media and the scientific and legal professions.[4] [5] The resulting discursive constructions help to shape the way we perceive, understand, and deal with risks[6]. Contemporary public health communication[7], too, is driven by this pervasive, expert-led idea of risk,[8] [9]

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[1] Giddens A. *Modernity and self-identity*. Cambridge: Polity; 1991.
[2] Beck U. *Risk society: towards a new modernity*. London, Newbury Park and New Delhi: Sage Publications; 1992.
[3] Beck U. *World Risk Society*. Malden, MA: Blackwell Publishers Inc., 1999.
[4] Douglas M. *Risk Acceptability According to the Social Sciences*. New York: Russell Sage Foundation; 1985.
[5] Beck U 1992, p. 23.
[6] Lupton D. *Risk*. London and New York: Routledge; 1999, p. 15
[7] I define "public health communication" as mainstream national and international communication efforts aiming to prevent and control health problems that have been defined as relevant from a population standpoint by health experts, international health agencies, and government health agencies. Government agencies, public health staff, social workers, NGOs, community leaders, and the media, among others social actors, are frequently engaged in public health communication. Academic publications are outside the domain of public health communication, but they heavily influence public health policy and practice.
[8] Petersen A, Lupton D 1996, p. 18-22.

understood as "the probability of an adverse event and the magnitude of its consequences"[10].[11]

There are two different semantic worlds in this definition. One of them is numeric, and "probability" and "magnitude" are key words here. Numbers rule behind the curtains of public health policies and campaigns. Mainstream health risk discourse stems from epidemiological estimates of population and individual risk[12] that put some people at higher or lower risk of an unfavourable outcome than others –e.g., the odds of getting HIV/AIDS when using or not using condoms; the odds of getting a certain type of cancer during our lifetime. The scope and severity of public health problems are often expressed in terms of frequencies, proportions, and rates.[13]

In many cases, these numbers are semantically qualified to provide an interpretation, to tell us what they mean. Terms like "high prevalence"[14], "high incidence"[15], or "high rate" contain a common marker that indicates the presence of a certain health problem and calls our attention to it.[16] Moreover, frequencies, proportions, rates and even odds are often framed and presented as "facts" –in other words, as pieces of reality.[17] The prestige

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[9] Geist-Martin, P, Berlin-Ray E, Sharf B. *Communicating Health: Personal, Social and Political Complexities*. Belmont, CA: Wadsworth Publishing:, 2003, p. 23-25.

[10] Rayner S, Cantor R. How fair is safe enough? The cultural approach to societal technology choice. In Lofsted R, Frewer L (eds.), *The Earthscan Reader in Risk & Modern Society*. London: Earthscan Publications Ltd, 1998, p. 91-99, quote on p. 92.

[11] Although from a statistical point of view it could be argued than risk analysis involves the likelihood of certain outcomes (regardless of whether they are "good" or "bad"), the notion of risk is now almost universally used, particularly in public health communication, to indicate probabilities of harm. See, for instance, Douglas M 1985, p. 20, and Lupton D 1999, p. 8-10.

[12] Population risk is the likelihood of something happening to a given population group or subgroup. Individual risk is the likelihood of something happening to an individual.

[13] Rychetnik L, Hawe P, Waters E, Barratt A, Frommer M. A glossary for evidence based public health. *Journal of Epidemiology and Community Health* 58:538-545, 2004, p. 540.

[14] Prevalence is the proportion of people in a population who have a certain health condition at a given time. Most crucially, from a risk perspective, it is also used to define "at risk" groups –for instance, those groups where the prevalence of the same condition is higher than for the overall population- and for clinical assessment of individual cases. Ibid, p. 541.

[15] Incidence is the number of new events –e.g., a disease- in a population over a period of time. Ibid, p. 540.

[16] An expression like "high rate of maternal mortality" indicates how we should read a certain proportion; at the same time, it establishes maternal death as a serious problem in the public agenda. A "high rate of maternal mortality among indigenous women" goes a step further and points to a serious problem among a specific group of people –who now happen to be "at risk".

[17] Scientific reality, says Beck, "has sublimated into data that are produced". These facts "are nothing but answers to questions that could just as well have been asked differently, products of rules for gathering and

accorded to numerical evidence in scientific enquiry –and the role of scientific enquiry in the creation of knowledge in modern times- certainly contributes to this effect. In other words, the use of numbers –both to generate and communicate knowledge- seeks to confer authority to public health discourse:

> [Statistics are] immigrants into ordinary speech outside of their original context. They are used to generate the semblance of a referent which may only be a pseudo-reality, but which at the same time gives the impression of something very important and obvious, and which the layman cannot understand without an explanation by experts.[18]

This numeric nature of modern risk is hardly a novelty, but its claim as the pre-eminent, all-encompassing way of understanding risk and responding to it only goes back a few decades. Skolbekken, who detected a rapid increase in the number of medical and epidemiological articles on health risks between 1967 and 1991, says this trend has epidemic proportions, in terms of "prevalence" and "contagiousness" within the medical community.[19] The author contends that this process is linked to changes in science and technology that make scientists believe that risks can only be identified by science and that they can be best handled and understood in terms of statistical probabilities.[20]

This numeric, probabilistic component of risk coexists with a sense of impending danger –the "adverse event and the magnitude of its consequences". Douglas says that risk is a modern redefinition of danger in terms of probabilities and scientific calculation, insofar as the new wording –and the scientific aura that comes with it- shows danger as subject to calculation, prevention and control –in other words, to human agency and rational

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omitting. A different computer, a different specialist, a different institute –a different 'reality'." Beck U. *Risk society: towards a new modernity*. London, Newbury Park and New Delhi: Sage Publications, 1992, p. 166.

[18] Duden B. Population. In Wolfgang Sachs, ed., *The Development Dictionary: A Guide to Knowledge as Power*, p. 146-157. London: Zed, p. 149. Quoted in Roth Allen D. 2002, p. 38.

[19] Skolbekken, JA. The risk epidemic in medical journals. *Social Science and Medicine* 40: 291-305, 1995, p. 296. The author defines "contagiousness" in terms of "the increase in the number of illnesses/diseases that are subject to some kind of risk approach".

[20] Ibid, p. 297.

behaviour narrowly defined from a cognitive paradigm.[21] Joffe, too, portrays the public health notion of risk as "danger dressed in modern clothes".[22]

Every bit as important in the surge of risk as an explanatory model and an action-oriented idea in public health is the underlying belief that we –rather than external forces- are in control of our lives.[23] The health risk approach is born of these twin certainties: *we can turn risks into numbers and we can do something about them.* Health promotion, with its focus on risk factors and disease prevention, is a major vehicle for these ideas.[24] Risk analysis, risk assessment, risk communication, and risk management have flourished since the late 1970s, as fields of research and practice, with their eyes set on people's perceptions of and responses to risk.

Douglas points to some critical issues in this expert-led definition of risk that may help explain the frustration of risk experts when people do not react as they expect –and this happens more often than not. One of these issues has to do with the numeric world that inhabits the definition of risk. Risk experts unreasonably expect people to evaluate risks as scientists do: "The assessment of combined probabilities of an occurrence and the magnitude of its consequences is too specialized a form of calculation to be helpful in thinking of the ordinary person's perceptions," says the author.[25] Another major problem plagues the semantic world of "danger" and "adverse events", insofar a risk experts, policy-makers, and governments define hazards as "recognized causes of death or loss", leaving out people's own definitions of wha t they perceive as threats in their lives, what is at stake in different circumstances, and their own evaluation of competing risks.[26] [27]

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[21] Douglas M 1992, p. 14 and 24-25.
[22] Joffe H 1999, p. 4.
[23] Stolbekken JA 1995, p. 297.
[24] Closely following Petersen and Lupton, I define health promotion as a body of public health strategies, activities and techniques, including health education and social marketing, which have been increasingly concerned "with identifying and changing 'unhealthy' or 'risky' lifestyles" as defined by governments, international agencies, and health experts. See Petersen A, Lupton D 1996, p. 15.
[25] Douglas M 1985, p. 24-25.
[26] Ibid, p. 26.
[27] In the context of this research, this would be the case with culturally defined threats and causal explanations, such as frights, cravings, and loss of the *nahual*, which I discuss below.

Safe motherhood policies have neglected alternative views of maternal health risk – particularly, women's own views and experiences. Based on evidence from rural Tanzania, Roth Allen contends that

> ... official definitions of risk do not always accurately reflect the realities of women's experiences of pregnancy and childbirth; that these incomplete or inaccurate definitions of risk have sometimes led to the development of inadequate solutions for reducing maternal mortality in Tanzania; and that some of the solutions proposed as a result of relying exclusively on official definitions are, in turn, perceived as risks themselves by local community members.[28]

2.1.2. Risk factors, risk identities, and self-control

Epidemiological analysis ushers the notion of risk into clinical practice and public health discourse. In the past, epidemiological risk tended to be directed to environmental conditions, such as water, air quality and sanitation[29], or to viruses and bacteria that penetrated the organism[30]. Nowadays, there is a focus on *lifestyle risks* –which are framed as the result of our choices and therefore subject to self-control[31]. Lupton explains this trend as follows:

> Epidemiological risk factors are now often used to exhort individuals to engage in self regulation. Thus, for example, if a certain population group is identified through statistical calculations as being at "high risk" of developing heart disease, based on such attributes as gender, age and diet, then members of that group are then encouraged to deal with the risk factors themselves. This process does not necessarily involve consultations and examination of individuals by health professionals, but rather often takes place through mass-targeted media campaigns which rely on individuals identifying themselves as being "at risk" and taking steps voluntarily to reduce their exposure to risk. This is an

[28] Roth Allen D 2002, p. 9. The author defines as "official" risks "the various factors that have been identified by international and national policymakers as posing risks to women's survival during pregnancy and childbirth".
[29] Lupton D. 1999, p. 97.
[30] Ogden J. Psychological Theory and the Creation of the Risky Self. *Social Sciences & Medicine* 40(3):409-415, 1995, p. 412.
[31] Lupton D 1993, p. 427.

> example of "government at a distance", for it relies upon voluntary participation in technologies of self-surveillance and a sense of self-responsibility rather than direct interventions.[32]

In our daily lives, we are bombarded with these risk appeals. As Ogden points out, "health promotion encourages safe sex, healthy eating, screening, smoking and drug abstinence and alcohol moderation."[33] This happens because, from an epidemiological standpoint, unsafe sex, unhealthy eating, and substance abuse are risk factors for major health problems. A risk factor is basically "something that increases a person's chances of getting a disease".[34] For instance, we "know" that smoking increases our chances of getting lung cancer; and we "know" that driving without a seat belt increases our chances of getting injured or dying as a result of a car crash. But, how do we "know" these things? In part, because public health discourses about cancer and road safety, based on evidence from epidemiological risk analysis, gradually burrow their way into common sense. Of course, there is power –and trust- involved in this process: We have invested risk experts and public health spokespersons with the authority to call our attention to health risks and ways of dealing with them. In turn, these people "know" because they have learned and accepted the findings from epidemiological research. And epidemiology is the established source of knowledge in contemporary public health.

By the same token, and based on statistical analysis of risk factors in large population samples, certain population groups –e.g., people who are overweight and have high blood pressure- are deemed at risk of developing certain diseases –e.g., diabetes and heart disease. Of course, these are not the only people who can have these health conditions; in strict epidemiological terms, they are at *higher* risk than people with lower weight and lower blood pressure. As a result of the epidemiological analysis of different risk factors, we are all labelled at "high", "average" or "low" risk for these maladies. Such labels then

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[32] Lupton 1999a, p. 97

[33] Ogden J, 1995, p. 413.

[34] *Definition of risk factor.* MedicineNet.com. 1998. Available at http://www.medterms.com/script/main/art.asp?articlekey=5377 Accessed November 13, 2008. I have chosen to draw this definition from a well-known site dedicated to "knowledge translation" and popular diffusion of medical information, because it is part of public health risk discourse, as I have defined it above.

emerge in the public sphere through health promotion campaigns that seek to make us *aware* of the risks and how we should keep them under control. We are hailed –in althusserian terms, which I discuss below- and identified as belonging to a certain at-risk group and, therefore, of being ourselves at risk.

Indeed, mankind had been exposed to many of these threats before public health discourse came into existence, but we either did not "know" –in health communication jargon, we were not "aware"-, or if we knew, we did not know what made us more prone to –what were the risk factors for- this or that health threat. *Nor were we defined in terms of what we were at risk of* –in other words, being at risk was not a part of our self and our social identity. Nowadays, it certainly is.[35]

2.1.3. Biases and limitations in health risk communication

Over the years, there has been mounting criticism of risk estimates in public health communication. Rockhill questions the very notion of individual risk, since "a risk factor is a probabilistic concept that applies to an aggregate of individuals, not to a specific individual".[36] The same, says the author, happens with epidemiological –probabilistic- notions of "cause" and "prevention". In advocating for a population-base approach to preventive medicine, she states:

> The misleading message that an individual will prevent a particular disease by altering a particular behavior or exposure (and its converse, that an individual will develop a particular disease if such behavior is not changed) has unfortunately been widely conveyed. Rather, risk factor findings, by necessity couched in probabilistic language, call for aggregate-level policies: if exposure can be eliminated for (say) 1000 individuals, 5 cases (for example) will be averted over a 10-year time period.[37] [38]

[35] Being at risk of something has become part of our identity in the "risk society". These identities have very concrete social implications –each time smokers must tick a "smoker" box in an application form, they are not only made aware of their at-risk identity, but they also know that someone in a position of power will not be warming up to them; obese people, too, may already be feeling like this.
[36] Rockhill B. The privatization of risk. *American Journal of Public Health* 91(3):365-368, 2001, p 365.
[37] Ibid, p. 366.

Rockhill's critique points to statistical, philosophical, and communicational problems for the use of population risks to shape and project individual risks. The problem deepens for certain public health issues, such as maternal mortality, because maternal deaths are rare events. In other words: How can risk-based and risk-oriented safe motherhood discourse connect with people's perception of risk in communities where there have been very few –if any- maternal deaths throughout the years?[39]

Challenges to the communication of statistical risk cut across borders and ethnic groups. For starters, it is not easy to grasp the idea of "degrees of risk" (high, medium, low); some people think in absolute terms of "good" or "bad", instead.[40] People may also read risk severity instead of probability.[41] Equally crucial, people tend to misinterpret risk factors as *causes* of disease or death –in epidemiology, smoking is a lead risk factor for and not a cause of lung cancer; obesity is a risk factor for and not a cause of heart disease. It has also been well documented that people may or may not consider statistical evaluations of risk when making individual and collective decisions.[42] And even when they do, they often do not act as governments and experts would expect them to, since alternative rationalities, "often portrayed by experts as inaccurate or irrational",

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[38] This population-based approach to statistical language points to a collective dimension of risk prevention. It can resonate with planners and policy makers, but not with individuals, since it would be impossible, following the same example, to tell them whether they would be among the five cases that would be free of the problem.

[39] Kaufert P, O'Neil J 1993, p. 44. The authors capture the essence of these contrasting –and conflicting- views of maternal risk in a dialogue between a physician and an Inuit woman in northern Canada.

[40] Andersson N, Roche M, Laucirica J. *SEPA: Socializing Evidence for Participatory Action.* [In preparation, p. 62.] In 1994, health researchers working in Nepal discussed in focus groups with rural women the risk of diarrhoea in relation to water quality. None of the women understood how there could be varying degrees of safe water and therefore varying degrees of risk. They felt that water was either safe or not safe.

[41] Rothman AJ, Kiviniemi MT. Treating people with information: an Analysis and Review of Approaches to Communicating Health Risk Information. *Journal of the National Cancer Institute Monographs* 25:44-51, 1999, p. 46. For instance, instead of smokers being five times more likely to get lung cancer than non-smokers, we may understand that lung cancer is five times worse for smokers than for non-smokers.

[42] Fischhoff B. Risk perception and communication unplugged: twenty years of process. In: Lofstedt R and Frewer L, eds. *The Earthcan Reader in Risk & Modern Society.* London: Earthcan Publications Ltd., 1998, p. 133-145. The author observes that even when people, including experts, agree on the numbers, they may not agree on the degree of risk.

competing priorities, and personal experiences play a role in people's decisions.[43] As Douglas points out:

> A risk is not only the probability of an event but also the probable magnitude of its outcome, and everything depends on the value that is set on the outcome. The evaluation is a political, aesthetic, and moral matter. In practical life, private decisions about risk are taken by comparing many risks, and their probable good and bad outcomes. No risk item will normally be considered in isolation[44]

Social and cultural influences cannot be ignored, because they have an impact on people's identities, including risk-taking and risk-aversion attitudes and behaviours.[45] Moreover, risk perceptions and evaluations do not remain static, but shift constantly in response to changes in personal experience, local knowledge and expert advice.[46]

Public health risk communication also has a biomedical foundation. The biomedical paradigm, which dominates public health and medical practice since the mid nineteenth century, assumes that being healthy is a universal drive, focuses on biological rather than social and psychological aspects of illness, treats disease as an individual problem, invests medical practitioners with the social and institutional authority to diagnose and cure diseases, and anchors clinical and public health practice on evidence from scientific research only.[47] [48] As a result, mainstream models of health communication leave out

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[43] Lupton D 1999a, p. 111.
[44] Douglas M 1985, p. 31.
[45] Douglas M 1992, p. 102-103.
[46] Ibid, p. 113.
[47] Annandale E. *The Sociology of Health and Medicine: a Critical Introduction.* Cambridge: Polity Press, 1998.
[48] Kleinman observes that biomedicine differs from other forms of medicine because it defines nature as essentially physical, which is at the root of the split between "hard" (biological, physical, surgical) and "soft" (cognitive, narrative, experiential) knowledge and practices, the former providing the most reliable input and the best solutions. "The psychological, social, and moral are only so many superficial layers of epiphenomenal cover that disguise the bedrock of truth, the ultimately natural substance in pathology and therapy, the real stuff: biology as an architectural structure and its chemical associates. The other orders of reality are by definition questionable," says the author. Kleinman A. *Writing at the Margin: Discourse between Anthropology and Medicine.* Berkeley, Los Angeles and London: University of California Press, 1995, p. 29-31.

many social and cultural dimensions in people's understanding of health and disease and widen the gap between expert and lay evaluations of risk.[49] [50] [51]

Typically, public health communication couples risk estimates with cognitive theories of behavioural change.[52] These models assume that risk evaluation and health behaviour are the product of rational decisions made by individuals based on knowledge or awareness of risks and calculations of cost and benefit, which include perceived vulnerability and severity of the threat, perceptions of self-efficacy to take action, and subjective norms, among other behavioural constructs.[53] [54] Douglas takes issue with the social and culturally bounded notion of rationality within cognitive models of health behaviour:

> With no link between cultural analysis and cognitive science, clashes inevitably occur between theory and evidence. Since the theory is not being radically adjusted, irrationality tends to be invoked to protect the too narrow definition of rationality. So instead of a sociological, cultural, and ethical theory of human judgment, there is an unintended emphasis on perceptual pathology.[55]

2.1.4 Ideological implications of health risk discourse

The problematic nature of health risk discourse goes beyond a mismatch between expert and lay views of risk. Health risk discourse implies an attempt to impose systems of ideas, which have the potential to change people's behaviours and to challenge or reinforce power relations between different social groups. These systems of ideas are learned and exchanged through social practice and discourse, and they aspire to become

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[49] Lofstedt R, Frewer L 1998, p. 3-27.
[50] Duff C. The importance of culture and context: rethinking risk and risk management in young drug using populations. *Health, Risk & Society* 5(3):285-289, 2003.
[51] Dutta-Bergman MJ. The Unheard Voices of Santalis: Communicating About Health from the Margins of India. *Communication Theory* 14(3):237-263, 2004.
[52] Rhodes T. Risk theory in epidemic times: sex, drugs and the social organization of 'risk behaviour'. *Sociology of Health & Illness* 19:208-27, 1997, p. 209-211.
[53] Norman P, Conner M 2001 reprint, p.197-225.
[54] Rutter D, Quine L. Social Cognition Models and Changing Health Behaviours. In D Rutter and L Quine (eds), *Changing Health Behaviour*. Philadelphia, PA: Open University Press, 2002 reprint, p. 1-27.
[55] Douglas M 1985, p. 3.

"natural" components of our daily existence.[56] The process is always in state of flux, because different groups or coalitions of groups struggle to make room for their own ideologies in different institutions and social events –like pregnancy and childbirth. Certain groups obtain a temporary hegemonic position, and so do their knowledge, values, and ideas, which they try to impose through policies, legislation, and discursive strategies, until they become part of common sense.[57] This is very much the case with public health risk discourse.

The "fact-based", biomedically-oriented, individualistic discourse of risk-aversion reflects middle-class morality –and structural life conditions- in rich Western nations,[58] [59] but it has become pervasive in health risk communication worldwide. The mechanism for its dissemination is heavily top-down, and fraught with ethical implications[60] [61] and power overtones[62]. Academic experts, international health and development agencies in developed countries define what constitutes public risk and put together a discourse of risk embraced and legitimated by national governments, NGOs, and the media, among other social actors within developing countries. Joffe observes in this regard:

> Western representations of AIDS... have far wider currency throughout the world than non-Western representations do, due to the universally dominant position held by the Western mass media and by Western science itself. Dominant groups exert their control by controlling the process of representation; some representations gain greater currency than others on the world stage.[63]

In Latin America, mainstream health risk discourse has been channelled through policies, research projects, and health education and promotion campaigns sponsored by multilateral financial institutions such as the World Bank (WB) and the Inter American

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[56] I have coined this conceptual approach to ideology from a variety of sources, which I discuss in chapter 3.2, p. 102-105, in the context of the theoretical and methodological framework for discourse analysis.
[57] I follow Gramsci's conception of hegemony, which I discuss in more detail in chapter 3.3, p.105-109.
[58] Førde OH 1998, p. 1155-1158.
[59] Lupton D 1995, p. 18 and 53.
[60] Guttman N 2000.
[61] Guttman N, Salmon CT 2004.
[62] Førde OH 1998
[63] Joffe H 1999, p. 29.

Development Bank (IADB), international health agencies such as the Pan American Health Organization (PAHO), and government and development agencies in the United States, Canada, and Western European countries.[64] This trend has been reflected in safe motherhood discourse, which I discuss below, as governments from developing nations –like Mexico in our case- import global policies and characterizations of risk, including discursive constructions of at-risk groups and individuals, and use them in public health practice across ethnic and cultural groups within their own borders.

The ideological workings of public health risk discourse are manifold. Health risk discourse interpellates –hails- us in the sense coined by Althusser[65] [66], as subjects of public health definitions, values, and priorities. In our case, as I will show in chapters 4 and 5, it labels and hails pregnant women -particularly indigenous pregnant women- as being at risk and bearing responsibility for looking after themselves and their babies, and for keeping the threat of maternal and perinatal mortality under control. In public health risk discourse, the "at-risk" individual is himself or herself at risk, but he or she is at the same time *a threat to others* –as has been documented with regards to HIV/AIDS[67]. This interpellation happens in the public sphere, often in the shape of *risk awareness* campaigns –where awareness entails not only knowing about a certain risk, but rather seeing it and reacting to it *as risk experts and public health officials would want us to.*[68]

[64] Fox E, Coe G. *Teorías del comportamiento y comunicación social. ¿Hacia dónde nos llevan?* Bilbao, Colombia: La Iniciativa de la Comunicación, 2001, last updated May 2002. Available online at http://www.comminit.com/en/node/150560. Accessed November 10, 2008.
[65] Woodward K. The Statistical Body. In Coupland J, Gwyn R (eds), *Discourse, the Body, and Identity.* New York, NY: Palgrave MacMillan, 2003, p. 225-245, reference on p. 226.
[66] Althusser L 1971, p. 170-176. Althusser formulated the concept of interpellation to describe the process by which ideology addresses and constitutes individuals –i.e., citizens- as subjects. The process implies identity and guilt (or at least responsibility, as is the case with health risk discourse), as when we turn around when a policeman calls our name in the street. Whenever we are interpellated, we are given a certain identity, tarnished by guilt, and we recognize ourselves in it. In practical terms, we are usually interpellated as members of a certain collective –e.g., gender, social, and ethnic groupings; an audience, a nation, a community, etc. By designating "at-risk" groups, public health communication makes us aware of our new identity and the responsibilities that come with it.
[67] Lupton D 1994, p. 135-138.
[68] Førde OH 1998, p. 1158.

As Lupton points out, mainstream models of health risk communication revolve, one way or another, around the ideas of individual choice, responsibility, and blame.[69] The use of population risks to shape and project individual risks contributes to this trend, also known as the privatization of risk. "This system –says Rockhill- gives primacy to personal autonomy and action and seeks to induce personal change rather than to promote social interventions that often must confront opposing interests."[70]

Power inequalities compound these effects, particularly when health communication addresses groups who do not have a dominant position in society, such as women and ethnic minorities, as is the case with safe motherhood discourse in Mexico. Based on findings from her study of interactions between women, clinical practitioners and traditional healers in Mexico, Módena observes in this regard:

> En la dimensión ideológico-cultural de estos hechos predomina la reproducción de una subalternidad vivida como responsabilidad individual y culpa, en especial frente al discurso médico, por no resolver satisfactoriamente aquello que se considera una obligación.[71]

Seen in this light, public health risk discourse also fits Foucault's notion of governmentality, or the management of modern societies through discursive strategies that encourage self-regulation of individual and population behaviours in line with medical knowledge and public health priorities.[72] "To be designed 'at high risk' compared with others -says Lupton- is to be singled out as requiring expert advice, surveillance and self-regulation".[73] Statistical analysis of populations and subpopulations is a fundamental tool in this process.

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[69] Lupton D 1993.
[70] Rockhill 2001, p. 365.
[71] Módena ME. *Madres, médicos y curanderos: diferencia cultural e identidad ideológica*. Mexico City: Ediciones de la Casa Chata, 1990, p. 121.
[72] Foucault M 1991.
[73] Lupton D 1999c, p. 61.

Indeed, the ideological implications of risk are not new. In cultural theory, danger and blame are crucial dimensions of risk across all human societies. "Anthropologists would generally agree that dangers to the body, dangers to children, dangers to nature are available as so many weapons to use in the struggle for ideological domination," says Douglas.[74] At the same time, this modern idea of risk serves the purpose of casting blame in the face of misfortune –common to all societies- with the language of scientific rationality. As Douglas points out, when it comes to explain misfortune, we all choose from a fixed menu of socially determined forms of explanation. Whichever explanation we attempt, *danger is defined to protect the public good and casting blame is the norm.*[75] [76] "Under the banner of risk reduction –she says-, a new blaming system has replaced the former combination of moralistic condemning the victim and opportunistic condemning the victim's incompetence".[77] Seen in this light, blaming seems to permeate the notion of individual responsibility, a key dimension of health risk appeals.

The privatization of risk also feeds into what Giddens calls "the reflexive project of self-identity" in post-traditional social environments[78], that is, the idea that the self is not a given, but something than can be constructed. Taking responsibility for one's life is a core component of this construction, which depends on "the progressive freeing of the life course from traditional norms, beliefs, expectations and social relations that has emerged in the wake of industrial society"[79]. On the surface, we should become more autonomous, but then the construction of the self takes an all-too-modern turn: when it comes to risk, we must rely less on personal experience and more on expert knowledge[80].

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[74] Douglas M 1992, p. 13.
[75] Ibid, p. 6.
[76] A textbook case on this interaction between public danger and blaming occurred during the outbreak of swine flu in Mexico and the United States in April and May 2009. Anti-immigrant hatred, especially directed against illegal Mexican immigrants, spread on conservative talk radio and websites in the US, at a time of lingering political debate about illegal immigration from Mexico. Bloggers and commentators blamed Mexican immigrants for carrying swine flu into the US, with some going as far as talking of terrorist plots "to bring an altered virus into Mexico, put it in the general population, and have them march across the border." See, for instance, Alexander B. Amid Swine Flu Outbreak, Racism Goes Viral. *MSNBC.com*, May 1, 2009. Available at http://www.msnbc.msn.com/id/30467300/. Accessed May 1, 2009.
[77] Douglas M 1992, p. 16.
[78] Giddens A. *Modernity and self-identity. Self and society in the late modern age.* Cambridge: Polity Press, 1991, p. 178.
[79] Lupton D 1999c, p. 67.
[80] Beck U 1992, p. 53.

Accepting expert knowledge -in any culture- entails trust, another key dimension of the risk puzzle. Lofstedt and Frewer suggest that "one of the most likely explanations for the failures of risk communication initiatives is that reactions to risk communication are not only influenced by message content but also by trust in those responsible for providing the information"[81] As Giddens observes, the combination of high awareness of risk and lack of trust in the experts who are supposed to protect us is a dominant characteristic of our times. "Abstract systems," he says, "depend on trust, yet they provide none of the moral rewards which can be obtained from personal trust, or were often available in traditional settings from the moral frameworks within which everyday life was undertaken."[82]

When it comes to health risks, trust in clinical practitioners has been the bridge between public health priorities and people's need for guidance and support. But the doctor-patient relationship gets short-circuited in government health services in remote rural villages with majority of indigenous population, like Xochis, where white or mestizo doctors are passing through –to fulfill medical residency requirements- and turnover is very high. Language barriers and competing rationalities also hinder doctor-patient communication, as husbands, elderly women, traditional birth attendants, and traditional medical practitioners come into the picture with their own views of pregnancy and childbirth. This competition for trust is ideological in nature, as it places certain groups and individuals in a position where they can provide authoritative explanations, encourage or disapprove behaviours, enact rules and regulations, label groups and individuals, cast blame or assign responsibility, and avert evil –most of this in the name of society.

Because they are defined and contested in the public sphere, contemporary risks are "particularly open to social definition and construction".[83] There is an ongoing struggle, a "competition of rationalities" between the "objective" calculations of probabilities and

[81] Lofsted R, Frewer L 1998, p. 11.
[82] Giddens A 1991, p. 136.
[83] Ibid, p. 23.

hazards in scientific discourse on the one hand and lay perceptions of risk on the other. This tension is a key feature of contemporary "risk society", because it has to do with how we want to live.[84] I have adopted this constructivist and ideological view of risk to analyze how the notion of *maternidad sin riesgo* is engineered in government discourse, how it resonates in the discourse of indigenous women and men, how these constructions influence each other, and how they impact the ideological complex[85] in the community. By fully acknowledging the social construction of risk, I also try to deal with the thorny issue of the "reality" of risk. As Mary Douglas[86] contends, some risks are very real –air and water pollution, or maternal death for that matter. But real or not, there is nothing "objective" in the way they are played out in the public sphere, where all risks are politicized and *framed* in a certain way, in order to achieve social control and legitimize a given moral order. This framing entails expert definitions, political decisions, moral judgments, and normative implications, all channelled through public health discourse. Health risks are wrapped up in words and displayed in the public sphere, where we all become members of newly created social groups and identities –we are at-risk individuals with unsolicited membership in at-risk groups. There is no denying, as Luhmann says, "that the evaluation of risk and the willingness to accept risk are not only psychological problems, but above all social problems."[87]

The present work is framed within this moderate version of social constructivism[88], also known as "weak constructivism"[89]. In other words, I do not intend to argue that there are no risks for women and their babies in pregnancy and delivery. Nor do I dispute that women –indigenous or otherwise- would be safer to deliver in a hospital setting in certain circumstances. I do state that safe motherhood and healthy pregnancy discourses carrying these ideas also have value and power implications for all those involved, including

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[84] Ibid, p. 57-58.
[85] For a definition and a discussion of this term, see chapter 3.3, p. 105-109.
[86] Douglas M 1992, p. 29.
[87] Luhmann N. *Risk: A Sociological Theory*. (R. Barrett, Trans.) (First paperback edition). New Brunswick, NJ, and London: Aldine Transaction-A Division of Transaction Publishers, 2005, p.3. English translation originally published in New York: A. de Gruyter, c1993.
[88] Fairclough N. Fairclough N. *Analysing Discourse: Textual analysis for social research.* Routledge: London and New York, 2003, p. 8-9.
[89] Lupton D 1999a, p. 28.

governments, health staff, traditional healers, traditional birth attendants, pregnant women, their husbands, and other family members. In particular, they imply an ideological construction of motherhood, since they tell women "what they should be, do and feel as mothers."[90] Therefore, the "weakness" in this approach should only be understood in epistemological terms; it does not imply that socially constructed discourse is weak by definition or that it has weak effects.

2.2. Safe motherhood as global discourse

2.2.1. Birth, rise, and consolidation of the safe motherhood agenda

The discussion about the key dimensions and ideological implications of safe motherhood discourse is closely connected to the evolution of social discourses around motherhood, pregnancy, and childbirth. The first and most crucial change on the road to safe motherhood discourse in the Western world was bringing maternal and child health from the privacy of homes into the public sphere:

> For centuries, care for childbirth and young children was regarded as a domestic affair, the realm of mothers and midwives. In the 20th century, the health of mothers and children was transformed from a purely domestic concern into a public health priority with corresponding responsibilities for the state. In the opening years of the 21st century, the Millennium Development Goals place it at the core of the struggle against poverty and inequality, as a matter of human rights. This shift in emphasis has far-reaching consequences for the way the world responds to the very uneven progress in different countries.[91]

Recorded expressions of international concern about maternal health and high levels of maternal mortality date back to at least 1930.[92] In 1948, the Universal Declaration of

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[90] Meyer ME, de Oliveira DL. Breastfeeding policies and the production of motherhood: a historical-cultural approach. *Nursing Inquiry* 10(1):11-18, 2003, p. 12.
[91] WHO 2005, p. 2
[92] AbouZahr C. Safe Motherhood: a brief history of the global movement, 1947-2002. *British Medical Bulletin* 67:13-25, 2003, p. 14.

Human Rights called for "special care and assistance" for mothers and children; that year, WHO was born with a mandate "to promote maternal and child health and welfare" –all of which "added an international and moral dimension to the issue of the health of mothers and children".[93] However, there were no agreed-upon statistics of maternal deaths[94] until the mid 1980s, when WHO carried out the first community studies to assess the magnitude of the problem in developing countries.[95] These findings gave scientific "consistency" to the issues –in the authoritative sense I discussed above-, gained consensus among WHO members, and shaped the whole safe motherhood movement for decades to come. AbouZahr sums up this seminal moment, showing how numerical evidence can help reshape public health issues and give them global scope:

> Based on these studies, and what little information was available from vital registration and hospital studies, WHO produced the first 'guestimates' of the extent of the problem and announced that half a million maternal deaths were occurring each year, 99% of them in developing countries. By 1987, Dr Hafdan Mahler, then the WHO's Director-General, was able to assert that 'Sound estimates based on new data are ... the foundation of our current understanding and concern'. In February that year, WHO, UNFPA[96] and the World Bank jointly sponsored the first international Safe Motherhood Conference in Nairobi. The conference declared that '...something can, should—indeed must— be done, starting with the commitment of heads of states and governments'. The Conference was the effective starting point of what came to be known as the Safe Motherhood Initiative (SMI).[97]

Safe motherhood, both as a global public health concern and a widespread discursive entity, was born right then and right there. Before this time, the literature talked mostly about prevention of maternal death or maternal mortality; although these expressions did

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[93] Ibid, p. 2

[94] According to the Tenth International Classification of Diseases, a maternal death is "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes". See World Health Organization. *International Statistical Classification of Diseases and Related Health Problems.10th Revision, Version for 2007.* Available at http://www.who.int/classifications/apps/icd/icd10online/. Accessed June 1, 2010.

[95] AbouZahr C 2003, p. 15.

[96] United Nations Population Fund.

[97] Ibid, p. 15-16.

not lose currency in research and policy-making, "safe motherhood" was the catchphrase for maternal health[98] and the political and institutional rallying cry to take on maternal morbidity and mortality on a global scale for two decades.[99] [100] [101] The SMI defined safe motherhood as "ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth".[102]

The SMI was a joint effort of international health and development agencies and NGOs to "raise awareness of the scope and dimensions of maternal mortality and to galvanize commitment among governments, donors, UN agencies and other relevant stakeholders to take steps to address this public health tragedy."[103] The initiative also had a very concrete goal: to halve maternal mortality rates by the year 2000.[104] The SMI operated through an Inter-Agency Group (IAG)[105] whose mission was

> [...] to contribute to improved maternal and newborn survival and well-being by promoting and supporting the implementation of cost-effective interventions in the developing world. The IAG carries out policy support and disseminates best practices and other information among policy makers, program managers, and other stakeholders worldwide".[106]

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[98] Family Care International. *Safe Motherhood: A Review. The Safe Motherhood Initiative 1987-2005*. New York, NY: Family Care International, 2005, p.9. Available at www.familycareintl.org/UserFiles/File/SM_A%20**Review**_Exec_Sum_%20FINAL.pdf

[99] Rosenfield A. The history of the Safe Motherhood Initiative. *International Journal of Gynecology & Obstetrics* 59(Suppl.2):S7-S9, 1997.

[100] Weil O, Fernandez H. Is safe motherhood and orphan initiative? *Lancet* 354:940-943, 1999.

[101] The expression "safe motherhood" yielded 377,000 hits through a Google search on November 17, 2008. As of that date, it was used by all major international national and international agencies and NGOs working in maternal and newborn health.

[102] SafeMotherhood.org. 2005. Available at www.safemotherhood.org. Accessed November 18, 2008.

[103] Family Care International 2005, p.4.

[104] Ibid, p. 9.

[105] The IAG was formed by the three sponsors of the Nairobi conference, together with UNICEF, United Nations Development Programme (UNDP), and two international NGOs, International Planned Parenthood Federation (IPPF) and the Population Council.

[106] SafeMotherhood.org. 2005. Available at www.safemotherhood.org. This quote about the mission of the IAG was retrieved from the site on March 22, 2007. The site was downsized sometime after that date, as the SMI was successively replaced by the SMNH and the PMNCH. The quoted text is now available from Euro-fam.org. *About the Safe Motherhood Initiative*. 2002.http://www.euro-fam.org/documents/shared/pub/News/2004/safe%20motherhood%20%20inter-agency%20group.htm. Accessed on November 17, 2008.

The SMI supported a broad range of preventive actions to tackle the most frequent risk factors and complications associated with pregnancy, childbirth and postpartum, including family planning, prenatal checkups, emergency obstetric services, community-based maternal services, and social policies.[107] Throughout the 1990s, the IAG organized several international conferences "that made safe motherhood an accepted and understood term in the public health realm".[108] Development agencies, national governments, and NGOs designed, funded and carried out maternal health programs at the global, regional, national and sub-national levels.[109] In Mexico, a nationwide network of government agencies, NGOs, and academic units, the *Comité Promotor por una Maternidad Sin Riesgos en México*, has been operating since 1993, "to help bring down maternal mortality and contribute in the search of a maternity without risks for all Mexican women, which means being able to live a joyful maternity, one they have freely decided upon, without violence, and with quality care."[110]

This global push to reduce maternal and child mortality has had an enormous impact on public health agendas throughout the world, particularly in developing countries[111]. In the course of a few decades, maternal and child mortality rates became two of the most politically charged indicators of human development on the global scene. Comparing progress towards the MDGs –between regions, between countries, and within countries- puts additional pressure on governments at all levels. This pressure has been passed along to civil society, families, and individuals through public health policies and regulations, poverty-alleviation and social assistance programs, and safe motherhood discourse.

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[107] Roth Allen D 2002, p. 8.
[108] Starrs AM. Safe motherhood initiative: 20 years and counting. *The Lancet* 368:1130-1132, 2006, p. 1130.
[109] Family Care International 2005, p. 4.
[110] Comité Promotor por una Maternidad sin Riesgos en México. *Acerca del Comité*. 2008. Available at http://maternidadsinriesgos.org.mx/web/?page_id=66. Accessed June 25, 2009. I discuss the expression *maternidad sin riesgos* (maternity without risks) in 2.2.4 below.
[111] Powell-Jackson T, Borghi J, Mueller DH, Patouillard E, Mills A. Countdown to 2015: tracking donor assistance to maternal, newborn, and child health. *Lancet* 368:1077-1087, 2006. Data on international funding for maternal, newborn, and child health confirms that safe motherhood policies have been mostly oriented towards the developing world.

Over less than one hundred years, maternal and child health went from private concern to global issue. Public discourses of pregnancy and childbirth came into being where there were none. Ushered and legitimized by agreed-upon numerical evidence, maternal mortality finally took center stage as a certified "tragedy" in the international public health arena. Safe motherhood discourse and policies gave it unprecedented global scope.

2.2.2. Maternal and child health: One and the same?

Both the definition of safe motherhood and the IAG mission statement have several interlocked components of relevance to my research. If we consider the definition of safe motherhood, we can observe that:

a) it is a political and institutional call for action at global level;
b) it gives safe motherhood the imprint of a collectively manageable risk, amenable to collective action, such as political and social pressure for policy change, a discursive trait more frequently associated with environmental risks than with lifestyle risks[112];
c) it places women in a passive role of receiving "the care they need";
d) it acknowledges the right of all women to be "safe and healthy" throughout pregnancy and childbirth, without further elaboration of these terms. As critics have mentioned, and I expect to show in the Mexican case, the SMI has sponsored a biomedical –and risk-oriented- notion of safety and health.
e) it does not state any type of agency or responsibility in providing "the care they need" or in guaranteeing the right to be "safe and healthy".

In Mexico, this call for collective action has overlapped with a risk approach to safe motherhood, particularly regarding issues of individual and familial responsibility in providing women "the care they need", as I hope to establish based on the evidence from this thesis.

[112] Joffe H 1999, p.4.

The IAG mission statement semantically expands the definition of safe motherhood to cover "newborn survival", which has crucial implications in terms of individual and collective responsibility. In fact, it had been a long road for maternal health to become a public health concern of its own in the mid 1980s. Before the Nairobi conference, child survival and health had been a primary focus of international efforts[113]. The advocacy of women's rights during The United Nations Decade for Women 1976-1985 brought attention to women's health; but maternal health continued to be a by-product of child survival and health well after the Nairobi conference.[114] In Latin America, there was a shift in focus starting in the early 1990s, with intense advocacy from global and regional NGOs pointing to the high rates of maternal mortality in the region, the social and gender imbalances at the root of the problem, and high-level political responsibility in reverting the trend.[115] The tide turned to a point where the maternal mortality rate is now commonly held as "one of the most sensitive indicators of poverty and social inequity".[116] National governments have made a priority of reducing maternal mortality figures, as agreed in the Millennium Development Goals.[117] Mexico is no exception in this regard.

However, the seemingly natural and inextricable bond between maternal health and child survival has always been present in safe motherhood discourse, both globally and nationally. At the global level, this connection became fully operational when the Safe Motherhood Initiative turned into the Partnership for Safe Motherhood and Newborn Health (PSMNH) in 2004.[118] The latter further merged into the Partnership for Maternal,

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[113] Rosenfield A, Maine D. Maternal mortality—a neglected tragedy. Where is the M in MCH? *Lancet* 2: 83–5, 1985.
[114] AbouZahr C 2003, p. 16.
[115] Ibid, p. 17.
[116] Leal McC. The challenge of the millennium: maternal mortality in Brazil. *Cadernos de Saúde Pública* 24(8):1725, 2008. Available at http://www.scielo.br/scielo.php?pid=S0102-311X2008000800001&script=sci_arttext&tlng=en
[117] The Millennium Development Goals (MDGs) are eight international development goals agreed upon by the United Nations and major international NGOs. They should be achieved by 2015. MDG 4 seeks to "reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. MGD 5 aims to "reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio" and to "achieve, by 2015, universal access to reproductive health". Millennium Development Goals. United Nations. 2008. Available at www.un.org/millenniumgoals/. Accessed November 18, 2008.
[118] SafeMotherhood.org. 2005. Available at www.safemotherhood.org. The downsized website briefly refers to the new framework as follows: "Expanding the scope of the Safe Motherhood Initiative and

Newborn & Child Health (PMNCH) in 2005, together with the UNICEF-based Child Survival Partnership and the Healthy Newborn Partnership, an international coalition of NGOs, in an attempt to coordinate closely related health issues and to "accelerate efforts towards achieving Millennium Development Goals (MDGs) 4 and 5".[119]

The global strategic shift took the spotlight with the 2005 World Health Report, aptly titled "Make every mother and child count".[120] "It makes no sense to provide care for a child and ignore the mother, or to worry about a mother giving birth and fail to pay attention to the health of the baby," says the report.[121] The PMNCH assumes "that the health and wellbeing of women, newborns and children are closely linked and should be managed in a unified way".[122] The need for a "continuum of care" is said to support these transformations, which were welcomed in practitioner-oriented publications. A professional midwifery journal stated: "The latest move to establish a truly powerful partnership reflects the recognition that mothers', babies' and children's health is all interdependent, and needs to be maintained as a continuum."[123] Another publication sums up the new rationale:

> In developing countries, a mother's death in childbirth means that her newborn will almost certainly die and that her older children are more likely to suffer from disease. Moreover, when mothers are malnourished, ill, or receive inadequate care, their newborns face a higher risk of disease and premature death. Almost one-quarter

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building on the work of the Safe Motherhood Inter-Agency Group, the Partnership aims to strengthen maternal and newborn health efforts at the global, regional, and national levels, in the contexts of equity, poverty reduction, and human rights." Accessed November 18, 2008.

[119] *The Partnership for Maternal, Newborn & Child Health: Conceptual and Institutional Framework.* Geneva: World Health Organization, 2005, p.3. Available at www.who.int/entity/pmnch/activities/cif/conceptualandinstframework.pdf. Accessed December 10, 2008.

[120] WHO 2005.

[121] Ibid, p. xiii.

[122] Sines E, Tinker A, Ruben J. *The Maternal-Newborn-Child Health Continuum of Care: A Collective Effort to Save Lives.* Washington, DC: Save the Children and Population Reference Bureau, 2006, p.1. Available at www.prb.org/pdf06/SNL-ContOfCare_Eng.pdf. Accessed November 20, 2008.

[123] Launching the partnership for maternal, newborn and child health: after a number of recent changes in the global agencies working for mothers' and babies' wellbeing, ICM's role is at the heart of a new and powerful partnership. *International Midwifery* 18(4):41, 2005. A/N: ICM stands for International Confederation of Midwifes. Available at http://findarticles.com/p/articles/mi_m0KTL/is_4_18/ai_n17210759. Accessed November 20, 2008.

> of newborns in developing countries are born low birth weight, largely due to their mothers' poor health and nutritional status, which results in increased vulnerability to infection and a higher risk of developmental problems.[124]

A focus on optimization and cost-effectiveness of public health interventions underlines these changes. As the same authors point out, "health programs in the fields of maternal, newborn and child health have generally focused on one issue alone", when integrated interventions "could save millions of lives at a lower cost than separate initiatives".[125] Concern about neglected newborn health problems may have been another major driver of strategic change. "Newborn babies seem to have fallen between the cracks of safe motherhood programmes on one side and child survival initiatives on the other", said WHO in 2005.[126] In light of all the above, the concept of "continuum of care" seems to be a new take on –and a new name for- medicalized pregnancy, childbirth and puerperium. As such, I will consider it a key dimension of safe motherhood discourse.

2.2.3. Notions of risk and safety within safe motherhood discourse

For the SMI and successive global partnerships, and for the biomedical establishment, access to skilled health personnel and high-quality maternal health services, particularly during and after childbirth, is the key to safe motherhood. In safe motherhood discourse and practice, this entails getting care from doctors, nurses, nurse-midwives, and professional midwives, and giving birth at medical facilities.[127] For some, "today, more than ever, the solution is in the hands of obstetricians".[128] This biomedical focus is based on epidemiological studies that link the steady decrease in maternal mortality across the developed world, since the 19th century, not to economic growth and higher educational

[124] Sines E, Tinker A, Ruben J 2006, p. 2.
[125] Ibid, p. 2.
[126] WHO 2005, p. xv.
[127] WHO 2005, p. 68-71.
[128] Weil O, Fernandez H 1999, p. 943.

levels, but to improvements in and access to obstetric care[129], and particularly in emergency obstetric care.[130] [131]

Women have increasingly chosen to give birth in hospitals, embracing this option as safer and less painful than traditional birth practices.[132] There have been ideological reasons, too. Litt interviewed Jewish and African American women who were mothers in Philadelphia in the 1930s and 1940s. In spite of their traditions, second-generation Jewish mothers, members of a marginal but upscaling social group, and upper-class African American women, both embraced biomedical practices as a means of social mobility. Poorer African American mothers held onto traditional practices and remained sceptical of the growing medicalization of motherhood, which the author contends reflected and reproduced ethnic and social power relations in American society.[133]

In most of the Western world, these developments resulted in the "management" of pregnancy and childbirth through medicalization, hospitalization, and technologization by the middle of the twentieth century.[134] Critics of this process claim it led to the disempowerment of pregnant women, obstetrician-led pregnancies and deliveries, big business around pharmacology and technology, and excessive rates of caesarean sections.[135] [136] [137] Something similar is happening in developing areas of the world subject to biomedical discourse and practice of childbirth.[138] [139] [140].

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[129] Ibid, p. 941.
[130] Rohde JE. Removing Risk from Safe Motherhood. *International Journal of Gynecology & Obstetrics* 50(Suppl.2):S3-S10, 1995, p. S4.
[131] Rosenfield A. 1997.
[132] Johns JS 1996, p. 9-10.
[133] Litt JS 2000, p. 157-161.
[134] Johns JS 1996, p. 54.
[135] Johanson R, Newburn M, Macfarlane A. Has the medicalisation of childbirth gone too far? *BMJ* 324:892-895, 2002.
[136] Johns JS 1996, p. 2-3 and p. 9-10.
[137] Inhorn MC. Defining Women's Health: A Dozen Messages from More than 150 Ethnographies. *Medical Anthropology Quarterly* 20(3):345-378, 2006.
[138] Castro A, Heimburger A, Langer A. *Iatrogenic epidemic: caesarean sections in Mexico*. Working paper. Cambridge, MA: The David Rockefeller Center for Latin American Studies, Harvard University, 2000. Available online at http://drclas.fas.harvard.edu. Accessed July 12, 2006.
[139] Hopkins K. Are Brazilian women really choosing to deliver by caesarean? *Social Science and Medicine* 51:725-740, 2000.
[140] Rose Hunt N. *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo*. Durkham & London: Duke University Press, 1999.

The SMI and successive global partnerships have reaffirmed this trend. Both the IAG and the PMNCH have promoted "evidence-based", "cost-effective"[141] policies and actions in developing countries. The evidence base refers mostly to epidemiological findings and randomized controlled trials. The PMNCH mission, in particular, states that:

> Recent research finds that at least two-thirds of these deaths could be prevented with proven, cost-effective interventions that could and should be available to every woman and child today. By expanding access to these interventions and integrating maternal, newborn and child health efforts, an estimated 6 million deaths of women and children could be prevented each year.[142]

The PMNCH mission statement sustains all of its contents through the topic semantic position of "recent research", which gives factual standing to epidemiological estimates and scientific authority to "proven" interventions that integrate maternal, newborn and child health. This discursive framing gives the idea that the estimated results can only be reached by carrying out the "proven" actions, which makes it hard for donors, researchers and governments to deviate from these globally sanctioned –hence, heavily normative- guidelines. All "proven" actions are technical –hence, biomedical- and logistical in essence:

> There is broad agreement that good-quality maternal health services need to include skilled care for both routine and complicated cases, including emergency obstetric services for life-threatening complications, and a functional referral system to ensure timely access to appropriate care.[143]

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[141] Cost-effectiveness analysis has been increasingly used in public health evaluation, particularly in North America and Western Europe; it refers to "the least costliest way to achieve a given level of [non-monetary] benefits". See Floyd K. Costs and effectiveness –the impact of economic studies on TB control. *Tuberculosis* 83:187-200, 2003, p. 188.

[142] The Partnership for Maternal, Newborn & Child Health. *Why a new global health partnership for maternal, newborn and child health?* Geneva: World Health Organization. 2008. Available at http://www.who.int/pmnch/about/mission/en/index.html. Accessed November 20, 2008.

[143] Family Care International 2005, p. 83. The expression "broad agreement" is a not as strongly qualifying as "proven" when it comes to research findings. The former entails a social, institutional, and political process whereby certain research findings gain authoritative status among researchers and experts. The adjective "proven" gives research findings and estimates a factual quality.

At the same time, the PMNCH mission statement turns away from social, cultural, and ideological implications of safe motherhood policies, in favour of the "proven" effectiveness and cost-effectiveness of these interventions. Below, I will discuss some of these implications regarding indigenous views and practices of childbirth in Mesoamerica, particularly for the sustainability of traditional birthing and the survival of traditional birth attendants.

What are the results of this approach, in terms of hard indicators? A two-decade evaluation of the SMI by one of its core partners talks of success "on a number of key indicators, including the proportion of pregnant women receiving antenatal care, and the proportion of births attended by a skilled birth attendant."[144] In other words, the SMI has succeeded in terms of putting a greater proportion of pregnant women under control of the medical profession, making them subject to technological monitoring, and having them deliver in hospitals and health centres with biomedically trained obstetricians.[145]

But for all this progress in the institutionalization and medicalization of pregnancy and childbirth, the SMI was not able to reduce maternal mortality by 50% by the year 2000, as it had originally intended, despite reductions in some countries[146]. Yet more puzzling, "maternal mortality remains high even in some countries where utilization of maternal health care (such as antenatal and delivery care) has improved." The report places blame for the poor results on "faltering political commitment, inadequate funding, and a lack of

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[144] Ibid, p. 5. The report elaborates on numerical evidence of success: "Since 1990, coverage of antenatal care in developing countries has increased by 20%, and more than 50% of women receive at least the four recommended antenatal visits. Between 1990 and 2003, the presence of a skilled attendant at delivery increased significantly, from 41% to 57% in the developing world as a whole."

[145] It would be hard to overstate both the normative implications and material impact of such framing of safe motherhood at a global level. As Treichler points out (see Treichler P 1989, p.437), multiple meanings of the same expression can coexist at different levels, "but a definition is much less democratic. It sets limits, determines boundaries, outlines. Unlike meanings, which are bound up in what people think and have in their minds and intend, definitions claim to state what is. A definition is meaning that has become 'official' and thereby appears to tell us how things are in the real world." Biomedical definitions of safe motherhood, couched in statistical language, have driven international funding, national policies, clinical practice, and academic research in most of the world over the last two decades.

[146] Koblinsky M (ed.) *Reducing maternal mortality: learning from Bolivia, China, Egypt, Honduras, Indonesia, Jamaica, and Zimbabwe.* Washington DC: World Bank, 2003.

clear technical priorities."[147] Whatever the reasons, it is clear that institutionalizing and medicalizing pregnancy and childbirth has not been the all-in-one solution to reducing maternal deaths in the developing world.

2.2.4. The "risk paradox" in safe motherhood discourse

A "risk paradox" embedded in safe motherhood policies and discourse further raises the stakes. In the early years of the SMI, there was much emphasis on reproductive, socioeconomic, and medical risk factors for maternal mortality.[148] But after decades of prenatal screening for "high-risk" pregnancies, most experts have concluded that "no amount of screening will separate those women who will from those who will not need emergency medical care"[149].

As Rohde points out, measures of relative risk between different population groups cannot help predict what will happen to this or that person during pregnancy and childbirth, "because they are markers for groups of women, but not for causes of mortality".[150] In other words: risk analysis –and the resulting risk labelling of pregnant women- cannot predict the actual emergence of complications. Rohde explains the limitations of a risk-factor approach to maternal health:

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[147] Family Care International 2005, p. 5.

[148] Roth Allen D 2002, p. 43-45 Examples of "official" reproductive risk factors are age –complications during pregnancy and childbirth are more frequent in women younger than 20 and older than 35 years of age- and previous pregnancies –less than two and more than three implies higher risks. Socioeconomic risk factors range from poor educational, economic, and human rights' statuses, to locally specific "handicaps" (like being indigenous, being small, or not speaking Spanish in Xochis). Medical risk factors are directly or indirectly related to maternal deaths: Malnutrition, anaemia, tetanus, reproductive tract infections, and sexually transmitted diseases can lead to complications during pregnancy and childbirth.

[149] WHO 2005, p. 69. The report cites Maine D, Rosen.eld A, McCarthy J, Kamara A, Lucas A. *Safe motherhood programs: options and issues*. New York, NY, Columbia University, 1991.

[150] Rohde JE 1995, p. S4. Epidemiological analysis and safe motherhood discourse oftentimes group complications (direct and indirect causes of maternal mortality) with risk factors. According to Roth Allen D 2002, p. 45-52, malnutrition, anaemia, tetanus, and sexually transmitted diseases are indirect causes of maternal death. The leading direct causes of maternal death are obstructed labour (when the infant's head is much larger than the mother's pelvis); prenatal and postnatal haemorrhage; sepsis (a potentially deadly infection that spreads through the bloodstream, usually associated with unhygienic conditions during delivery); and unsafe abortion. Eclampsia, or pregnancy-related hypertension, is a direct cause of death of particular relevance to this thesis, since it was the leading cause of maternal death in the state of Guerrero at the time of my research. Starting in 2006, the government of Guerrero ran a State-wide campaign to detect eclampsia at an earlier development stage called pre-eclampsia. An educational video for the prevention of pre-eclampsia is a central piece in the analytical corpus of this thesis (see chapter 5).

> Let us consider a few of the commonly used risk factors that I have drawn from many studies... One category includes height, weight, age, parity[151], previous history and use of antenatal care services; all seem to have some correlation with higher risk... (This category) identifies populations of women who tend to have a higher proportion of complications, groups, but not any individual in particular. Even in a 'high risk' group, complications remain relatively rare. Therefore, we identify large numbers of women who never develop complications in any case... At the same time, (these risk factors) divert crucial attention from the many low-risk women who do go on to develop complications and comprise 50% or more of all maternal deaths.[152]

As a result of this critical revision, global discourse on safe motherhood now tells us that there is no such thing as "high risk" pregnancies –moreover, "low risk" pregnancies often lead to the worst outcomes[153]. However, removing degrees of risk from safe motherhood discourse does not imply *removing risk* altogether, because health risk, as we have seen, is not only about statistical probabilities, but also about a host of dangers, such as complications of pregnancy and childbirth, and both maternal and perinatal death. As I have discussed above, the "danger" component is instrumental to the translation of risk across cultures.

Mexican guidelines and health services still resort to levels of risk for the prevention of illness and death during pregnancy and childbirth,[154] in spite of the global shift in focus and the fact that most women who die in Mexico have been labeled as having "low risk".[155] In reality, both criteria coexist on the ground, fuelled by political pressure to avert maternal deaths at any cost. Applying risk criteria was standard policy within the

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[151] Parity is the number of times a woman has given birth (A/N)
[152] Rohde JE 1995, p. S4. This is a perfect example of the problems that arise when population-based epidemiological analysis is used to single out at-risk individuals –which I discussed in 2.1.
[153] WHO 2005, p. 69.
[154] Freyermuth Enciso G, Meneses Navarro S. Evaluación de la atención institucional a la urgencia obstétrica en los altos de Chiapas. In Freyermuth Enciso G (ed.), *Maternidad peligrosa: Evaluación de la atención institucional a la urgencia obstétrica en los altos de Chiapas*. Mexico City: CIESAS-Indesol, 2004, p. 17-71.
[155] Luna Gordillo R 2009.

Ometepec health district, at least until the first half of 2008, as a district health official confirmed around that time:

> Nosotros manejamos unos flujogramas que clasificamos a las embarazadas de alto riesgo, de bajo riesgo y sin riesgo [...] De acuerdo a ello, las de alto riesgo se tienen que atender en el centro de salud, se tienen que atender en el hospital... hay que referirlas oportunamente para que no se presente ninguna complicación.

Frontline health workers used similar criteria for handling their patients. A doctor working in a remote community explained how he indicated ultrasound to pregnant women:

> **Q**: ¿Y qué pasa con las ecografías? ¿La gente las acepta?
> **D**: Sí, sí... ya para eso hay que bajarlas al hospital.
> **Q**: ¿Y las bajas a todas en algún momento?
> **D**: No, a las de alto riesgo. Entonces yo tengo un censo y, pues, se hace un esfuerzo por tratar de tenerlas a todas las embarazadas, y entonces ya yo hago una clasificación por la historia clínica que les hago. Clasifico a las mujeres de alto riesgo y las que no tienen tanto riesgo.

At the same time, and as I will show with data from Xochis, the connection between safe motherhood and risk discourse is so deep in public health communication that pregnancy and childbirth are construed as *meaning* risk and all pregnant women as being "at risk" [156] [157] –together with their foetus, their older children and their communities, since public health risk discourse characterizes society as being in grave peril, too[158], and "at risk" groups and individuals as bearing responsibility[159].

Instead of removing risk from safe motherhood, the shift in focus makes it yet more pervasive. Two authors who played a leading role in turning public health attention to

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[156] Lupton D 1999c, p. 66.
[157] Post M. *Preventing Maternal Mortality through Emergency Obstetric Care.* Policy paper. Washington, D.C.: Support for Analysis and Research in Africa (SARA) Project, 1997.
[158] Douglas M 1992.
[159] Guttman N 2000.

maternal health in the 1980s made this clear when they summarized –and advocated- the new approach after ten years of scant progress in curbing maternal deaths: "The best strategy is to assume that all pregnant women are at risk for serious complications and to focus efforts on improving the quality of, access to, and utilization of emergency obstetric care services."[160] [161]

This paradoxical "removal of risk" makes it all the more challenging to accommodate cultural traditions of home delivery within the universe of safe motherhood discourse. These limitations come to life in the words of an Inuit elder in Canada: "We always wanted women in our communities to have their babies in the community, as long as the medical people know that it will not endanger the mother".[162] The elder could not know that the conditional clause in his statement –indeed, a submission to medical authority- made having babies in the communities all but impossible. The way safe motherhood discourse shapes "safety" creates a discursive closure on this issue: medical people "know" that having babies is essentially dangerous.

The safe motherhood risk paradox is even deeper in Spanish language, since the expression is translated as *maternidad sin riesgo* –which we can back-translate as *maternity without risk.* This amounts to an oxymoron: How can there be such a thing as risk-free maternity, when safe motherhood discourse equals pregnancy and childbirth with risk? "In reality, therefore," says Lupton, "there is no such thing as 'no risk' in pregnancy, for the potential is ever present for danger to threaten foetal wellbeing,

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[160] Maine D, Rosenfield A. The Safe Motherhood Initiative: Why Has It Stalled? *American Journal of Public Health* 89(4):480-482, 1999, p. 481.

[161] Sustained political stress on maternal mortality and contradictory pregnancy risk criteria have had a deep impact on government health services in Xochis and the Ometepec health district as a whole, where many perceive the management of indigenous pregnancies as tantamount to walking in a minefield. At the time of fieldwork for this study, conflicting risk approaches coexisted within government health services, which created additional hurdles and uncertainties for all involved. On the one hand, government health services tried to identify higher risk pregnancies for closer monitoring and institutionalized delivery – however, there was no consensus on who should be referred, when, and where. On the other hand, it was official policy to encourage all pregnant women to give birth in hospitals and health centres.

[162] Ross Leitenberger K. *Aboriginal Midwifery and Aboriginal Birthing Systems Revised and Revitalized: Interviews with First Nations Elders in the North West Region of British Columbia.* MA thesis. The University of Northern British Columbia, 1998, p. 33. The author took the original quote from Voisey E, Okalik A, Brown M, Napayok A. Cultural Perspectives on Pregnancy and Childbirth. In O'Neill JD, Gilbert P (eds.). *Childbirth in the Canadian North: Epidemiological, Clinical, and Cultural Perspectives.* Winnipeg, MB: University of Manitoba, 1990, p. 37-42, p. 38.

particularly if a woman should let her guard down."[163] Because it is almost impossible to extricate risk from safe motherhood discourse, the pregnant woman is the target of "a complex network of discourses and practices directed at the surveillance and regulation of her body"[164]. As Lupton points out,

> Risk is a central discourse among those that surround the pregnant woman. Much of the appraisal and advice she receives is directed at containing risks, both those threatening her own health, but even more intensely, those threatening the wellbeing of the foetus that she carries.[165]

Prenatal control is a good example of this tangled link between safe motherhood and risk discourses. Even though its efficacy has been questioned within safe motherhood discourse, prenatal control is still a core component of maternal health policies worldwide, and is to this day a primary policy for keeping maternal health under surveillance in Mexico, where the nationwide social program *Oportunidades* makes monthly payments to pregnant women contingent upon their attending prenatal chats checkups.[166] At the same time, safe motherhood implies self-control, as "pregnant women are encouraged to be highly vigilant in their policing of their bodies so as to ensure that the health of their foetus is not compromised by their own actions."[167]

2.2.5. Ideological implications of safe motherhood discourse

Safe motherhood discourse has anchored a global health governance agenda aiming to shape people's attitudes, behaviours and priorities around motherhood. This global agenda has been endorsed by and channelled through a pool of powerful stakeholders, including 260 representatives of member countries, UN and multilateral agencies, nongovernmental organizations, health professional associations, bilateral donors and

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[163] Lupton D 1999c, p. 66.
[164] Ibid, p. 59.
[165] Ibid, p. 60.
[166] Almost 90% of women surveyed for the MNH Project 2008 baseline who had been pregnant over the previous three years had gone for prenatal checkups at government health units.
[167] Ibid, p. 64.

foundations, and academic and research institutions. National and provincial governments usually incorporate these globally agreed criteria into their own policies and guidelines. Media at all levels –including the World Wide Web- have given ample room for the construction and circulation of mainstream safe motherhood discourse.

The global scope, political clout, scientific foundation, and moral echoing of safe motherhood discourse gave it unprecedented hegemony. Such unchallenged rule came to obscure value assumptions and ideological implications at all levels –a common feature of development-oriented initiatives, as Pigg points out:

> The agendas of major development donor institutions are made to seem like the only possible way to deal with problems of poverty and social inequality. Faced with the moral discourse of "saving lives", we have to be careful to distinguish between evaluation of the medical initiatives being promoted and evaluation of the actual social and institutional means through which these medical techniques are introduced [...] Certain power asymmetries are strengthened through the very efforts made to promote even life-saving medical techniques [...] Relations of power, as well as states of health, are at stake in health development encounters.[168]

Of particular relevance for my research, the massive tsunami of safe motherhood discourse was bound to have far-reaching ideological implications, as government discourse, policies, and guidelines overlap with local practices, power relations, and "local moral worlds"[169] –and this is particularly the case in rural areas and indigenous cultures throughout the world. Given the social centrality of motherhood across cultures,

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[168] Pigg S. Acronyms and Effacement: Traditional Medical Practitioners (TMP) in International Health Development. Social Science & Medicine 41(1):47-68, 1995, p. 49.

[169] Kleinman A 1995, p. 45-46. The author draws a difference between the "ethical" and the "moral". "Whereas ethical discourse is a codified body of abstract knowledge held by experts about 'the good' and ways to realize it, moral accounts are the commitments of social participants in a local world about what is at stake in everyday experience," he says. This is an important distinction when focusing on the ideological implications of discourses on people's moral deliberations. It is also a good lens to look at people's own views of what is at risk. In another work, Kleinman spells out the immediate relation of morality and everyday life: "The passion-laden, practical self is caught up in what I have called our local moral worlds, what William James called genuine reality. The reflective self is caught up in ethical deliberation and aspiration." See Kleinman A. *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger.* New York, NY: Oxford University Press, 2006, p. 219.

this may imply the reshaping of power relations within families, neighbourhoods, and villages, and those involving traditional and biomedical experts, and indigenous and non-indigenous groups.

As I will show in later chapters, engineers of government discourse in Mexico co-opt certain stakeholders and discourses –e.g., husbands, religious beliefs-, marginalize certain others or undermine their authority –e.g., elderly women, traditional healers, parteras, traditional knowledge concerning maternal health-, in the complex social interplay around motherhood in indigenous societies. Pregnant women have to negotiate between these values and find their way between these often-colliding worldviews. "One of the major messages of women's health ethnography," says Inhorn, "is that such moral decisions are part and parcel of women's health experiences".[170] [171]

At the same time, the global push towards full medicalization of pregnancy and childbirth has faced growing resistance from women in developed countries[172] [173] [174] and is hard to sustain in the day-to-day reality of many rural and indigenous communities, where the barriers are cultural, attitudinal, economic and geographic –as qualitative research from verbal autopsies[175] in Mexico clearly shows[176]. Indigenous people are low on governments' priority lists, especially when they live in remote areas where services are

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[170] Inhorn MC 2006, p. 365.

[171] The expression "women's health ethnography" refers to anthropological studies looking at how women's health beliefs and behaviours are affected by their culture environment.

[172] Davis-Floyd R, Davis E. Intuition as Authoritative Knowledge in Midwifery and Homebirth. *Medical Anthropology Quarterly* 10(2):237-269, 1996, p. 239.

[173] Johns JS 1996, p. 4-5.

[174] Treichler P 1989, p. 434-435. The author points to questioning of medicalized childbirth from the feminist movement, the women's health movement, the midwifery model, "and a broad spectrum of policymakers". The midwifery model, in particular, "defines birth as a normal , natural physiological process; though high-risk conditions and/or medical complications may occur and necessitate medical solutions, most pregnant women are considered to be essentially healthy beings who usually need little medical management during the birth process."

[175] A verbal autopsy is "a method of finding out the cause of a death based on an interview with next of kin or other caregivers". Anker M, Black R, Coldham C, Kalter H, Quigley M, Ross D, Snow R. A Standard *Verbal Autopsy Method for Investigating Causes of Death in Infants and Children.* Geneva: World Health Organization. WHO/CDS/CSR/ISR/99.4, p.1. Available at http://www.who.int/csr/resources/publications/surveillance/WHO_CDS_CSR_ISR_99_4/en/index.html Accessed March 2, 2009.

[176] Castro R, Campero L, Hernández B, Langer A. A Study on Maternal Mortality in Mexico Through a Qualitative Approach. *Journal of Women's Health & Gender-Based M*edicine 9(6):679-690, 2000.

difficult and costly to provide. Even where services are available, they are often of poor quality. Many indigenous people are reluctant or afraid to use them because staff can be insensitive, discriminatory, and unfriendly.[177] [178] This is the case for many indigenous communities across the Americas[179].

By putting the stress on and calling for "simple and cost-effective" technical interventions as the key to reducing maternal mortality and morbidity,[180] global safe motherhood discourse may also draw attention away from the structural causes of these problems –as is the case with health risk discourse[181]- or even invert the relationship of causality. The already cited evaluation of two decades of safe motherhood policies by key members of the SMI explicitly reaches such a conclusion: "As one of the essential components of a comprehensive reproductive health framework, safe motherhood is central in the fight to reduce poverty and advance human development."[182]

2.3. Motherhood and childbirth among indigenous cultures in Mesoamerica

2.3.1. The ideological value of the old and the new

Safe motherhood discourse and policies do not operate in a social, cultural, and institutional vacuum. "Childbirth," says Cosminsky, "is a universal life crisis for which every society provides a means of management, including a system of beliefs and practices concerning pregnancy, labour, and delivery, the postnatal period, and emotional and social support for the mother."[183]

In Xochis, as in many other places in Mexico, safe motherhood discourse interacts with indigenous views and practices of pregnancy and childbirth. These ways of thinking and acting, though not frozen in time, are part of traditional, holistic knowledge and health

[177] Stephens C, Porter J, Nettleton C, Willis R. 2006.
[178] WHO 2005, p. 28.
[179] Center for Reproductive Rights 2005.
[180] Family Care International 2005, p. 83.
[181] Lupton D 1993, p. 433.
[182] Family Care International 2005, p. 83.
[183] Cosminsky 1986, p. 75.

systems that have many points in common with other indigenous traditions across Latin America and, particularly, within Mesoamerica.[184] [185] I will only refer to certain aspects of these systems of knowledge that are particularly relevant to the research questions and objectives, such as conceptions and practices of pregnancy and childbirth, and the connections between human body and ideology.

López Austin –whose classic study on the ideological implications of the Nahua's views of the human body I will follow in this section- contends that conceptions of the human body guided and justified the behaviour of the different social groups in most of Mesoamerica, as they tried to fulfill their interests and expectations, and were functional to the reproduction of the social order.[186] Says the author:

> Las diferencias entre sexos, edades, grupos sociales, las relaciones de gobierno, la división y distribución del trabajo, los valores morales o el fundamento del control social, descansaron, en buena medida, en una particular concepción del cuerpo humano que hacía físicamente distintos a esclavos y a libres, a malos y a buenos, a nobles y a plebeyos, a jóvenes y a viejos o a hombres y mujeres, reforzando las reglas de distribución de las funciones sociales de cada hombre.[187]

These conceptions were also deeply cosmogonist, insofar as notions of the body helped mould a vision of the cosmos and vice versa –all of which strengthened their ideological implications, including a strict dependence on knowledge experts who were either part of the government bodies or a satellite group of societal leaders:

> Sustraerse a la consulta de los especialistas era tanto como desafiar las fuerzas de los destinos, de vivir a ciegas en el mundo, de exponer a la desgracia y a la muerte a la familia. Los *tonalpouhque* o lectores de los libros de los destinos adquirían los

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[184] Mesoamerica is a cultural, archaeological, and geographical area extending from central Mexico to Honduras and Nicaragua. The expression usually refers to pre-Columbian peoples who lived –or still live- in the region.
[185] Montenegro R, Stephens C. Indigenous health in Latin America and the Caribbean. *The Lancet* 367:1859-1869, 2006.
[186] López Austin A 1980, p. 9.
[187] Ibid, p. 9.

conocimientos necesarios para la interpretación en las escuelas de los nobles, los *calménac*.[188]

We can somehow liken the pivotal role of these specialists to that of epidemiologists, researchers, and health experts in our time. To be sure, the nature of their knowledge was essentially different –they would "transmit" rather than generate knowledge-, but they held a very similar status as knowledge brokers with great power to shape the government agenda and normative views of health and disease. Similarly, traditional and biomedical health systems share another crucial trait: healers and medicines hold a central position when it comes to dealing with health and illness.[189] In other words, both the definition of the public health agenda and the restoration of health –however with define it- have been subject to socially sanctioned institutions and power relations both in traditional and modern societies.

But López Austin does not suggest that social mores and normality are tantamount to unchanging tradition. In order to shed light on systemic transformations, the author distinguishes traditional elements from more recent incorporations –something I have also tried to do through the analysis of discursive interactions in Xochis- in a context where the more powerful actors apparently "respected" traditional views and ideologies, "modifying and adding them in their own benefit". [190]

The coexistence of long-held views with newer or more marginal ideas of health and the body within a given social order is of the essence to any ideological analysis. López Austin does not only take this coexistence into account when he describes social relationships in pre-Columbian times, but also when he assesses the dynamics of coercion and persuasion in the colonial period. The colonial government tolerated the survival of indigenous ideas as long as they did not challenge the colonial rule, and came to see them as "typical of societies that had not yet come of age, which obviously strengthens the

[188] Ibid, p. 87.
[189] Módena ME 1990, p. 14.
[190] Ibid, p. 13-14 and p. 98.

ideology of the dominant group and justifies the persistence of coercive measures".[191] Centuries later, new chapters of this process are still unfolding in indigenous communities in Mexico, where current safe motherhood discourse and practices entail, at least partially, a process of *desindianización* (de-indianizing),[192] understood as the forceful eradication of indigenous views, practices, and traditions –to the extent that they threaten public health definitions and goals.

Some authors do not see these interactions as top-down impositions of the dominant culture over subordinate groups. Coronado views them as interethnic dialogues and negotiations that shape and reshape both indigenous and mestizo cultures. There is conflict, creativity, contradictions, adaptation, appropriation (of meanings and practices from another culture) and refunctionalization (of meanings and practices from the in-group) in these exchanges.[193] Data from this thesis shows some of these processes at work in Xochis. From the author's standpoint, this does not imply that indigenous and mestizo groups have equal power, but it does not mean that indigenous peoples are passive recipients of the dominant culture, either. She says in this regard:

> La cultura de los grupos hegemónicos es parte del mundo indio de muchas maneras. Incluye la ideología transmitida por los medios de comunicación masiva, el contenido de los programas educativos y también las prácticas sociales e ideologías de los grupos con los que interactúan por medio de la religión, el impacto económico, las innovaciones tecnológicas, etcétera. Sin embargo, la presencia de la cultura hegemónica no significa que los grupos indios sólo reaccionen pasivamente para incoporar los significados y prácticas culturales que les son impuestos. El proceso es más complejo y dialógico, no unidireccional.[194]

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[191] Ibid, p. 26. My own translation.
[192] Bonfil Batalla G. *México profundo: una civilización negada.* 1987. Mexico City: Grijalbo, 1990, p. 42-43. "El proceso de desindianización", says the author, "[...] no implica necesariamente la interrupción de una tradición cultural, aunque sí restringe los ámbitos en que es posible la continuidad y dificulta el desarrollo de la cultura propia." Ibid, p. 43.
[193] Coronado Suzán G 2003, p. 33-34 and 45-60.
[194] Ibid, p. 74.

2.3.2. Indigenous views of dangers and sources of unbalance during pregnancy

The geometrical nature of the universe is a fundamental explanatory principle behind Mesoamerican indigenous worldviews. From this essential tenet stems a binary opposition of contrary yet complementary polarities, such as heaven and earth, hot and cold, light and darkness, man and woman, strength and weakness, which help understand the diversity and intrinsic harmony in the cosmos. When it comes to health and illness, the heuristic value of the hot/cold interaction has not lost its currency to this day:

> La división dual, principalmente por lo que respecta a la integridad corporal del hombre, a la enfermedad, a los alimentos y a las medicinas, se proyecta, aún en nuestros días, en la división de lo frío y lo caliente, al considerarse al ser humano formado por ambos principios, armonizados en un estado de equilibrio. Este equilibrio puede ser perdido por fuerzas exteriores o interiores; y en la misma forma, factores externos y la acción del enfermo pueden recuperar el equilibrio perdido.[195]

The balance between hot and cold is therefore very important, and extremes of both kinds should be avoided. Physiological changes alter this balance and throw life in disarray – for those who experience the changes and those who come in contact with them. Motherhood implies a series of unbalances, from pregnancy to puerperium:

> Pregnancy is considered as a hot state because of the blood accumulated in the body, whereas the postpartum state is a cold one, because of the loss of blood (considered as a hot substance). Care is taken to restore the balance. This belief runs through all phases of the birth process and forms the basis of many of the related practices, including the use of herbs, hot baths, and restrictions and prescriptions relating to diet and activity, both as preventive and as therapeutic measures.[196]

Equally important is to keep and restore emotional and social balance. Most indigenous cultures in the region believe that strong emotions can bring about complications during

[195] López Austin A 1980, p. 60.
[196] Cosminsky S 1986, p. 76.

pregnancy, childbirth and the postpartum period.[197] As I discussed in 1.2.1, and our own data confirm, the Amuzgo people from Xochis share these concerns. The *espanto* or *susto* (fright) is a common source of ill health. A frightened woman can suffer greatly, and so can her child.[198] Fright usually stems from enduring or witnessing violence or distress. *Coraje*, a series of symptoms related to negative emotions such as anger, frustration, and grudges, is equally stressful and potentially dangerous, and it can be contagious, even at a certain distance from stressful events or from someone affected by this syndrome.

Cosminsky observes that most incidents of *coraje* and *espanto* arise from conflict or changes in social relations, which require that balance be restored in this sphere.[199] Modern epidemiology has not been able to prove an association between stress during pregnancy and negative outcomes to the mother and the child –other than from physical violence-, but the connection makes sense to people across cultures. Safe motherhood discourse focuses on biological aliments; only a few campaigns mention domestic violence, implicitly acknowledging the connection with maternal health.

The *antojo* (craving, particularly for food) is a very popular belief that indigenous peoples had in common with the Europeans at the time of colonization –and that the Amuzgo currently share with indigenous and non-indigenous peoples across the Americas. *Antojos* are usually seen as desires of the unborn child expressed through her mother. Unsatisfied cravings provoke a sharp unbalance that needs to be restored before it causes harm to the child.[200] A much feared state –though not an emotion- is the loss of the *nahual* or *tono*. As explained in the Introduction, the nahual is the soul of an animal – or the animal itself- that becomes a person's alter ego. Each person has his or her *nahual*.

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[197] Ibid, p. 76.
[198] Most TBAs in Xochis said a pregnant woman who is not cured from a fright could die or lose her child. Others mentioned the child could be "affected" or there could be other complications during pregnancy and childbirth. Data from the MNH Project 2008 baseline survey in Xochis.
[199] Cosminsky S 1986, p. 76.
[200] A majority of TBAs in Xochis said an unsatisfied craving could either "affect the child" or make the woman "lose her child". Data from the MNH Project 2008 baseline survey in Xochis.

When people have physical or emotional ailments, one possible explanation among the Amuzgos is that their *nahual* has taken ill or has been attacked by another nahual.[201]

These cultural sources of unbalance can operate as risk factors and complications, because they are associated with negative obstetric outcomes, and sometimes considered direct and indirect causes of maternal and child death.[202] [203] There is, however, a crucial difference: *antojos*, *corajes*, *espantos* and the loss of the *nahual* are social, emotional, and spiritual problems that manifest themselves through physical signs –such as bleeding, vomits, and headaches. This is not to say there are no conceptions of physical risk within the culture –e.g., women can perceive that having contact with cold water under certain circumstances can affect their fertility[204]. But "official" risk factors for pregnancy and obstetric complications always work the other way around, namely as physical problems that cause anxiety and emotional unbalance –it is rarely the other way around.

Equally relevant for my research, symptoms of cultural sources of unbalance tend to overlap with biomedical alarm signs of complication during pregnancy. As I will show in chapters 4 and 5, government producers of safe motherhood communication materials assume there is only one explanatory model –with a western biomedical foundation- and expect indigenous women and parteras to read the messages of their bodies within this frame of reference. Health staff complain that indigenous women first resort to traditional healers and TBAs when they feel signs of unbalance during pregnancy, which results - they argue- in culturally oriented diagnosis and potentially harmful delays.[205]

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[201] Most TBAs in Xochis said an unresolved loss of *nahual* could result in the death of a pregnant woman or her child, or in complications for either of them. Data from the MNH Project 2008 baseline survey.
[202] Castañeda Camey X, García Barrios C, Romero Guerrero X, Núñez-Urquiza RM, González Hernández D, Langer Glass A. Tradicional birth attendants in Mexico: advantages and inadequacies of care for normal deliveries. *Social Science & Medicine 43(2):199-207,* 1996, p. 204.
[203] Roth Allen D 2002, p. 186. The author refers to these non-biomedical risks as "unofficial risks". From her research in Tanzania, she observes that the biomedical approach stresses the risks *of* motherhood, while indigenous women were more concerned with a host risks *to* motherhood, that is, "with conditions that prevented them from carrying a pregnancy successfully to term, such as secondary infertility and miscarriage." Pregnant women do not seek biomedical care for unofficial risks.
[204] Castañeda X, Langer A, García C. *Significados y Significantes de la Fertilidad: Pertinencias de la Metodología Cualitativa en la Salud Reproductiva.* Unpublished essay, 1995. Available at www.hsph.harvard.edu/Organizations/healthnet/_Spanish/course/index.html. Accessed October 10, 2006.
[205] Some 27% of men surveyed for the MNH Project 2008 baseline said women showing "signs of danger" during pregnancy should consult a traditional healer first.

2.3.3. The meanings of risk in pregnancy and childbirth

But the idea of risk surrounding pregnancy and childbirth is not alien to indigenous societies in the region. At the time of the European invasion, the Nahuas compared delivery to agony.[206] And while most indigenous peoples consider pregnancy and childbirth as "normal events, rather than medical problems," many also see them as potentially dangerous,[207] which is the case with the Amuzgos in Xochis, as my own data confirms. Cosminsky mentions some telling expressions in this regard:

> In Ica, Peru, pregnancy is considered a special instance of an *estado delicado* (i.e. a "delicate" or potentially dangerous state).[208] In some cases, terms denoting illness are used to label pregnancy, such as *está enferma* ("she is sick") used in Mexico and Guatemala. Jordan cautions that the term *enferma* may not indicate an "illness view" among Mayan women in Yucatan, since the parallel with illness may lie in the fact that both illness and birth are stressful times associated with ritual and physical danger.[209]

Módena points out that popular expressions about conception (*enfermarse de niño*, or "becoming sick with child")[210] and delivery (*aliviarse*, which is used as a synonym of "giving birth" or "delivering", though it literally means "to relieve oneself ")[211] place these events semantically close to the domain of illness.[212] Even though these expressions may not refer to "illness" in biomedical terms, they do convey a sense of danger, burden, and relief that allows for semantic impregnation from public health risk discourse. I will analyze these connections and potential implications in chapters 6 and 7.

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[206] López Austin A 1980, p. 339. The author quotes a Nahua text -*"... llegó (la mujer) al tiempo de muerte: ya quiere parir..."*- as an indication of grave concern for a society where death while giving birth must have been a frequent event.
[207] Cosminsky S 1986, p. 76.
[208] The expression "*estado delicado*" is quite common when referring to pregnancy in Spanish.
[209] Ibid, p. 76.
[210] Many Amuzgo women refer to their own pregnancy as "being sick".
[211] *Aliviarse* is a common expression among younger women in Xochis. Older women tend to use the equivalent to the Spanish term *acostarse* (to lie down to rest), which refers to the tradition of 40 days resting in isolation.
[212] Módena ME 1990, p. 125.

However, while governments and experts see the "safety" in safe motherhood primarily in terms of death and disease, it is clear that women and their families feel other values are at stake. Research findings from other rural areas in Mexico[213] [214], from other indigenous Latin American peoples[215] and other non-Western cultures[216] [217] [218] [219] [220]validate this claim. Women point to accepting pain as something inherent to giving birth, getting assistance from other women, having culture- and language- friendly services available, having family members with them during childbirth, keeping modesty and privacy, avoiding vaginal exams, and granting appropriate care of the placenta, among other issues of personal safety. Cultural considerations permeate both trained and untrained TBA's perception of maternal risk in Mexico[221] [222] and elsewhere[223].

Trying to answer why many indigenous women in Guatemala do not go to the hospital at the first sign of difficulty, researchers unveiled a common pattern of disconnection between mainstream and indigenous views of safe motherhood: "The problem frequently is not that Mayan midwives, their clients and families fail to understand the biomedical information about dangers in birth, but rather that this information fails to fit into an already existing social system of understanding birth and birth-related knowledge."[224]

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[213] Hunt L, Glantz NM, Halperin DC. Childbirth care-seeking behaviour in Chiapas. *Health Care for Women International* 23:98-118, 2002.
[214] Molina Rosales DO, 2002.
[215] Center for Reproductive Rights 2005, p. 6.
[216] Kruske S, Kildea S, Barclay L. 2006.
[217] MotherCare 2000.
[218] Watson J, Hodson K, Johnson R, Kemp K. The maternity experiences of indigenous women admitted to an acute care setting. *Australian Journal of Rural Health* 10:154-160, 2002.
[219] Douglas VK 2006.
[220] Adams V, Miller S, Chertow J, Craig S, Samen A, Varner M. 2005.
[221] García-Barrios C, Castañeda-Camey X, Romero-Guerrero X, González-Hernández D, Langer-Glas A. 1993.
[222] Anderson BA, Anderson EN, Franklin T, Dzib-Xihum de Cen A. Pathways of Decision making Among Yucatan Mayan Traditional Birth Attendants. *Journal of Midwifery & Women's Health* 49(4):312-319, 2004.
[223] Lang J, Elkin E. A study of the beliefs and birthing practices of traditional midwives in rural Guatemala. *Journal of Nurse-Midwifery* 42(1):25-31, 1997.
[224] Berry N 2006.

Bonfil contends that indigenous peoples reject the imposition of certain innovations from outside their communities –he gives the example of vaccination- because they imply a loss of group autonomy. In other words, they are signs of cultural resistance:

> La vacunación, aparte de que por sus características de aplicación es vista como una peligrosa agresión directa del mundo dominante, también genera dependencia porque no forma parte de los elementos culturales propios que emplea la comunidad para enfrentar sus problemas de salud y enfermedad: no está dentro del cuadro de recursos que el grupo produce y controla. Se trata, en fin, en todos los casos, de la lucha permanente por el control de los espacios culturales: quiénes deciden (nosotros o los otros) y sobre cuáles aspectos de nuestra vida deciden. El conservatismo, en la situación de los pueblos oprimidos, es también una lucha de resistencia encaminada a mantener el derecho a las decisiones y los elementos culturales propios.[225]

The collision between biomedical and indigenous views of maternal health is nowhere more evident than in practices of childbirth. Indigenous women across Latin America – particularly those living in indigenous communities- have customarily had their children at home, often helped by traditional birth attendants, also known as *parteras* or *comadronas*, and sometimes assisted by their husbands and other family members.[226] [227] In rural Mexico, as elsewhere in the Americas, government policies and frontline medical practice –in line with global safe motherhood guidelines- have increasingly insisted women deliver in hospitals and health centres.

Indigenous women have traditionally delivered their children in upright, sitting or squatting positions. Government health staff and most medical practitioners discourage these practices, in favour of giving birth while lying down, flat on the back –what is known in obstetric jargon as the gynaecological position-, despite a growing body of epidemiological evidence that finds no clear, definitive obstetric advantage of either

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[225] Bonfil Batalla G 1990, p. 195.
[226] Castañeda Camey X, García Barrios C, Romero Guerrero X, Núñez-Urquiza RM, González Hernández D, Langer Glass A 1996.
[227] The MNH Project 2008 baseline shows that 60% of Amuzgo women had delivered their last child at home.

system, and even points to certain benefits in traditional positions.[228] [229] [230] In Mexico, the official 1993 norm for assistance during pregnancy and delivery calls for "respecting, primarily, all the positions that the woman wishes to use, as long as there is no medical counter-indication."[231] In spite of these guidelines, as well as policy and advocacy from the national direction of Traditional Medicine and Intercultural Affairs at the Secretary of Health, the vast majority of medical practitioners working in government health units and hospitals ask women to lie down on their backs for delivery. At the time of fieldwork, this was also the case in Xochis and the reference hospital in Ometepec.

The disposal of the placenta offers another typical example of the disconnection between clinical obstetric practice and traditional indigenous women's views and practices. It is an almost universal tradition among Latin American indigenous peoples to bury the placenta, wash it with water from a river, or burn it and scatter the ashes in farmland –all rituals closely linked to the wellbeing of the child. Government health staff and medical practitioners usually throw away the placenta, because they do not understand the spiritual dimensions of childbirth as indigenous peoples do.[232]

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[228] Gupta JK, Hofmeyr GJ, Smyth R. Position in the second stage of labour for women without epidural anaesthesia. *Cochrane Database of Systematic Reviews*, Issue 1. Art. No.: CD002006. DOI: 10.1002/14651858.CD002006.pub2, 2004. From a systematic review of the literature, the authors concluded that there was less blood loss when women gave birth on their backs; but this position was more painful for women and caused more problems with the baby's heartbeat; also, forceps were more frequently used and there were more episiotomies (cuts to the birth outlet).

[229] Lawrence A, Lewis L, Hofmeyr GJ, Dowswell T, Styles C. Maternal positions and mobility during first stage labour. *Cochrane Database of Systematic Reviews*, Issue 2. Art.No.: CD003934. DOI: 10.1002/14651858.CD003934.pub2, 2009. According to the authors, who reviewed 21 studies with 3706 women, there is evidence that walking and upright position in the first stage of labour reduce the length of labour and do not seem to have negative effects on the mother and the baby.

[230] The MNH Project 2008 baseline reveals that women who had their children while lying down were twice as likely to suffer tears than women who delivered in upright, sitting or squatting positions.

[231] *La atención intercultural del trabajo de parto en posición vertical en los servicios de salud.* Mexico City: Secretaría de Salud, 2007, p.6.

[232] Barroso Calderón CG. La fecundidad indígena en México vis a vis la visión de los programas oficiales: ¿caminos divergentes? *Estudios Sobre las Culturas Contemporáneas* 10(20):79-105, 2004, p. 96. *Red AlyC-La Hemeroteca Científica en Línea en Ciencias Sociales*. www.redalyc.com. Available at http://redalyc.uaemex.mx/redalyc/pdf/316/31602004.pdf. Accessed February 25, 2007.

2.4. *Parteras*, from key resource to outcasts in safe motherhood discourse

The role of TBAs in childbirth is one of the most contentious issues in safe motherhood policies and practices. *Parteras* have been key resources for maternal obstetric and spiritual health across Latin American indigenous cultures.[233] They not only assist deliveries in a client-friendly, culturally relevant manner, but they also provide some prenatal care, most notably through abdominal massages to make pregnancy less painful, keep the uterus in place, and arrange the foetus for normal delivery if necessary –which most clinical practitioners consider a dangerous practice.[234] Immediately after delivery, they attend to the newborn and, in places like Xochis, they massage the woman's body from head to toes, to close it and defend it from physical and spiritual strains, and tightly bind the woman's abdomen to help it heal.[235] They also give advice, which may include indications for their clients to go for prenatal care in government health units, as it happens in Xochis.[236] Their intervention is typically more personal, supportive and holistic, as well as less invasive, than care from government health staff.[237]

Safe motherhood policies have triggered a fundamental disruption in this regard. During the 1970s and 1980s international health agencies placed much hope for reduced maternal and infant mortality in the training of TBAs.[238] [239] Then, in the 1990s, there was a reaction in the opposite direction, to the point that, for many, the case is closed: "It has now been shown that even trained traditional birth attendants cannot, in most cases, save women's lives effectively because they are unable to treat complications, and are often

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[233] Cosminsky S 1986, p. 77.
[234] Ibid, p. 78. According to the MNH Project 2008 baseline, some 65% of women who had been pregnant during the three previous years had gone for prenatal control with a partera.
[235] Flores Arellano AN 1996, p. 96-102.
[236] According to the MNH Project 2008 baseline, 77% of all *parteras* in Xochis recommended their pregnant clients go for prenatal checkups at government health centres. Women were seven times more likely to have gone for prenatal checkups if *partera*st had told them so.
[237] Cosminsky S 1986, p. 84.
[238] WHO. *Traditional birth attendants. A field guide to their training, evaluation and articulation.* Geneva: WHO, publication no. 44, 1979.
[239] WHO defines a TBA as a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through an apprenticeship to other TBA. World Health Organisation. *Traditional birth attendants: A joint WHO/UNICEF/UNFPA statement.* Geneva: WHO, 1992.

unable to refer."[240] These expert voices overlook the fact that most "skilled" attendants would also hit a dead-end if they had to assist complicated deliveries in the same conditions TBAs do –and they would certainly play no meaningful role from a cultural perspective. WHO has dismissed TBAs as "another disappointment", because "evidence emerged that training TBAs has had little impact on maternal mortality" and because "there are no elements to demonstrate that this training is cost-effective"[241].

But not everyone is convinced about the inefficacy of TBAs in making childbirth safer. Some authors have noted that it is difficult to evaluate TBA contribution within larger packages of safe motherhood interventions.[242] [243] [244]. Others have criticized TBA training for being often condescending and impractical, lacking quality control, using inappropriate methods and inadequate teachers, being dismissive of TBA knowledge and discouraging practices that may be beneficial, like traditional birthing positions.[245] [246] [247] Training programs have also had deleterious effects on traditional midwifery roles, which are often much broader and more complex than those with which the biomedical sector is concerned.[248] [249] [250] WHO's position in this regard reveals the primacy of Western epidemiological and biomedical criteria over cultural concerns and traditional roles:

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[240] Carlough M, McCall M. Skilled birth attendance: what does it mean and how can it be measured? A clinical skills assessment of maternal and child health workers in Nepal. *International Journal of Gynaecology & Obstetrics* 89(2):200-8, 2005.
[241] WHO 2005, p. 70
[242] Ray AM, Salihu HM. The impact of maternal mortality interventions using traditional birth attendants and village midwives. *Journal of Obstetrics and Gynaecology* 24(1):5-11, 2004.
[243] Sibley L, Sipe TA, Koblinsky M. Does traditional birth attendant training improve referral of women with obstetric complications: a review of the evidence. *Social Science & Medicine* 59(8):1757-68, 2004.
[244] Sibley LM, Sipe TA. What can a meta-analysis tell us about traditional birth attendant and pregnancy outcomes? *Midwifery* 20:51-60, 2004.
[245] Goldman N, Glei D. Evaluation of midwifery care: results from a survey in rural Guatemala. *Social Science and Medicine* 56:685-700, 2003.
[246] Lang JB, Elkin ED. A study of the beliefs and birthing practices of traditional midwives in Guatemala. *Journal of Nurse-Midwifery* 42(1):25-31, 1997.
[247] Kruske S, Barclay L 2004.
[248] Pigg SL: Acronyms and effacement: traditional medical practitioners (TMP) in international health development. *Social Science & Medicine* 41(1):47-68, 1995.
[249] Hinojosa SZ. Authorizing tradition: vectors of contention in Highland Maya midwifery. *Social Science & Medicine* 59(3):637-51, 2004.
[250] Jenkins GL. Burning bridges: policy, practice, and the destruction of midwifery in rural Costa Rica. *Social Science & Medicine* 56(9):1893-909, 2003.

> Childbirth is a central event in the lives of families and in the construction of communities; it should remain so, but it must be made safe as well. For optimum safety, every woman, without exception, needs professional skilled care when giving birth, in an appropriate environment that is close to where she lives and respects her birthing culture. Such care can best be provided by a registered midwife or a health worker with midwifery skills, in decentralized, first-level facilities... Skilled midwifery professionals do need the back-up only a hospital can provide, however, for women with problems that go beyond the competency or equipment available at the first level of care. [251]

In this critical example of safe motherhood discourse, WHO discourages home birth in favour of the biologically defined "optimum safety" of institutional delivery. In doing so, global safe motherhood discourse also leaves TBAs out of "skilled care" and safe childbirth –thus labeling TBAs unskilled and TBA-assisted deliveries as unsafe. Meanwhile, TBAs continue to be a key traditional obstetric resource in Mexico, where they attend to some 40 percent of deliveries in rural areas[252] [253]. In Xochis, they still assist two thirds of all pregnancies and half of all deliveries.[254] The government's strategy in the region has been to train as many *parteras* as possible, based on biomedical conceptions and practices, "so they will cause no harm" and in the hope of gradually phasing them out of existence.[255]

Tensions around where to deliver and with whom are part of a larger set of power relations involving government health staff, private medical practitioners, traditional healers, *parteras*, pregnant women, husbands, and elderly women. Although there is no agreed-upon articulation between biomedical and traditional practitioners, much of this happens under the surface, as indigenous populations straddle both worlds and negotiate

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[251] WHO 2005, p.xv.
[252] See, among others, Castañeda-Camey X. Embarazo, parto y puerperio: conceptos y prácticas de las parteras en el estado de Morelos. *Salud Pública de México* 34(5):528-532, 1992.
[253] Castañeda Camey X, García Barrios C, Romero Guerrero X, Núñez-Urquiza, RM, González Hernández D, Langer Glass A. Traditional Birth Attendants in Mexico: Advantages and inadequacies of care for normal deliveries. *Social Science and Medicine* 43(2):199-207, 1996.
[254] This evidence comes from the MNH Project 2008 baseline study.
[255] This was the official training policy in the Ometepec health district during my last visit to the field in April-May 2008, despite some efforts at the federal level to engage *parteras* and medical practitioners in mutual training programs that were labelled as *enriquecimiento mutuo* (mutual enrichment).

their own practices.[256] However, these negotiations should not obscure what some authors describe as the overall trend in the uneasy coexistence of biomedical and traditional views of health and illness: the growing assimilation of the traditional within a hegemonic model of public health.[257] WHO's exclusion of TBAs from the definition of "skilled" assistance and TBA training programs in rural Mexico confirm the instrumental role of safe motherhood discourse and practice in this regard.

2.5. Conclusions

In this chapter, I have shown how risk discourse dominates contemporary public health and how it connects with the safe motherhood agenda that has defined global policies to prevent maternal mortality over the last two decades. These connections project Western-born, expert-led ideas of maternal and child health across different countries and cultures. Among other things, these global discursive trends imply that health risks, such as obstetric complications and maternal deaths, are subject to calculation and control by "at risk" individuals and communities.

Experts behind global safe motherhood policies have changed their mind regarding risk approaches to maternal health (in particular, they have dismissed the use of population-based risk factors to predict obstetric complications); but the notion of risk is very much alive when it comes to frontline public health practices. If anything, doing away with degrees of risk has made risk yet more pervasive: all pregnant women are now at risk. Moreover, certain population groups, such as pregnant indigenous women, continue to be labelled at higher risk than women in the overall population. Because safe motherhood discourse draws heavily from health risk discourse, each pregnant -hence, at-risk- woman is responsible for her own health and the wellbeing of her child.

In places like Mexico, there is heavy political pressure to mobilize individuals, families, and communities in the prevention of maternal deaths, as a response to the political

[256] Módena ME 1990, p. 215.
[257] Ibid, p. 209-211.

stigma associated with higher than average rates of maternal mortality. This pressure bears mostly upon rural indigenous communities and translates in health prevention and promotion policies based on institutional control of all pregnancies and deliveries.

I have also discussed how key components of health risk and safe motherhood discourses may interact with indigenous views of pregnancy and childbirth. Popular expressions related to pregnancy and childbirth somehow connote danger and a certain burden in these events, though they may not necessarily translate into biomedical views of risk and safety in safe motherhood discourse. I examine these connections in chapters 6 and 7, based on data from Xochis.

A major point of departure from traditional birthing practices is the idea that women can have "optimum safety" if they deliver in hospitals and government health units. I will explore these assumptions in government discourse and how they resonate with pregnant women and recent mothers in Xochis.

In traditional indigenous Mesoamerican societies, conceptions of the human body have guided and justified the behaviours of different social groups. Using data from Xochis, I analyze how government-sponsored notions of health risks and safety contribute to produce and reproduce these and other power relations within a hegemonic model of maternal and perinatal health.

Traditional and biomedical health systems share a fundamental trait: certain experts have the social power to cure. In indigenous Mesoamerica, traditional healers and birth attendants have contributed to give meaning to life events such as pregnancy and childbirth, and have had the power to restore physical, emotional, and social balance in indigenous societies. As data from my research reveals, government policies have tried to co-opt, dismiss, or ignore these traditional sources of knowledge, in favour of the medical profession –even when government discourse at the federal level claims otherwise. I discuss these findings in chapters 5, 6, and 7.

Chapter 3: Analytical and methodological framework

In this chapter, I will discuss the relevance of discourse analysis to address the main research problem. I will also present an integrative analytical framework for linking actual discourse analysis with social critique. To set up this framework, I have drawn from critical discourse analysis (CDA), and more specifically, from Fairclough's textually oriented approach to the study of language in connection with social and cultural change[1].

CDA is an interdisciplinary approach to the study of discourse that focuses on the links between language and power.[2] CDA authors connect discourse and power mostly through the notion of ideology and the analysis of texts. I will first explain how I have used the concept of ideology here, with emphasis on the ideological effects of health risk discourse and safe motherhood discourse. In close relation with the notion of ideology, I will discuss two key theoretical constructs from social semiotics: hegemony and ideological complex, as elaborated by Hodge and Kress from classical Gramscian theory.[3] [4] I have complemented these sources by drawing from Lupton's work on the use of risk discourse in public health.[5]

My purpose, in setting up this framework, is to take into account both stability and change in discourse. Therefore, I have tried to make it flexible enough to cover key dimensions of mainstream safe motherhood discourse and to allow for the emergence of new categories from the data.[6]

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[1] Fairclough N 1992, p. 1-11.
[2] Wodak R. Critical Discourse Analysis. In Clive Seale, Giampietro Gobo, Jaber F. Gubrium, and David Silberman (eds.), *Qualitative Research Practice*. London: Sage Publications, 2004, reference on p. 197-214.
[3] Hodge R, Kress G, 1988, p. 2-12.
[4] Hodge R, Kress G, 1993, p. 158.
[5] See p. 11 above for a complete list of works by Lupton referenced throughout this thesis.
[6] For a definition of emerging categories and how I use them here, see chapters 3.6.2.3, p. 133-135 and 6.1, p. 295-303.

I will discuss the interactions between different components of the theoretical framework and between theory, methodology, and data. In particular, I will explain how Fairclough's three-dimensional analysis of discursive events as texts, discursive practices, and sociocultural practices accounts for the dynamic interaction between language and other aspects of social life, and how I have used it in my work. I will also discuss the notion of intertextuality, which has been a key resource to explore how the producers of government communications texts and people from the communities draw from different discourses to make meaning about maternal health.

I will also give an overview of the research process, including a discussion on the links between this dissertation and the maternal and newborn health research initiative (the MNH Project) where my own research is nested. I will give an account of my activities as member of the multidisciplinary research team and I will show how my own research drew from and contributed to this multi-stakeholder effort.

In a separate section on methodological issues, I will discuss the selection of the corpus, including government health promotion materials, and interviews with community participants and key informants. I will describe the process of questionnaire design, fieldwork, translation, and transcription of interviews. I will then review some specifics of textual analysis for different kinds of texts, and I will address familiar concerns about the search for ideological markers in language and other semiotic resources.

3.1. Relevance of discourse analysis to address the main research problem

In chapter 1.1.2, I have defined discourse as the production of meaning through language and other semiotic resources[7] [8] [9]. Discourse, in this general sense (I will call it Discourse), is a social process, a semiotic practice enacted in discursive events[10], with

[7] Hodge R, Kress G 1988, p. 6.
[8] Lemke J 1995, p. 6.
[9] Fairclough N 1992, p. 62-65.
[10] See definition of discursive events on 3.5 below.

both symbolic and material effects, including the construction of social identities, social relationships, and systems of knowledge and belief.

This is not to say that everything in social life is Discourse. Families make decisions about pregnancy and childbirth based on previous experiences and cost-benefit tradeoffs. Anthropologists have explored the subjective, "lived" experience of individuals regarding motherhood and childbirth –I have mentioned several examples of this approach from the literature in chapters 1 and 2. Data from my own research shows how people often refer to their own experiences when asked about a general state of affairs. But the very recreation of "lived experience" is framed in Discourse,[11] and is the result of a tension between "given" discourses and personal construals.[12] In other words, the lived experience is "socialized" through Discourse –down to the complex engineering of public health campaigns, as I expect to show here. In other words, Discourse is a primary element in the construction of the social world.[13]

In a more restricted sense, I will refer to discourse as a particular way of constructing a subject matter or an area of knowledge[14] through language and other semiotic resources. This construction –a *construal*, as defined on p.7 above- represents a certain point of view. As we have seen in chapter 2, health risk discourse is a particular way of construing health issues in the public sphere, while "safe motherhood" and *maternidad sin riesgo* are discursive constructions of motherhood from the perspective of international agencies, governments, and the medical profession. Of course, these discourses share the main traits and have the same potential effects than Discourse in a general sense –among other things, they shape practices and are shaped by them.[15] Here is how Lupton defines discourse in this restricted sense:

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[11] I refer to these narrations as "personal biographies", where what counts is not so much what really happened as how people construe those events.
[12] As Martin and Stenner point out: "In qualitative research we are dealing with complex forms of communication. As such, our participants must be affirmed simultaneously as meaning-making beings and as beings who are made by meanings. Martin A, Stenner P 2004, p. 403.
[13] What Fairclough considers a moderate version of social constructivism (Fairclough N 2003, p. 9) and Lupton calls "weak" constructivism (Lupton D 1999a, p.28).
[14] Fairclough N 1992, p. 3 and 128.
[15] Lupton D 1994, p. 29-30. The author explains this symbiotic relationship between discourse and practice with an example from the framing of health issues in the public sphere. The news media's portrayal of

> A discourse may be understood as a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery. Through discourses we perceive and understand the social, cultural and material worlds in which we move. Discourses both delimit and make possible what can be said and done about phenomena such as risk. Thus, for example, it may be said that there are a series of discourses on risk that serve to organize the ways in which we perceive and deal with risk. Discourses are constantly in a state of flux: some come to prominence at certain times but then make way for others, and this has implications for our understanding of and response to phenomena... Discourse analyses of risk reveal the shifting meanings around risk phenomena and the struggles over these meanings.[16]

In other words, discourses construe[17] and convey models of reality through semantic resources. These models of the world include participants, actions, subject positions, and expected behaviours. As Machin points out, "once discourses become dominant and become realized in different models of communication they take on a quality of truth" and "may lead to many kinds of realizations".[18]

Discourse analysis is the study of both Discourse and discourses. The expression designates a theoretical and methodological approach to qualitative research that covers a wide range of practices, including conversation analysis, narrative analysis, deconstructive analysis, critical discourse analysis, systemic functional linguistics, and sociolinguistics, among other traditions.[19] Discourse analysis searches for meaning beyond explicit texts and utterances –e.g., word selection, clause organization, choice of

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surgeons as heroes and patients as saved from death by medical technology "both supports and reinforces societal attitudes on the funding of high technology research and equipment." This discourse, which shapes expectations at all levels of society, "conflicts and competes with discourses that portray good health as a preventive issue, focusing on lifestyle modification rather than medical intervention as the preferred solution to disease and illness."

[16] Lupton D 1999a, p. 15.

[17] By "construe" and "construal" I refer, as mentioned in chapter 1 , to the semiotical construction of life experiences, social events, and whatever happens in the "real" world. We construe texts both as producers and interpreters.

[18] Machin D. *Introduction to Multimodal Analysis*. London: Hodder Arnold, 2007, p. 14.

[19] Martin A, Stenner P 2004, p. 399.

images, relations between text and image, and between text and social context- to unveil cultural, ideological, and political structures that speak through the speaker.

Discourse analysis can help identify key dimensions of health risk discourse from different theoretical frameworks, such as risk awareness, choice, responsibility, blame, danger/threat, trust, and control/self-control, as well as key dimensions of mainstream safe motherhood discourse, such as pregnancy risks, safe childbirth, skilled assistance at birth, and the wellbeing of the foetus and the newborn, all of them discussed in chapters 1 and 2, within discourses of pregnancy and childbirth in Xochis.

As Van Dijk points out, "specific, local meaning of discourse may be constructed in and by interaction of social participants".[20] To capture these dynamics, I have explored other discursive categories related to safe motherhood discourse emerging from our data, which could reflect the influence of locally relevant orders of discourse.

3.2. Ideologies

Most authors within the CDA tradition explore the links between meaning making, social practices and relations of power[21] [22] [23] Many use the conceptual notion of ideology to make this connection, and they bring it to life through the analysis of actual texts in relation with associated social, political, and cultural practices.

Much has been said about ideologies, and there are many definitions of this slippery notion. Here, I will focus on the use of ideology within the CDA tradition. I will explain how I intend to use this concept, with particular emphasis on the ideological effects of health risk discourse and safe motherhood discourse, as discussed in chapter 2.1.4.

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[20] Van Dijk TA 1995, p. 257. The author cites Coulter J. *Mind in Action*. Cambridge: Polity, 1989.
[21] Van Noppen JP. CDA: A discipline come of age? *Journal of Sociolinguistics* 8(1):107-126, 2004, p. 108.
[22] Wodak R 2006.
[23] Fairclough N, Wodak R. Análisis crítico del discurso. In T Van Dijk (ed.). *Estudios sobre el discurso II: El discurso como interacción social*. Translated by Elena Marengo. Barcelona: Gedisa, 2000, p. 367-404.

By and large, CDA scholars understand ideologies as systems of values and ideas of any social group or class, which promote and legitimate the interests and actions of that group or class, and which contribute to create and maintain relations of domination[24] [25] [26], often in a covert way.[27] Ideologies are not innate, but learned through social practices and Discourse.[28] In short, we can say that "ideology is meaning in the service of power."[29]

Contrary to classical Marxist theory, many CDA authors rule out ideologies as false consciousness –as opposed to "true" consciousness or "true" knowledge- and I have adopted that restriction for my work. As van Dijk et al point out, "ideologies are not false of true in any interesting sense, and even less when falsity is typically attributed to the ideas of ideological Others."[30] For epistemological purposes, "whether for 'dominating' or 'dominated' groups, or whether as means of domination or as means of resistance, ideologies should be described in the same terms".[31]

Fairclough shares this wider conception of ideologies and puts forward a definition that seeks to combine textual analysis with a social orientation to discourse. He defines ideologies as "significations/constructions of reality (the physical world, social relations, social identities), which are built into various dimensions of the forms/meanings of discursive practices, and which contribute to the production, reproduction or transformation of relations of domination".[32] Following Althusser, he maintains that ideologies have "material existence in the practice of institutions", insofar as they

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[24] Van Dijk T, Neff-van Aertselaer J, Pütz M. 2004.
[25] McAndrew J. Towards a framework for analyzing ideology. In M Pütz, J Neff-van Aertselaer, T van Dijk (eds.). *Communicating ideologies: Multidisciplinary Perspectives on Language, Discourse, and Social Practice*. Frankfurt am Main: Peter Lang, 2004, p. 119-173.
[26] From a CDA perspective, ideologies help sustain a range of unequal power relations by favouring class, corporate, ethnic, gender or age interests. CDA strives to uncover these ideological effects and contribute to prevent or revert power imbalances and inequalities across all domains of social life.
[27] Van Noppen JP 2004, p. 112.
[28] Van Dijk T, Neff-van Aertselaer J, Pütz M 2004, p. xvii.
[29] Dobbin M. Stephen Harper's National Security State. *Rabble.ca*. November 12, 2009. Available at http://rabble.ca/blogs/bloggers/murray-dobbin/2009/11/stephen-harper%E2%80%99s-national-security-state. Accessed November 12, 2009.
[30] Ibid, p. xv-xvi.
[31] Ibid, p. xvi.
[32] Fairclough N 1992, p. 87.

"interpellate" individuals and thus constitute subjects.[33] He also notes, in classical Gramscian tradition, that ideologies are most effective "when they become naturalized, and achieve the status of 'common sense'".[34]

Lupton takes these views of language and power and explores them across her body of work on health discourse. She, too, puts aside the idea of a "false consciousness" and refers to ideology as "a system of abstract shared beliefs, images or concepts which give structure to everyday life and which assist individuals to make sense of the world."[35] To the extent that they attempt "to persuade audiences to accept a particular version of reality over another," and this implies contesting, ignoring or consolidating social relations of power, public health discourses become ideological.[36] In particular, Lupton contends that "the approach to risk behaviours which assumes rational calculation, the weighing up of costs and benefits, also tends to ignore the role played by power relations".[37] [38]

López Austin's pioneering work on the ideological implications of discourses on health and religion in pre-Colombian Mesoamerica provides a strong theoretical connection between current research on the ideological effects of contemporary public health discourse and my own work on the impact of safe motherhood discourse in Mexican indigenous communities. In particular, López Austin's work speaks to the relevance of the research topic and my own approach through this dissertation. As the author observes in his study of ideological construals of the human body among the Nahuas:

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[33] I have discussed in chapter 2 how health risk discourse constitutes at-risk groups and interpellates their members as individuals and, therefore, subjects with certain characteristics and responsibilities.
[34] Fairclough N 1992, p. 87. In a Gramscian sense, we can say that ideology is domination through common sense.
[35] Lupton D 1994, p. 29.
[36] Lupton D 1999a, p. 113.
[37] Ibid, p. 113.
[38] Hodge R and Kress G (1993, p. 6) also include science among ideologies, because it "deals in hypothetical constructs whose status is not always so very different" (from that of political ideology). Of course, not everything is science is ideological in nature, but scientific discourse has powerful ideological dimensions. What makes science particularly effective from an ideological perspective is the fact that it has entered contemporary public discourse as eminently non-ideological. Public health risk campaigns are often mounted on the unchallenged authority of "scientists", "evidence-based research", or "scientific research".

> Las concepciones del organismo humano guiaron y justificaron el comportamiento práctico de los distintos componentes de la sociedad, dirigiéndolo a la satisfacción de las aspiraciones e intereses de los particulares grupos sociales, y haciéndolo servir frecuentemente como medio para la reproducción de las relaciones sociales. Las diferencias entre sexos, edades, grupos sociales, las relaciones de gobierno, la división y distribución del trabajo, los valores morales o el fundamento del control social, descansaron, en buena medida, en una particular concepción del cuerpo humano que hacía físicamente distintos a esclavos y a libres, a malos y a buenos, a nobles y a plebeyos, a jóvenes y a viejos o a hombres y mujeres, reforzando las reglas de distribución de las funciones sociales de cada hombre.[39]

According to Lupton, one of the tasks of CDA is "to uncover latent ideologies and to question their taken-for-granted nature and political use."[40] Throughout her work, she makes the following questions at the ideological level of analysis: What ideas, values, notions, concepts and beliefs are present in the texts, and which are absent? Whose voices receive attention over others? Whose interests are served by the reproduction of these ideas, values, notions, concepts and beliefs in the texts? How do elite groups, institutions and social structures shape discourses and favour some discourses over others? How are power relations sustained and justified by discursive choices? What kinds of stereotypes are perpetuated in texts? What norms and values are privileged over others? How might audiences' view of the world be influenced by the texts? What types of resistances and alternative discourses are generated in response to dominant discourses?[41] I have addressed some of these questions in subsequent chapters.

3.3. Hegemony and ideological complexes

Because they tend to advance power interests and claim universal status through common sense, ideologies coexist and clash in language and semiotic practice. Discourses, as the sites of these confrontations, and texts, as products of discursive events,[42] can show traces of contradictory ideologies. The result is a hegemonic balance of meaning and power,

[39] López Austin A 1980, p. 9.
[40] Lupton D 1994, p. 29.
[41] See, for instance, Lupton D 1994, p. 29, and Lupton D 1997, p. 5.

always unstable but powerful enough to have material effects on any given domain of social life. I will explain these dynamics throughout this section.

Hegemony is defined by Gramsci as "intellectual and moral leadership (*direzione*) whose principal constituting elements are consent and persuasion."[43] A social group or class has a hegemonic role "to the extent that it articulates and proliferates throughout society cultural and ideological belief systems whose teachings are accepted as universally valid by the general population".[44] Gramsci, whose conception of hegemony is rooted in his concern with a unified grammar for the Italian language in the context of a revolutionary strategy, highlights the political nature and inherent instability of hegemonic processes.[45] Linguists who study the presence of ideology in language recognize the influence of Gramsci, precisely because of this dynamic connection between language, ideology, and power. Fairclough[46] says that Gramsci's conception of power in terms of unstable balance of hegemonic forces is superior to Foucault's deterministic view of the constitution of the subject, because it "provides a way of theorizing change in relation to the evolution of power."

Hodge and Kress adopt and further develop Gramsci's notion of *ideological complexes* as overarching sites of discursive articulation and confrontation through a mix of consensus and coercion. According to these authors, ideological complexes are "functionally related set of contradictory versions of the world, coercively imposed by one social group on another on behalf of its own distinctive interests or subversively offered by another social group in attempts at resistance in its own interests."[47] In order to accommodate these tensions, ideological complexes must sustain relationships of power and solidarity, thus

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[42] For definitions of "discursive events" and "texts", see 3.5.1 below.
[43] Fontana B. *Hegemony & Power: On the Relation between Gramsci and Machiavelli.* Minneapolis and London: University of Minnesota Press, 1993, p. 140
[44] Ibid, p. 140
[45] Ives P. *Gramsci's Politics of Language: Engaging the Bakhtin Circle and the Frankfurt School.* Toronto: The University of Toronto Press, 2004, p. 50. The author points to the dynamic nature of political intervention: "Much of the confusion surrounding Gramsci's use of 'hegemony' arises because he is using the term to describe both how a normative grammar has been imposed and how friction among different immanent or spontaneous grammars and normative grammar continues to lie unresolved. But it is also an attempt at a projected solutions of this problem –a solution that involves relieving the tensions".
[46] Fairclough N 1992, p. 92.
[47] Hodge R, Kress G. *Social Semiotics.* Cambridge: Polity Press, 1988, p. 3.

representing the social order as simultaneously serving the interests of both dominant and subordinate.[48] We can bring this abstract notion to life with an example from Guerrero, in Mexico, where government imposes prenatal checkups through coercive means, like conditioning social benefits (power function), while it does not always discourage the relationship between *parteras* and pregnant women (solidarity function).

Coronado gives another good example of these ideological articulations within the Mexican public health system, when she refers to biomedical-centred training of traditional healers, as seen from the perspective of the healers:

> La única ventaja que mencionaron todos los entrevistados con relación a la capacitación es que por medio de ese programa obtienen documentos que los autorizan a ejercer su trabajo, evitando así posibles problemas legales con las instituciones nacionales de salud (...) Su participación en los cursos legitima su trabajo y conocimientos en el contexto institucional nacional, otorga un reconocimiento simbólico, un diploma, que es aceptado como válido por las autoridades (...) Al mismo tiempo, continúan reproduciendo su ya existente legitimidad social dentro de las comunidades.[49]

Ideological complexes have control mechanisms to regulate their functioning. Hodge and Kress call these mechanism *logonomic systems*, and define them as "sets of rules prescribing the conditions for production and reception of meanings; which specify who can claim to initiate (produce, communicate) or know (receive, understand) meanings about what topics under what circumstances and with what modalities (how, when, why.)"[50] Many of these rules operate as legal, economic, and social constraints in specific domains. Logonomic systems rest on a set of classifications of people, topics and circumstances, "which are the result of contestation over long periods, but which ultimately derive from the ruling ideas of the dominant group".[51]

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[48] Ibid, p. 3, and Hodge R, Kress G 1993, p. 157-158.
[49] Coronado Suzán G 2003, p. 337.
[50] Hodge R, Kress G 1988, p. 4. Logonomic rules are taught and policed by specific social agents, such as parents, teachers, and employers. They tend to shield and consolidate power structures at different levels of society. Favouring certain discourses and interpretations is one way of doing this, among many others.
[51] Ibid, p. 5. From a discursive perspective, an ideological complex includes *relational models* (classifications of kinds of social agents, actions, objects, etc., which can also imply judgment, e.g., "all

Training of traditional birth attendants in the regional jurisdiction of Ometepec, at the time of my research, provided another good example in this regard. Government officials and health staff engaged parteras in top-down training, aiming to improve and standardize their practices from a biomedical standpoint. Among other things, they encouraged TBAs to assist deliveries in gynaecological position, against longstanding practices among indigenous peoples. At the same time, and as a result of advocacy from indigenous organizations and mounting evidence from clinical research,[52] the Direction of Traditional Medicine and Intercultural Development at the federal Ministry of Health promoted a different type of approach to TBA training, based on "mutual enrichment" (a conceptual change in genre, as discussed in 3.4) between parteras and clinical practitioners and the acceptance of upright positions for delivery. This view is still marginal within government health services, and will unlikely gain any further prominence until mainstream journals, international health agencies, and national governments accept the results of scientific research *on the terms and conditions of the biomedical paradigm and its gatekeepers*. The experience of parteras and Aboriginal women counts very little when it comes to setting the rules for the production and circulation of knowledge about pregnancy and childbirth. Even when many diverse forces have some bearing on the emergence on alternative models, chances are the logonomic systems in place will only change when the dominant groups –government, medical practitioners, researchers, policy makers- accept indigenous knowledge and ultimately imposes a new set of rules.[53]

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pregnant women are at risk", or, within a different order of discourse, "pregnancy is a normal thing in life") and *actional models* (specifications of actions and behaviours required of, permitted or forbidden to different kinds of social agents, e.g., "pregnant women need periodic checkups at government health facilities", or, within a different order of discourse, "*Parteras* should visit pregnant women in their home").

[52] See chapter 2.3.3 for clinical and epidemiological references in this regard.

[53] The MNH Project brought this property of logonomic systems to the fore. Most resources in intervention communities have been aligned with the needs of traditional parteras, who are training new parteras on their own terms and with full support from the project. Clearly, the intervention is a departure from mainstream discourse and policies. However, this shift comes from the ability of the researchers to get buy-in from government health officials, based on evidence from the baseline study. None of this would likely have happened without a challenge to the ideas of the dominant groups in the shape of epidemiological knowledge from legitimized sources, in this case, academic researchers funded by international donors.

Hodges and Kress observe that logonomic systems serve the purpose of classifying "large areas of semiosis as 'private', to be treated as beyond the reach of the 'public'/social" realm.[54] In rural Guerrero, safe motherhood discourse calls for women to go for prenatal checkups and deliver in health facilities, while traditional community mores and local culture have tended to keep maternal care within the family fold and call for women to give birth at home. The pull towards the "private" seems to come from these local orders of discourse (though, as I will show, this is far from monolithic), while government and other institutions make maternal and newborn care an issue of public health. Following Bonfil, one could see these colliding views and social practices as a manifestation of the wide gap between the *criollos novohispanos* and the Mesoamerican peoples, and more specifically, as a sign of resistance from the latter to the hegemonic project of the former. This resistance happens within the last resort of everyday life –most other spheres of life having been colonized.[55] [56]

The above example illustrates how critical discourse analysis and social semiotics can help understand not only how logonomic systems operate within safe motherhood discourse and local orders of discourse, but also –and most significantly- how they get intertwined within the ideological complex, how women as a pivotal risk group negotiate these contradictory interpellations, and what signs of resistance, appropriation and innovation –all three essential mechanisms of cultural survival and development[57]- can be traced in the discourse and practices of dominated groups.

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[54] Hodge R, Kress G 1988, p. 8.
[55] Bonfil Batalla G. *México profundo: Una civilización negada*. Mexico DF: Grijalbo; Consejo Nacional para la Cultura y las Artes, 1990, p. 190-195
[56] Hodge and Kress make a point of the potential for change within long-built ideological complexes and locked-in semiotic regulations: "Attention to the detail of semiosic process reveals countless instances of contestation, where smaller-level shifts in power have significant effects, leading to modification in the structures of domination, at times tracing the success of dominated groups, at times the success of the dominant". (Hodge R, Kress G 1988, p. 7.)
[57] Bonfil Batalla G 1990, p. 191.

3.4. Intertextualities

As analysts, how can we show the coexistence of different discourses and ideologies in semiotic practice? How can we show them clash and coalesce? One way of doing this is through the study of intertextualities, a very powerful tool in discourse analysis. Fairclough draws from Foucault, Bakhtin and Kristeva to bring this dynamic dimension into discourse analysis.[58] [59] According to the author, "the intertextuality of a text is the presence within it of elements of other texts (and therefore potentially other voices than the author's own), which may be related to (dialogued with, assumed, rejected, etc.) in various ways."[60] He also describes intertextuality as "the property texts have of being full of snatches of other texts, which may be explicitly demarcated or merged in, and which the text may assimilate, contradict, ironically echo and so forth".[61]

From Foucault, Fairclough takes the idea that "there can be no statement that in one way or another does not reactualize others."[62] Unlike Foucault, he sees opportunities for semiotic expansion in this property of Discourse. To support this shift in perspective, Fairclough reworks Bakhtin's notion of "heteroglossia", which Kristeva reintroduced as "intertextuality".[63] According to Bakhtin, "each utterance is a link in the chain of speech communication", retrospectively oriented to previous utterances and prospectively pointing "to the anticipated utterances of the next speaker".[64] But intertextuality is more than responding to other texts. "The intertextuality of a text," says Fairclough, "can be seen as incorporating the potentially complex relationships it has with the conventions (genres, discourses, styles, activity types) which are structured together to constitute an order of discourse."[65]

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[58] Fairclough N 1992, p. 84-86 and 101-105.
[59] Fairclough N 2003, p. 39-61.
[60] Ibid, p. 218.
[61] Fairclough N 1992, p. 84.
[62] Ibid, p. 101.
[63] Ibid, p. 101.
[64] Ibid, p. 102.
[65] Ibid, p. 103.

Fairclough distinguishes two levels of intertextuality. There is "manifest" intertextuality when other texts are more or less explicitly present in the text under analysis.[66] From a broader perspective, we can also find "constitutive" intertextuality or "interdiscursivity", which is the "heterogeneous constitution of texts out of elements (types of convention) of orders of discourse", such as genres, activity types, discourses, and styles. Because it involves so many different dimensions of the discursive event, interdiscursivity becomes instrumental to unstable hegemonic balance in any order of discourse.[67]

As a result of all these discursive interconnections, intertextuality becomes a source of ambivalent meanings and apparent incoherence, as "different meanings may coexist, and it may not be possible to determine 'the' meaning".[68] Also, elements of a text may be designed or interpreted in different way by different readerships or audiences, which is another source of ambivalence and an opportunity for creativity and resistant reading. The notion of "coherence" looms large here. Fairclough sees coherence more as a property of interpretation than as a property of texts [69] -a conceptual shift that further connects textual analysis with sociocultural practices. From this standpoint, we can think of coherence as a negotiation between text producers and interpreters, based on assumptions about ideational, relational, and textual meaning, genres, contextual information and knowledge from different orders of discourse. This "shifted" notion of coherence can be productively linked to mainstream conceptions of "rationality" behind health risk discourse and biomedical thinking. For instance, what kind of coherence – what kind of rationality- can we find in indigenous discourses about pregnancy and childbirth, when they draw from different –and apparently contradictory- discourses? In chapter 6, I discuss specific examples of intertextuality and their implications in terms of coherence and "rationality".

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[66] Ibid, p. 117-123. The author gives the following examples of manifest intertextuality: Discourse representation (reported speech considered both in content and form), presupposition (propositions that we take as given), negation (to contest or reject other discourses), metadiscourse (to make one's own discourse relative, or to take distance from certain levels or components), and irony.
[67] Ibid, p. 124.
[68] Ibid, p. 105, 134.
[69] Ibid, p. 84.

Looking into these cross-pollinations between events, discourses, and orders or discourse should also allow for a richer understanding of how key components of safe motherhood discourse interact with indigenous discourses of pregnancy and childbirth and what are their potential ideological effects. For instance, how do mainstream and folk notions of prenatal control interact in the corpus? What discourses do government communication designers and people from the communities draw from? What are the contradictions and ambivalences? Are they solved in ways that may indicate innovation and change?

3.5. Theoretical framework: components and interactions

In order to bring together discourse analysis and social theory, I have articulated the CDA framework developed by Fairclough around a three-dimensional view of discursive events as texts, discursive practices and sociocultural practices,[70] with the social semiotic perspective of Hodge and Kress –in particular, their concepts of ideological complexes and logonomic mechanisms[71] [72]. (See figure 1, on page 113, for a visual synthesis of the core components and interactions within this framework, adapted to the Xochis context).

Below, I provide an overview of the three dimensions of discourse analysis. Although I do this in separate sections, all three dimensions overlap in mutually influencing relations.[73] By stressing this interaction, Fairclough brings together three analytical traditions: *close textual analysis, macrosocial* views (social structures), and *microsocial* perspectives (people actively produce and make sense of social practice on the basis of shared commonsense procedures and logonomic regulations). In doing this, he also provides an answer to critics who contend that discourse analysis does not take into account the structural circumstances surrounding language use "the way molecular biology ignores the real structures that are present in every biological organism".[74]

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[70] Ibid, p. 72-73. I use the expression "sociocultural practices as a synonym of social practices".
[71] Hodge R, Kress G 1988.
[72] Hodge R, Kress G 1993.
[73] Discursive events reflect patterns, structures, conditions and meanings from discursive practices and sociocultural practices, which are in turn affected by discursive events –particularly through innovative, multilayered uses of discourse.
[74] Martínez Migueles M 2004, p. 123.

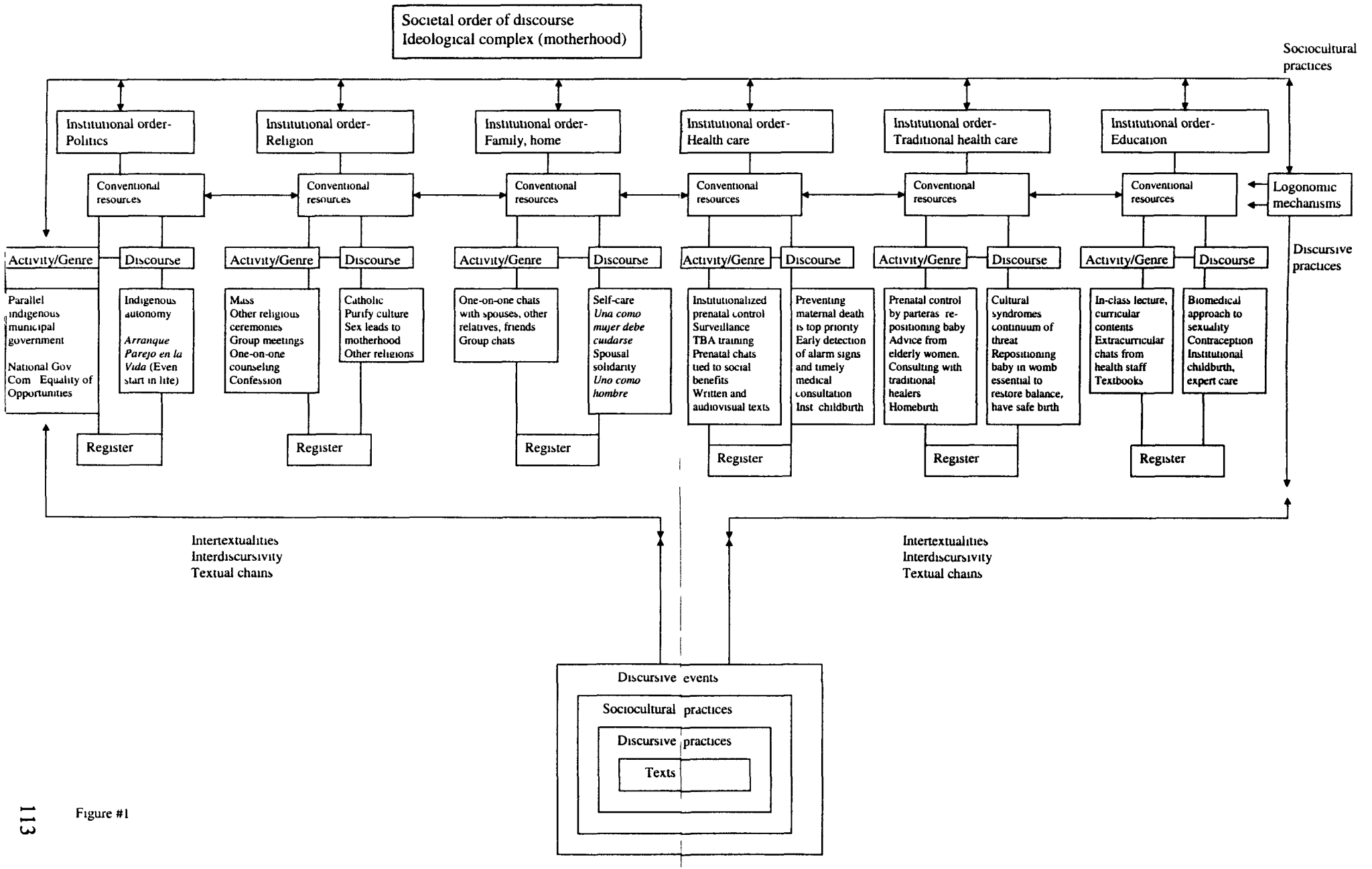

Societal order of discourse
Ideological complex (motherhood)
Sociocultural practices
Institutional order-Politics
Institutional order-Religion
Institutional order-Family, home
Institutional order-Health care
Institutional order-Traditional health care
Institutional order-Education
Conventional resources
Logonomic mechanisms
Discursive practices
Activity/Genre
Discourse
Parallel indigenous municipal government
National Gov Com Equality of Opportunities
Indigenous autonomy
Arranque Parejo en la Vida (Even start in life)
Mass
Other religious ceremonies
Group meetings
One-on-one counseling
Confession
Catholic
Purify culture
Sex leads to motherhood
Other religions
One-on-one chats with spouses, other relatives, friends
Group chats
Self-care
Una como mujer debe cuidarse
Spousal solidarity
Uno como hombre
Institutionalized prenatal control
Surveillance
TBA training
Prenatal chats tied to social benefits
Written and audiovisual texts
Preventing maternal death is top priority
Early detection of alarm signs and timely medical consultation
Inst childbirth
Prenatal control by parteras re-positioning baby
Advice from elderly women.
Consulting with traditional healers
Homebirth
Cultural syndromes continuum of threat
Repositioning baby in womb essential to restore balance, have safe birth
In-class lecture, curricular contents
Extracurricular chats from health staff
Textbooks
Biomedical approach to sexuality
Contraception
Institutional childbirth, expert care
Register
Intertextualities
Interdiscursivity
Textual chains
Discursive events
Sociocultural practices
Discursive practices
Texts

Figure #1

3.5.1. Discursive events and texts

A discursive event, that is any instance of meaning making, is the realization of Discourse along these three dimensions –and, as such, a multi-layered unit of analysis. Discursive events materialize in a text. I define texts as *any product or record of discursive practice, whether written or spoken, in words or images.*[75] This definition closely follows Fairclough[76], but it incorporates other symbolic materials, in line with the social semiotics approach of Hodge and Kress[77] and van Leeuwen[78]. Therefore, the "text" dimension of discourse analysis attends to semiotic analysis of texts.

At this textual level, I have looked into meaning potential, assuming a conventional –not arbitrary- relationship between form and content[79], with attention to such things as wording and imagery, grounding (what is in focus or out of focus, in the foreground or in the background of texts), emphasis (as indicated through agency, responsibility, and prominence), thematic positions (i.e. at the beginning of sentences and paragraphs), grammar, cohesion, text structure, pragmatics (deictics, illocutionary and perlocutionary acts), visual grammar, placement of graphic information (e.g., "new" and "given" content), macrostructures (global textual structures that convey the global meaning of a text), and intertextuality. I have also looked for implications, understood as "meanings (...) not always explicitly expressed, but somehow semantically implied, or entailed by other, explicit expressions and their meaning"[80]. I have paid closer attention to all these elements for the analysis of heavily "engineered" texts, such as health promotion materials from government sources.

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[75] It follows from this definition that transcripts of interviews and conversations, medical records, or brochures containing words and pictures would all be called texts.
[76] Fairclough N 1992, p. 71.
[77] Hodge R, Kress G 1988, p. vii-viii.
[78] Van Leeuwen T 2005.
[79] Hodge R, Kress G 1993, p. 204.
[80] Van Dijk TA 1995, p. 268.

3.5.2. Discursive practices

This dimension refers to text production, distribution and interpretation, "for example which types of discourse are drawn upon and how they are combined".[81] Discourse types are conventional resources we draw from in order to organize the relational and ideational elements of different orders of discourse -in medicine, religion, education, and so on.[82] These conventional resources range from turn taking in conversation to rituals of politeness, wording, sequence of activities, etc. Fairclough identifies four discourse types: "genre", "activity type", "style" and "discourse".[83] These are key notions for linking discourse analysis with social critique, because they can act at the same time as constraints and enabling resources, that is, as forces of continuity and change. Instead of "types of discourse", I will call them "conventional discursive resources" or simply "conventional resources", for both conceptual and practical reasons. Conceptually, I think this expression reflects the dual nature of these conventions. From a practical point of view, I am trying to limit the use of the term "discourse" (in restricted sense) and, therefore, to narrow the likelihood of confusion.

3.5.2.1. Genres and types of activities

The notions of genre and activity type are deeply intertwined. Activity types are social activities conventionally structured around a sequence of actions and a set of subject positions for the people involved in these events [84] –as we have seen, prenatal checkups and institutional birthing are examples of activity types in mainstream safe motherhood discourse. In consonance with his dynamic conception of the relation between discourse and social change, Fairclough points out that activity types "delimit a range of options rather than specifying a single rigid pattern".[85] [86]

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[81] Fairclough N 1992, p. 4.
[82] Ibid, p. 5.
[83] Ibid, p. 124.
[84] Ibid, p. 126.
[85] Ibid, p. 127.
[86] For instance, in the context of this thesis, we can hypothesize that rigid patterns of activity types –such as prenatal care- are positively related to unequal relations of power between government health staff, TBAs, and indigenous women.

Drawing from Bakhtin, Fairclough defines genre as "a relatively stable set of conventions that is associated with, and partly enacts, a socially ratified type of activity, such as informal chat, buying goods in a shop, a job interview, a television documentary, a poem, or a scientific article." [87] This definition highlights the close connection between genre and activity type, so much so it is hard to tell whether there is a difference at all.[88] I have opted to group both conventional resources as "genre/activity type", with a focus on genre because the concept is clearly connected with the use of language and other symbolic resources and, as such, widely accepted in the humanities and social sciences.[89] In this sense, genres are *conventional ways of organizing social activities from a communicational perspective*. Paraphrasing Bakhtin, we could say that genres are the drive belts between orders of discourse and social practices, insofar as "changes in social practice are both manifested on the plane of language in changes in the system of genres, and in part brought about through such changes".[90]

3.5.2.2. Register and style

Fairclough's approach to "style" closely resembles the concept of "register" from systemic linguistics, as it covers most of its main parameters: tenor, mode, and rhetorical mode. I chose to use "register" instead of "style", for conceptual reasons. Register is a more overarching notion, which refers to situational features of language use –style being one of those features. We can think of style in terms of "ways of being" or "identities" in the language[91] –including idiosyncratic traits-, whereas register refers to how we use language and other semiotic resources for a specific purpose in a particular setting.[92]

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[87] Ibid, p. 126.
[88] I will not attempt to discuss here whether activity types are extra-discursive in nature. But I will contend that many –if not most- activity types cannot be conceived without a discursive dimension, in this case, a combination of conventional discursive resources, such as genre and register.
[89] See, for instance, Swales JM. The concept of genre. In *Genre Analysis: English in Academic and Research Settings*. Cambridge, UK: Cambridge University Press, 1990, p 33-67. Also, see Eggins S, Martin J. Géneros y registros del discurso. In Teun van Dijk (ed.), *Estudios sobre el discurso I: discurso como estructura y proceso*. Barcelona: Gedisa, 2000, p. 335-371.
[90] Fairclough N 1992, p. 126.
[91] Fairclough N 2003, p. 223.
[92] Eggins S., Martin JR 2000, p. 340-344.

In functional systemic linguistics, register is the collective system of tenor, field and mode. By and large, Fairclough and the systemics define tenor and mode in the same way. Tenor is about interpersonal relations, including roles, status, power and solidarity between the participants in any instance of communication (e.g., formal, informal, hierarchical, etc.).[93] Tenor also reflects the attitude of those involved in the communication towards each other and what they are communicating about.[94] Mode refers to the role of language and other semiotic devices in the organization of the text. The literature reflects a wide range of mode-related variables, such as channels (written, spoken, audiovisual), physical distances (mass communications versus face-to-face interaction), rhetorical modes (narrative, didactic, persuasive, argumentative, descriptive, etc.) and rhetorical devices (e.g., framing as necessity or probability, metaphors, alliterations, and repetitions), and others.[95] [96] [97] [98] [99] In order to work with homogeneous sets of variables, I will refer to channels and physical distances as the "media" of a discursive event and I will reserve the notion of "mode" for the use of language and other semiotic modes in the organization of the text. Mode is realized through the textual metafunction of language.

Fairclough does not take into account the notion of "field", another key component of register in the systemic tradition, where it corresponds to the topic or subject matter of the communication (the given "theme", e.g., prenatal control and self-control) and the type of activity, the institutional focus that operates as a "natural", given reality –for instance, the promotion of prenatal checkups for a healthy pregnancy. The field is realized through ideational meaning.[100] Fairclough substitutes the concept of field with "discourse" in the restricted sense that I have mentioned above. In this context, discourse also refers to areas

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[93] Martin JR, Rose D 2003, p. 248-252.
[94] Ibid, p. 16.
[95] Fairclough N 1992, p. 127.
[96] Eggins S, Martin JR 2000, p. 340.
[97] Martin JR. Cohesion and texture. In D. Schiffrin, H. Tanner & H. Hamilton (Eds), *The handbook of discourse analysis*. Oxford: Blackwell, 2006 reprint, p. 35-53, reference on p. 45.
[98] Swales JM 1990, p. 40.
[99] Van Dijk TA 1995, p. 268.
[100] Martin JR, Rose D 2003, p. 243.

of knowledge and ideational meaning, but from a particular point of view[101] –e.g., techno-scientific medical discourse, which Fairclough himself mentions, or safe motherhood discourse in our case. I have kept both notions –field and discourse- within my framework. I agree with Fairclough that discourse should be treated as an autonomous element among conventional resources, for two main reasons. First, I have defined discourse as "a particular way of constructing a subject matter"[102] and "a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery"[103]. Therefore, I share the assumption that ideational meaning "enters texts in the mediated form of particular constructions".[104] Granting conceptual autonomy to the notion of discourse is also useful because it makes for a better exploration of the complex relations between genres and discourses.[105] But I have also retained the notion of field because it can accommodate different types of activities and ideational content from different discourses in a single discursive event.[106] Using the concept of field is also relevant to this thesis because it relates to the organization of knowledge around "disciplines" –a way of controlling the production and reception of discourse by determining what belongs and what does not belong in a given field.[107] This is particularly evident in the general domain of science and in the specific case of medicine –and what I have defined as biomedical paradigm.

Within this framework, Lupton's conception of discourse as "a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to

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[101] Fairclough N 1992, p. 128.
[102] Ibid, p. 128.
[103] Lupton D 1999, p. 15.
[104] Fairclough N 1992, p. 128.
[105] Ibid, p. 128. As Fairclough observes, "a discourse such as techno-scientific medical discourse is standardly associated with a range of genres (scientific articles, lectures, consultations, and so forth) and can show up in all sorts of other gen res (conversations, television chat shows, or indeed poems)."
[106] Overall, I feel that the system of tenor, field, and mode provides an excellent tool for looking into the articulations between genre, discourse, and their situational enactment in discursive events.
[107] Foucault M. *El orden del discurso*. 3rd. ed. Barcelona: Colección Cuadernos Marginales 36/Tusquet Editores, 1987, p. 27-28. According to the author, the pre-eminence of disciplines implies that accepted knowledge (which he calls Truth) must be produced and established within the assumptions, theories, and methods of each particular discipline. Of course, language is key in this regard. Foucault observes how, at the end of the 17th Century, a proposition that aspired to be admitted within the realm of botany could not refer to symbolic virtues or properties of plants –which was common practice in Antiquity.

reality via words or imagery,"[108] has a twofold role at the level of discursive practices. On the one hand, it matches Fairclough's view of discourse in a restricted sense, as "a particular construction of a subject matter" –and thus as a conventional resource to draw upon in communication. On the other hand, it points at a combination of resources and, therefore, at a range of articulations between genres, types of activities, and discourses, and their realization through the system of field, tenor and mode in discursive events.

I have also paid special attention to logonomic regulations among the resources and restrictions operating at the level of discursive practices -genre rules, for instance, are hard-wired logonomic systems.[109] We can better appreciate the importance of logonomic systems at this level with an example of discursive production and textual transformations in the context of the proposed framework. Prenatal medical consultation in Xochis –mostly guided by medical questioning of patients who do not speak Spanish in a heavily one-sided exchange- is transformed into medical records, which go on to feed statistical compilations and, eventually, clinical guidelines and health promotion materials, which are then used in government health units and medical consultation, and so on. Not everyone can have a say in this process, and those who can are not the same at each stage. To start out with, the doctor –and not the patient- has the right to elaborate a medical record. Doctors usually write down a series of clinical "facts" using biomedical jargon. The patient's lived experience is either condensed into this jargon –in the sense that Lemke refers to condensation[110]- or disregarded as a series of "subjective" impressions. We will rarely see a "co-construction" of a medical record. But even when there are traces of subjective experience in these documents, they get definitely lost when clinical "facts" are turned into statistical "evidence". Later on, the creators of safe motherhood communication materials may reintroduce "lived" experiences and clinical facts into communication products, trying to guide their interpretation through a host of semiotic devices, as we will see in chapter 5.

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[108] Lupton D 1999a, p. 15.
[109] Hodge R, Kress G 1988, p. 5.
[110] Lemke J 1995, p. 61-65.

3.5.3. Sociocultural practices

The sociocultural dimension of discourse refers to political, social, and institutional circumstances in which the discursive practice takes place and the discursive event is produced.[111] It is at this level that we talk about orders of discourse and ideological complexes.

The sum total of discursive practices within an institution or society, and the relationships between them, constitute what Fairclough calls institutional and societal *orders of discourse*[112] -such as the institutional orders of religion, education, public health, traditional community health care, family/home, and the media. Fairclough draws the expression from Foucault, but he uses it in a different, somehow expanded way.[113]

These orders of discourse are keystones in the sociocultural dimension of any discursive event, since they have primacy over particular conventions –genre, register, and discourses. In our case, many orders of discourse may have an impact on discourses about motherhood and maternal and newborn care. In figure 1, I have tried to give some potentially relevant examples, like the institutional orders of religion, education, public health, traditional community health care, family/home, and local politics. I have also tried to show how safe motherhood discourse features in this wide and tangled web, hypothesizing about its relatively greater relevance in some orders of discourse, like public health and education, and in some discourse practices, like consultations and checkups in government health facilities and after-school chats with parents.

It is worth noting that Fairclough takes a dynamic view of orders of discourse. He acknowledges their relative stability and durability, but he sees them in unstable balance

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[111] Fairclough N 1992, p. 4.
[112] Ibid, p. 43.
[113] Foucault originally referred to "the order of discourse" as the underlying conditions and procedures that determine the production, circulation, and interpretation of knowledge in any given society. These conditions include commentaries to existing discourse, taboos, rituals, conventions, prohibitions, discipline assumptions and methods, distinctions between opposites such as true and false, reason and madness, etc. (See Foucault M 1987). This could be the equivalent of what Fairclough calls the "societal order of discourse".

and made up of heterogeneous elements, all of which can reflect hegemonic struggles and re-accommodations both within and between orders of discourse.[114] For instance, a pregnant woman may go for prenatal control and exams at government health centres, seek the *partera* to re-position the baby in her womb, and choose to deliver her children in the home, construing these choices as a safe and sound combination, which is often the case in Xochis, as it emerges from chapter 6. Fairclough contends that "perceived contradictions between such domains may become the basis for struggles to redefine their boundaries and relationships."[115] Exploring these fluctuations within orders of discourse "can make a significant contribution to current debates on social change".[116]

At the societal level, the different orders of discourse converge onto unstable ideological complexes, as discussed on 3.3 above. Within the proposed framework, the notion of an ideological complex of motherhood –as a set of ideas about being a mother and mothers as a social subgroup- makes for a meaningful connection between theory and research topic for different reasons:

a) it includes a set of practices, relationships, and discourses of traditional maternal and newborn care, as it emerges from the literature and our own research;

b) it takes into account the order of discourse of public health, including safe motherhood discourse;

c) it captures other discourses that bear upon motherhood and maternal care;

e) it takes into account stability and change as a result of the interactions between safe motherhood discourse, traditional maternal care, and related orders of discourse.

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[114] Fairclough N 1992, p. 93, and Fairclough N 2003, p. 220. Outside the order of discourse of public health, there are many other orders of discourse and discourse types challenging the hegemonic pretensions of government and biomedical views of health, disease, safety, risk, life and death. This state of discursive collision and collusion opens many opportunities for change within and between different domains of social life

[115] Ibid, p. 69.

[116] Ibid, p. 99.

3.6. Methodology

3.6.1. The research process

3.6.1.1. Research context and location

In line with the above framework, I have looked into key dimensions and ideological implications of safe motherhood discourse in Xochistlahuaca, a remote rural community with majority of indigenous population in the *Costa Chica* region of Guerrero, one of Mexico's poorest states[117]. I focused on this topic in June 2006, when I decided to embed my doctoral research within an international, intercultural, multi-stakeholder research initiative that aims to articulate traditional and biomedical approaches to maternal and newborn health, in order to help reduce maternal and newborn mortality and morbidity in remote rural communities with majority of indigenous population without further marginalizing indigenous cultures.

Frontline research users -Amuzgo health promoters from Xochis- set this effort in motion.[118] They teamed up with CIETmexico, the Tropical Disease Research Centre at the University of Guerrero, in Mexico; CIETcanada, an academic NGO that carries out public health research in several countries; Guerrero State's Health Secretariat, and other user partners from government and civil society.[119] As a member of the research team, I have been deeply involved in most aspects of the MNH Project, including the following activities:

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[117] I have described the ethnic, cultural, political, and public health context of Xochis in chapter 1.1.4.1.
[118] See letter from the Amuzgo Indigenous Health Promoters Network to Ascencio Villegas Arrizón, director of CIETmexico –Annex I, p. 508.
[119] See letters from Guerrero State Secretary of Health, Guerrero State Secretary of Indigenous Affairs, Guerrero State Secretary of the Woman, Guerrero State Population Council, Autonomous University of Guerrero, municipalities of Xochis and Tlacoachis, Kinal Antzetik, Fundación Justicia y Amor, and Iniciativa por una Maternidad sin Riesgos en México, to Ascencio Villegas Arrizón, director of CIETmexico –see Annex I, p. 509-519.

-Research for and writing of two research proposals, as detailed in the Introduction.
-Liaison between the CIETcanada and CIETmexico teams.
-Project design and team building meetings with public health authorities, NGOs, community authorities, Amuzgo health promoters, and academics from the Universidad Autónoma de México, the Universidad Autónoma de Guerrero, and the Centro de Investigación y Estudios Superiores en Antropología Social (CIESAS) in Mexico.
-Design and coordination of an intercultural research design workshop that took place in September 2007 in Acapulco, where CIETmexico is located.
-Systematic literature reviews on training of traditional birth attendants and community-based safe motherhood interventions.
-Design of questionnaires and interview guides for key informant interviews, household surveys, in-depth interviews, and focus groups.
-Training of Amuzgo community-based researchers.
-Fieldwork for baseline study in April-May 2008.
-Analysis and interpretation of data from the baseline survey.
-Preparation of different reports and presentations to share the findings from the baseline study with community stakeholders, government health officials, and donors.
-Skype sessions with members of the research teams and other stakeholders to discuss and follow-up on community-led, evidence-based interventions.

My own research for this thesis has drawn from and contributed to these activities and studies. My involvement in all aspects of the MNH Project has added value to this thesis in many concrete ways:
-I had unrestricted access to many sources and texts from government institutions and health care services.
-I was able to use transcriptions and translations from in depth-interviews and focus group discussions.
-During fieldwork and meetings, I took notes and made observations that added to the complexity of the analysis (in particular, at the level of discursive and sociocultural practices), the discussion of the results, and the conclusions.

-I was able to use quantitative findings from an April-May 2008 household survey, which I triangulated with data from discourse analysis, field notes, and observations.
-I have direct access to all research partners and stakeholders in order to share and discuss the results and recommendations from my own research.

3.6.1.2. Fieldtrips

In July 2006, I made a first visit to Guerrero State, where I interviewed key informants in the municipalities of Xochis, Tlacoachis, and San Luis Acatlán; at the government health district hospital and headquarters in Ometepec; and at Guerrero State's Secretary of Health in Chilpancingo. I also established research links with community health promoters and other fieldworkers in Xochis. I gathered safe motherhood promotional materials from government health facilities and began to identify the main lines of safe motherhood discourse in Xochis and the Ometepec health district.

In September-October 2007, I completed the second stage of fieldwork in Mexico, including the following activities:
a. I co-designed and coordinated a three-day intercultural research design workshop with Amuzgo indigenous health promoters from Xochis, and social scientists and epidemiologists from the UAG, in order to frame the MNH Project. This workshop also aimed to explore cultural and community issues that would later feed into key informant interview guides and participant questionnaires.
b. I developed key informant interview guides and trained male and female indigenous interviewers in Xochis.
c. I carried out key informant interviews with government health staff, schoolteachers, and community leaders.
d. I collected communication materials at provincial, district and municipal levels.

In April-May 2008, I carried out the third stage of fieldwork in Mexico, including:
a. Institutional meetings with officials from the Instituto Nacional de Lenguas Indigenistas (INALI), the Mexico's Health Secretariat and Guerrero State's Health

Secretariat, aiming to set up intercultural training workshops for government health staff, Amuzgo community health promoters, and intercultural mediators, based on findings from the MNH Project.
b. Training of Amuzgo community health promoters to carry out in-depth interviews with indigenous women.
d. Coordination of in-depth interviews with *parteras* for the baseline survey.
e. Interviews with key informants from educational and religious institutions.

3.6.1.3. Corpus, sources of information, and data collection

For purposes of text selection, I have taken into account Lupton's comments on her use of sampling for critical discourse analysis (CDA):

> In critical discourse analysis, unlike quantitative research, the sample size is not necessarily a very important factor, for the primary focus of the analysis is upon the structure, style and persuasive features of texts and how these features reflect the socio-cultural context, rather than the statistical representativeness of the chosen texts... A few exemplary extracts from relevant texts can more economically support observation than the tedious and redundant repetition of similar samples. However, it is important to be clear about the research problem and objectives, and to give a clear description of the nature of the texts used and why they were chosen.[120]

For in-depth analysis of safe motherhood discourse from government sources, I selected two of the richest and most representative health promotion texts targeting primarily pregnant women and, to a lesser extent, their husbands and the general population in Xochis at the time of fieldwork. By rich and representative I refer to the complex way they condense key dimensions of safe motherhood discourse from both the global scene and the Mexican context. They were also important either because of their universal availability (the perinatal carnet) or the elaborated audiovisual narrative development of key safe motherhood topics (the video film), particularly in a rural indigenous context with high rates of female illiteracy. These materials were available from government

[120] Lupton D 1994, p. 31.

health services between July 2006, during my first visit to the field, and May 2008, when we completed the baseline study for the MNH Project. These texts have different formats and serve different primary functions, but are equally illustrative of government discourse in Xochis, the Ometepec health district, and Guerrero state at large:

-A perinatal health card or *carnet perinatal* (I will call it "*Carnet*") issued by Mexico's Health Secretariat, which all pregnant women must submit to their doctors for periodical checkups and whenever they request assistance at government health facilities during pregnancy, childbirth and puerperium (the period covered in the definition of "safe motherhood"). Guerrero State's Health Secretariat distributes this Carnet to the general population, mostly out of government health facilities across the state, including Xochis.

-A promotional video for the early detection of pre-eclampsia and the prevention of eclampsia, a medical conditions associated with hypertension, which was the most frequent cause of maternal death in Mexico in 2006 and in the state of Guerrero during 2005.[121] The National Centre for Gender Equity and Maternal Health produced and distributed the video under the title *Hazle caso a los mensajes de tu cuerpo* ("Pay attention to the messages of your body") through Mexico's Health Secretariat for use in government health centres nationwide. Spanish and Amuzgo versions began circulating in Xochis and the Ometepec health district at the beginning of 2008.

-From September 2007 to May 2008, I interviewed key informants whom I also consider sources of safe motherhood discourse with direct bearing in Xochis. In particular, I talked with government health officials and health staff at hospitals and primary care units, including sources at government health district headquarters in Ometepec and government health officials at Guerrero's Health Secretariat in Chilpancingo, the state capital, because policies and guidelines at these levels are in effect in all government health units in Xochis. The Ometepec hospital is also the second level reference centre

[121] Guerrero State Health Secretariat, PowerPoint presentation, July 26, 2006. In the first half of 2006, the proportion of deaths from eclampsia (5.8 out of 100,000) doubled the proportion of deaths from postpartum bleeding (2.9 out 100,000), the second leading cause of maternal death in all of Mexico. In 2005, eclampsia was also the leading cause of maternal death in Guerrero state, where it accounted for 28 out of 85 deaths.

where community health services transfer complicated pregnancies and deliveries from the *Costa Chica* region of Guerrero.

In Xochis, I also interviewed government health staff, community health promoters working outside the government health system, schoolteachers, and leaders of religious institutions. I have used excerpts from some of those interviews,[122] [123] trying to capture as many local sources of safe motherhood discourse as possible. In all cases, I have substituted pseudonyms for real names of quoted sources. During fieldwork, I also collected government documents and medical guidelines, PowerPoint presentations, training materials, and other audiovisual texts. These sources of government safe motherhood discourse did not reach the general public and that is why I have not analyzed them here; instead, I have used some contents to help me understand the views and discourses behind government safe motherhood policies.

To explore the resonance and implications of safe motherhood discourse –and associated dimensions of public health discourse- among the primary target audiences, in an intercultural context, I designed and coordinated in-depth interviews with Amuzgo women and men from the communities. Taking into account the ethnic distribution of the population of Xochis[124] and the far-flung location of Mixteco villages (which are also more directly linked, in terms of health services, with the neighbouring municipality of Tlacoachis), I decided to focus on the majority Amuzgo population. I also took into account that Amuzgo health promoters had been the initiators of the MNH Project.

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[122] All key informants were contacted and interviewed following the procedure described before and approved by the Research Ethics Board at the University of Ottawa and the Universidad Autónoma de Guerrero. In these cases, I used interview guides approved by the ethics boards (Annex II, p. 520-531) and fine-tuned over the course of the interviews. All key informants received letters of information and gave either written or verbal consent to be interviewed and to register the exchange on audio digital recorders. The local coordinator of the MNH Project and a bilingual junior anthropologist from Xochis translated and transcribed all interviews in Amuzgo directly into Spanish. To unify translation and transcription criteria, I held two working sessions with the translators and a bilingual Amuzgo linguist who supervised their activities.

[123] Amuzgo community-based researchers interviewed traditional birth attendants (both trained and untrained by government health staff), but I have not used those interviews here.

[124] Eighty percent speak Amuzgo at home, compared to 11% who speak Spanish and 8.5% who speak Mixteco, according to the MNH Project baseline study.

As a male Spanish-speaking researcher from outside the community, I was not able to speak with Amuzgo women about intimate experiences of pregnancy, childbirth and motherhood. This was both impractical for language reasons[125] and improper from an indigenous perspective. I personally trained two bilingual female Amuzgo health promoters to carry out in-depth interviews based on structured questionnaires. Abraham de Jesús García, the bilingual Amuzgo coordinator of the MNH Project in Xochis, and Geovani Valtierra Gil, a bilingual Amuzgo anthropologist from Xochis, trained other interviewers who later joined the MNH Project. In total, we carried out 14 interviews with women of childbearing age, following a convenience sample that tried to balance stages of motherhood (pregnancy and immediate postpartum), number of pregnancies (first-time mothers and multiparous women), and place of residence (those living in a central location, where both hospital and primary health care are available, and those living in remote villages). The selection was constrained by realities on the ground: the interviewers had limited time availability, were not always able to travel to distant villages, and did not always find pregnant women and recent mothers who were willing to talk about their experiences. Male Amuzgo community health promoters interviewed 12 husbands from different communities; in all but one case, these men were not related to the female participants.

These community-based researchers used structured questionnaire with open-ended questions,[126] which I developed and refined over several months, based on a combination of sources: a) literature review; b) key informant interviews; c) preliminary analysis of the selected government texts and other safe motherhood promotional materials circulating in Xochis; d) results from the baseline study. These questionnaires aimed to capture women and men's views on pregnancy and childbirth, including key dimensions of safe motherhood discourse and potential intertextualities and interactions with other orders of discourse.

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[125] According to the baseline household survey, 6 out of 10 women in Xochis did not speak Spanish. Direct observation confirmed that many others did it with difficulty. This is a crucial barrier in the interaction between indigenous women and government health staff, particularly medical practitioners.
[126] See Annex II, p. 532-538.

I used structured questionnaire with open-ended questions for both conceptual and practical reasons. Conceptually, I used this approach to make sure that we would be able to explore our participants' views on the core concepts guiding this research. From a practical standpoint, I opted for this format because the interviewers lacked the experience to manage non-structured questionnaires and we only had limited time and resources to complete the interviews. The bilingual coordinator of the MNH Project discussed and verbally translated and back-translated the questionnaire together with the interviewers. There was no written translation, because the interviewers could not read or write in Amuzgo. There was, however, a second process of back-translation, since I went over the questions in the Spanish transcript of the first interviews.

All interviews took place between September 2007 and September 2009. All but two were carried out in Amuzgo and all were registered on digital tape recorders. All participants gave verbal consent, with their first names or fictitious names, at the beginning of the recordings, following the procedure approved by the Research Ethics Board at the University of Ottawa. To further protect their identity, I have not used real names in the transcriptions of our conversations. All female participants were interviewed by female Amuzgo health promoters. For ethical reasons, we avoided direct questions that would make pregnant women or recent mothers feel anxious or uncomfortable.[127] We interviewed all women in their homes and male participants in different places within their communities. The interviewers then discussed the results with the bilingual coordinator or the bilingual anthropologist, who then translated and transcribed the digital recordings into Spanish. I went over the transcriptions and discussed them with the coordinator and the anthropologist via the Internet-based program Skype. The coordinator and the anthropologist then exchanged views with the interviewers, based on our discussion of each interview. This dynamic proved very useful in order to analyze the interaction during the interviews, fine-tune the questionnaire, and improve the overall results, with input from researchers involved at different levels of this project.

[127] For instance, we would not directly ask a pregnant woman if she had lost a child in the womb during previous pregnancies. We would nonetheless consider follow-up questions if the participant mentioned any such episode spontaneously during the conversation.

The eminently oral nature of everyday communication and the low level of formal education among women in Xochis[128] fully warranted the use of face-to-face interviews as a means of gathering data. Women talk with family members about their maternal experiences; TBAs talk with childbearing women; community norms and practices are woven in oral discourse; and government health staff interact orally with their patients, often through translators. Oral accounts also allow women to better express their "lived experiences", which can then be analyzed in terms of discursive constructions.

3.6.1.4. Ethical clearance

I obtained ethical approval for this study from CIETmexico's ethical review panel, which included members of the community of Xochistlahuaca,[129] and from the Research Ethics Committee at the University of Ottawa.[130]

Following the ethical guidelines, I provided information about the study to all those who were invited to participate. All sources gave either written or oral consent for the interviews and were granted confidentiality. In many cases, I have changed the names of our sources to better protect their identities, particularly among government officials and health staff. In case of future publications emerging from this research, I will take further measures in this regard.

[128] According to the MNH Project 2008 baseline, 3 out of 10 women had no formal education and other 5 out of 10 had between 1 and 6 years of elementary education.
[129] See Annex III, p. 540.
[130] See Annex III, p. 541-544.

3.6.2. Discourse analysis

3.6.2.1. Applying the theoretical framework to the corpus

I used the theoretical framework described and discussed in 3.5 to analyze and integrate data from government and community sources, including health promotion materials and transcripts from interviews. In particular, I made a thorough analysis of the selected health promotion pieces, because they aim at key target audiences within the general public and because they are the result of professional semiotic engineering by communication experts working for government agencies.

Following Fairclough, I analyzed discursive events along three dimensions -as texts, discursive practices and sociocultural practices. At the textual level, I addressed both form and meaning potential –and how form affects meaning- in government communication pieces. For this, I looked into textual dimensions such as images, wording, metaphors, grammar, speech acts, cohesion, and text structure. I examined clauses, blocks of text (e.g., paragraphs) and texts as a whole. At the same time, I looked at the level of discursive practices regulating the production, distribution and interpretation of texts, with a focus on register, coherence, intertextuality, interdiscursivity, and logonomic regulations. I also examined sociocultural practices, including genres and orders of discourse. I took into account contextual knowledge, and social, cultural, institutional and political circumstances. I have recursively moved between these dimensions, adding insight from fieldwork and from frequent exchanges with MNH Project colleagues in Xochis.

For the specifics of textual analysis, I used an integrative approach from different traditions, according to the type of text. Mostly, I have drawn from Fairclough himself[131], from systemic functional linguistics[132 133 134 135] and from the social semiotics approach to multimodal analysis[136 137 138 139].

3.6.2.2. Multimodal analysis

I used a multimodal approach for the study of images and their interaction with text Multimodality takes into account "semiotics other than language-in-use, such as image, music, gesture, and so on".[140 141] More precisely, it deals with the co-deployment and co-patterning of different semiotic modes to make meaning in any given text.[142] This semiotic focus is of much relevance in a context where many among the target audience of government health campaigns can read neither Spanish nor their own native language, and health communication often relies on drawings, pictures, and videos. The use of colour, typography, expressions, and image framing in health cards and brochures is a good example of these concerns.

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[131] Fairclough N 1992 and Fairclough N 2003.
[132] Halliday MAK, Matthiessen CMIM. *An Introduction to Functional Grammar (Third edition).* London: Oxford University Press, 2004.
[133] Eggins S, Martin JR 2000.
[134] Martin JR, Rose D. Working with Discourse: Meaning Beyond the Clause. London: Continuum, 2003.
[135] Martin JR 2006.
[136] Hodge R., Kress G 1988.
[137] Van Leeuwen T 2005.
[138] Kress G, van Leeuwen T. *Reading Images: The Grammar of Visual Design*, 2nd edition. London: Routledge, 2006.
[139] Baldry A, Thibault PJ. *Multimodal Transcription and Text Analysis: A Multimedia Toolkit and Coursebook.* London and Oakville, CT: Equinox Publishing Ltd, 2006.
[140] Iedema R. Multimodality, resemiotization: extending the analysis of discourse as multi-semiotic practice. *Visual Communication* 2(1):29-57, 2003, p. 33
[141] The use of the term "multimodality" in this context is not related to the concept of "modality" in functional systemic linguistics, where it refers to "the speaker's judgement, or request of the judgement of the listener, on the status of what is being said" (e.g., it *could* be, it *may* be, it *must* be, it *will* be), as defined by Halliday MAK and Matthiessen CMIM 2004, p. 143. I will retain this systemic notion of "modality" here and I will refer to "multimodal" and "multimodality" only in the sense of combined semiotic analysis of language, images, etc.
[142] Baldry A, Thibault PJ. *Multimodal Transcription and Text Analysis: A multimedia toolkit and coursebook.* London and Oakville, CT: Equinox Publishing Ltd, 2006, p. 4-21.

Baldry and Thibault have been a primary reference for the multimodal analysis of the video film in chapter 5,[143] together with well-known works on edutainment and film theory.[144] I have also drawn from multimodal analysis of health promotion materials,[145] biology textbooks,[146] and documentaries on public health issues.[147] Some authors have analyzed the portrayal of women in contemporary imagery,[148] [149]and I have relied on their tools and insight. I have added value to this multi-semiotic focus from semiotic studies on the use of photos and other images, and their interaction with verbal text, in advertisement and the media[150] [151] [152] [153], and from Peirce's canonical view of signs in terms of icons, indexes, and symbols[154]. I have also resorted to the social semiotics framework developed by van Leeuwen[155] and Kress and van Leeuwen[156] for additional resources and a general overview of the field.

3.6.2.3. Analysis of interviews

My own approach to questionnaire design and interview analysis is closely related to previous qualitative research on people's perceptions, interpretations, and reinterpretations of risk. As Tulloch and Lupton point out, any meaningful exploration of

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[143] Baldry A, Thibault PJ 2006, particularly chapters 1 and 4.
[144] I discuss these references in chapter 5.
[145] Jewitt C, Oyama R. Visual meaning: a social semiotic approach. In van Leeuwen T, Jewitt C (eds), *Handbook of Visual Analysis*. London: Sage Publications, 2001, p. 134-156.
[146] Guo L. Multimodality in a biology textbook. In Kay L. O'Halloran (ed.) *Multimodal Discourse Analysis: Systemic-Functional Perspectives*. London, New York: Continuum, 2004, p. 196-219.
[147] Iedema R. Analysing Film and Television: a Social Semiotic Account of Hospital: an Unhealthy Business. In In KL O'Halloran (ed.), *Multimodal discourse analysis: Systemic functional perspectives*. London and New York: Continuum, 2004, p. 183-206.
[148] MacDonald M. *Representing Women: Myths of Femininity in the Popular Media*. London: Hodder, 1995.
[149] Bell P, Milic M. Goffman's *Gender Advertisements* revisited: combining content analysis with semiotic analysis. *Visual Communication* 1(2):203-222, 2002.
[150] Vilches L. *La lectura de la imagen. Prensa, cine, televisión*. Barcelona: Paidós, 1988.
[151] Perlmutter DD, Wagner G. The anatomy of a photojournalistc icon: marginalization of dissent in the selection and framing of 'a death in Genoa'. *Visual Communication* 3(1):91-108, 2004.
[152] Lister M, Wells L. Seeing beyond belief: Cultural Studies as an approach to analyzing the visual. In van Leeuwen T, Jewitt C (eds), *Handbook of Visual Analysis*. London: Sage Publications, 2001, p. 61-91.
[153] Knox J. Visual-verbal communication on online newspaper home pages. *Visual Communication* 6(1):19-53, 2007.
[154] Peirce CS. *La ciencia de la semiótica*. Buenos Aires: Nueva Visión, 1986.
[155] Van Leeuwen T 2005.
[156] Kress G, van Leeuwen T 2001.

these issues should integrate different theoretical traditions regarding risk and should ask some of the following questions:

> What risks do people consider most threatening or important to themselves and to members of the society in which they live? Which individuals, social groups or institutions do they see as causing or having responsibility over risk? What are the narratives, epistemologies, discourses, rhetorical moves, choices of 'rational arguments', and courses of action which people use to organize 'risk' as a cultural concept? What kinds of risks do they choose to take or avoid, and why?[157]

Along these lines, our interviews with pregnant women and recent mothers aimed to capture their views on: a) key dimensions of safe motherhood discourse, including health risk components; b) explicit and implicit references to key indigenous concerns regarding pregnancy, childbirth and the postpartum period, as identified from the literature and key informant interviews; c) explicit and implicit references to other institutional orders of discourse regarding pregnancy, childbirth and postpartum, as identified from key informant interviews; and d) emerging, unscripted categories related to the main research questions and the objectives of this research.

In my analysis of interview transcripts as three-dimensional discursive events, I tried to see whether people perceived themselves at risk, and if so why and how, or what competing risks and values they pondered in their narratives. I also explored how the different discourses and representations of risk interacted in people's words, and how these texts were transformed and made into something new. I have done this by looking into utterances and paragraphs that convey risk-related ideational and relational content. These textual segments can include a range of content, from names and definitions to narrations of personal experiences or views and opinions of things that happened in the community. In doing this, I have selected different types of content, such as:

[157] Tulloch J, Lupton D 2003, p. 11.

a) Segments or expressions that were semantically connected with safe motherhood discourse from government and medical sources.

b) Segments or expressions that reflected other local discourses related to pregnancy and childbirth.

c) Segments or expressions that may point to other discursive dimensions of pregnancy and childbirth –what I call "emerging categories", a notion at the core of grounded theory.[158] [159] This is not to say that I have developed grounded theory. Rather, I have used the concept of emerging categories in order to capture discursive dimensions that might have otherwise gone unnoticed due to my reliance on preconceived categories from safe motherhood discourse and interviews with key informants.

d) Paradigmatic examples, which Martínez Migueles defines as "situations that are both typical and representative, studied in-depth within their complex structural reality"[160] I made these selections not only because of what they reveal about the community and cultural context, but also because of value clashes and collusions, and changes and transformations they bring to the light.

e) Critical cases or episodes[161] that may shed light on people's values and motivations as they are tested under extreme circumstances. I found this very useful in my research, particularly regarding people's narratives of personal experiences and interaction with government health services during obstetric emergencies.

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[158] Álvarez-Gayou Jurgenson JL. *Cómo hacer investigación cualitativa: fundamentos y metodología.* México DF: Paidós Educador, 2003, p. 90-98. Looking for grounded theory is a typically inductive process. The first step in this process is to identify relevant categories and properties from the data, what is called "coding" in terms of grounded theory. These categories must have the ability to sensitize the researchers, that is, they must allow them to listen to the people who are subjects of research and to vividly see their circumstances. Emerging categories are then integrated into higher-level, theoretical categories through constant comparison, leading to logical patterns and emerging theory.

[159] Martínez Migueles M. *Ciencia y arte en la metodología cualitativa.* 2004. Ciudad de México: Editorial Trillas, republished 2007, p. 76. The author says that "true categories", that is, those categories that will reveal the logic behind individual and group behaviour in any given social environment, will most likely not be preconceived categories, but will emerge from the data.

[160] Ibid, p. 72.

[161] Hernández Sampieri R, Fernández Collado C, Baptista Lucio P. *Metodología de la investigación.* 3rd ed. Mexico City: McGraw Hill, 2003, p. 453.

3.6.2.4. Tracing ideology in texts

Of course, not all language and semiotic production conveys ideology all the time. Seeing ideologies everywhere would lead to a dead end. But the opposite can also happen: that discourses are taken for granted, both in form and content, when they are indeed enacting ideological effects and imposing an "unexamined consensus."[162]

As a rule, we should be able to trace ideological grounding in attitudes and beliefs that presuppose norms and values, particularly when the use of language aims at changing people's behaviours. But what should we make of personal accounts of lived experiences? Should we take people's words at face value? A pregnant mother could say that she does not bother with prenatal checkups because it is hard and costly for her to reach the nearest health care centre, and because when she gets there she finds there is no one available to help her. Should we double-guess her in search for ideological meaning?

Fairclough argues that we cannot answer this type of question without looking into the discursive event, materialized in a text (what she said, how she said it); into the discursive practices, including what discourses she draws upon; and into the wider social structures and circumstances, including orders of discourse (those of the family and the neighbourhood, religious discourse, the media, public health discourse, etc.).[163] [164] In short, it is not just a matter of her individual experience, but also of what she conveys and represents in terms of social meanings and experiences.[165]

At the textual level, Fairclough points to assumptions (presuppositions) as implict meaning with ideological potential, because they operate as tacit knowledge, as

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[162] Hodge R, Kress G 1993, p. 35.
[163] Fairclough N 1992, p. 72-73.
[164] Fairclough N 2003, p. 218. Textual analysis can contribute to ideological analysis and social critique, says the author, "provided it is framed within a broader social analysis of events and social practices".
[165] Van Dijk contends that "ideologies only control knowledge at the general, global level of the group, that is, shared knowledge, and not necessarily personal knowledge." In Van Dijk T. Discourse, knowledge and ideology: Reformulating old questions and proposing some new solutions. In M Pütz, J Neff-van Aertselaer, T van Dijk (eds.). *Communicating ideologies: Multidisciplinary Perspectives on Language, Discourse, and Social Practice*. Frankfurt am Main: Peter Lang, 2004, p. 5-38; quote on p. 17.

unquestioned common ground in the foundation of all social interactions[166] Hodge and Kress pay special attention to textual transformations. They start from "surface structures" –the ones actually used on the text- and search for "underlying structures", that is, hypothetical forms that could have been used instead of the available ones, and they consider the differences in their possible ideological effects and motivations.[167]

3.7. Conclusion: making room for stability and change

Following a longstanding tradition in qualitative research and previous studies based on discourse analysis on women's bodies and identities, I see theory and data analysis "as necessarily mutually informing".[168] Along these lines, I adopted a malleable theoretical framework, treating it as a work in progress, as I made room for key dimensions of safe motherhood discourse and new categories from the data.[169]

Fairclough's three-dimensional view of discursive events as texts, discursive practices, and sociocultural practices proved useful to account for the dynamic interaction between language and other aspects of social life. The author's approach to intertextuality was a key resource in this regard, as it helped me to show, in very concrete ways, how different texts, discursive practices and sociocultural practices coexist and collide in semiotic practice, and what these connections and reelaborations imply in terms of local-specific construals of motherhood and risk. Hodge and Kress' reworking of hegemony and ideological complexes allowed for a nuanced articulation of power relations. Overall, the analytical framework worked quite well in terms of reflecting and explaining tendencies toward stability and change. I set up a methodological toolkit to suit this approach, drawing from different traditions of discourse analysis, according to the type of text.

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[166] Fairclough N 2003, p. 55-61. Ideological assumptions reflect and reinforce hegemonic discourses.
[167] Hodge R, Kress G 1993, p. 15-37. Typical of such differences is the use of passive voice and nominalization, instead of active voice and transactive structures, which often distort issues of agency, causality and responsibility
[168] Coupland J, Gwyn R. Introduction. In Coupland J, Gwyn R (eds), *Discourse, the Body, and Identity.* New York, NY: Palgrave MacMillan, 2003, p. 1-18.
[169] Fairclough warns in this regard: "Too rigid an analytical framework can lead one to lose sight of the complexities of discourse". Fairclough N 1992, p. 124

Lupton's work on health risk discourse –and pregnancy risk in particular- further anchored CDA theory within a strong research literature on the topic of this dissertation.

I have also given an overview of the research process, including a discussion on the links between this doctoral dissertation and the MNH project where it is nested. In particular, I have shown how my own research drew from and fed into this multi-stakeholder effort, and how this deep immersion in a community-driven initiative contributed to the development of suitable instruments, the relevance of the analysis, the observation of ethical research principles, and the action-oriented discussion of the findings.

Chapter 4: Discursive analysis of a perinatal card

4.1. Introduction

On this chapter, I will apply the theoretical and methodological framework presented in chapter 3 to analyze a perinatal health card or *carnet perinatal* (I will call it *Carnet*) issued by Mexico's Health Secretariat. All pregnant women must submit the Carnet to their doctors for periodical checkups and whenever they request assistance at government health facilities for pregnancy, childbirth, puerperium, and newborn care. The Health Secretariat of Guerrero distributed this Carnet mostly out of government health facilities across the state, including the municipality of Xochis, from before my first visit to the field in 2006 to at least the end of 2008. I will analyze two different versions of the Carnet, where the main semiotic differences happen at the level of visual modes but have a multimodal impact on meaning.

I will show how these texts reflect a particular discourse, "a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery".[1] [2] In particular, I will show how *Embarazo Saludable* ("Healthy Pregnancy"), the official title and apparent main topic of the Carnet, is construed mainly as a variant of mainstream discourse on *Maternidad Sin Riesgo*, the Spanish version of safe motherhood, a specific type of contemporary public health risk discourse – articulated around conceptual dimensions like risk awareness, danger/threat, individual agency and responsibility, choice, self-control, guilt and blame, medicalized control of maternal health, trust in government, and subordination to biomedical staff.

In Mexico, maternal health has been the dominant issue in public health over the last decade –with increasing governmental pressure to avoid maternal deaths, as data from this thesis shows. However, the good health of the foetus and the newborn has also been strongly present in government discourse: As I will show here, public health

[1] Lupton D 1999a, p. 15.
[2] My definition of "image" includes all non-linguistic components, such as typography, illustrations, photographs, background pattern, lines, pictures, and charts.

communication has not only linked maternal and child health within safe motherhood discourse, but it has also held the mother responsible for her own health and for the survival of her child.

I will also discuss how government communicators have articulated safe motherhood discourse -and embedded dimensions of risk discourse- with other types of discourse and orders of discourse, and how this construal seeks hegemonic status within the ideological complex of motherhood at the societal level. Finally, I will point to specific ideological effects at the level of power relations in Mexico.

Following Fairclough[3] [4], I simultaneously address questions of form and meaning potential –and how form affects meaning. I look into textual dimensions like images, wording, metaphors, grammar, speech acts, cohesion, and text structure, at the level of clauses, blocks of text (such as paragraphs) and the text as a whole. I analyze the use of intertextuality and interdiscursivity, which are of the essence to understand specific semantic articulations in the Mexican context. I also discuss discursive practices regulating the production, distribution and interpretation of the Carnet; and I examine socio-cultural practices, including orders of discourse and ideological effects, by looking into the use of register, genres, and logonomic regulations (which I defined in chapter 3 as a set of rules for the production and reception of meanings), as well as the social, cultural, institutional and political context. As Fairclough suggests, I move recursively between the different levels of the analytical framework. Typically, I start from the texts and the discursive practices, moving onto the socio-cultural practices and back to the other two levels. As for the methodological toolkit, I use an integrative approach, drawing from systemic functional linguistics, social semiotics, and multimodal analysis, as discussed in chapter 3.

[3] Fairclough N 1992.
[4] Fairclough N 2003.

4.2. The Carnet: Articulating two genres for control and self-control

The Carnet is a foldout triptych that can also be used as a single-page, double-face document. When unfolded, the front[5] shows public health communication content for an *Embarazo Saludable* -"healthy pregnancy" –I will call this generic component "*Leaflet*". The back[6] is a typical clinical record to follow up on the health status of the patient and her newborn –I will call this generic component "*Record*".

I make this distinction because print public health communication materials and clinical records are two distinctive genres within the order of discourse of public health. Their combination in this textual sample is a clear-cut case of interdiscursivity that shapes the Carnet as a powerful discursive event. Print health communication materials constitute a specific genre, usually linked with health communication[7] and health promotion[8] as types of activities[9]. Health promotion leaflets are a staple of that genre. Medical records are normally associated with "health monitoring and control" as a type of activity. This Carnet has been intended as a personal health record and, at the same time, as a health promotion vehicle, a reminder of practices that will contribute to a "healthy pregnancy". As a result, health monitoring and health promotion are combined, showing two faces of the same coin, control and self-control, as I have discussed them above.

I will first go about the Carnet as a folded triptych –the most likely way it will be handed out for distribution. The front panel[10] displays a complex discursive synthesis through the vertical articulation of six different blocks of language and imagery: the Secretary of Health logo; a photograph of a male doctor weighing and measuring a pregnant indigenous woman;[11] the expressions *Embarazo Saludable* and *Carnet Perinatal*; three

[5] Appendix A, p. 546, and/or Appendix F (CD), image 1.
[6] Appendix A, p. 547, and/or Appendix F (CD), image 2.
[7] I have defined public health communication on p. 48.
[8] I have defined health promotion on p. 51.
[9] I have discussed the difference between genres and activity types on 3.5.2.1, on p. 115-116.
[10] Appendix A, p. 548, and/or Appendix F (CD), image 3.
[11] In hospitals and health centres of Xochis and the Ometepec district, it is usually the nurse who does the routine checkup –weight, height, blood pressure, initial follow-up questioning- as reflected in the video

lines at the bottom for people to fill out with their personal information; and a greyish blue tiled pattern in the background.

The tiled background operates as a syntactic device that articulates all elements on this page, making for visual cohesion and vertical continuity –this also happens within the horizontal sequence in the unfolded single-page layout, which I will refer to below. It also channels ideational meaning, insofar as the tiles can be associated with glazed-tiles on hospital walls.

The Secretary of Health logo[12] has both cohesive and logonomic properties. It also conveys the illocutionary force of a declaration: "This is the government speaking". It features prominently, at the top of the page, towering over all other elements, overlapping[13] the tiled background, and starting a chain of top-down semiotic articulations within the same panel. The logo itself has three components: The ideogram, the name Salud, and a green and blue strip that frames the other two components in the context of the front panel –the green segment of the strip extends over the other two panels of the Leaflet. The word *Salud* ("Health") implies at the same time the field, the

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drama (see chapter 5). In some communities without health centre, primary care health workers known as TAPS (técnicos en atención primaria de la salud) take on these tasks. Clinical practitioners are less frequently engaged in these activities; they often meet the pregnant woman afterwards –in some cases, only if the nurse thinks there is reason for the patient to talk with the doctor. However, doctors are the ultimate source of knowledge and authority within these institutional settings and before the population. The presence of the doctor as a participant in the photograph speaks to this self-referential position within the biomedical establishment and, at the same time, seeks to establish the doctor as the reference expert before the target audience (this is also the case in the video drama). At the same time, viewers can relate the white uniform and all other canonical visual elements in the image with their own personal experience in similar circumstances. Thus, at the level of ideational meaning and sociocultural practices, the male doctor in the image also stands in for other health workers in hospitals and health care centres.

[12] This logo was used in health promotion materials produced and distributed by the Secretary of Health during the presidency of Vicente Fox (December 2000-December 2006). As of November 2009, the Secretary of Health was using Mexico's coat of arms –as were all federal secretariats- and a new logo in all its campaigns, publications, and web pages. However, the perinatal health card and other printed materials bearing the former logo were still circulating in Guerrero state during fieldwork for this thesis in 2007 and 2008. Target audiences would likely recognize the logo as a government-related icon, particularly when the word *Salud* was one of its main components and it continues to be the official short name for the Health Secretariat. The fact that the same materials, including the perinatal card, were distributed out of government health services –and by different governments- for a number of years in Xochis would have also contributed to the recognition of the old Health logo.

[13] Overlapping is a semiotic resource conventionally used in visual advertisement to carry meaning from one segment of the visual representation to another, or to combine meaning from different visual semiotic components (text and image, two different images, etc.) Van Leeuwen T2005, p. 12-13.

order of discourse, and the source of the text. The concept of Salud is further connoted through the use of white typography, matching the colour of the white uniform in the photograph, which is typically used by doctors, nurses, and other government health staff.

The ideogram in the logo depicts two elongated eel-like twin objects interlinked in a swirling, dynamic circular pattern –connoting closeness, togetherness, interconnectedness, even partnership.[14] This pattern has ample semiotic potential. On the one hand, it can be seen as linking doctors and patients, community and individuals, government and society. Of equal importance in the context of maternal and perinatal health, the protruding roundness of the overall pattern could evoke the mother's womb, and the dynamic depiction of the two swirling objects could also stand for healthy foetuses inside the womb.[15] One of these twin objects is rendered in blue and the other in green, and both are flanked by contrasting green and blue segments of the thick horizontal strip that runs alongside the top margin of the brochure. The green segment of the strip continues along the central and back panels, giving strong visual cohesion, together with the tiled background, to all three panels and, particularly, to the unfolded Leaflet. The cluster made up of the logo, the green and blue stripes, and the Salud name in white against the blue background is a core intermediate structure connecting local semiotic components –colours, text, and shapes, together with their interpersonal and ideational meanings- to the semiotic construal of the Carnet as a whole.[16]

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[14] This ideogram resembles other visual patterns widely used to symbolize bilateral symmetry, interdependence, and holistic balance, such as the taijitu sign representing complementary forces (ying-yang) in Taoist philosophy, and similar patterns from other cultures. Of particular interest here, the interlinked figures in the taijitu stand for the feminine and passive in the ying and the masculine and active in the yang. See Monastra G. The "Ying Yang" among the Insignia of the Roman Empire? *Sophia* 6(2), 2000. Available at http://www.estovest.net/tradizione/yinyang_en.html#t24. Accessed November 17, 2009.

[15] Of course, this is not the intrinsic meaning of these or other semiotic elements within the text –for instance, the greyish blue tile background that I discuss above. Rather, they bring a semiotic potential that takes on a particular meaning when associated with (co-patterned by) other elements that partake of the discursive event. This re-contextualization, which affects both semiotic resources and sociocultural practices, is at the core of multimodal analysis (see, for instance, Baldry A, Thibault PJ 2006, p. 18-19, 178, and 213). It also ressembles what Lotman calls "secondary semantization" in literary theory. Lotman Y. *La Sémiosphère*. Trad. Anka Ledenko. Limoges: Presses Universitaires de Limoges, 1999, p. 71-72.

[16] Clusters are local groupings of semiotic resources that define a region or subregion of a text. There is a functional, back-and-forth relation between clusters and host texts, whereby clusters are "small-scale arrangements of items which are nested within larger wholes." Baldry A, Thibault PJ 2006, p. 31.

4.3. Power and solidarity without words

The logo cues in a photograph that takes up almost half the front page and becomes the locus of attention[17], the single most important image within the textual construction. We can first examine what Kress and Van Leeuwen call the "representational dimension" of this picture, that is, the narrative processes and the ideas emerging from it.[18]

The narrative process links participants through lines of energy or direction –e.g., direction of gaze or gestures. Active participants are the ones who drive these forces. In this case, the doctor is active and the woman is passive. Their eyes never connect and their interaction is one-sided. His bodily gesture and his gaze drive the action and the ideational content. He is weighing her on a scale, his right arm drawing the imaginary diagonal in the picture, as it moves toward the measures in the scale, his body turned and his eyes focused on his action, always driving diagonally. She stands on the scale, her arms at both sides of her body, her head slightly bent downwards, looking neither at him nor at us, but diagonally towards the floor, a perfect geometrical counterpoint to his own stance, in a clear sign of silent conformity and subordination.[19] This critical power imbalance connotes a paternalistic interaction, which closely resembles the prevailing dynamics between doctors and female indigenous patients and between these and the health system as a whole. Sociocultural practices play out quite bluntly here, as the image reflects a typical pattern of male dominance, not only within public health, but also

[17] Textually, the locus of attention is an eye-catcher, a prominent component of the visual lead that "arrests the attention of the viewers" and has three key functions: "Interpersonally attracting attention, and Ideationally construing reality in a way intended by the advertisers, where the viewer's perception of reality is manipulated. Textually, it is a springboard for further development of the central idea". Cheong YY. The construal of Ideational meaning in print advertisements. In Kay L. O'Halloran (ed.), *Multimoldal Discourse Analysis: Systemic-Functional Perspectives*. London and New York: Continuum, 2004, p. 163-195, quote on p.165.

[18] Kress G, Van Leeuwen T 2006, p. 59.

[19] This image provides a textbook example of what Goffmann calls the ritualization of women's subordination in advertisement, including frequent portrayals of women under the physical care of men, which ultimately connotes the "infantilization" of women. Goffman E. *Gender Advertisements*. New York: Harper, 1976, p. 40-46. Data from fieldwork confirms that many among government health staff tend to see indigenous women as children.

within other domains, like familial and public interactions between men and women in the community. Given its prominent placement in the front panel, the picture also anchors the construal –and instructs the reading- of the overall text.

Even more crucially in terms of health risk discourse, this image implies the need to *trust* doctors and government health services –in this case, trust them through submission, control and self-control-, and an entire system of knowledge and beliefs, in the context of a struggle for women's confidence.[20] As the analysis of the government video for the prevention of preeclampsia shows, government health communication strategists operate under the assumption that women have conflicting sources of information and split loyalties when it comes to pregnancy and childbirth. Trust emerges as a key dimension of both government safe motherhood discourse and indigenous discourses of pregnancy and childbirth. Despite the rationalistic view underlying the biomedical paradigm, questions of trust are removed from rational evaluations of scientific evidence and settled –also within government discourse- in terms of power and sociocultural practices. But power is not sheer coercion; it is rather a hegemonic construction –as discussed in chapter 3.3- where trust can play a significant role. The image dominating the front panel of the Carnet speaks to this intimate relationship between power and trust, as it conveys a paradoxical sense of proximity and distance, of power and solidarity, two interlocked components of ideological complexes.[21]

Additionally, this photo makes meaning as icon, index, and symbol.[22] The fairly comprehensive iconic representation enables the viewers to indexically connect what they see with a well-known interaction in a real institutional setting –a prenatal checkup in a government health facility. In the immediate context of the page and the text, where the

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[20] In an alternative version of the Carnet, which I discuss in 4.11 below, the appeal for trust is framed in terms of solidarity through a different photograph.

[21] Hodge R, Kress G 1993, p. 157-158.

[22] I follow Peirce's conception of icons, indexes, and symbols, as laid out in Peirce CS. *La ciencia de la semiótica*. Buenos Aires: Nueva Visión, 1986. An icon, according to Peirce, has a relation of similarity with the object or part of it –as is the case with the different objects in this photograph. An index has a real (existential) relation of proximity, of contiguity with the object; it articulates two parts of one and the same experience –in this case, what we see in the image clearly indicates an episode of prenatal checkup in a government health centre. The relationship between them is real (existential). On the other hand, symbols bear a purely conventional (socially construed) relationship with the object.

picture is physically coupled with the expression "healthy pregnancy" and the government signature, this seems to create a subject position -that of a pregnant woman who is submitting herself to institutionalized control and hence reducing health risks for herself and for her child. Therefore, this woman is not only an icon of pregnancy, but she also acquires conceptual power *as a symbol of healthy pregnancy.* Thus seen, the picture has metonymic effects, as it stands for a larger process and a greater set of roles and relationships. This metonymy carries ideological meaning, as it does not so much portray the way things are, but more significantly, the way *they ought to be.*"[23] [24]

We can also appreciate how the designers of the Carnet have used the interpersonal metafunction of images[25] to direct our reading. The photograph on the front panel is a frontal, medium (in terms of both distance and vertical plane) shot of the participants' hierarchical interaction, which clearly stands out from the tiled background and places us as onlookers receiving visual information in a seemingly realistic, factual, unadorned manner[26] –a typical pattern of health risk communication. Thus seen, the imagery in the front panel creates the illusion of an informational offer, whereas in the context of the page –and of the card as a whole- it eventually becomes a demand.[27] In other words, the

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[23] According to Barthes, we tend to take for granted this second –connotative, ideological- layer of meaning. (See Van Leeuwen T 2005, p. 37-39.) Barthes also points to poses and objects as "connotators". I have already discussed the poses in this image. As for the objects, they are typical of the clinical "lexicon" (another word from Barthes): white uniform, a scale, a stethoscope, and the patient's file. These visual elements clearly point to the field of medical consultation and, in this case, to the genre of prenatal checkups. All of this leaves little doubt that the authors of the text are using this connotative potential to cement a particular discourse and a well-established set of sociocultural practices.

[24] Cheong contends that greater contextualization in print advertisement limits the interpretative space for viewers to create meaning. Cheong YY 2004, p. 191. This is all the more relevant in this case, since many – if not most- indigenous women in Xochis may not be able to read the written text. By crowding the photograph with key elements from safe motherhood discourse and references to sociocultural practices, the designers of the Leaflet are trying to pre-empt any reading outside the biomedical definition of safe motherhood.

[25] The interpersonal metafunction, or interpersonal meaning, involves relations between: a) represented participants (people and things in the image); b) the viewers and the represented participants of the image; and c) the producers and the viewers of the image. Kress G, van Leeuwen T 2006, p. 114.

[26] Some photographs are marked "by their lack of apparent artifice or display of pictorial convention. Indeed, sometimes referred to as 'straight photography to distinguish it from the elaborate arrangement, setting up, lighting and theatricality of other kinds of photography (advertising, fashion, art), the very invisibility of convention seems to speak instead of photography's power to provide direct evidence of events." Lister M, Wells L 2001, p. 78.

[27] Kress and van Leeuwen consider that images make a "demand" when represented participants look at the viewer's eyes, whereas they seem to "offer" information if there is no such eye contact. Kress G, Van

designers of the Carnet have used this photo to construe the viewer as an objective observer of a naturalistic description of events/facts. At the same time, they allow –and encourage- the identification of the viewers –pregnant women and government health staff- with the participants, thus giving them specific 'subject positions'[28], that is, social and ethnic identities with normative implications in terms of their knowledge and interaction.

In terms of functional modality, the bright, saturated colour scheme in this image may reinforce conceptual patterns, such as the prototypic, symbolic role of participants and other graphic elements –a doctor that stands for all doctors, an indigenous woman that represents all native women, a tiled background that represents hospital walls-, as it "reduces the individual to the general, and the concrete to its essential qualities."[29] For instance, we can tell the woman in the picture belongs to an indigenous group because of strong, archetypical iconographic markers, such as her angular facial features, her long hear and pony tail, the –graphically saturated- dark tone of her skin, and the intense –amplified- colour of her traditional huipil.[30]

In the context of the Mexican culture –and of indigenous Mexico in particular-, the use of colour saturation also speaks to the interdiscursive nature of the Carnet. Whereas in Western Europe, the United States or Canada, sharp, intense colouring could indicate abstraction or hyperrealism[31], in our case it can connect with the bold use of colours in Mexican arts, crafts, and architecture, and therefore with a naturalistic colour orientation closer to common sense than to the lower modality of epidemiological and biomedical language. This commonsense coding –here, I use the terminology coined by Kress and

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Leeuwen T 2006, p. 119. As I argue here, texts can create a demand through a variety of multisemiotic resources.

[28] On the semiotic construal of subject positions, I have drawn from Lister M, Wells L 2006, p. 88-89.

[29] Kress G, Van Leeuwen T 2006, p. 165.

[30] In this case, the designers of the Leaflet have used a combination of cultural and biological categorizations to represent kinds of participants, rendering them as stereotypes and thus turning them into categories, in order to project meaning beyond the specific interaction of the man and the woman in this particular photograph. On categorizations, I have drawn from Machin D 2007, p. 120-122.

[31] In their approach to the grammar of visual design, Kress and van Leeuwen contend that, in contemporary visual communication, "we judge an image real when, for instance, its colours are approximately as saturated as those in the standard, the most widely used photographic technology." Kress G, van Leeuwen T 2006, p. 159.

van Leeuwen[32]- resonates across social and ethnic groups and, as a result, contributes to communication with the target audience.[33] In this case, the saturation of colours also brings to the fore the dark skin tones of *both* participants –the effect is even more apparent in the contrast between the doctor's white uniform and the colour of his skin-, which creates a softer balance between power and solidarity than would have been achieved through a male participant with lighter skin.

4.4. *Embarazo Saludable*, normative and descriptive

It is at this point in the vertical reading of the front panel that the expression *Embarazo Saludable* kicks in. This phrase is a nominal group[34] made of a noun (embarazo) and a classifier (an adjective, *saludable*). The presence of the classifier indicates "a particular subclass of the thing in question",[35] in this case, a subclass of pregnancy -a healthy pregnancy. As a result, the Leaflet reads not only as a set of *instructions* to carry a healthy pregnancy, but also as a *description* of this particular type of pregnancy. This manipulation can create a powerful semantic illusion, since we are presented not with a particular view of pregnancy, but with a naturalized category of things, an absolute entity that claims universal validity, whereby the reader "is led to believe in its absolute, timeless and unconditional existence"[36] –an attempt at a logonomic restriction in a cultural environment where, traditionally, other interpretations have prevailed.

We can analyze the expression Embarazo Saludable as a nominalization in the context of the overall Pamphlet. In functional grammar, nominalizations are linguistic transformations –essentially, shifting from verbs to nouns- with certain "metaphorical"

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[32] Ibid, p. 166.
[33] The distinctive, trademark "Mexican" use of colours has deep roots in indigenous cultures, both in pre-Colombian and contemporary Mexico. See, for instance, Ortiz Marín VM. Algunos antecedentes sobre el uso del color en el México indígena. *Relaciones* 12(48):105-114, 1991. Available at http://www.colmich.edu.mx/files/relaciones/048/pdf/Victor%20Manuel%20Ortiz.pdf. Accessed September 15, 2009.
[34] A nominal group is "basically a group of words based around a noun that describes its qualities, actions, etc." Machin D 2007, p. 4.
[35] Halliday MAK, Matthiessen CMIM 2004, p. 319-320.
[36] Guo L 2004, p. 207.

effects, such as presenting processes "as if they were things",[37] turning "temporary processes and activities into permanent states and objects, and concretes into abstracts",[38] and collapsing complex relations into single entities, which contributes to assert simplicity "where in reality complexity is the case."[39] In our example, one can decompress[40] the expression and bring back all the "original" complexity by reading the introductory statement and the long list of symptoms, warnings, and reminders on the back page of the folded triptych. As mentioned above, the nominal group on the front page is a condensed version of a normative and descriptive semiotic complex, which includes the recommendations on the back page, the ideational and interpersonal meaning throughout the Carnet, and the fields and contents of the "Record". All of this implies authoritative statements and instructions from experts and health authorities, as well as the construal of a compliant pregnant woman.

None of these actions and participants is overtly featured in the standalone expression Embarazo saludable. However, the designers of the Pamphlet have construed this normative and descriptive complex, through different semiotic modes, right from the front panel. There, the overlapping of Embarazo Saludable with the lower segment of the photograph has deictic, assertive, declarative, and directive force[41], as it projects a twofold meaning: "This is a healthy pregnancy" and "This is how you (should) go

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[37] Halliday MAK, Martin JR. *Writing Science: Literacy and Discursive Power*. Pittsburgh: University of Pittsburgh Press, 1993, p. 15.

[38] Fairclough N 1992, p. 182. The author observes that these transformations carry "considerable cultural and ideological importance," as these new semiotic entities "become the focus of cultural attention and manipulation". Among other things, nominalizations can be framed as goals and even agents of processes. Ibid, p. 183. In this case, Embarazo Saludable is presented as both a taxonomic category and a goal that requires maternal agency.

[39] Hodge R, Kress G 1993, p. 27. Nominalizations are descriptions of actions where the involved participants are either abstract nouns (nominals) or the result of actions. This typically implies avoiding explicit indications of causality (of action passing from the actor to the affected, as in "doctors check women's weight in health centres") and excluding or effacing certain categories of participants (e.g., "weight checking for pregnant women"). Ibid, p 20.

[40] Throughout this chapter, I use expressions like compression/decompression, condensation/de-condensation, and packaging/un-packaging as synonyms. They refer to semantic construals – nominalization among them- that summarize complex processes, and activities, often obscuring or taking for granted some of its components –and meanings. I draw from Lemke's definition and discussion of condensation, particularly with regard to technical writing. Lemke J 1995, p. 58-65.

[41] Here, as elsewhere in this text, I have followed Searle's classification of illocutionary acts. See Searle J. *Expression and Meaning: Studies in the Theory of Speech Acts*. Cambridge, UK: Cambridge University Press, 1979, p. 12-18.

through a healthy pregnancy". The "Salud" logo cues in the picture from above to reinforce this authoritative reading.

All three blocks –logo, picture, and title- converge within a common space. They are further connected by the rhyming[42] use of colours –in this case, different shades of lime green on the strip running alongside the top of the brochure, one of the twin components in the logos' ideogram, the woman's dress, the cover of the file in the doctor's left hand, and the typography of Embarazo Saludable. Similarly, the white colour in the word Salud matches the white on the doctor's uniform and on the borders between both large and small tiles on the background pattern. Across the panel, there is a rich, complex articulation between the different visual and linguistic elements, where one can read: "*Salud recommends you go for prenatal checkups in government health units, if you want to have a healthy pregnancy.*"

Right below "*Embarazo Saludable*" we can see the expression "*Carnet Perinatal*"[43]. This nominal group has illocutionary force as a self-referential assertion (it states that this brochure and this text *are* actually a health card), a declaration (it *declares* it as such, that is, as a document, with obvious implications) and a commitment (in that it *commits* the government to a certain course of action). Therefore, the folded triptych that the reader has in her hands is established as a perinatal health card, a document issued by the government, which makes its content legal, legitimate and authoritative. At the level of discursive practices, this expression, together with the logo, reinforces the logonomic framework for the reading and understanding of its content.

Right below *Carnet Perinatal*, there is an indication –and a space- for the reader to write down her name, address, and place of residence.[44] This also has a deictic, assertive and

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[42] In multimodal analysis, visual rhyming occurs when different elements in the same image are linked in some meaningful way through the use of shape, colour, bodily posture, etc. Machin D 2007, p. 155.

[43] The word "perinatal" refers to the period ranging from approximately 5 months before birth to one month after delivery.

[44] In many if not most cases when dealing with illiterate indigenous women, health staff will fill out this portion of the Carnet. This practice does not change the essential fact that the person whose name is on the front of the Carnet is considered the bearer of the document -and thus both *entitled and committed* to a continuum of care from government health services.

declarative function –this *is* the card of the person whose name it bears, of this cardholder. At the same time, it operates as a means of interpellation in the context of both the Record and the Leaflet. The Carnet is an *identity* card –and one could argue that this would operate as a third, overarching genre. When the leaflet addresses the reader as "you", as it does, it addresses *this* reader, this irreplaceable "*you*", saying what is expected of her, what she must do to guarantee a continuum of care for herself and for her child.[45] At the level of discursive practices, the health record keeps control of what this reader, this singular "you", has *in fact* done out of all she is expected to do.

Visually, *Carnet Perinatal* and the text block for personal information appear somehow separated from both the picture and *Embarazo Saludable*, but they are integrated by the tiled pattern in the background. Taken as a whole, the front page articulates the two generic components of the Carnet –Leaflet and Record-, in a solid interdiscursive formation, anchoring the ideational and interpersonal meanings of the Leaflet with the deictic and illocutionary force of the expression *Carnet Perinatal* and the personal information block.

We can elaborate a bit more on the semiotic role of layout in this regard. Van Leeuwen observes that it is common practice in visual design to separate information-as-knowledge from information-as-action along the vertical dimension of the image.[46] What happens at the bottom consolidates the semantic content, "giving a firm 'footing' or 'grounding', to authoritatively presented ('high') knowledge".[47] In other words, the idealized –or ideologically salient- content (the "ideal") is at the top, while the more practical information, like directions for action (the "real") is at the bottom.[48] Here, we have the main tenets of public health discourse on the top half of the page and what

[45] Here, we can clearly appreciate the deep connection between the textual dimension (the signature block) and the discursive practices (signing and becoming the bearer of a carnet) in the same discursive event. In fact, the discursive practices will have a strong impact on the interpersonal metafunction and the overall reading of the Carnet. The government does not propose Embarazo Saludable as one among many other discourses of pregnancy and childbirth, but as the logical, "natural", and authoritative organization of knowledge and practices regarding maternal health.
[46] Van Leeuwen T 2005, p. 199-200.
[47] Ibid, p. 200.
[48] Ibid, p. 205.

readers are expected *to do* on the lower half. By filling out the card with her name, address and place of residence, the reader signs a contract, becomes a cardholder and consolidates a mutual commitment between herself as a pregnant woman, the government, and the people and processes legitimized by the government to oversee a healthy pregnancy. As it becomes clear from the overall text, this contract is based on risk awareness, self-control, agency, responsibility, and trust (through subordination).

The argumentative structure on the front panel reveals the rationality behind it[49]: close medical monitoring results in a healthy pregnancy, and this requires responsibility and agency from pregnant women. A closer look at the textual function supports this conclusion: Embarazo Saludable, though topically salient in terms of typography and colour, is not the theme of this semiotic construction -Salud as governmental authority is- but the rheme, the New, the outcome of awareness, control and subordination. The rationale of the new public health, with its biomedical and behavioural foundations, is in full display here.

4.5. Logonomic regulations: power and solidarity

The back panel[50] of the folded triptych shows several vertically differentiated blocks of text, which are framed by the green stripe at the top and the tiled background to provide visual cohesion with both the front and middle pages.

Block 1, at the top, is a two-clause complex that serves as an introduction to all other blocks on this page: "*Para lograr un embarazo saludable es importante que sigas las siguientes recomendaciones:*" In principle, the main clause (the one that could stand alone) is "es importante que sigas las siguientes recomendaciones", while "para lograr un embarazo saludable" is a purpose clause that supports the main clause. However, from a textual perspective, the dependent clause is giving thematic status (in this case, both topic

[49] Fairclough suggests exploring text structures as a way of getting insight into modes of rationality and systems of knowledge and beliefs (Fairclough N 1992, p. 76.)
[50] Appendix A, p. 549, and/or Appendix F (CD), image 4.

and given), while the main clause is the rheme (both comment and new).[51] As Halliday observes, this tactical permutation in the "normal" clause sequence is typical of procedural texts, such as this one, where they usually create a cohesive link with a previous part of the text. [52] Here, the thematic dependent clause connects with Embarazo Saludable on the front panel –it brings it to the back panel, if you will.

Thus, this two-clause complex un-packages –and translates into normative language- the semiotic construction of the front page, indicating purpose or goal -*para lograr un embarazo saludable*- while placing a strongly evaluated condition to the achievement of that objective: *es importante que sigas las siguientes recomendaciones* –here, "*es importante*" functions as "objective modality", whereby the speaker makes a claim of universal validity.[53] In our case, the statement becomes "authoritative" in a double sense, because it comes from the authority and because it is universal.

This authority makes an appeal for trust, built into the subjunctive construction of the verb "*seguir*" ("*que sigas*") and through the labelling of the listed actions as recommendations. This modalization glosses over the heavy imperative mood of the page and acknowledges that the reader has to be persuaded not only to behave in a certain way, but also to trust the voices –government, experts- behind this text.

Interpersonal meaning is key in this opening statement. The authors of the leaflet have chosen to address the readers –pregnant women- by using the informal "*tú*", instead of the formal "*usted*". This attitudinal deixis signals social status and tries to establish a one-sided informal tenor within the register.[54] Firstly, the use of *tú* reminds the reader of a social hierarchy in a particular context: medical consultation. In Mexico –as elsewhere in Latin America- it is likely that doctors, and other health staff, will use *tú* to address their

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[51] I use the notion of theme in the tradition of systemic linguistics. Halliday defines theme as "the element which serves as the point of departure of the message. It is the element the speaker selects for 'grounding' what he is going to say". The author also describes the theme as "that which locates and orients the clause within its context." Halliday MAK 1994, p. 58 and 64-65. In Spanish, as in English, all clauses open up with their theme. The remainder of the clause is a development of the theme. Halliday calls it rheme.
[52] Halliday MAK, Matthiessen CMIM 2004, p. 393.
[53] Fairclough, N 1992, p. 159.
[54] Verschueren J. *Understanding pragmatics*. London: Arnold, 1999, p. 20.

patients –especially when they belong to lower social strata-, but most patients –let alone poor, indigenous women- would not dare address their doctors in the same manner. This *tuteo* often conveys a patronizing, paternalistic tone that implicitly or explicitly reaffirms authority –doctor knows best. Together with the hierarchical interaction depicted in the photograph on the front panel, this informal way of addressing the reader, and the markers of authority across the different panels, provide strong interpersonal cohesion across the text and try to construe a position of power with respect to the target audience. This discursive practice draws upon and reenacts the sociocultural circumstances within government health services, and tries to impose the authority of biomedical systems of knowledge and beliefs over traditional views and practices.

The informal *tuteo* (second-person address), together with the heavily exhortative modality and the passive depiction of the target audience, betrays the positioning of the reader as a child-like figure in need of medical guidance and government control. This is a common trait of health promotion leaflets,[55] intensified in the social context of Xochis by the extremely one-sided, hierarchical relationship between mostly Mestizo clinical practitioners and illiterate indigenous women, whom the former often view as immature, disobedient children.[56] This view guides maternal surveillance policies in the region, as a government health official confirmed during our interview in Ometepec:

> Este año se está diseñando una vocal de nutrición que vigile, que supervise a las embarazadas, que se tomen el Nutrivida que se les da, que es como papilla también, y se

[55] In a review of studies of health promotion leaflets, Dixon-Woods observes that they reveal a patronizing view of patients, whom they tend to depict as "irrational, passive, forgetful and incompetent." Dixon-Woods M. Writing wrongs? An analysis of published discourses about the use of patient information leaflets. *Social Science & Medicine* 52(9):1417-32, 2001, quote from page 1419.

[56] Although it may sound as if I am possibly overstating the case regarding the use of informal second-person address -since *tú* is gaining ground as the prevalent pronoun in advertising across Mexico, presumably in its informal solidarity function-, the adds should be analyzed at the level of discursive and sociocultural practices in the specific domain of prenatal control. In this case, it could be argued that using "usted" would not reflect the reality of medical consultation in rural Mexico and would make it harder for women to identify their role in that context. At the same time, and *precisely because of this*, we can argue that using the formal *usted* would somehow weaken the subordinate subject position of women in the context of government health services, and would undermine the strength of the interpellation. That is why the use of *tuteo* tends to reinforce the heavily one-sided interaction between doctors and patients, as is also quite clearly the case in the video film in chapter 5. Here, again, we can appreciate the logonomic systems that organize relations of solidarity and power as they operate at all levels of the discursive event.

> está diseñando eso también a través del personal de salud... que vigile, que vaya hasta su casa, que entre si es posible, a ver si se las tomó, o en la consulta pedirle el frasco de vitaminas y ver si se los está tomando. Prácticamente es un control como niñitas que hay que estarlas cuidando, que hay que estarlas vigilando todo el transcurso de su embarazo, su alimentación, todo [...]

Addressing the reader/viewer in second person, the authors of the Leaflet have also shifted focus from a population group –such as pregnant women- to its members, reflecting the move along a textual chain from population statistics to individual risk, which is typical of health risk discourse. Finally, it means that they have decided to address the reader *as* individual, demanding her personal attention, and to interpellate her as a subject of public health.

At the level of discursive practices, the authors of the text have created two distinct participants: on the one hand, a collective speaker who never shows his or her face, but who is either the government or speaks on behalf of the government; on the other, each pregnant woman as an individual reader/viewer. Doctors and other health staff are also brought into the text, but in a different manner: they are necessary participants of the commissive act and the discursive "contract", and a powerful source within the collective voice of the speaker. So, the government –or whoever speaks on his behalf- is now talking one-on-one to pregnant women –to *me* as a pregnant woman who has been construed as a subject through ideational meaning and deictic textual operations. Most importantly, the government addresses "me" informally, reproducing and reinforcing the sociocultural practices from this order of discourse.

At this point, we have a strong logonomic mechanism in place, running through all three dimensions of the discursive event. The government –whether it is the government of Mexico or the government of Guerrero, it makes little difference- addressing pregnant women as individuals, from a power position that "puts them in their place", so to speak, and reminds them where they stand in this interaction. The discursive mechanism –and the ideological effect- are even more complex if we articulate this linguistic device with the picture on the front page. What the authors have really done is bring the doctors as

participants –and identify the speaker with their interests- by using their voice and their image *on behalf of the government.* By the time women reach the anaphoric conclusion of the opening statement on the back page of the triptych (that is, the colon announcing a set of recommendations), both the government and the doctors have told them that a healthy pregnancy is not a given, that there are things to do in order to have a healthy pregnancy, and that they –in fact "*yo*", this "*yo*" deictically interpellated as "*tú*" by this authoritative "*ellos*" (both government and doctors)- are responsible for the outcome.

With these social identities and subject positions firmly in place as a logonomic regulation, we can explore what comes after the opening clauses. Block 2 shows a monolithic pattern of imperative clauses –a procedural clause complex where all clauses have equal status[57]- worded through the infinitive form of the verbs –the subjunctive glossing is no longer there. Women are *given agency* through a list of actions that they must carry out in order to achieve a healthy pregnancy. In fact, these imperative actions are the theme of all clauses in block 2: "*acudir* a tus consultas"; "*alimentarte* adecuadamente"; "*evitar* el consumo de refrescos, tabaco, alcohol y drogas"; "*checar* que te apliquen la vacuna", "*tomar*..." But this is loaded agency, in a pattern of power and solidarity: The government gives women agency –and most crucially, passes responsibility onto them- to do as expected and required, that is, to submit to medical authority and monitoring.

Block 3 is introduced by a typographically highlighted phrase that requires articulation with the bulleted phrases in the same block. This articulation is indicated by the anaphoric use of colon. Here is one example: "*Acude de inmediato a cualquier unidad de salud si tienes dolores de parto en cualquier mes de embarazo.*" The common element in all these clauses -"*Acude de inmediato a cualquier unidad de salud*:"- is phrased as an

[57] Blocks 1 and 2 should be seen as one interrelated clause complex, where the dominant clause is « *Es importante que sigas estas recomendaciones* ». All other clauses depend on this clause. At the same time, all clauses on Block 2 can be seen as comments on the thematic (in this case, also topic) clause "Para lograr un embarazo saludable". Functionally, they enhance the meaning of Embarazo Saludable, by telling the reader what are the means to achieve a healthy pregnancy. In this way, the complex becomes both normative and descriptive. For this analysis, I have followed Halliday MAK, Matthiessen CMIM 2004, chapter 6, "The clause complex" p. 363-441; on clause enhancement, I have drawn from p. 410-415.

intensified imperative ("acude *de inmediato*"), and this imperative is visually constructed at the top of the block. Here, women are *given/demanded* agency to submit to prenatal control, not only through the thematic placement of the imperative (normally, one would expect the subordinate conditional in thematic position), but also through the syntactical and visual (bulleted) thematization of each conditional – "*si tienes*..."-, which reminds them when they should take immediate action.

Block 4 starts out with another imperative interpellation –"*recuerda*"- and goes on to list a series of imperatives, which differ from the ones on block 2 because they are constructed in the second person (informal) and not through the infinite form of the verb ("alimenta", "verifica", "llévalo"). Block 5 resembles block 3 in its syntactic pattern – technically, syntactic rhyming- and reflects the same imperative construction of agency as all other blocks on this page. What is different about blocks 4 and 5 is that they introduce *newborn care* as a new topic –or as a key component of the overall topic, in a clear reference to the continuum of care enshrined in global safe motherhood discourse.

The ideational –existential- acknowledgment of this new being and his/her newly acquired discursive relevance is marked by elliptically placing the baby at the beginning of each one of the two last bullets ("*tiene* fiebre, etc.", "*llora* demasiado, etc"), which articulate with the opening statement of block 5. Thus, babies are turned into implicit themes in these bulleted statements –e.g., "(*si tu bebé*) tiene fiebre, etc. As an overall result, there is a double thematization on block 5: that of the mother in the opening statement and that of the baby within each bullet. This graphic and linguistic device reminds the mother what the alarm signs are, but also that she is responsible for her child.

Different elements make for a cohesive, coherent reading of the pamphlet as a document that refers to the health of both the mother and the child in her womb. As we have seen, this text is both a leaflet promoting healthy pregnancy and a "perinatal" health card. The card itself has a section for the newborn. At the level of sociocultural practices, pregnant women are used to being framed as "two persons", or "two subjects of health care", within the public health care system –and within the traditional health system of their

community. As Lupton points out, "pregnant women are encouraged to be highly vigilant in their policing of their bodies so as to ensure that the health of their foetus is not compromised by their own actions."[58] Therefore, the interpellation to get immunized against tetanus and diphtheria in block 2 would sound coherent to them. In fact, most recommendations in blocks 2 and 3 refer implicitly to the foetus and could be interpreted in this way –and eventually accepted as "common sense".

What all this reveals is a hegemonic construction going on at the level of sociocultural practices. The topical and thematic foregrounding of newborns in Blocks 4 and 5, together with "Carnet Perinatal" on the front page and the space for newborn data on the Record, expand the semiotic scope of Embarazo Saludable and put it squarely within the realm of *maternidad sin riesgo* as defined above. Which only goes to confirm that *maternidad sin riesgo* –with all its implications- is at the core of government policy on maternal and newborn care and the dominant discourse within the institutional domain of public health in Mexico.

4.6. Risk awareness, intertextualities and interdiscursivity

Before turning to block 6, I will briefly examine some patterns in the use of language on this panel that reveal key dimensions of health risk discourse and shed light on issues of intertextuality and interdiscursivity.

1. Wording choices connote the presence of risk, understood as "threat" or "danger", all over the text. This happens right from the top of the panel. On the surface, the opening statement is an indication of purpose or goal, or even the introduction to a set of instructions –"this is how you achieve a healthy pregnancy". But we know from the assertive, modalized use of the imperative -"*es importante* que sigas las siguientes recomendaciones:"- that is also *an implied warning*, phrased as a condition. In Spanish, it would read something like this: *"Si no sigues estas recomendaciones, puede que no tengas un embarazo saludable."* Or, even more bluntly, given the implications of "*para*

[58] Lupton D 1999b, p. 64.

lograr" as indication of necessity: "*Si no sigues estas indicaciones, no lograrás un embarazo saludable*". Whichever the reading, it seems unlikely that this warning will go unnoticed. In fact, from that point on, many of the required actions in the text take on the meaning of *risk awareness and prevention*, when we read them together with this opening statement or with the opening phrase in each block. Statements in block 2 can be read in light of block 1: "*Si no te alimentas adecuadamente, y si no evitas el consumo de refrescos, tabaco, alcohol y drogas, puede que no tengas un embarazo saludable.*" Statements in block 3 can be read as follows: "*Si tienes dolores de parto en cualquier mes del embarazo y no acudes de inmediato a cualquier unidad de salud, puede que no tengas/no tendrás un embarazo saludable.*" I have already discussed the particular situation of blocks 4 and 5, where the newborn explicitly enters the text. The same reasoning applies here.

Safe motherhood discourse and the embedded risk paradigm can also be traced by piecing together many of the expressions on this page, from verbs like "*evitar*" and "*checar*", through modalized verbs such as "alimenta *exclusivamente*" and "acude *de inmediato*"; to nouns and expressions like "*tétanos*", "*difteria*", "*tabaco*", "*alcohol*", "*drogas*", "*dolores de parto*", "*dolor de cabeza*", "*zumbido de oídos*", "*vista borrosa*", "*ver luces*", "*sangrados*", "*dolor de vientre*", "*hinchazón de pies, manos y cara*", "*dolor en el abdomen*", "*vacunas BCG y Sabin*", "*fiebre*", "*vomita*", and "*pálido*"; and clauses like "*si no sientes el movimiento de tu bebé*", "*si se te rompe la fuente o sufres algún accidente*" and "*(si) no quiere comer*". Delivery and childbirth, too, are framed in a context of risks –and as risks in themselves-, as I will explain below.

The dominance of risk discourse is all the more glaring *because it excludes other possible discourses.*[59] Like an oil stain, risk awareness spills all over the text. In other words, the "risk awareness" dimension of health risk discourse has been packaged and built into the concept of Embarazo Saludable –a type of pregnancy where women are aware of a range of risks and take action before it is too late.

[59] This is not the case on the video drama "Heed the messages of your body", as I will show in Chapter 5.

2. The rhetorical style[60] of this back page also contributes to its overall meaning. As I mentioned above, it functions as an "extended definition" of healthy pregnancy. It is also instructive and exhortative, as it simultaneously *tells* women what to do and *exhorts* them to do it. But there is a more subtle rhetorical effect running across this text: *an inverted cause-effect chain*,[61] which alters the traditional pattern for this style –that is, showing the causes and then the effects, or each new event as the logical result of the previous one.[62] In our case, we are given the effect first –a healthy pregnancy- and we are invited to read each subsequent "recommendation" as a cause contributing to that effect –e.g., "*acudir a consultas*", "*alimentarte adecuadamente*", "*checar que te apliquen la vacuna*", and so on, or through a more mediated connection, as I have shown before, "*acudiendo de inmediato a cualquier unidad de salud si, etc....*" In other words, a healthy pregnancy is the effect of a series of actions –performed both in the private and the public spheres- which imply control and self-control and require maternal agency, in a closely monitored and heavily medicalized continuum of care.

It is also telling to analyze this inverted cause-effect chain in terms of clinical and epidemiological thinking, that is, in terms of outcomes, risk factors, associations –rather than causal links- and interventions. A healthy pregnancy is a typical epidemiological outcome, which will *likely* occur, or *will more likely occur if* pregnant women go to checkups, eat well, avoid certain substances, get immediate assistance should they present certain symptoms, and so on. One can say that the producers of the Carnet are making their case from epidemiological evidence and through an epidemiologically grounded rhetorical style –which is, in itself, a textual indication of a particular discourse

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[60] By rhetorical style, I refer to the rhetorical "modes": descriptive, expository, informative, explanatory, exhortative, etc. Fairclough N 1992, p. 127 and 129. This includes the use of rhetorical formations and combinations, such as question and answer formats, cause and effect chains, etc. The argumentative structure of the text can combine different modes and rhetorical formations. (Ibid, p. 174-175).

[61] Syntactical and logical inversion is a major resource in this text, as we have also seen with the imperative main clause + conditional structure I discussed above.

[62] The cause-effect pattern is a typical rhetorical formation in scientific writing. Lemke describes *rhetorical formations* as "mini-genres", such as question-answer, problem-solution, and cause-effect, which are not specific to a particular genre but occur "in essentially the same form" in many of them –and thus constitute intertextual resources. Clause complexes, like the ones on the back panel of the Carnet, realize a certain type of rhetorical formation. Lemke JL. Ideology, Intertextuality and the Communication of Science. In PH Fries, M Cummings, D Lockwood and W Spruiell (eds.), *Relations and Functions within and around Language*. London and New York: Continuum, 2002, chapter 2, p. 32-55, reference on p. 33-34.

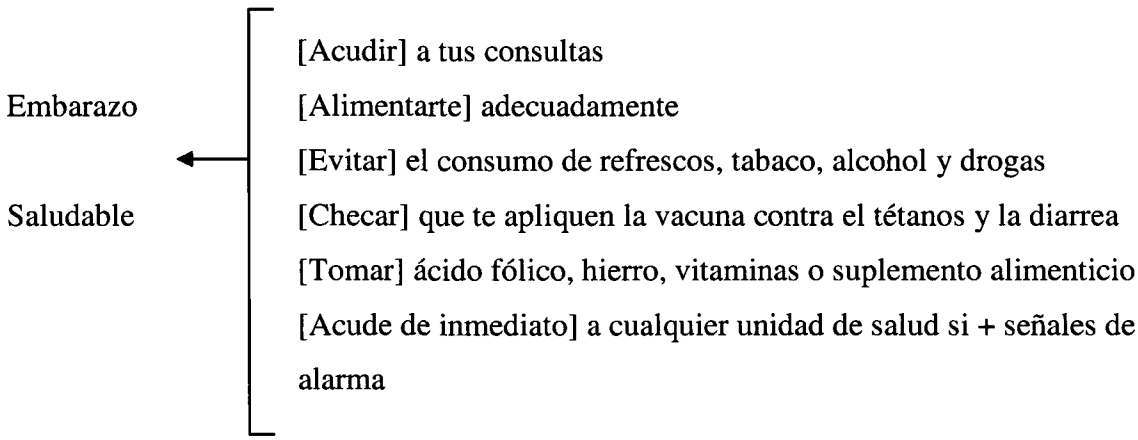
and its relative power within the order of discourse of public health. However, there are no traces of typical epidemiological modalization here. The Speaker does not talk of likelihood and probabilities, particularly on the second block of text, where a series of recommendations –such as going for frequent checkups, eating "adequately", and taking folic acid and food supplements- is linked with a healthy pregnancy as a specific outcome. The Speaker frames the exposures –in this case, the requested behaviours- as *necessary* to the outcome –a healthy pregnancy- and it does so with a strong evaluation – *es importante*. In the absence of any expression of probability, and because the Speaker does not explicitly say that these actions *are not sufficient* to achieve a healthy pregnancy, the strong evaluation of the condition of necessity (*es importante)* and the thematic placing of "*para lograr*" ("to achieve") to state purpose at the beginning of the panel –and not even as a subordinate clause- suggest a direct causal link between the requested actions and the outcome.[63]

3. The engineers of the text have also borrowed -and subordinated- expressions from other orders of discourse in an attempt to "translate" the meanings from the biomedical knowledge system. While there is no manifest intertextuality in this text, we can find interdiscursivity in the coexistence of language from clinical settings and every day speech. Although clinical discourse is apparent –and at times without transformation, as in "*ácido fólico*", "*puerperio*", or "*tamiz neonatal*"- the producers of the text often use vernacular expressions such as "*dolor de cabeza*", "*zumbido de oídos*", "*vista borrosa*", "*hinchazón en pies, manos y cara*", o "*se pone morado*", which are common currency in conversations between medical practitioners and patients in Mexico –and elsewhere in the Spanish speaking world. On occasion, these different orders of discourse get tangled up, as in the following clause: *"(si) llora demasiado, tiene diarrea, presenta dificultad para respirar o se pone morado (boca, uñas y pies)*", where the verb "*presentar*" betrays

[63] As we can see, two major changes occur in this type of intertextual use of epidemiological findings: a) statistical relations of probabilities are framed as cause and effect; b) population statistics are framed as guarantees of a healthy pregnancy for individual readers. In both cases, there is a linguistic manipulation that turns risk analysis into public health risk discourse for the sake of government control. What we see in the leaflet, as opposed to epidemiological discourse, is strong interpersonal commitment, in terms of functional linguistics, on the part of the Speaker. As a result, likelihoods are turned into certainties. In this case, there is also a reframing of people's experience in terms of biomedical knowledge and discourse.

the clinical jargon and exposes one of the key discourses at the foundation of this text (lay people would have used "*tener*" instead).

4. We can also foreground the epistemological and biomedical mindset behind this text by identifying a key grammatical feature of scientific texts and, in particular, of educational science texts: the construal of natural-like taxonomies.[64] For instance, the processes described in blocks 2 and 3 can be interpreted as essential components of *Embarazo Saludable*, as follows:



I have bracketed the thematic placement of the material processes realized through the imperative mood because it points to a critical feature of the taxonomical construal within the health promotion order of discourse: This taxonomy is not only ideational and descriptive, but also *interpersonal* and *prescriptive*. In other words, *it maps a prescription for maternal agency (to do as expected) onto a descriptive constitution of Embarazo Saludable as a technical and scientific category.* As a result, it turns this "natural" view of pregnancy into a political one, whereby maternal agency –through self-control and biomedical control in the public sphere- is a constitutive (taxonomic) component of healthy pregnancy. At the same time, the authors of the Leaflet are further honing the subject position of pregnant women, who must not only submit themselves to an institutionalized continuum of care, but also *take the lead in doing so.*

[64] Here, I follow Veel's enumeration of typical grammatical features of scientific texts. Veel R. The greening of school science. Ecogenesis in secondary classrooms. In JR Martin and Robert Veel, *Reading Science: Critical and Functional Perspectives on Discourses of Science.* London and New York: Routledge, 1998, p. 114-151.

Strictly speaking, blocks 4 and 5 do not pertain to this taxonomic construal, insofar as they refer to circumstances and situations that will happen –or may happen- after childbirth. Moreover, the visual arrangement (and the implied grammatical connection) of blocks 4 and 5 with respect to block 1 might render the text on this panel incoherent if readers/viewers did not take into account contextual and discursive practices: prenatal consultation often involves advice regarding childbirth and newborn care. This also allows reading the back panel as an implicit, incomplete[65] taxonomic construal of safe motherhood, with a strong emphasis on maternal agency and responsibility in a medicalized continuum of care. Such reading reveals that Embarazo Saludable channels key dimensions of safe motherhood discourse.

5. The "public control" dimension of public health management is also carved into this section of the leaflet, mostly through institutionalization of pregnancy. We can better appreciate the relative importance of this discourse by comparing those phrases and clauses that require to take or avoid action in the private sphere against those that require acting *in public* –basically through medical consultation and visits to government health units. I have grouped these expressions in table 1.

Private actions	Public actions
Alimentarte adecuadamente *Evitar el consumo de refrescos, etc.* *Tomar ácido fólico, hierro y vitaminas* *Alimenta exclusivamente a tu bebé con...*	*Acudir a tus consultas* (9 monthly visits) *Checar que te apliquen la vacuna contra el tétanos y la difteria* *Acudir de inmediato a cualquier unidad de salud si...* (there are 14 different symptoms or circumstances listed here) *Verifica que le hayan aplicado al nacer...* *Verifica que le han realizado la prueba del tamiz neonatal*

[65] The draft taxonomic construal of safe motherhood is only partial because it has no mention to care of the mother during puerperium.

	Llévalo a consulta a los 7 días *Llévalo a consulta a los 28 días* *Acude de inmediato a cualquier unidad de salud si tu bebé...* (8 different symptoms or circumstances are listed here)

Table 1

6. The "public control" dimension of discourse appears in close connection with the notion of *self-control, self-policing* or *self-regulation through technologies of the self* –in terms of Foucault.[66] In this case, self-control applies both to private and public actions – the latter depending upon women going for prenatal checkups. The often-intensified imperative constructions that dominate the register in this section of the text make women responsible for the outcome of their pregnancies and the health of their newborns. Moreover, they are held *publicly* responsible for *private* actions. In this regard, they are prescribed and imposed *agency* to *take action* –both private and public- on their behalf, on behalf of their children, on behalf of the government health system, and for the common good. This is an imported model from western societies where public health puts great emphasis on autonomous, self-regulated citizens. As Lupton observes, following Foucault, "(women's) efforts in fulfilling these responsibilities are aligned with those of the state through risk and public health discourses".[67] In our case, the Mexican government requires women to do things *to themselves and to various others.* I will briefly illustrate this in table 2, with categories developed by Hodge and Kress to classify syntactical descriptions of events from the world in terms of transactives and non-transactives. [68]

[66] Lemke T. "The birth of bio-politics": Michel Foucault's lecture at the Collège de France on neo-liberal governmentality. *Economy and Society* 30(2):190-207, 2001.
[67] Lupton D 1999b, p. 62.
[68] Hodge R, Kress G 1993, p. 8-9. Transactives involve two entities related by a process, with an action passing from one to the other ("The police opened fire on the suspects"). Non-transactives involve one entity related to a process ("The police opened fire").

Non-transactives	Transactives
Acudir a tus consultas *Alimentarte adecuadamente* *Evitar el consumo de refrescos, etc.* *Tomar ácido fólico, etc.* *Acude de inmediato a cualquier unidad de salud si...*	*Checar que te apliquen la vacuna* *Alimenta exclusivamente a tu bebé...* *Verifica que le hayan aplicado al nacer...* *Verifica que le hayan hecho la prueba de tamiz neonatal* *Llévalo a consulta médica...* *Acude de inmediato a cualquier unidad de salud si tu bebé...*

Table 2

I have included some transactives that do not appear as such on the surface -I will call them "hidden transactives", because they are disguised as non-transactives. They are important precisely because they hide entities or parts of a process. Take, for instance, "*checar que te apliquen la vacuna*". In order to do this, the woman reading the leaflet has to keep an eye on what her doctor and other health staff are doing, ask what kind of vaccine they are giving her, evaluate whether her shot against tetanus and diphtheria is due, think how to best tell the doctor about it, and finally ask, demand, or insist to be immunized. The same goes for "*verifica que le hayan aplicado al nacer las vacunas BCG, Sabin y realizado la prueba del tamiz neonatal.*"Another hidden transactive is built into "*Acude de inmediato a cualquier unidad de salud si tu bebé...*" Here, we can see the condensation of a very complex process, involving the baby, the woman (in active monitoring of these practices, addressing government health staff and using technical vocabulary, and perhaps bringing this issue to the attention of her husband and other family members, which may in turn spark an argument on the appropriateness of requesting these practices), various other participants, and probably issues of distance and cost and transportation. This condensation does not only take for granted a series of actions that the woman should carry out, *but also ignores a series of structural barriers that she may have to overcome.*[69]

[69] The video film in chapter 5 addresses some of these structural barriers, as I will discuss below.

The authors of this text have shaped the call for "self-control" and responsibility in other ways –e.g., through the use of presuppositions, and "given" and "new" elements.[70] [71] The very first recommendation in block 2 –and an essential one for the system to monitor and control pregnancies- is "*acudir a tus consultas*". There are two basic assumptions behind this exhortation: that all potential readers know about prenatal checkups and that these checkups are a matter of fact for pregnant women.[72] Moreover, the key semantic element here is the possessive adjetive "*tus*", which far exceeds its more obvious deictic function (already discussed), to become a "natural" qualifier to "*consultas*". *Tus consultas* is then presented as a given -which not only assumes that checkups are common sense, but also that "you" are responsible for them, because they are yours, and not a matter of, say, family discussion or spousal consent. The "new" in this exhortation comes in the shape of translated epidemiological knowledge: that you have to go for prenatal checkups in order to have a healthy pregnancy.[73]

Something similar happens with these clauses: "*checar que te apliquen la vacuna contra el tétanos y la difteria*" and "*verifica que le hayan aplicado al nacer las vacunas BCG, Sabin y realizado la prueba del tamiz neonatal*". Both convey the assumption that women agree with the need for, and appropriateness of, these procedures.

7. Delivery and childbirth, crucial instances in safe motherhood discourse, and in any discourse about maternal care, have a muted presence throughout the Leaflet. For sure, delivery is included in the concept of "perinatal", on the front page; but this is clinical jargon, seldom if ever used in everyday speech. Pregnant women –and doctors interacting with patients- would likely use verbal constructions such as "*dar a luz*", "*aliviarse*", or "*parir*", and the noun "*parto*". *Parto* appears only once, in the upper half of the middle

[70] Hodge R, Kress G 1993, p. 165-167.
[71] Halliday MAK, Matthiessen CMIM 2004, p. 87-91. The authors define information, in a grammatical sense, as "the tension between what is already known or predictable and what is new or unpredictable" (p. 89), where the new is in focus. Because the given is usually taken for granted, it makes for insightful analysis.
[72] For a similar analysis, see Fairclough N 1992, p. 182.
[73] As I have discussed before, global "safe motherhood" discourse admits that checkups will not identify "high risk" pregnancies, which basically results in all pregnant women as being "at risk", particularly facing delivery.

panel, as part of a series of circumstances when women should have their perinatal card handy. Delivery is also alluded to in the very first recommendation within block 3 on the back page, which would read as follows: "*Acude de inmediato a cualquier unidad de salud si tienes dolores de parto en cualquier mes del embarazo.*" This would certainly cover delivery, as would the last recommendation in this block: "... *si se te rompe la fuente o sufres algún accidente"* ("if your water breaks or you have an accident"). But in both cases, delivery is classified within a range of probable circumstances –e.g., having contractions *at any time* during pregnancy; if the water breaks *or* you have an accident. Delivery does not stand alone anywhere in the leaflet. Moreover, the two instances where it does appear, it is framed together with problems or risks –which in a way classifies delivery *as a risk.*

A silent dialogue and a complicated intertextuality seem to take place around delivery and childbirth within this text. I find two possible –and interrelated- explanations for this indirect approach to such a crucial issue in mainstream safe motherhood discourse:

a) Many indigenous women are averse to giving birth in hospitals and a good number of them deliver in their homes.[74] The elliptical allusion could then be an implicit negotiation between the order of discourse of public health and the order of discourse of traditional health care (or maybe, at the level of discursive practices, the result of a very concrete negotiation with advocates of the indigenous right to give birth at home).
b) In the immediate context of the text –where everything is about institutionalization of pregnancy and newborn care, while other voices and options are largely absent-, delivery in public health facilities would be a given, a presupposition, something taken for granted *in terms of recommendations.* The reality of home childbirth is thus backgrounded, while the normative dimension of discourse points in the direction of public health.

[74] According to the MNH Project 2008 baseline survey, 60% of the women who had been pregnant in the previous three years had given birth in their homes, most assisted by a *partera,* some by family members, and some others by themselves.

8. Several linguistic and visual features of this text, including the combination of descriptive, instructive, and normative meaning, the use of taxonomic categories, and the overall asymmetric nature of the communicative event, reveal the pedagogic intention of the Leaflet. This is a typical trait of public health risk discourse –and one the Carnet shares with the video film in chapter 5.

4.7. Packaging surveillance and responsibility

We can now turn to block 6, at the very bottom of the same panel. It is made up of two clauses: *"¡Cuida tu salud y la de tu bebé!"* ("Look after your health and that of your baby!") and *"Para arrancar parejo en la vida"* ("To start even in life"). The first clause operates as an ideational and interpersonal conclusion to the text on this panel, and indeed to the entire Leaflet. It packages the major syntactic and semantic components that populate the text: the main ideational components of the field ("*cuidar*", which again frames pregnancy as risk; "*tu salud*", "*tu bebé*", which speak of double risk and double responsibility), the rhetorical style, and the interpersonal orientation. It has been phrased as an imperative in the second person singular (informal), intensified by an exclamation mark connoting the strong feeling of the text producer, and foregrounded through capital letters and larger font size. Again, this can be interpreted as a warning, as a call for action, and even as an implicit reproach *in case "you" do not act as demanded* –because "we" know, based on population statistics of pregnant women as a risk group, that "you", being one of them, may have not done as indicated or may not do it in the future.

We can trace the presence of government, clinical, and epidemiological sources in this conclusion of the text. After all, it is from medical records –like the one on this card-, epidemiological surveillance, and population statistics that policy makers know the proportion of pregnant women who go for prenatal checkups and the average number of recommended checkups women attend to in each part of the country. They also know about the epidemiological associations between the number of checkups and pregnancy outcomes, and between maternal monitoring and newborn health. Based on cognitive models of rational choice and decision-making, they have likely attributed women's

missing checkups and health problems with newborns to lack of awareness and "biased" judgment –faulty evaluation of risk. All of which becomes apparent from the text on this panel and the heightened personal interpellation that brings it –almost- to an end. Policy makers –and the government- know that not all women will go to all prenatal checkups and may not do what is epidemiologically linked with better newborn health. They do not only exhort them to do what is expected, but they also turn the "faulty evaluation of risk" from population statistics into a personal warning –with overtones of guilt and blame.

Of course, there are many other possible explanations for women not going to checkups and not following all the recommended regarding the health of their newborns. But these possible explanations have no room on the Leaflet, where we only find traces of biomedical and government voices, with a hint of vernacular in the register.

We can, for the sake of argument, consider that the text on this panel has come to a full conclusion at this point. As we have seen, it is highly cohesive and it should not present any challenges for coherence. The producers of this Carnet have said all they had to say about healthy pregnancy, safe motherhood, risk, control, self-control, and individual responsibility –adding a few drops of guilt and blame for good measure. Or haven't they?

In fact, there is one more clause in this last block –one that has great semiotic impact on the text as a whole. "*Para arrancar parejo en la vida*" does not come from the same biomedical discourse, and it seems, in principle, alien to the traditional societal order of discourse around safe motherhood. Where does it come from and what is the impact on the discursive event? An even start in life can be traced to a growing current of thought in population health that is known as "health equity".[75] Health equity is slowly moving centre-stage from the margins of the ideological complex around population health at the international level.[76] One of the basic premises behind this current of thinking is that health inequities both reflect and have an impact on broader socioeconomic conditions.

[75] On the concept of health equity, see, for instance, Ruger JP. Ethics and governance of global health inequalities. *Journal of Epidemiology and Community Health* 60:928-936, 2006.
[76] See Shah I, Chandra-Mouli V. Inequity and unwanted fertility in developing countries. *Bulletin of the World Health Organization* 85(2):85-160, 2007, among others.

Drawing from this theoretical and policy approach, the Mexican government set up the program *Arranque Parejo en la Vida* ("An Even Start in Life", or "An Equal Start in Life"), as part of the National Health Program 2001-2006, with external funding from the World Bank. The program aimed to give universal coverage and the same quality and conditions of health care to pregnant women during pregnancy, delivery and puerperium, as well as to children during their first two years of life, "thus contributing to an authentic equality of opportunities".[77]

Arranque Parejo has been widely publicized since its inception, and pregnant women and government health staff most likely know by now that it deals with maternal and newborn health. Therefore, the last clause in the Leaflet should not disturb a coherent interpretation of the text. The expression has been used –with different transformations- as a slogan in advertisement, publications, and health promotion material. In this case, the nominalization *Arranque Parejo en la Vida* has been transformed in a statement of purpose, through the use of the preposition "*para*" coupled with the verb "*arrancar*".[78] This clause has been articulated with the clause immediately above it, in a grammatical operation that closely resembles the one linking the opening statement (block 1) and the other blocks on this panel. Therefore, the two clauses can be read separately, but the reader is induced to pull them together by the preposition "para", which breaks the self-enclosement of the previous clause within exclamation signs, points to the dependent nature of the second clause, and indicates what the actions prescribed in that first clause are for or lead to. As a result, the two clauses are bound in a sentence that reads as follows: *Cuida tu salud y la de tu bebé para arrancar parejo en la vida.*[79]

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[77] *Programa de Acción: "Arranque Parejo en la Vida"*. Mexico DF: Secretaría de Salud, 2002, p. 13. Available at www.salud.gob.mx/docprog/estrategia_2/**arranque_parejo_vida**.pdf. *Accessed September 10, 2009.*

[78] Professor Rodney Williamson, an analyst of journalistic and political discourse in the Mexican media, points to a case of intertextuality in the expression *arrancar parejo*, which he traces to the use of the phrase *jalar parejo*, or "to pull evenly" (in the sense that "we should *all* pull evenly"), by Vicente Fox, Mexico's president between 2000 and 2006. In his comments to my own analysis, Williamson says that this was Fox's "colloquial take on a traditional political equality slogan that didn't change much from the PRI to the PAN: "*la solución somos todos*" ("We *all* are the solution").

[79] Nevertheless, this complex meaning would be lost to Amuzgo speakers, since the expression "*arranque parejo*", in terms of equal opportunities, does not translate into Amuzgo language. The very concept of "*oportunidades*" is alien to the Amuzgo speaker. Bilingual Amuzgo CIET team members in Xochis were lost for words when trying to translate these expressions. In fact, the conceptual meaning built into names

In other words, the reader has to look after her own health and that of her baby for an equal start in life. But *whose* start? The reader can logically infer that this equal start does not refer to her, but to her child. She must act to give her newborn equal opportunities in life. Thus, the slogan –and the government program it represents- is about maternal and newborn care, but it puts the emphasis *on the child.* The mother must look after her own health, sure, but she must do it *for the sake of her child*, so that her newborn does not fall behind the minute he or she enters this world. Following that line of thought, the overall interpellation in the Leaflet gets slanted towards maternal care *of the child*, from the moment of conception through to his or her first 45 days of life. Through this interdiscursive effect, the reader –this mother, "tú"- is constructed *as responsible for her child's even start in life.*

Lupton calls the attention to the shift towards foetal risk in western countries, with significant implications for the experience of pregnancy. "Despite the discursive separation of foetus from woman's body," she says, "the pregnant woman remains positioned as responsible for the foetus' wellbeing. Her body, therefore, is constructed as doubly at risk and she is portrayed as doubly responsible, for two bodies."[80] From my analysis, this trend was firmly in place in Mexico during most part of the last decade. Worse yet: as framed in Mexican public health discourse, pregnant mothers are responsible not just for the wellbeing of the foetus, *but also for the life chances of the newborn.*

Moreover, Arranque Parejo is not only about the child of this particular reader –or of any other reader-, but about reverting social injustice and creating "authentic equality of opportunities" in Mexico. Zooming in on the text from this political order of discourse – that exceeds public health-, we can see the binding of the last two clauses in a different light: The reader –this pregnant woman, *tú*- has to police her own body and the health of

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of programs like Arranque Parejo en la Vida soon takes back seat to acronyms and other denominations in the daily speech of government health staff and patients alike. Health staff in Xochis, and elsewhere, usually say "APV", while lay people may use the same acronym or refer to "*el programa del gobierno*", as they do with many other programs.

[80] Lupton D 1999b, p. 63.

her child *to contribute to the reversion of health equalities and social injustice in Mexico.* Talk about guilt: failing to do so, she would have failed not only her own child but also what Mexico expects and needs from her.

Of course, this subject positioning has to be seen as social constructions within ideological complexes, the most immediate of which is that of motherhood at the societal level and the most encompassing probably that of the social and political alliance that governs the country. From this level of sociocultural practices, we can appreciate how this ideological effect would operate, as the government commits to reverting social inequities and injustices, but places a great deal of the burden –at least within the institutional order of discourse of public health and the societal order of discourse of motherhood- on pregnant women. Put differently, it seems to request –indeed, exhort and demand- pregnant women take the lead in reverting unequal social conditions that many of them –like indigenous women in rural Guerrero- are suffering on a daily basis.

4.8. A crucial reminder and a strange case of intertextuality

The middle panel[81] of the folded triptych presents an unusual combination of words and imagery –in such way that we could be led to think it reflects an afterthought. It is not, as I hope to prove through the analysis.

This panel is vertically divided in two halves, always connected through the top green strip and the tiled background that give visual cohesion to the Leaflet. In the upper half, there is one single, short paragraph, which has been typographically highlighted by using white lettering within a blue text box. There are two sentences in that paragraph. The first one reads: *"Este carnet contiene información indispensable para tu salud y la de tu hijo."* ("This card contains essential information for your health and the health of your child"). The nominal group "*Este carnet*" is at the same time thematic, deictic and declarative: by placing the Carnet as the Theme, pointing to it with a demonstrative pronoun (this), and

[81] Appendix A, p. 550, and/or Appendix F (CD), image 5.

declaring it an official document[82], it establishes a discursive hierarchy between the Leaflet and the Record. Just as it happens on the front page, the reader knows that the object in his hands is *primarily* a health card –the pragmatics of the language having settled that. Moreover, it is *her identity card*, a document that constructs her as pregnant woman within a system. This card, in turn, contains a clinical record –*her* record.

This is not to be taken for granted –though it probably is in everyday use-, because leaflets and health cards are of a very different nature and interpellate readers from different power positions. Promotional leaflets are usually meant to inform and persuade, which gives us behavioural options. We can choose to read and disregard the content – not in this case, though-, and we can trash them without any immediate repercussions. Leaflets establish two basic participants: the speaker (in this case, the government or someone who speaks on behalf of the government) and the reader -who is a potential reader, an ideal reader, always a member of a target audience. Health cards –and health records- are nothing like that. Cards are meant to incorporate someone within a system. Records are meant to capture personal information across a period of time. They are government *documents*, which we cannot alter or tamper with. And they entail more than two basic participants. The government has an almost material presence behind them; medical staff working for the government have exclusive authority to fill them out; and we have the obligation to sign them and submit them for monitoring purposes. We may choose not to do it, but to our own risk –in Mexico, skipping scheduled prenatal checkups implies losing social benefits. Finally, all participants *commit* to something in order to ensure a continuum of care: women will do as they are requested, and government will assist them through the public health system, *provided that women take action.* This last statement is essential to grasp the implications of the discursive event: *it is up to pregnant women to set into motion and realize this entire set of commitments.*

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[82] In Spanish, the word "carnet" or "carné" usually refers to an identity card issued by government agencies or other institutions, stating that the bearer of that document belongs to a given group or organization. In Mexico, all of the main health insurance institutions issue standard documents called carnets to indicate that the bearer has the right to be attended in the health system. In this case, the Carnet officially labels the holder as pregnant and, therefore, entitled to coverage and care by government health services upon her request. From a semiotic perspective, the Carnet also establishes the bearer as member of a risk group, who is responsible for her own health and the health of the child in her womb.

Therefore, the opening two words of this text remind the reader what she has in her hands is a government document, and that she should read it as such –including the "informational" component –which is now *integral part* of the Carnet, and not just a leaflet. This is assertively accomplished within the same opening sentence, where the simple present tense ("*contiene*") realizes a categorical modality[83]. As a result, the reader is faced with facts ("*información*") further modalized as "*indispensable*", towards the attainment of a "given" ("*para tu salud y la de tu hijo*", which "we" assume you care about). It is worth noticing how the Speaker has constructed this initial statement with the "new" component at the very beginning –*Este carnet contiene información indispensable-* and the given at the end of the sentence. The new, in turn, establishes itself with the force of an official document, the authority of facts and its qualification as something indispensable.

The second sentence is a clause complex made up of two main clauses of equal status (parataxis) and two dependent clauses introduced by the subordinating conjunction "toda vez que" (whenever, every time that), which have lower status than the first two ones (hypotaxis). There is an imperative mood in the first (and dominant) two clauses (*Llévalo contigo y entrégalo al equipo de salud...*), which gets qualified, and at first glance tempered, through two dependent clauses (*...toda vez que requieras una atención/ya sea para el embarazo, parto, puerperio o control de crecimiento y desarrollo de tu hijo)*, which lay out the conditions under which the actions in the two main clauses.

So, the government tells the reader she should take her card and give it to health staff *whenever* she requires medical attention for pregnancy, childbirth, newborn control, or puerperium. Here, the qualifying temporal clause seems to indicate that is up to the reader to decide if and when to go for medical help; but we have already seen how the text on the back panel and the combination of words and imagery on the front panel frame a healthy pregnancy and a healthy child *as highly dependent on close and frequent institutional control.* Seen in this textual context and in the light of both logonomic

[83] Fairclough N 1992, p. 159. Verb tense is another way of realizing modality. Simple present tense ("is", "has") realizes a categorical, objective modality.

mechanisms and discursive practices –government health staff hand out the Carnet in government health units; pregnant women have long been prodded to check their pregnancies in government health centres[84]-, the temporal clause sounds more like a reminder of an obligation (to take the Carnet and hand it to "the health team") within a "natural" state of affairs ("every time that you require attention, either for pregnancy, childbirth, puerperium, or for controlling your child's growth and development"). In other words, we cannot read the clause complex in the middle panel as a standalone semantic unit: we have to read it in the context of the overall text, where the overarching semantic construal overrides the surface meaning from the structural organization of the subsystem in the middle panel. Finally, in terms of the new and the given, the first part of the text on this panel functions as the new –what the Carnet is and what you should do with it- and the second part as the given –seeking a continuum of care from the health team out of government health services.

A clinical chart takes up the lower half of this middle page, completely segregated from the upper half, in what at first glance looks like a strange instance of manifest intertextuality (the text indicates the original source of the chart). The chart refers to what is considered standard "fundal height" –the *fundus* is the main body of the uterus- according to the gestational age of the foetus. Measuring fundal height was common practice before ultrasound, in order to determine foetal growth and gestational progression. Still today, fundal height is considered useful in large clinics and other settings where patients may not get to see the same doctor each time they go for prenatal checkups.[85] The Record component of the Carnet contains a specific line to measure fundal height in each prenatal visit. This connection to the Record, together with the abstract, technical nature of the chart, the clear separation from the upper half of the panel, the reading barrier posed by the clinical jargon, and the mention to the source of information, all seem to indicate that this particular component of the Leaflet is meant for medical staff –and may have been included here for lack of space on the Record.

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[84] This, in turn, has had an impact on sociocultural practices, because women discuss prenatal checkup in their households, with parteras and traditional healers, as it emerges from interviews in Xochis.
[85] See, for instance, *Fundal height measurement*. Gyn[OB].com. 2008. www.gynob.com/fh.htm. Accessed July 17, 2008.

Whatever the reasons for it, the presence of the chart on the Leaflet is clearly "out of place" and makes for highly contrasting intertextual reading. The chart "irrupts" onto this panel, bringing the full iconic and symbolic force of a different kind of knowledge, knowledge of the woman's body that belongs to a few "skilled providers". These providers are not a mere abstraction: they are the members of the "health team" specifically mentioned on the upper half of the same panel. Placed right under a deictic declaration of *this* document as a Carnet, as a health card to be handed out for periodical checkups, childbirth, postpartum, and newborn care, the chart refers to knowledge ("*información indispensable para tu salud y la de tu hijo*") that directly affects the pregnant woman and her child, but that only these experts have access to. And even if "non skilled providers", such as traditional birth attendants, can learn to measure fundal height,[86] neither them nor most pregnant women –never mind illiterate indigenous patients in rural Guerrero- can fathom the abstract, impenetrable representation of this knowledge on a chart. In fact, the reader does not need to "read" the chart, just "view" it, in order to perceive its power –and the power of the knowledge it conveys.

There is yet another possible reading in the context of indigenous Guerrero. In order to measure fundal height, doctors introduce one hand in the vagina, reaching inside through the birth canal. Amuzgo and Mixteco women do not like being touched by men who are not their husbands –let alone in this kind of intimate, invasive contact. This is one reason why indigenous women are reluctant to go to prenatal checkups and to deliver in health facilities. Untrained *parteras*, by contrast, do not use invasive methods to assess the evolution of pregnancy. The chart glosses over the uncomfortable reality of this procedure, by turning it into an abstraction with no human features and investing it with the authority of scientific language and imagery.[87]

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[86] In fact, this knowledge can be bestowed upon them –some say it should- through medical training for use in "well-supervised". See, for instance, Buchmann E. The use of symphyseal fundal height in antenatal care: RHL practical aspects. *The WHO Reproductive Health Library*. Geneva: World Health Organization. Available at http://apps.who.int/rhl/pregnancy_childbirth/antenatal_care/general/ebguide/en/print.html. Accessed November 6, 2009.

[87] Kress and van Leeuwen observe that "diagrams, maps and charts are most often found in contexts that offer a kind of knowledge which, in Western culture, has traditionally been valued highly –objective,

4.9. Horizontal reading: the Leaflet as single-page layout

The triptych has been designed so it can also be unfolded and read as a single panel with horizontal layout. In fact, that is the only way doctors can work with the Record. Here, I will only focus on some key aspects of the unfolded Leaflet[88] –in particular, issues of narrative structure and cohesion-, in order to show how they both draw from and contribute to the reading of the front panel as the macrostructure of the overall text.

Kress and van Leeuwen[89] show how double-page spreads and other landscape-type designs tend to place essential information –including images and new content- to the right. The "already given" –the familiar, the "agreed-upon"- comes on the left. But there is more to this kind of layout than meets the eye:

> This structure is ideological in the sense that it may not correspond to what is the case either for the producer or for the consumer of the image or layout. The important point is that the information is presented as though it had that status or value for the reader, and that readers have to read it within that structure, even if that valuation may then be rejected by a particular reader.[90]

If we apply this theoretical approach to our single-page leaflet, we can clearly see how the "narration" progresses from the self-referential deixis (*Este carnet*) and the illocutionary force (assertive, declarative, commissive) of the text within the blue box at the top on the left side of the page, right through the imperative recommendations of the centre section, to the ideal outcome of a healthy pregnancy –highlighted through a salient photograph- and the contractual grounding of the personal information for the Carnet on the right. One potential meaning development of this "given-new" sequence could be phrased as follows: "You now have a health card in your hands. You know it is a

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dispassionate knowledge, ostensibly free of emotive involvement and subjectivity." Kress G, van Leeuwen T 2006, p. 121.

[88] Appendix A, p. 546, and/or Appendix F (CD), image 1.

[89] Ibid, p. 179-185.

[90] Ibid, p. 181.

government document and you know what it is for (left, top). And you now have a reminder of things that you know and you should do for a healthy pregnancy (middle section). If you do as expected, you will achieve a healthy pregnancy (right, top). It is your turn to act now. Start here (right, bottom)."[91]

Of course, if we go back to the "given" and look below its assertive surface, we will find –as we have- vested interests, excluded voices and maybe even the transformation of women's "irrational" fears into painless charts (left, bottom). Furthermore, the core of the "given", in this layout is the Carnet itself, which implies that pregnant women accept this way of government control and institutionalization of pregnancy and newborn care as a normal state of affairs. In other words, what the Carnet takes for granted is the rationality of institutionalized prenatal care.

The single-page view of the triptych also allows for a better appreciation of how graphic grammar plays a semiotic role and how the designers of the Carnet have used these elements as means of visual cohesion and vehicles of ideational and relational (interpersonal) content. The green strip extends across the top of the three panels, as both thematic (opening position in the vertical reading) and topic (common semantic fields) connector, leading into the Salud ideogram on the right panel, with its ideational connotations of partnership and maternal health including children in the womb, and linking vertically with other key textual elements such as the woman's dress (with its connotation of indigeneity), the clinical chart (monitoring, continuum of care), and the expression Embarazo Saludable –the expected outcome of biomedical logic and successful health risk communication. The cohesive character of the green strip carries over onto the Record, where it horizontally highlights two key issues of the Leaflet: *Embarazo Actual* ("current pregnancy") and *Recién Nacido* ("newly born").[92]

[91] This narrative is even more rounded in an alternative version of the same Carnet issued by the Hospital de la Madre y el Niño Guerrerense, which I analyze on 4.11 below.
[92] Green colour has also been used to indicate hypertrophy in the fundal height chart on the left panel.

In terms of relational content, the overarching presence of the green strip across the top of the unfolded triptych and within the Salud ideogram, combined with the strong presence of white in the doctor's uniform and the background, can imply protection of the reader/viewer by government health services, in exchange for self-control and subordination and control (as we have seen, all of these notions are textually symbolized in green). This association becomes all the more cogent when we take into account that green and white stand side by side on two of the three vertical stripes in the Mexican flag. This visual connotation complements, rather than contradicts, the strong verbal emphasis on women's responsibility –all of which points to a mix of solidarity and power. In other words, the Mexican government only guarantees a healthy pregnancy *as the outcome of a complex interaction where women bear the bulk of the burden –and the responsibility.*

Equally relevant is the use of white colour across the unfolded Leaflet, where it stands out in the lettering of the top box of the left panel (a thematically placed description of what the Carnet is and how it should be used, which includes, as we have seen, the framing of medicalized care as a given); the Salud logotype, the doctor's uniform, and the borders between large and small tiles in the background. At the ideational level, this whiteness alludes to key components of safe motherhood discourse, such as government health care, medicalized pregnancy, and qualified practitioners. As a relational function, it connotes protection, authority, superiority, and control. The use of white carries these meanings onto the Record, where logonomic regulations allow doctors to operationalize the bureaucratic procedures of monitoring and control.

Finally, the unfolded Leaflet affords the clearest, most sweeping view of the tiled background pattern and its strong resemblance to glazed tiles on hospital walls. All other graphic elements stand out from the background and, most crucially, *are supported* by this pattern. Colour modulation has a powerful effect here. The overall lightness of the background with respect to the foregrounded elements creates an illusion of *clean* walls - and an aseptic hospital environment. At the level of discursive practices, this connotation is all the more relevant when paired with data coming from interviews with government health staff; there, the notion of *cleanliness* emerges strongly as a reason why indigenous

women should deliver their children in government health services and not in their homes. There is one such example in the following exchange with a government health official working in the Ometepec health district:

> **Q:** ¿Ustedes están dispuestos aceptar el parto domiciliario como alternativa?
> **A:** [...] En ciertos casos especiales se atiende así cuando la embarazada ya está en período expulsivo, porque ya no hay otra más que atender ahí en su domicilio. Pero en sí, este, no, no se está recomendando la atención intradomiciliaria por la situación que se maneja de la limpieza, la higiene, y eso puede contaminar...el niño también. De ahí la situación que se oferta en el centro de salud; pero intradomiciliario, en ciertos casos especiales nada más.
> **Q:** Pero no como norma...
> **A:** No.
> **Q:** O como política general...
> **A:** No.

Gradual modulation of grayish blue from very light on the right and moderately dark on the left of each individual tile –and of each column of tiles- also allows for a nuanced interaction between this lighter background and deeper blues in foregrounded elements, which has a marked cohesive effect across panels. The dominance of blues may also contribute to create a soothing impression -and perhaps also a trusting predisposition- in viewers who may be wary of –or even hostile to- government health services.[93] Overall, the use of saturated green and muted blues creates a warmer visual space that somehow tones down the pervasive depiction of pregnancy as risk throughout the Carnet.

It is also worth noting that the tiles on the bottom and on both sides of the brochure have been framed in a way that creates an illusion of continuity outside the paper. This effect is an index of something larger, more pervasive and enveloping than the fragment we can actually see, which reinforces the idea of healthy pregnancy resting –and depending- on institutionalized care.

[93] Kress and van Leeuwen observe that the blue end of the scale from blue to red (which indicates colour hue) is generally associated "with cold, calm, distance, backgrounding". Kress G, van Leeuwen T 2006, p. 235.

Another important graphic element is typography -words *as* imagery. As Stöckl remarks, typefaces point to the nature of the document, and they can also carry emotional value.[94] Across this unfolded page, we have black sans serif typography, within genre conventions in public health discourse, supporting the overall register of the text, conveying formal, realistic meaning, and contributing to organize the thematic hierarchy of the different elements through font size, italics, size, text blocks and a chart.[95] A few key elements stand out from the overall style. One of them is the logo, which is a given in any publication by the Health Secretariat. Another is the word "Salud" in white typeface –which matches the doctor's white coat and the white borderlines between tiles- against a blue background. Yet another one is the expression *Embarazo Saludable*, which is given salience through larger size, bright green typeface and a rounded white outline. I have already discussed the potential semiotic impact of this use of colours.

4.10. The clinical Record

The Record[96] is the second generic component of the Carnet, and it is directly related to a specific type of activity: prenatal checkups in government health facilities. The Record is meant for doctors to fill out with the patient's personal and clinical information. (age, educational level, marital status, smoker/non smoker), clinical background (personal and family history of certain medical conditions; gynaecological history); current pregnancy; monthly consultations; pregnancy outcome, including puerperal period; and health status of the newborn.[97]

At the level of discursive practices, the Record entails strict logonomic regulations. To start out with, only medical practitioners in government health facilities can fill out this document. They will do so across a period of time, covering many developments, all of

[94] Stöckl H. Typography: body and dress of a text –a signing mode between language and image. *Visual Communication* 4(2):204-214, 2005; reference on p. 206.
[95] Here, too, I have followed Stöckl H.2005, p. 210.
[96] Appendix A, p. 547, and/or Appendix F (CD), image 2.
[97] Content wise, there is no space on the Record for narrative data or any other information outside the standardized requirements. As a result, the Record leaves out the patient's voice –and the doctors' comments, for that matter- and anchors the assessment around a standard set of biomedical criteria

which entails several follow-up visits during pregnancy, childbirth and postpartum. And they will do it after examining and interviewing the patient, requesting and reading a series of tests and technological procedures, perhaps assisting in delivery, and eventually controlling the evolution of the mother and the newborn during puerperium. Moreover, it is likely that different practitioners will fill out the Record at different stages of the process.[98] A meaningful analysis would involve registering a sample of these interactions, seeing how the Record evolves over time, and how patients and doctors co-construct it. This task lies outside the scope of this thesis. Here, I will only touch on some aspects of the ideational meaning reflected in the different categories of the Record and what they imply for the Carnet as a discursive event.

The Record is made up of five different blocks. In all of them, there is a predetermined set of questions and categories, all meant to draw data from the cardholder and to register a series of circumstances in terms of clinical statistical information, which will later be used for epidemiological analysis of population aggregates.[99] These numbers will, in turn, feed into policy papers and eventually influence policy making and operational guidelines in the domain of public health. Given time, this chain of texts will help shape – and be part of- health promotion texts like the one on the Leaflet segment of this very same card.

I will not make a detailed analysis of the many possible discursive implications emerging from the management of this information; but I will mention some potential effects related with safe motherhood and health risk discourses. Block 1 in the Record requires socioeconomic information, like age, marital status, educational level, and a basic differentiation between professional and non-professional status.[100] Block 2 collects information on familial and personal medical conditions that have been identified –in

[98] These records also facilitate clinical control if patients visit different government and private health services. .

[99] Government health services keep a parallel record with the same information. These data are collected through a monthly census of pregnant women. Also based on these clinical records, each health centre reports high-risk pregnancies to the district Health headquarters in Ometepec on a weekly basis.

[100] It is noteworthy that the classification of the patient as "smoker" or "non-smoker" –a very important risk factor for pregnancy- is included among the categories that make up socioeconomic profiles of pregnant women.

epidemiological analysis- as risk factors for pregnant women. It also requests obstetric and gynecological data, all of which goes into the construction of a personal clinical history.

Block 3 collects information about the current pregnancy, including Papanicolaou test, breast exams, and fundal height, all three of them involving biomedical procedures that are potentially discouraging for indigenous women. There is also a detailed list of 13 dimensions to be monitored across nine scheduled prenatal visits. Block 5 is about the newborn, although it includes three boxes for "maternal release" from the facilities, "maternal death" (during pregnancy, delivery or puerperium), and birth control methods grouped under "family planning".

Block 4 collects information about delivery, making room for two elements from the order of discourse of traditional health care: doctors can check whether women delivered in their home, and "*partera tradicional*" is an option under "assistance" during pregnancy and to the newborn. However, these two elements are simply coded as "yes" or "no", a binary mode that feeds into quantitative epidemiological analysis and leaves out any narrative account of the circumstances. There will probably be more information on the parallel record kept at the health centre, but it is unlikely that this document will register much outside the observations of the clinical practitioner. This framing of the options may condition the epidemiological analysis, which in turn has an impact on health risk discourse. Thus, data from this Record may turn up at the other end of the statistical grinder as something like this: "Women assisted by traditional parteras in their homes were more likely to experience complications during delivery," while missing out on valuable insight on the situation and the context –such as the voice of the parteras. All of this has direct bearing on mainstream safe motherhood policies.

There is an aura of scientific neutrality upon first reading of these categories and boxes, and a taken-for-granted factuality in the reports of statistical procedures that pool them together. However, there are many different ways of pooling, analyzing and interpreting this information –and many more in which it can shape public discourse. It is not unusual

to find reports and papers based on statistical and epidemiological analysis based exclusively on this kind of information where, for instance, "low socioeconomic status" is associated with "fewer prenatal checkups". Depending on how these two variables get linked in policy and public health discourse, the end result may be an ideological reading where poor pregnant women seem irrationally reluctant to go for prenatal care. The strong emphasis on women's responsibility and the institutional exhortation for them to take action emerging from the Leaflet point to this type of ideological construction.

4.11. Few changes, a sea change

An alternative version of the Carnet was issued by the Hospital de la Madre y el Niño Guerrerenses (HMNG), the highest-level maternal and child care health unit in Guerrero, located in Chilpancingo, the state capital. A few visual elements change from the standard health card handed out in Xochis, but they make for a significant twist in meaning. Evaluating these changes and their potential discursive impact is relevant to my objectives because they are grounded in powerful imagery, and images aimed at female viewers will likely carry a greater weight than written language in communities where most women are illiterate.[101] [102]

On the hospital version of the Carnet,[103] the photograph of the doctor and the pregnant woman in a prenatal checkup setting has been replaced with an image that captures a woman and her newborn child after delivery,[104] which we can infer partly from the image and partly from the textual context (this reading is possible even from the isolated front

[101] According to the MNH Project 2008 baseline survey, some 60% of women in Xochis had no knowledge of Spanish. It is safe to assume that an even larger percentage cannot read or write in that language.
[102] The analysis of this alternative Carnet is warranted on several other grounds: a) as it becomes clear both from the literature and from interviews in Xochis, Ometepec and Chilpancingo, many indigenous women remain reluctant to give birth in hospitals, whereas many others perceive institutional birthing as being safer and less painful; b) although the hospital health card was not widely distributed in Xochis, women from these communities are referred to hospitals in Xochis, Ometepec, Chilpancingo, and Acapulco, and this is a crucial issue for the intersection of safe motherhood discourse and indigenous views and experiences in Xochis; c) on a more general note, much discourse analysis refers to what is absent from a particular discursive event, or what could have been different in any of the three dimensions. This alternative health card offers an opportunity to effectively compare two closely related discursive events featuring significant changes in terms of textual content and discursive practices.
[103] Appendix A, p. 551, and/or Appendix F (CD), image 6.
[104] Appendix A, p. 552, and/or Appendix F (CD), image 7.

panel, since the hospital logo is superimposed to the lower portion of the picture, next to the expression "Carnet Perinatal"). This picture not only has different narrative and ideational contents, but also –and more remarkably- a distinct graphic treatment, all of which bears an impact on its overall discursive effect.

The picture is a very close shot of a woman and her male newborn. Contrary to the woman in the Xochis carnet, she bears no explicit markers of indigenous identity.[105] We can see most of her face and her head tilted to one side, as she leans on her left arm, presumably on a pillow that lies out of sight. She seems to be dressed in a light blue shirt, or maybe covered with a blanket of the same colour. She smiles tranquilly, without opening her mouth, a relaxed expression across her face, as her eyes look lovingly down onto her child and her right index finger, entering the image from the left, also reaches out to almost touch him. We can see most of his face, his eyes shut as he sleeps peacefully, his head wrapped in what looks like a white woolen cap. From the portion of the image that is available to the viewer, one can infer that he is lying next to her. Through underexposing, cropping and the use of the tiled pattern in the foreground, the designers have blurred most of the described features and have excluded all other elements from the immediate context. The overall effect is of deep communion between the mother and the child, and of subdued, silent intimacy in a comforting environment –a highly crafted, yet perfectly "natural" image of maternal bliss.

The mother's gaze drives the reading of the whole panel. Strong diagonal lines follow the tilting of her head along the parallel contours of her eyebrows, eyelashes, mouth, and index finger, from the upper left half of the image towards the lower right side. Other, less explicit diagonals add to this powerful vector from the mother to the child, to the point of almost fusing the two of them. Kress and van Leeuwen term this glance-driven pattern between participants as "reactive" –rather than transactive- and, in this case, would call the woman a Reacter and the child a Phenomenon[106] –the result of a healthy pregnancy driven and guarded by qualified health professionals. We can further argue in

[105] This makes sense in terms of potential target audiences, since the HMNG offers prenatal care to women from Chilpancingo and surrounding areas and receives obstetric patients from all over Guerrero state.
[106] Kress G, van Leeuwen T 2006, p. 67-68.

favour of this reading if we consider how all narrative chapters on the other two panels of the unfolded brochure[107] pour into this vector and, like a waterfall, onto the sleeping child.

However, based on the same narrative pattern –and other components of the Leaflet-, we can also describe the mother as an Actor who has given life to the child, who loves him and looks after him, and equally importantly in terms of safe motherhood goals, *who will continue to do so in a medicalized continuum of care*. We can also tell that they are both safe. And we can infer that this idealized outcome is the result of *her* agency to set the process into motion and keep it on track through self-control (it is certainly her agency what the Leaflet promotes, and requests, in terms of behavioural goals). In other words, she is *making him* safe and, by doing so, she is the embodiment of a responsible mother who looks after her own health and that of her child so he can have an even start in life. This maternal agency is presented as a given[108] and additionally stressed by placing the mother in thematic position on the upper left section of the image, where graphic designers have framed four large tiles from the background into one bigger tile and further muted the background pattern colours to afford a clearer view of her face and her satisfied expression.[109] In other words, the woman is both the actor and, together with her child, the goal in a process of safe motherhood –a bidirectional transactional structure[110] that points to the intrinsic connection between control and self-control in public health risk discourse.

While the frontal medium shot and the "realistic", factual grammar of the image on the Xochis health card invited to keep a certain distance with the participants (in that case,

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[107] Appendix A, p. 551, and/or Appendix F (CD), image 6.

[108] In the standard structure of mainstream visual advertisement, the right is usually the site of new information and key messages, while the left is the side of what the reader is supposed to know (Ibid, p. 180.) In this case, framing the caring mother as both the actor and the given takes for granted not only that she will care for her child, but also signals that she will do it by following the recommended actions in the Carnet.

[109] This graphic manipulation makes the expression in the woman's face the undisputed locus of attention on the front panel, both interpersonally (by engaging the viewer's attention) and from an ideational perspective (as an explicit iconic representation of happiness and satisfaction).

[110] In bidirectional transactional structures, each participant can play "not the role of Actor, now the role of Goal". Kress G, van Leeuwen 2006, p. 66.

the doctor and the pregnant woman) and what's going on between them, the photograph of the mother and her newborn child is an extreme close-up of their tender interaction, graphically rendered through low modality, that is, lessening the level of detail. This graphic treatment has a paradoxical effect: On the one hand, it idealizes the situation, framing it as an idea or a concept rather than as a moment in time[111] -not unlike the way in which grammatical metaphor turns processes and events into things. At the same time, it draws the readers into the image, so they can partake in –yet more important, *aspire to*- that delicate intimacy, the successful outcome of a medicalized pregnancy –and of a biomedical sequence of cause and effect. By signing on the bottom part of the front panel, pregnant women commit to reenact this narrative and become entitled to the same idealized result.[112] The combined effect of graphic design is one of projection and intimacy that we can take part of, precisely because it is the outcome of Embarazo Saludable, *a universal state –and not just the particular fate of the two participants in the photograph- that we can aspire to.*

There is personal -rather than social or cultural- distance here, both between the represented participants and between them and ourselves (the viewers): most women could project and identify with this interaction, regardless of ethnic or social boundaries. This heavily manipulated image is as cross-cultural as it gets. Taken either as an opener and a theme in the context of the front panel, or as a denouement in a horizontal reading of the unfolded brochure, it builds emotional involvement in a suggested biomedical setting and in the context of safe motherhood discourse. Another major discursive implication of this semiotic shift, in terms of health risk discourse, is the construction of

[111] In multimodal analysis, the lower the articulation of detail the lower the modality –which means that the image does not reflect the elements as we would have seen them had we been there when the photograph was taken. Machin D 2007, p. 48-49.

[112] In canonical graphic advertisement, placing visual elements in the upper section is a way of idealizing or generalizing the essence of the information, and lowering modality implies "'what using the product will be like' as fantasy or promise, as 'what might be' rather than as reality, as 'what is'". Kress G, van Leeuwen T 2006, p. 159 and 186. Here, the combined effect is that of an ideal –and idealized- maternal outcome. This effect holds when we follow the narrative of the unfolded brochure.

trust mostly around solidarity rather than around power and submission, as is happens with the photograph in the other version of the Carnet.[113]

The picture in the hospital version of the health card addresses another crucial issue for safe motherhood discourse in Mexico: the tension between home (private) and institutionalized (public) delivery and the reluctance of many indigenous women to give birth in hospitals.[114] As we have seen, this heavily engineered image opens (in the folded brochure) and closes (in the unfolded reading) a narrative where institutionalized pregnancy leads to safety and satisfaction *in an intimate setting*. The construction of "privacy" and "intimacy" is a central trait at the level of discursive practices. This has been obtained through the close-up shot of the mother and the baby, the softening and low differentiation of colours, and the cropping of the picture to eliminate any visual signs of the hospital environment –and the presence of health staff.[115] Not only is the reader denied the view of the immediate context (bed, walls, night table, curtains), but the tiled background is rendered in a grey scale, in order to subdue the iconic and indexical association with hospital walls. This muted background pattern has also been delicately foregrounded to let us get a glimpse of the interaction between the mother and the baby as if through a curtain, *without disturbing and invading their privacy.*

The absence of an immediate setting contributes the necessary semantic flexibility to map the private world onto the public sphere. Although the front panel of this Carnet carries the logo of a hospital, the photograph equates post-delivery conditions with those of the home. It is a private moment in a public discourse: safe motherhood materializing in a private-like public space. A narrative ellipsis glosses over the moment of delivery in a hospital setting –which conjures up dreaded images for many indigenous women, as we

[113] At this point, I wish to remind the reader about the impact of discursive practices on the discursive event. This picture of maternal bliss as a result of medicalized care is on the cover of a permanent health card that women have to carry from pregnancy to the end of puerperium. It is not a disposable brochure.
[114] As other data from Xochis shows, indigenous women are wary of hospital deliveries, among other things, for the loss of privacy and familial support.
[115] In fact, no one else is in sight –neither family nor friends nor neighbours, let alone parteras. There is a perfect isolation of the mother and the child. This decontextualization helps turn the represented participants into archetypes and the situation into an abstraction, a conceptual idea. Kress G, van Leeuwen T 2004, p. 161.

have seen from the literature and I have ratified with data from fieldwork. By acknowledging women's perceptions about the quality of delivery and post-delivery at home, the producers of the Carnet have implicitly captured key voices and concepts from a different order of discourse (traditional home birthing). This constitutes an exemplary case of interdiscursivity emerging from the textual components of the Carnet.

As for the other visual changes, the expression Embarazo Saludable becomes the most salient typographic feature on the front panel. These two words do not overlap with the photograph, creeping in from the bottom, as they do in the Xochis version of the Carnet; but they are more fully integrated with it.[116] They have now been placed at the very centre of the page and boldly foregrounded through the use of deep pink with a white outline against the muted grey background, and clearly placed over both the mother and the child, at the same time feeding off and feeding into the ideational and relational content of that image –what Cheong calls "bidirectional investment of meaning"[117]. Here, we can fully appreciate how the visual locus of attention highlights the construed meaning of a healthy pregnancy –that is, pregnancy and childbirth under institutional medical control.[118] At the same time, the saturated, "hyper real" use of pink, the white outline, and the shading around Embarazo Saludable seem to create a third dimension within the image and a separate, salient space for this expression. This graphic manipulation projects a stronger labelling drive than the lime-green lettering, lower placement and lack of shading of Embarazo Saludable in the Xochis carnet –where the photograph has undisputed prominence as carrier of ideational and interpersonal meaning in the context of primary health care.

Finally, the expression Carnet Perinatal, now overlaps the image of the child, clearly embracing him –together with his mother's gaze- as the centre of care and attention. The

[116] In multimodal analysis, integration implies occupying the same space –e.g., text placed over images-, while overlapping occurs when a segregated element spills over the space of another element. Machin D 2007, p. 153-154.
[117] Cheong YY 2004, p. 176.
[118] This effect comes in full focus if, as Cheong suggests, we consider the linguistic component of the interaction –in this case, Embarazo Saludable- without the visual locus of attention. In that case, the words "would be mere statements weakened of their persuasive force to manipulate perception in a way intended by the advertiser." Ibid, p. 168.

link between the top of the page (the Ideal) and the lower portion of the panel (the Real) becomes stronger in this alternative version of the Carnet. Here, the ideational and interpersonal components of the expression Carnet Perinatal and the signature block at the very bottom anchor and legitimize the ideal outcome of an Embarazo Saludable.[119]

4.12. Conclusions

The discursive analysis of both versions of the Carnet reveals how "healthy pregnancy", the overall topic of this text, is constructed mainly as a variant of mainstream "safe motherhood" discourse, which in turn is a specific type of health risk discourse, understood as a "bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery".[120]

Key dimensions of safe motherhood discourse and health risk discourse, as discussed in chapter 2, underpin the narrative structures and the relational and ideational contents across the three dimensions of the discursive event: text, discursive practices, and social practices. There is also a powerful interdiscursive effect that expands individual responsibility of pregnant women beyond the immediate outcome of their pregnancy and connects it with health and social equity, two additional discursive dimensions embedded in the Carnet.

In short, here is what both versions of the Carnet tell the reader/viewer:
-Pregnancy is fraught with risks
-Pregnancy and maternal care are public issues
-A healthy pregnancy, including childbirth and newborn care, is a closely monitored and institutionalized one
-This is a universal state that she –and all women- can and must aspire to
-A healthy pregnancy requires trust in and submission to biomedical health staff
-The safe (public) outcome of a healthy pregnancy can be lived as a private one

[119] As Machin points out , "what is placed in the real can also be used to give credibility to the ideal, the fantasy at the top. In this way the real can have a legitimizing role." Machin D 2007, p. 146.
[120] Lupton D 1999a, p. 15.

-A healthy pregnancy is a contract with the government (and biomedical health staff), whereby government ensures her "the care she needs" and a safe outcome, while she commits to private self-control and public control of her pregnancy
-She has the agency to do as requested
-She is responsible for her own health and the health of her unborn/newborn child
-Deep down, it is the child who matters most
-She is responsible for her child's even start in life
-She bears responsibility in reverting health inequalities and social injustice in Mexico

Through discursive engineering, the authors of the Carnet define "healthy" as "safe" in biomedical terms. As we saw from the analysis, a healthy pregnancy and a healthy child depend upon close and frequent institutional control at government health centres, with qualified health staff (as defined in safe motherhood discourse) for pregnancy, in a continuum of care that covers childbirth, puerperium, and newborn care. From a risk perspective, it also calls for self-monitoring, trust, and individual commitment from pregnant women. A crucial effect of this semiotic engineering is the shifting of the main topic in the Carnet from Embarazo Saludable –a nominalization without manifest traces of agency, causality, behavioural expectations, and power implications- into the result of a complex combination of processes and commitments, all of which construes pregnant indigenous women as responsible for the idealized outcome of a closely monitored, medicalized pregnancy -a universally valid way of doing things.

I showed how the combination of ideational, relational and textual meaning (field, tenor, and mode in terms of register theory) provide cohesion and coherence, reflect and construe subject positions, and set up logonomic regulations. I also showed how wording, modality, deixis, thematization, nominalization, illocutionary force, and actional processes (transactives and non-transactives) contribute to convey the imminence of risk and place the reader as the ultimate responsible for her own health and that of her child. I discussed how the textual handling of visual elements –through framing, foregrounding and backgrounding, narrative and conceptual processes, metonymy, articulation of "ideal" and "real" contents, and use of "given" and "new" information- replicates

sociocultural practices and contributes to naturalize a particular type of discourse and a set of values, practices, and expected behaviours.

At the level of discursive practices, I also revealed how a particular argumentative structure signals epidemiological and biomedical thinking as the main tributaries of public health risk discourse. In particular, and through the analysis of ideational and interpersonal meaning, I confirmed the presence of biomedical discourse, frequently transformed to accommodate vernacular expressions from everyday life. And I have shown how the authors of both versions of the text drew from government discourse of public health to embed health risk discourse –specifically, *maternidad sin riesgo*-, within a public document such as a personal health card, investing this particular view of reality with the authority of facts and government sanction.

Key logonomic devices are rooted at this level of the discursive event, such as the pairing of solidarity and power (e.g., proximity and personal distance in the image of the doctor and the pregnant woman; use of "tú" with the imperative mode, all of which allows the Speaker to maintain an authoritative but concerned presence, like a "good" doctor in front of his patient). The coupling of words and imagery on the front page –the most prominent textual feature in this regard- places a logonomic restriction throughout the text, framing a naturalized, idealized -and ideological- view of pregnancy as part of a contract between the reader, government, and government health staff. Also at this level of discursive practices, I have shown the presence of other institutional orders of discourse within the societal order of discourse of motherhood –such as home birthing and traditional community health care-, always subordinated to government views of safe motherhood.

Something else is happening at this level of discursive practice: an attempt to narrow and close the potential meanings of the events represented here. There is only one possible healthy pregnancy, and the text is set up so the reader understands and reinterprets her

personal experiences in light of this universal claim.[121] By placing the viewer/reader as someone who needs to make meaning according to a certain explanatory model, a particular system of knowledge and beliefs, while leaving aside their own cultural models, the Carnet reveals its ideological nature as a discursive event.

We can also see the ideological effects of the Carnet at the level of sociocultural practices. The Carnet bears key markers of government discourse on health and social equity, framed as "*arranque parejo*", or "even start" in life, and connected to individual responsibility. The text interpellates the reader as a subject of public health management: she is constructed as a pregnant woman –thus essentially at risk- who is *given* agency to monitor herself and her child and thus achieve a healthy pregnancy. From the moment she signs or has her name written on the front of the Carnet, she will also be interpellated as a cardholder -this individual "tú" who entrusts –submits to- government and health staff with her own health and that of her child, and who must take action to effectively realize this mutual commitment. Not only that: she is also responsible for her child's life chances, and at least co-responsible in reverting health inequalities and social injustice in Mexico. Which brings to the fore a core ideological assumption behind the discursive construction in this Carnet Perinatal: *that Mexico can revert health inequalities and social injustice without changing fundamental relations of power.*[122]

[121] All of this amounts to what Guo, analyzing visual semiotics on a biology textbook, calls the "enculturation of the learner into the discipline of biology". Guo L 2004, p. 196. In our case, we can substitute "biological worldview" for "biology" and we get the same result.

[122] As other data from fieldwork show, some of these meanings are being contested in the sphere of everyday life –many indigenous women do not want to deliver in health facilities and would rather keep their pregnancies as private as possible. But there are also signs of deep impact of these semiotic construals over indigenous views and practices. In chapter 6, I explore these other voices and conceptions, as well as their interactions with mainstream safe motherhood discourse. In chapters 6 and 7, I discuss the implications for the societal order of discourse about motherhood.

Chapter 5: Discursive analysis of a health promotion video film

5.1. Introduction

In this chapter, I will analyze a 14-minute narrative video drama[1] for the prevention and early detection of pre-eclampsia and eclampsia, two stages of a severe medical condition associated with hypertension, which at the time of fieldwork was the most frequent cause of maternal death in Mexico and one of the two most frequent –severe bleeding was the other- in the state of Guerrero.[2] The National Centre for Gender Equity and Maternal Health, a government agency within the Health Secretariat of Mexico,[3] produced and distributed the video under the title *Hazle caso a los mensajes de tu cuerpo* ("Heed the messages of your body") for use in government health centres nationwide.

The Health Secretariat of Guerrero State, together with the national health program Arranque Parejo en la Vida (Even Start in Life, or APV), handed out copies of the video to government health units across the state. Spanish, Amuzgo, and Mixteco versions of the video were beginning to circulate within the regional Health district of Ometepec in October 2007, but they were very hard to come by in Xochis, even at the end of 2009. Here, I will analyze the original Spanish version of the film, which was the most frequently used in government health facilities and programs.

The explanatory note in the CD insert acknowledges the "educational" nature of this discursive event, with particular emphasis on discursive practices regulating the distribution and interpretation of the text. According to these instructions, the video

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[1] I will also use the expressions "video film", "video", "film", and "text". See Appendix E for DVD.
[2] Guerrero State Health Secretariat, Power Point presentation, July 26, 2006. In the first half of 2006, the proportion of deaths from eclampsia (5.8 out of 100,000) doubled the proportion of deaths from postpartum bleeding (2.9 out 100,000), the second leading cause of maternal death in all of Mexico. In 2005, eclampsia was also the leading cause of maternal death in Guerrero state, where it accounted for 28 out of 85 deaths.
[3] The English version of the Centre's mission states this is a "public organism that aims to improve reproductive health by incorporating a gender equality perspective to public health programs and strategic actions including sexual and reproductive health, always with outmost respect for human rights." Centro Nacional de Equidad de Género y Salud Reproductiva, Secretaría de Salud. Misión. English version. December 2008. Available at http://www.generoysaludreproductiva.salud.gob.mx/paginas/english.html. Accessed October 15, 2009.

drama should be used in educational chats in government health facilities and other public venues, where government health personnel would be able to frame the issue and guide the interpretation of the film.[4] [5] Strong logonomic regulations operate here, since beneficiaries of anti-poverty programs –such as Amuzgo women in Xochis- must attend these meetings in order to stay in good standing and receive their monthly payments.

This educational video is part of a public health campaign seeking to raise awareness of pregnancy risks and complications, increase knowledge about alarm signs and their interpretation, encourage favourable attitudes towards consulting government health centres and hospitals, and prompt immediate action in case of alarm, *both with pregnant women and their husbands.*[6] In that regard, the film bears the marks of key constructs from different cognitive theories commonly used in public health communication to change health behaviours, such as heightened perception of risk (severity of the threat and vulnerability to it), response efficacy (the belief that carrying out a behaviour can remove the threat), subjective norms (a person's beliefs about whether significant others think he or she should engage in that behaviour), and self-efficacy (a person's belief that she has the skills, resources, and opportunity to carry out the expected behaviour).[7]

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[4] The text on the insert that comes with the CD case is signed by the head of the Health Jurisdiction 03 Centre and the APV manager and reads as follows: "Compañera(o) at the Health Jurisdiction 03 Centre: The present CD contains a video produced by the National Centre for Gender Equity and Maternal Health, 'Heed the Messages of your Body', targeting the general population and dealing with the issue of preeclamsia-eclampsia, which, as you know, is the leading cause of maternal death nationwide. We hope that you will circulate it intensively in educational chats at the health centre and/or municipality where you work, and we invite you to strengthen the action of the program Even Start in Life."

[5] Narrowing the polysemic nature of narrative texts is a common challenge in public health communication. As Petraglia points out, "an effective narrative intervention requires not only the production and dissemination of narratives, but also an intervention in the listener's sense-making process to narrow the range of likely interpretations." Petraglia J. Narrative Intervention in Behavior and Public Health. *Journal of Health Communication* 12:493-505, 2007, quote on p. 499.

[6] An accompanying guide for health staff describes the target population as "preferably pregnant women, their partners and relatives." It also contemplates activities with the general population.

[7] I have synthesized these concepts from Norman P, Conner M 2001; Rutter D, Quine L 2002; and Committee on Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations, Board on Neuroscience and Behavioral Health, Institute of Medicine of The National Academies, *Speaking of Health: Assessing Health Communication Strategies for Diverse Populations.* Washington, DC: The National Academies Press, 2002, chapter 2, p. 28-75. Available at http://www.nap.edu/openbook.php?record_id=10018&page=28. Accessed October 28, 2009.

As Guttman points out, most public health interventions are attempts at social control, because they "typically are based on the assumption that the population targeted should and could adopt particular behavioural or attitudinal changes and that these changes are likely to be beneficial to them."[8] This is clearly the case here. I will show how the creators of the video use key dimensions of health risk discourse and safe motherhood discourse, coupled with behavioural constructs and certain elements from traditional orders of discourse, in attempt to turn pregnant women –and their husbands- away from cultural explanatory models and to promote biomedical views and authority regarding pregnancy and childbirth.

Educational videos constitute a distinctive genre within the order of discourse of public health, and they are typically associated with health communication[9] and health promotion[10] as types of activities[11]. Video dramas like "Heed the messages" also draw from the now established strategy variously known as "infotainment", "entertainment education", or "edutainment" (as I will call it from now on). This approach includes "media programs that intentionally incorporate one or more educational issues in an entertainment format in order to influence audience members' knowledge, attitudes, and overt behaviour regarding an educational issue."[12] Radio and television soap operas, comic books, popular music, and street theatre are common vehicles of edutainment.

5.2. Embracing a tradition of *telenovelas* for social change

In particular, "Heed the messages" draws from classical semiotic and narrative patterns of *telenovelas* (television soap operas), a well-established popular genre in Mexico and elsewhere in Latin America. The story features melodramatic themes found in most

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[8] Guttman N 2000, p. 22.
[9] I have defined public health communication on p. 48.
[10] I define have defined health promotion on p. 51.
[11] I have discussed the difference between genres and activity types on 3.5.2.1.
[12] Papa M, Singhal A, Law S, Pant S, Sood S, Rogers EM, Shefner-Rogers CL. Entertainment-Education and Social Change: An Analysis of Parasocial Interaction, Social Learning, Collective Efficacy, and Paradoxical Communication. *Journal of Communication* 50(4):31-55, 2000, quote on p. 32. Available at http://howtowin.visitsteve.com/wp-content/uploads/2009/03/entertainment-education.pdf. Accessed October 15, 2009.

Mexican telenovelas, such as family life, conflicts and struggle for survival[13] (in this case, including the "extended family" of *compadrazgo*[14]) and flat, one-dimensional characters, with discernible traits and predictable motivations.[15] Good characters are based on the lives and circumstances of average people in the audience, who must overcome hardships and triumph over evil forces to live a happy life[16]. There is also an implicit mention to destiny as mystic fate,[17] as something that cannot be changed, a supposedly widespread popular belief that the film sets out to undermine. This and other examples of intertextuality serve a dual purpose of alliance and opposition, power and solidarity, which speaks to the ideological implications of the video drama. Another crucial interdiscursive resource regarding telenovelas is the domestic and interpersonal narrative focus,[18] the ability to "speak the private",[19] to bring it into the open and to articulate it with –in this case ultimately subordinate it to– the public sphere, in a dynamic loop of control and self-control typical of health risk discourse.

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[13] Martín Barbero J. La telenovela en Colombia: televisión, melodrama y vida cotidiana. *Diálogos de la Comunicación* 17:46-59, 1989, reference on p. 7. Available at http://www.dialogosfelafacs.net/dialogos_epoca/pdf/17-04JesusMartin.pdf. Accessed November 9, 2009.

[14] *Compadrazgo*, or ritual coparenthood, is an important set of kinship practices across Roman Catholic Latin America. Lavenda and Schultz explain this practice as follows: "The baptism of a child requires the presence of a godmother and a godfather as sponsors. By participating in this ritual, the sponsors become the ritual coparents of the child. In Latin America, godparents are expected to take an active interest in their godchildren and to help them whenever possible. However, the more important relationship is between the godparents and the parents. They become compadres ("coparents"), and they are expected to behave toward each other in new ways." Lavenda RH, Schultz EA. *Anthropology : What Does it Mean to be Human?* Oxford, UK: Oxford University Press, 2007. Quote on companion website. Available at http://www.oup.com/us/companion.websites/9780195189766/student_resources/Supp_chap_mats/Chap13/Compadrazgo_Latin_America/?view=usa. Accessed October 16, 2009.

[15] Barsam R. *Looking at Movies: an Introduction to Film*. New York, London: W.W. Norton & Company, 2004, p. 95. Round characters, by contrast, are "three-dimensional, possessing several traits, sometimes even contradictory ones." Based on this characterization, it could be argued, for instance, that Jorge is a more rounded character in the second episode of the video film, because he breaks away from what the makers of the video film assume is the prevailing attitude among men in the target audience. But the multimodal device portrays him as a one-note character, prone to childish expressions of inner emotions, in both scenarios.

[16] Nariman HN. *Soap Operas for Social Change: Toward a Methodology for Entertainment-Education Television*. Westport, CT, and London: Praeger, 1993, p. 15-17.

[17] Lozano E. The Force of Myth on Popular Narratives: The Case of Melodramatic Serials. *Communication Theory* 2(3):207-220, 1992, reference on p. 209.

[18] Roura labelled telenovelas as "the empire of the private". Roura A. *Telenovelas, pasiones de mujer: El sexo del culebrón*. Barcelona: Gedisa, 1993, p. 37. Cited in Avila-Saavedra G. New Discourses and Traditional Genres: The Adaptation of a Feminist Novel Into an Ecuadorian *Telenovela*. *Journal of Broadcasting & Electronic Media* 50(3):383-399, 2006, quote on p. 386.

[19] Lozano E 1992, p. 210.

Edutainment components have been woven into soap operas since the 1967s to promote a range of issues and "socially desirable behaviours"[20], such as gender equality,[21] adult literacy,[22] rural development,[23] family planning,[24] prevention of teen pregnancy,[25] HIV prevention,[26] and home care services for elders,[27] mostly in developing nations and among ethnic minorities in the United States[28] and some European countries.[29] In fact, the pioneer of soap operas as vehicles for the explicit promotion of educational messages and social values was the Mexican Miguel Sabido, who produced six successful edutainment telenovelas between 1975 and 1981, when he was vice president for Research at Televisa, a Mexican multimedia company.[30]

The Sabido telenovelas –an obvious model for "Heed the messages"- make use of communication and behavioural sciences and dramatic theory.[31] At the very core of Sabido's cognitive approach is Bandura's social learning theory, which contends that we vicariously learn social behaviours through identification with fictitious characters, who act as role models and who get rewarded or punished for their actions in movies, television and other media[32] [33]-which is exactly what happens in "Heed the messages".

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[20] Nariman HN 1993, p. 2.
[21] Lozano E 1992, p. 213.
[22] Nariman HN 1993, p. 16.
[23] Singhal A, Rogers EM. *Entertainment-education: A communication strategy for social change*. Mahwah, NJ: Sage, 1999.
[24] Piotrow P, Rimon JG, Winnard K, Kincaid D, Huntington DL, Convisser J. Mass media family planning promotion in three Nigerian cities. *Studies in Family Planning* 5:265-274, 1990.
[25] Arroyave J. Testing the Effectiveness of an Entertainment-Education Health-Focused Soap Opera: Exposure and Postdiscussion in Colombian Young Adults. *Investigación y Desarrollo* 16(2):232-261, 2008. Available at http://ciruelo.uninorte.edu.co/pdf/invest_desarrollo/16-2/5_Testing%20the%20Effectiveness.pdf. Accessed October 15, 2009.
[26] Weinberg C. This is not a love story: using soap opera to fight HIV in Nicaragua. *Gender & Development* 14(1):37-46, 2006.
[27] Crist JD. *Cafecitos* and *Telenovelas*: Culturally Competent Interventions to Facilitate Mexican American Families' Decisions to Use Home Care Services. *Geriatric Nursing* 26:229-232, 2005.
[28] Wilkin H, Valente T, Murphy S, Cody M, Huang G, Beck V. Does Entertainment-Education Work with Latinos in the United States? Identification and the Effects of a Telenovela Breast Cancer Storyline. *Journal of Health Communication* 12(5):455-469, 2007.
[29] Papa M, Singhal A, Law S, Pant S, Sood S, Rogers EM, Shefner-Rogers CL 2000, p.32.
[30] Nariman HN 1993, p. 16.
[31] Ibid, p. 27-31.
[32] Ibid, p. 38-43.
[33] Bandura A. Social cognitive theory of mass communications. In J Bryant and D Zillman (eds.), *Media effects: Advances in theory and research*. 2nd edition. Hillsdale, NJ: Lawrence Erlbaum, 2002, p. 121-153.

From an entertainment perspective, Sabido's telenovelas "retain the style, the tone, and the expressive resources of the genre, but transform its content, plots (dealing with a single topic, such as family planning), and narrative status (after each program, a star comments on the "moral" of the day's episode)."[34] In other words, the edutainment telenovelas present educational messages in conventional melodramatic style, with characters that resemble real-life people in the target audience. These messages appeal to a combination of cognitive, emotional, and predispositional (instinctual) stimulations.[35] "Heed the messages" reproduces this interdiscursive engineering within the limits of the short video format. As in Sabido's work, the makers of this film not only resort to the melodramatic roots of telenovelas for schematic patterns of content (such as stereotypes of interpersonal relations and explicit moral messages), but also for canonical uses of semiotic resources, like the overemphasized emotionality of music, pacing, images, dialogue, and acting.[36] [37] [38]

This model of edutainment assumes that the texts are monosemic and the audiences homogeneous. In other words, they promote a single message that should be construed in the same way by everybody.[39] [40] The monosemic pretension also entails that the solution

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[34] Lozano E 1992, p. 214.

[35] These three levels correspond to the "three brains" in MacLean's conception of the triune brain: neocortex, paleomammalian brain, and reptilian brain. The melodramatic content and style of telenovelas stimulates the emotional response of the audience. Sabido would then seek to elicit instinctual gut-level reactions through calculated jolts –as is the case with the death of a main character in "Heed the messages". Cognitive information came through the addition of the epilogue, which was "designed to make rational sense of the emotional and predispositional stimulation" of the telenovela. Nariman HN 1993, p. 43-45.

[36] Lozano E 1992, p. 209.

[37] Aprea G, Mendoza Martínez R. Hacia una definición del género telenovela. In M Soto (ed.), *Telenovela/telenovelas. Los relatos de una historia de amor*. Buenos Aires: Atuel – Colección del Círculo, 1996, p. 17-30, reference on p. 21-22.

[38] Nariman HN 1993, p. 15.

[39] The "epilogues" of Sabido's telenovelas are an explicit attempt to guide the viewer's "correct" reading of the text. Each episode is followed by a brief epilogue where a well-known actor or actress sums up what just happened in the narration, adds comment and interpretation, and offers information about related government programs and resources available to the audience. Nariman HN 1993, p. 18. In "Heed the messages", the voice over provides an epilogue at the end of each episode.

[40] Of course, as Lozano herself points out, "a producer cannot determine the meaning a televisual program will have for diverse audiences, although he or she might control the structure of the program and privilege certain significations over others." Lozano E 1992, p. 215. Based on the analysis of "Heed the messages", I will contend that the creators of the text assume the existence of alternative, "cultural" readings of pregnancy and childbirth, and that they try to narrow the polysemy of the text and guide the intended reading as much as possible in that intertextual context. In fact, the existence of other texts and the need to establish relationships or Alliance and Opposition lies at the very foundation of the video drama.

is not with the viewer but with the expert.[41] For this to happen, says Lozano, "one changes the dialogue and leaves untouched the system of relationships, the aesthetic style, and the expressive dimensions."[42]

Some researchers suggest that edutainment may have an impact through identification and emotional involvement,[43] [44] while others see a less linear effect through discussion and social learning.[45] [46] Yet others are less concerned with edutainment success than with ideological implications and implicit values driving these campaigns.[47] [48] Some authors favour the social learning approach and contend that edutainment telenovelas do not create new values, but rather link their immediate behavioural objective –e.g., adult literacy- with pre-existing social values, such as self-improvement and mutual help, and dramatize how people can "more fully actualize these values in their lives by practicing the prosocial behaviour,"[49] with specific references to available government programs and resources. Others disagree. Dutta says that edutainment campaigns reflect the views of dominant groups with access to the discursive space and systematically target subaltern populations, which he defines as underprivileged and subordinated groups "in the realms of class, caste, age, gender, office, or in any other way."[50] Along similar lines, Lozano finds "textual affinity between melodramatic serials and mythical narratives" and

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[41] Lozano E 1992, p. 214. In "Heed the message", the whole idea is to rely upon the experts; in other words, to "heed the experts".
[42] Ibid, p. 214.
[43] "The essence of drama is confrontation, which generates emotion" says Kincaid. "Emotion is the motivational force that drives the actions of the characters, leading to conflict and its resolution. By means of involvement and identification, the confrontation and emotional response of the characters generate a corresponding emotional response in the audience." Kincaid DL. Drama, Emotion, and Cultural Convergence. *Communication Theory* 12(2):136-152, 2002, quote on p. 150.
[44] Smith R, Downs E, Witte K. Drama Theory and Entertainment Education: Exploring the Effects of a Radio Drama on Behavioral Intentions to Limit HIV Transmission in Ethiopia. *Communication Monographs* 74(2):133-153, 2007.
[45] Papa M, Singhal A, Law S, Pant S, Sood S, Rogers EM, Shefner-Rogers CL 2000, p.33.
[46] Arroyave J 2008. In a study conducted by the author, post-viewing discussion of an edutainment telenovela for the prevention of teen pregnancy increased knowledge and produced significant changes in attitudes and intended behaviour among young Colombian adults.
[47] Guttman N 2000.
[48] Salmon CT. Campaigns for 'social improvement': An overview of values, rationale, and impacts. In CT Salmon (ed.), *Information Campaigns: Balancing social values and social change*. Newbury Park, CA: Sage, 1989, p. 19-53.
[49] Nariman HN 1993, p. 17.
[50] Dutta MJ. Theoretical Approaches to Entertainment Education Campaigns: A Subaltern Critique. *Health Communication* 20(3):221-231, 2006, quote on p. 222.

suggests that "melodramatic serials might function as myth, that is, as a pedagogical and enculturating discourse."[51] I will return to these conflicting views with specific examples from "Heed the messages", since they are germane to the discursive analysis of the video drama in the social and ethnic circumstances of Xochis –and in the overall context of interactions between government and indigenous peoples in Mexico.

The canonical "closed" format of the genre[52] contributes to the ideological and moralizing intentions of edutainment telenovelas. As Williamson observes, "ideological commitment and moralizing ending are precisely what the Latin American telenovela offers, at times almost like a medieval allegory."[53] As I show below, this intrinsic moralistic ground of the genre is a perfect fit for some key dimensions of health risk discourse in "Heed the messages", such as choice, self-control, danger, blame, individual and familial responsibility. In a way, the film plays as a fable, as a practical moral tale that leaves room for the viewer to choose between two different resolutions in real life.

5.3. The story

In film theory, a story consists "of all the narrative events that are explicitly presented on the screen plus all the events that are implicit or that we infer to have happened but are not explicitly presented," while a movie's plot is the telling of the story through "everything we see and hear in a film".[54] In this section, I will give an overview of the video drama's story. I will analyze the dramatic construction of the narrative and the co-patterning of plot and semiotic modes in subsequent sections.

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[51] Lozano E 1992, p. 207. The author defines a myth as "a collective narrative that has explanatory and interpretive functions and that constitutes a *matrix* of stories" (ibid, p. 209). Although the video drama is not a serial, it nonetheless shares key features with this format, like the ability to erase the limits between "fiction" and "reality" –it is more "chronicle" than "fiction"- and to "provide a 'nonmediated' access to *what is taking place* in the world." (Ibid, p. 209).

[52] Allen RC. Introduction. In RC Allen (ed.) *To Be Continued... Soap Operas Around the World.* London and New York: Routledge, 1995, p. 17-24. The author distinguishes between "open" and "closed" serials. Being "closed", that is, having a specific conclusion, with moral and ideological closure, is a typical trait of telenovelas, as opposed to the "open" format of American, British and Australian soap operas, which are never-ending stories with no "ultimate closure".

[53] Williamson R. Situación comunicativa y estructura genérica en la telenovela mexicana. *ALED. Revista Latinoamericana de Estudios del Discurso 1(2):* 51-68, 2002. Quote on p. 53, my own translation.

[54] Barsam R 2004, p. 80.

However, "story and plot overlap because each includes the narrative events that we explicitly see and hear onscreen,"[55] which makes it difficult to refer to the story without mentioning the plot. This is particularly the case in "Heed the messages", where a compelling plot twist has been built into the narration with multiple purposes –all of them essential to both the entertainment and educational purposes of the video film.

"Heed the messages" is the story of Gabriela, a pregnant working class housewife who lives in an unspecified Mexican village without government health facilities.[56] Her features and her clothes denote a Mestizo ancestry –she is certainly not Amuzgo- and she speaks with an urban accent[57], as do all of the characters in the film. We do not know from the video whether she works outside her household. She is married to Jorge, a Mestizo backyard mechanic. They live in a small, modest -maybe self-built- and well-kept house made of low-cost materials. They make a humble living, but it looks like they fend for themselves.[58]

The film's opening shot shows Jorge and Gabriela's house from the outside. We then meet Gabriela while she is washing dishes in her kitchen and looking at Jorge as he works on a car and later takes a break to paint a crib in their back yard. While feeding the poultry, Gabriela feels a sharp pain in her abdomen. She stops, takes a few seconds to recover and then resumes her chores. We next see her sitting on her bed, still in distress, trying to put on her shoes with great effort and clear signs of swollen feet. Jorge realizes she is not feeling well. Sitting next to her in the backyard, he tells her so, but she

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[55] Ibid, p. 80.

[56] Although the mise-en-scéne never shows the immediate context of Gabriela and Jorge's house, we can safely infer they do not live in an urban setting from Jorge's response when the doctor asks him why it has taken him so long to bring Gabriela to the health centre. "*Es que el centro de salud nos queda bastante retirado*," he explains, alluding to a frequent access barrier in rural settings.

[57] "*Tienen acento de la ciudad*," was the first reaction of Amuzgo CIET team members when they saw the film.

[58] However, this construal does not apply in Xochis, where Gabriela and Jorge would be relatively "rich" people from a privileged ethnic minority in the context of a nearly-subsistence economy as described in chapter 1.1.4.1. "*Esto no refleja la realidad*," was the first reaction of CIET Amuzgo team members from Xochis upon first viewing of the video film.

dismisses his concerns.[59] She says she is only tired and then tells him: "Even your mom says these are common ailments that come with pregnancy and go away soon." Sometime later –perhaps the same day, though this is not clear-, Gabriela is cooking for Jorge and serving his meal while he is sitting at the table, inside the house. We can see from her face that she is suffering. Suddenly, she doubles in pain and makes hands gestures that indicate a splitting headache. She then groans and falls on her knees.

Jorge takes Gabriela to the health centre, where she lies on a stretcher while he stands by her side. She begins to have a seizure.[60] He fumbles for her in utter desperation, then rushes to the door and cries out for help: "Doctor! Doctor!". Two health workers run into the room and try to hold Gabriela. Jorge looks on in despair. We hear a voice in off, first over the images of the seizure and then over a non-fiction sequence featuring a de-contextualized close-up of Gabriela that progressively splits into myriad replicas, while the screen is gradually coated in red:

> La inmensa mayoría de los embarazos termina bien, con la mamá y el bebé en buen estado de salud. Pero, desgraciadamente, esto no sucede siempre. En nuestro país, en sólo un año, más de mil doscientas mujeres mueren durante el embarazo, en el parto o poco tiempo después, en la cuarentena. [*At this point, we see the image of a young indigenous woman, who is not a character in the story, sitting on a stretcher, while the hands of a medical practitioner examine her swollen feet*] Una tercera parte de estas muertes son causadas por un padecimiento llamado preeclampsia, o su manifestación más grave, la eclampsia, que en México es la primera causa de muerte materna. [*Here, we see the de-contextualized close-up of Gabriela again*] Y lo más triste es que la mayoría de estas muertes se podrían evitar si se actuara a tiempo.

At this point, the film "rewinds" past the images of Gabriela and Jorge in the hospital, her collapse in their home, her failed attempt to put on her shoes, and her first bout of

[59] This is another point of departure from the Amuzgo reality in Xochis. Most men do not work at home, but out in the fields or even out of town, and they have little or no knowledge about the evolution of their wives's pregnancies. It is very unlikely that the husband will be at hand –let alone as first helper- during a crisis like the one depicted in the film.
[60] Severe convulsion is the hallmark symptom of eclampsia.

abdominal pain, all the way back to their conversation in the backyard.[61] We hear them as they repeat their first exchange, only this time Jorge does not let her shrug off his concern. "Health is not something to play with. We are going to the health centre right away," he says.

In the next scene, we see Jorge helping Gabriela lean against a wall in the crowded waiting room of a health centre. He then leaves momentarily to find out how long it will take before they get to see the doctor. Victoria, an older woman, approaches Gabriela as she moans in pain. She offers to call the nurse, but Gabriela says that she feels embarrassed because it is not yet her turn. The woman insists and tells her that she has a daughter who had similar symptoms and took seriously ill. She asks Gabriela to wait and leaves to look for the nurse.

The nurse measures and weighs Gabriela on a scale. We learn from her questions and Gabriela's answers that she is in the fifth month of her pregnancy. Gabriela describes her symptoms: she has gained weight, her feet are swollen and her shoes hardly fit, she has headaches "all the time", she sees flashing lights, like spotty bright stars, and she has on-and-off ear buzzing. The nurse helps her step off the scale and checks her blood pressure. She tells Gabriela the reading is very high, asks her to collect a urine sample, and lets her know that she will ask the doctor to see her.

Sometime later, a male doctor talks to Gabriela while she lies on the stretcher with Jorge standing by her side. He asks her if her head aches –which se confirms- and scolds Jorge for taking too long to bring her to the health centre. Jorge explains that the centre is far from their home, but the doctor says "that is no pretext" and tells him that he is endangering the lives of both Gabriela and their baby. Then, the doctor explains Gabriela that pregnant women with high blood pressure experience the same symptoms she has. He says that these are likely signs of "a disease called pre-eclampsia". Jorge, in evident despair, wants to know if that is something serious, and the doctor says it is. He explains

[61] For dramatic purposes, and resembling the canonical structure of melodramatic serials, we can argue that a second episode of "Heed the messages" starts at this point. I elaborate on this interpretation on p. 207.

that pre-eclampsia "is something that only affects women when they are pregnant, during childbirth, or in the *cuarentena*[62]," and he warns that, if not treated immediately "it can cause serious damage to Gaby's health or to the baby". The doctor asks Gabriela whether her mother or maybe one of her aunts had any problems when their own children were born. Gabriela weeps as she says that her sister and her baby died during childbirth. The doctor also wants to know if someone in her family had heart disease, high blood pressure, kidney failure, or diabetes. Gabriela says her father did (though we do not know exactly which of these problems he had). The doctor tells them that, given her current symptoms and her family history, it is very likely that she has pre-eclampsia and therefore needs immediate hospital care. Jorge asks how to do that, implying that they do not have the means, and the doctor says: "Don't worry, we are going to help you." He tells them that he will ask the nurse to call the municipal government and make arrangements to transfer Gabriela to the hospital. "We still have time," he concludes, while Gabriela and Jorge thank him and sigh in relief.

Next, we see Gabriela going through ultrasound and later talking with a female doctor, who tells her that "everything is going very well" in her eighth month of pregnancy. The doctor asks Gabriela if she wants to know whether she will have a baby boy or a baby girl, and Gabriela says she would rather not know. We learn from their conversation that Gabriela's blood pressure is now normal, that her feet are much less swollen, and that she no longer has headaches. Gabriela wants to know whether she can stop taking her medicine, but the doctor tells her that she cannot do that because the risk is still there. She also asks her to keep watching for any symptoms of pre-eclampsia and, in that event, to request "the nearest person" to bring her to the hospital. Before Gabriela leaves, the doctor gives her an ultrasound image of her baby. Gabriela looks at it in awe.

Sometime later in her house, Gabriela is staring at the same image in delight, while she rests in bed and Jorge sweeps the floor. Their *comadre*[63] drops in for a visit and teases

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[62] *Cuarentena* (quarantine) is a family ritual of forty days of maternal care after childbirth. It roughly coincides with the biomedical period of puerperium. Among other things, women are expected to refrain from heavy work and sexual activity during this time.

[63] I have explained what this expression means in terms of extended social kinship on p. 27.

Jorge because he is doing the house chores. Jorge tells her that the baby is due within the week "with God's favour". She corrects him: "With God's favour and also thank to you, because you took care of her. Imagine if you didn't take her to the hospital. Maybe she wouldn't have made it alive! That's why the saying goes: Help yourself and God will help you along the way." She then gives him a stew that she made, so he will not have to do the cooking, and she sits next to Gabriela to look at the ultrasound image. They both engage in animated chat, while we hear a voice in off:

> Tu salud y la de tu bebé están en tus manos. Tienes que cuidarte durante tu embarazo, tu parto y los cuarenta días después de dar a luz. Que te duela la cabeza no es normal. Que se te hinchen la cara, las manos, los pies, no es normal. Si te mareas, ves lucecitas o escuchas zumbidos, no es normal y no se va a pasar. Lo más seguro es que tengas la presión alta y, probablemente, pre-eclampsia. No lo dejes pasar. Ve inmediatamente a tu centro de salud. Hazle caso a tu cuerpo, hazle caso a la vida.

As the voice-over says: "*hazle caso a tu cuerpo, hazle caso a la vida,*" we see the face of Gabriela's newborn. A nurse puts the baby in Jorge's arms and he looks at him ecstatically; then he stares up, a blend of happiness and gratefulness in his face, and he finally kisses his son. We hear the voice in off: "¡*Para que todo salga bien, cuídate*!" This phrase ends with Gabriela happily nodding from her kitchen window, as the image fades to black and the end credits start to roll.

5.4. Putting the ending in the viewer's hands

The single most salient trait of the script is telling the same story with two different endings. Or is it rather two episodes of the same story? Based on semiotic analysis, and taking into account the heavy imprint of edutainment telenovelas, I contend the film can be seen as a complex mix of both options, which bears on the interpretation and re-interpretation of characters, events, motivations, and overall message.

A combination of semiotic elements supports the two-episode reading at the textual[64] level. The "rewinding" sequence, after the seizure scene and the first epilogue, together with the re-enactment of the first part of Jorge and Gabriela's initial chat, allow for recapitulation and bring us back to a decision-making crossroads. All of this seems to indicate that a second chapter –a second episode in terms of the familiar telenovela genre- is about to start.[65] In this new episode, Jorge and Gabriela are given a second chance. And so are we, as members of the audience. This plot twist opens up the story to two possible endings *in real life*, highlighting the "edu" component of "edutainment" and providing a pragmatic, operational link between health risk discourse and the requested behavioural reaction from the viewers. In a way, this plot twist brings the story into the life of the viewers –more than it draws from it- *and puts the resolution in their hands*. Of course, this involves questioning personal assumptions, explanatory models, cultural myths, and relations of power within the target audience's world. All of which amounts to an ideological manipulation at the level of discursive practices and sociocultural practices, expressed through textual, ideational, and interpersonal functions.[66]

In particular, the visual backtracking of the narration, by means of involuted montage,[67] is a critical semiotic device that shapes the overall message of the video film. This is an extreme case of what Seale calls "reversals", or strong plot twitches that disrupt audience expectations.[68] We can see the film –and the narration- reverting its course before our very eyes, while the percussion keeps the visual pacing and rhythmically signals each one

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[64] I use this expression, here and elsewhere in this thesis, in the tradition of systemic functional analysis, where it refers to the "compositional" organization of the text. As Iedema points out, this organization "concerns how meanings are sequenced and integrated in dynamic text." Iedema R 2004, p. 192.

[65] From a logical standpoint, the backtracking of the images to this point also allows for a re-interpretation of what we have seen before. For instance, we can re-read the seizure scene as the "cliff-hanger" conclusion of the first episode. We can also infer that the first epilogue will not be the last. It is after the central "rewinding" scene and the partial re-enactment of the conversation between Jorge and Gabriela that we can see the conventional markers of a first episode. And it is not until the overall conclusion of the video film that we can re-construe the whole two-episode structure.

[66] The ideational, interpersonal and textual metafunctions realize the register variables of field, tenor, and mode, as discussed in chapter 3.5.2.2. The system of register, in turn, realizes the generic, or multi-generic, nature of any given text. Martin JR 2006, p. 45-46.

[67] Involuted montage, contrary to classic continuity cutting or "invisible editing", is a form of "disruptive" editing that "allows a sequence to be narrated without particular regard for chronology: an action can be repeated, shots can be edited out of order." Monaco J. *How to Read a Film: Movies, Media, Multimedia. 3rd edition.* New York: Oxford University Press, 2000, p. 219.

[68] Seale C. *Media and Health.* London, New Delhi, and Thousand Oaks: Sage Publications, 2002, p. 36.

of the key events along the tragic path to Gaby's death. The editors achieve at least two or three goals with this grammatical device. From a logical perspective, they make sure that the audience understands that we are going back in time to the first conversation between Jorge and Gabriela. (At the level of discursive practices, it would have been odd for an audience of mainstream telenovelas to cut or fade to this previous scene and to restart the narration without further ado.) As soon as we hear Jorge's answer –instead of his silence- after Gabriela tells him that is better to stay at home, we know that we are on a different version –indeed, a second episode- of the same story.

At the experiential level, by reversing the reading path, the creators of the video drama are able to show two contrasting behavioural models, side by side, with entirely different outcomes. In other words, they can show what happens to women when they do not heed the messages of their bodies (when they do not heed the right experts) and what happens when they do. At the interpersonal level, they can highlight a critical issue for health risk communication: each viewer, each pregnant woman, each husband can shape the course of action -in other words, we can do something to change our fate. There is double level of interdiscursivity here. On the one hand, the video drama implicitly acknowledges –and challenges- the representation of destiny as mystic fate in telenovelas (which I have mentioned above). On the other hand, it addresses the fatalistic view of life –particularly of misfortune-, which is assumed to prevail in traditional settings and among certain population groups.[69]

From a structural perspective, it is only after the second ending that the narration reaches an overall conclusion. Thus seen, the complete, two-episode drama operates as a "closed" serial with an "open" component, since the events in the first episode –the delay in

[69] Half of the husbands and elderly women surveyed in Xochis and Tlacoachis for the MNH Project 2008 baseline agreed that "nothing can be done when a child is destined to die during pregnancy or childbirth." A Mestizo doctor with many years of experience in the region said in that regard: "Cuando el curandero dice que la mujer o el bebé puede morir, la gente lo suele aceptar con resignación. Le tienen confianza al curandero, y casi siempre una declaración suya en ese sentido hace que la gente baje la guardia y renuncie a buscar otra opinión."

seeking help and the death of Gabriela and her child- are not construed as irreversible.[70] But this is not all in terms of "openness" and "closeness". The film keeps alive the perception that the ideal outcome of the second episode is not a foregone conclusion and that the outcome is in the hands of the viewer. In other words, it projects an open ending *in real life*. The voice-over in the epilogue of the second episode is very clear in this regard; but it is the fear appeal of the first episode that makes the warning ring true – Gabriela and her baby *must be* dead in one of two possible worlds. That is why this first outcome must retain a certain degree of autonomy, a "standalone" quality if you will. For this to happen, the first episode has to be "closed" to some extent –which contributes to the overall moral and ideological "closure" of the text.[71] It is in this sense that we can also talk of two different versions of the same story.

This structural ambivalence is of the essence in order to sustain a key dimension of health risk discourse, such as individual responsibility, and the twin idea from safe motherhood discourse that timely human agency can prevent maternal deaths. This balancing act between "openness" and "closeness" becomes a prime example of deep communion between content and form in the video film.

5.5. The structure of the film: sequences, scenes, and shots

For analytical purposes, and based on the analysis on 5.4 above, I have divided the film into two episodes and ten sequences,[72] not including the opening title, which I discuss on 5.7.2 below. The first episode contains three sequences:

1) "Domestic life", from the opening shot outside the house (0:08m) to the shot of Gabriela falling to the floor inside the kitchen (2:34m).

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[70] Allen says that telenovelas are "open" serials also because events taking place in the narration "are less determinant and irreversible than they are in other forms of narrative [...] In soap operas, it is not unusual to witness the resurrection of a character assumed to be but not actually dead." Allen RC 1995, p. 19.

[71] Kincaid says that an edutainment drama "has greater impact on audience members who understand the moral lesson from the story." Kincaid DL 2002, p. 139.

[72] In film theory, a sequence is "a series of edited shots characterized by inherent unity of theme and purpose". In other words, a thematic or sub-thematic segment within the film –like a chapter in a book. Barsam R 2004, p. 179. A sequence is made up of a group of contiguous scenes linked by dramatic unity. Iedema R 2004, p. 189-190. However, it is not always easy to distinguish sequence from scene –indeed, there are one-scene sequences in film

2) "Seizure", which is basically a two-shot sequence, from the first images of Gabriela lying on the stretcher and Jorge standing by her side (2:35m) to a close-up of Jorge in despair (3:10m). The voice-over starts during this sequence, at 3:01m.

3) "Epilogue", which begins with the voice-over (3:01m), overlapping the final images of the "Seizure" sequence, then runs through a non-fictional visual segment (a de-contextualize close-up of Gabriela's face looking outside the frame bookends this segment), and concludes together with the voice-over at 3:42m.

The second episode is made up of seven sequences:

1) "Rewinding", from a medium shot of health staffers trying to control Gabriela's seizure (3:43m) to the shot of Jorge and Gabriela talking in their yard (4:00m). This sequence is more like a bridge between the two episodes, but in keeping with classical serial narration, I consider the first epilogue as the ending of the first episode.

2) "Second chance", a one-shot sequence of the conversation between Gabriela and Jorge, from 4:01m to 4:43m.

3) "In the waiting room", from the establishing shot of people in the waiting room at the health centre (4:44m) to a close-up of Jorge in distress (6:14m)

4) "Emergency consultation", from a medium shot of Gabriela and the nurse weighing and measuring her on the scale (6:15m) to a close-up of Gabriela sighing with relief at the end of her conversation with the male doctor (10:05m). This sequence is comprised of three scenes[73]: a) "Nurse checkup", from 6:15m to 7:27m; b) "Urine test", from 7:28m to 7:33m; c) "Male doctor intervention", from 7:34m to 10:05m.

5) "Late pregnancy checkup", from images of Gabriela readying for ultrasound (10:06m) to a full-frame shot of the ultrasound image at the end of her consultation with the female doctor (11:39m). This sequence is comprised of two scenes: a) "Ultrasound", from 10:06m to 10:21m; b) "female doctor consultation", from 10:22m to 11:39m.

6) "Self-control and solidarity", from Gabriela lying in bed and staring at the ultrasound picture (11:40m) to Gaby and her comadre talking about this image (12:39m);

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[73] A scene is "a single shot, or a series of shots, that portrays events unified in time, location, and theme". Diefenbach D. *Video production techniques: theory and practice from concept to screen.* New York: Taylor & Francis, 2008, p 43. Harrington defines a scene as "a series of shots that the viewer perceives as taken at the same location during a rather brief period of time." Harrington J. *The Rhetoric of Film*, Boston, MA: University of Massachusetts. 1973, p. 15.

7) "Epilogue", from the same shot of Gaby and her comadre with voice-over ("*Tu salud y la de tu bebé están en tus manos*") at 12:46m, to a shot of Gabriela smiling and nodding from her kitchen window at 13:46m. This sequence is made up of two scenes: a) "Anticipation", where both women chat about the ultrasound, from 12:46m. to 13:22m.; b) "Reward", from the close-up of the baby at 13:23m. to the closing image of Gabriela.

I will not discuss these sequences in the order they appear in the film, but I will refer to them –and to the underlying structure of the script- throughout the analysis.

The notion of "shot", another key term in film language, needs to be defined at this point. Each shot is an "uninterrupted run of the camera,"[74] even though changes may occur through camera movements or changes of focal distance within the same shot. What the shot shows and how it shows it, including lightning, acting, dialogue, music, and sound effects –that is, the staging of all we see and hear on the screen within the time and space of a single shot- refers to the mise-en-scène.[75] Following O'Halloran, I will take the mise-en-scène as the basic unit of analysis, "because the major systems for each metafunction across the semiotic resources are operational at this rank."[76] This matches Barsam's definition of shots as "the building blocks of a film."[77]

5.6. Drama theory in "Heed the messages": roles, functions, and archetypes

In this section, I will analyze the plot in terms of the canonical relationship between structural drama theory and entertainment education. For this, I have drawn upon the frameworks described in Seale[78], Nariman[79], Kincaid[80], and Petraglia[81], and from the work of Propp and Greimas. I will link roles, functions, and archetypes with cognitive behavioural constructs and key dimensions of health risk discourse and safe motherhood discourse that lie behind the plot, the dialogue, and the characters. This approach both

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[74] Barsam R 2004, p. 228.
[75] Ibid, p. 122. Some authors do not include the soundtrack within the mise-en-scène, while others do. I will follow the latter for a more integrated multimodal analysis.
[76] O'Halloran KL. Visual semiosis in film. In KL O'Halloran (ed.), *Multimodal discourse analysis: Systemic functional perspectives*. London and New York: Continuum, 2004, p. 109-130, quote on p. 117.
[77] Barsam R 2004, p. 179.
[78] Seale C 2002.
[79] Nariman HN 1993.
[80] Kincaid DL 2002.
[81] Petraglia J 2007.

suits and calls attention to the multi-generic nature of the text, which draws as much from melodrama as it does from health education and cognitive behavioural interventions. As Petraglia points out, edutainment interventions may contribute to behavioural change "by helping individuals create cognitive and affective associations that influence 'psychosocial' variables such as self-efficacy, outcome expectation, and risk perception."[82] In Appendix B,[83] I have summarized some of these structural components, together with related behavioural constructs and health risk dimensions.

Discussing mass media treatment of health issues, Seale observes that the media resort to archetypical oppositions and narrative structures –such as outlined in structural drama theory- to make health issues palatable to their audiences. "Heroes and villains, pleasure and pain, safety and danger, disaster and repair, life and death, the beautiful and the ugly are all examples of such dichotomies, exploited in media health portrayals," says the author.[84] Health edutainment producers blend these dramatic staples with health risk discourse and behavioural theories. Their goal is to find compelling stories that will bring health messages to life. Their challenge is to present representative cases that will embody the issue behind public health numbers, in order to bridge the distance between population statistics and individual perceptions of risk. At the same time, they seek projection, identification, and vicarious learning from large audiences. As a result, they often turn characters and situations into categories and archetypes.

Archetypes and stereotypes were at the centre of Sabido's telenovelas, where characters represented "certain human forces caught between good and evil in exaggerated situations"[85] –a key melodramatic trait. Sabido took the notion of archetypes from Jung, who saw them as mythical expressions of "universal primal energies that have touched all of humankind from the beginning of time", to elicit emotive responses from the target audiences.[86] So, when characters move the plot forward in edutainment drama, the archetypes they embody are enacting or re-enacting mythical events, such as the passage

[82] Ibid, p. 501.
[83] Appendix B, p. 554-572.
[84] Seale C 2002., p. 27.
[85] Nariman HN 1993, p. 36.
[86] Ibid, p. 36.

from one stage of life to another. "Likewise," says Narinam, "myths have been used by all cultures to explain certain passages they must make collectively into a new era."[87] From a semiotic perspective, these archetypical characters operate like nominalizations, but unlike their linguistic counterparts, they enact the interaction between represented ideas –e.g., maternal health requires spousal companionship and true knowledge- through recognizable, "real-life" human interaction.

"Heed the messages" fits all the above. The creators of the film have dramatized and stereotyped characters, events and circumstances from real life in order to raise awareness about a public health priority, and to change knowledge, attitudes, and behaviours among some of the poorest and less educated segments of the population. For instance, in the second episode of the film, which I discuss below, Jorge and Gabriela's timely departure from the apparent safety of their home and their quest for real safety in government health facilities, represent an individual and collective passage from unawareness to risk awareness and from misconception (belief, false knowledge) to true knowledge and "enlightened" commonsense. In table 3, below, I have outlined some archetypical representations in the video drama, most of which imply a particular interpretation –if not a re-writing- of traditional mythical forces and stages of life from a governmental and biomedical point of view.

Character-archetype	**Stands for**
Gabriela	Motherhood, (at-risk) pregnancy, maternal health, at-risk women, women in need of care, struggle between false knowledge and true knowledge
Jorge	Fatherhood, companionship, manhood (new ideal), leadership, struggle between false knowledge and true knowledge
Baby	New life, maternal health, childhood in

[87] Ibid, p. 37.

	need of care
Mother-in-law (alluded to)	Traditional belief, misconception (false knowledge), irrationality, unawareness, "misguided" commonsense
Victoria (woman in waiting room)	Awareness, rationality, "enlightened" commonsense, wisdom, submission to experts, solidarity, maternal care
Comadre	Awareness, rationality, enlightened commonsense, submission to experts, solidarity, maternal care
Doctors	True knowledge, wisdom, solidarity, guidance, skilled care, healthy (safe) pregnancy, maternal care
Nurses	True knowledge, solidarity, guidance, skilled care, healthy (safe) pregnancy, maternal care
Technology	True knowledge, skilled care, healthy (safe) pregnancy

Table 3

According to structural drama theories, most folk narratives have similar patterns, including types of characters and situations.[88] [89] In typical fashion, "the phase in which

[88] Propp outlines stable, core narrative units or functions, which he describes as "an act of a character, defined from the point of view of its significance for the course of the action." Propp V. *Morphology of the folktale*. Trans. Laurence Scott. 2nd edition. Austin, Texas: University of Texas Press, 2003, p. 21. Many of these narrative components are present in "Heed the messages". In particular, I will refer to rules (in the form of suggestions or interdictions), violation of these rules, trickery (the villain attempts to deceive and take possession of his/her victim), complicity (victims or heroes unwittingly help the villain), villainy (villain or evil force harms member of a family), lack (the victim's family or the community identify something as missing or lacking, which may set the heroes into action or counter-action), mediation (a crucial stage where the hero discovers the act of villainy, although he may not yet have shown his heroic character or we may not be certain about it), testing (hero has to prove he has heroic qualities), departure (the hero leaves home in a quest), receipt of a magical agent, guidance (from helpers), rescue (hero escapes evil force, sometimes through aid of Helper or because of new skill or moral insight) exposure of the villain or evil force, struggle, and victory, and transfiguration (hero is rewarded). I have adapted these definitions from Propp (ibid, p. 25-65).

the story is set up, or prepared, may involve a rule or prohibition for the hero," and is often followed by complications ranging from harm to the hero or a loved one, "or the hero may be sent on a quest, involving leaving home or use of some magical agent, eventually leading to a struggle between hero and villain."[90] Seale mentions Todorov's charting of common narrative development "from a state of harmony, through disruption of this equilibrium (often involving a villain), to a final state of restoration (often brought about by a hero)."[91] These struggles and oppositions are all present in "Heed the messages"; some of them are straightforward –we can say they are part of the surface of the text- and some are not. All of them are associated and interact with cognitive behavioural constructs and/or key dimensions of health risk discourse and safe motherhood discourse.[92]

We can look at these roles and functions from different angles. I have already suggested the film can be construed as two versions and/or two episodes of the same story, which implies a shift in the understanding of roles and archetypes, and demands a re-interpretation of attitudes and assumptions from the audience. Following this line of thought in the analysis of the first episode, we can say that Jorge and Gabriela are

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[89] I have also drawn some key elements from Greimas' actantial model, such as the notions of Subject and Object (the Subject is someone or something directed towards an Object); Sender (someone or something that instigates the action), the Receiver (someone or something that benefits from it), the Helper (someone or something that helps the hero along the way), and the Opponent (someone or something that hinders the hero's actions). Greimas AJ. *Structural Semantics: An Attempt at a Method.* Trans. Daniele McDowell, Ronald Schleifer, Alan Velie. Lincoln and London: University of Nebraska Press, 1983, p. 174-212. Actants are not necessarily human beings; they can be objects, concepts, or even collective actors, such as institutions. There can true and false actants. For instance, participants in a narration may believe that someone is a Helper, but the Speaker and the reader/viewer may know that they are not. Actants can be possible and/or real (like a possible Helper who does not become a real Helper), and they can also be active or passive (a Helper who does not help in a crucial circumstance can be a passive Opponent), intentional or unintentional (for instance, someone who gives the wrong advice). All these categories are relevant to the analysis of the video film.

[90] Seale C 2002, p. 27.

[91] Ibid, p. 28.

[92] For these associations, I have also resorted to key components of Greimas' canonical narrative scheme, as discussed by Hébert L.Tools for Text and Image Analysis: an Introduction to Applied Semiotics. *Texto!*, 2006 [online], p. 68-72. Available at www.revue-texto.net/Parutions/Livres-E/Hebert_AS/Hebert_Tools.html. Accessed December 12, 2009. In particular, I have drawn from the breakdown of the action component into: a) competence (wanting-to-do, having-to-do, knowing-to-do, and being-able-to-do); b) performance (enabled by newly acquired knowledge or competence); c) manipulation (particularly of wanting-to-do and having-to-do); and d) sanction (reward or punishment). All these categories are particularly germane to the narrative analysis of behaviour-oriented health promotion narratives, as in the case of "Heed the messages"

innocent victims, or fallen heroes, who live in a state of misleading ignorance –they are not aware, in health risk jargon. Worse yet, they are prey to misconceptions –wrong beliefs about a series of health symptoms- that contribute to their ill fate. In fact, Gabriela herself spreads these wrong ideas: she thinks that sharp abdominal pains, intense headaches, ear buzzing, and swollen feet are common pregnancy ailments and that they will go away, so there is not much they can do about it. Jorge goes along with her understanding of the situation. Together, they take a wrong turn. Misguided and isolated, they undergo a painful and ultimately tragic ordeal. As we learn from the epilogue, the villain –rather, the evil force of pre-eclampsia- had been acting all along, but they did not know it. When the evil force finally unleashed its full power (eclampsia), we can sense Jorge's sense of Lack (and guilt). He realizes that something terribly wrong is going on and he perceives his low competence in terms of knowing-what-to-do (knowledge) and being-able-to-do (self-efficacy). He cries out for a Helper[93]/Hero (the doctor) to save Gabriela, restoring harmony in his life, but it is too late. The epilogue reveals the nature and scope of the evil force and conveys the moral of the story, which we now fully appreciate as an exemplum.[94] Jorge and Gabriela are sanctioned for their own ignorance, for not seeking timely help from the sources of true knowledge, and for heeding traditional commonsense advice and their own judgment in matters of life and death. In cognitive behavioural terms, they are unaware of the severity of the threat; they have weak attitudes towards consulting biomedical staff and weak intentions to seek help from the health centre. Social norms hinder timely assistance of the mother and the child. In sum, they have the wrong reference framework to interpret the messages from Gabriela's body and to carry out a safe pregnancy.

As I discuss in more detail below, this first episode revolves around the "delusional" perception of a safe pregnancy without medical control. We are presented with an initial state of apparent harmony, where evil forces lurk underneath the deceptive surface of

[93] The Helper gives support and guidance to the Hero. Propp says that "one of the most important attributes of the hero is his prophetic wisdom: the prophetic horse, the prophetic wife, the wise lad, etc." Propp V 2003, p. 83.

[94] An exemplum is a story genre, a type of moral tale with a social purpose: "to present a problematic incident and then interpret it for the audience, commenting on the behaviour of the people involved." Martin JR, Rose D. *Working with Discourse: Meaning Beyond the Clause*. London, New York: Continuum, 2003, p. 8.

everyday life. Moreover, possible Helpers, like elderly women, can turn into unwitting Opponents and instead help this evil presence to fool its victims. Some of these actants are also explicit or implicit anti-Senders, since they manipulate Jorge and Gaby into not-wanting-to-do (attitudes) and not-having-to-do (subjective norm) as expected from a biomedical perspective. The text construes subject positions of at-risk mothers and children and frames them as the result of people's trust in traditional views. There are explicit individual indictments (Jorge, Gabriela, Jorge's mother) and implicit attributions of collective blame. Jorge, in particular, is singled out for failing to act as head of his household. He should have been a firm, timely Helper, but becomes a passive, unintentional Opponent instead, rendering key potential Helpers (government health staff) helpless (not-being-able-to-do), and unwittingly damaging his wife and their child. Gabriela is an active though unintentional Accomplice, Opponent, and Anti-Sender, who manipulates Jorge's not-wanting-to-do, and so are the social and cultural forces that act upon her. Jorge and Gabriela are also responsible for not considering the health of the child, and thus become unwitting accomplices in the villainy. The baby is another victim of the evil force, though not as a result of his own actions.

The textual mention to Gabriela's mother-in-law is a primary vehicle for a muted opposition between True Knowledge and Traditional Beliefs, which I discuss in more detail below. In terms of structural theory, the mother-in-law is an active Opponent, a passive Accomplice in the villainy, a False Helper[95], and –most literally so- an Anti-Sender, who has power over Jorge and Gabriela and manipulates Gabriela's not-having-to-do and not-wanting-to-do. The film captures a common view among health staff of elderly women and family as influential opponents, as reflected in the following comments from a doctor working in the Xochis hospital:

> Pues ya le comentaba, ¿no? de que a veces no aceptan los servicios... A veces no es tanto porque la embarazada, la señora no quiera, sino por la misma cultura de la gente...

[95] Jorge and Gabriela think she is a true Helper, but the Speaker (the ultimate truth bearer) says she is a false Helper, and so is the social subgroup she represents. This has strong implications at the level of discursive practices, where it guides the reading of the text and encourages a re-interpretation of sociocultural practices.

> Porque no quiere la suegra, a veces eso también influye, que la suegra no quiera... o a veces no quiere la mamá, o no quiere el papá [...] Sí, eso también es una dificultad. A veces la misma familia la hace ser renuente... que parezca ella renuente. ¿Por qué?, porque no acepta venir para acá.

In other words, the mother-in-law in the film is the bearer of commonsense beliefs and social norms. Partly because of her intervention –and the cultural forces she represents-, Gaby has low attitude and weak intention towards the expected behaviour. A key dimension of social and cultural responsibility is invoked through Jorge's mother function in the story.

From a non-diegetic perspective[96], the omniscient narrator (whom I will call Speaker, and who represents the Health Secretariat) is the reference observer and the ultimate truth bearer throughout the film. It indicates who are Helpers and Opponents, evaluates characters and events, and decides on sanctions (in this case, punishment). The Speaker also acts as a Sender. The government wants Gaby and Jorge –and the real-life women and men they stand for- to seek immediate help from government health centres. This non-diegetic Sender leaves explicit textual marks through the sound and the content of the voice-over, and through the images that we see during the epilogue. In this first episode, the Speaker manipulates the having-to-do, seeking to establish new social norms and encouraging the viewers to deviate from traditional norms.

Some key roles and functions take on new meaning in the second version/episode of the story, and new ones emerge, while some others remain unchanged. It is Jorge who undergoes the most profound and influential transformation. This time, he is framed as an active Subject, who explicitly values Gaby and the baby's health as his primary concern. Though still unaware of the true nature of the enemy, he knows one thing: whenever in doubt, go to the health centre, even against the grain of commonsense advice and social expectations from the traditional order of discourse. He abides by the Speaker's rules,

[96] In film theory, diegetic materials are all the characters, events, objects, settings and sounds from within the story. All the things that we see and hear but come from outside the story (background music, titles, voice-over, etc.) are non-diegetic components of the script. Barsam R 2004, p. 80.

disregards Gabriela's objections, and timely takes her to the health centre. Thus, he becomes a Helper, a Sender, and a Hero[97]. He has the basic competence required by the Speaker (wanting-to-do, having-to-do, knowing-how-to-do, and being-able-to-do) in the emergency. In terms of cognitive behavioural constructs, he does not have enough knowledge of the threat, but he has the right attitude and intentions regarding government health services. From a health risk perspective, Jorge is a crucial instrument of control in the private sphere, all the more so because Gabriela is not able to fulfill expectations of self-control. Above all, he is aware of the limitations of traditional beliefs systems and commonsense advice to deal with potential pregnancy complications. That is why he is also –and crucially- framed as an Opponent of the traditional order of discourse (I elaborate on this opposition below). The construal of Jorge's subjective norm has the greatest leverage from a textual perspective. Because he deviates from traditional norms and has a positive response to external rules, we can imply (presuppose) that biomedical doctors are significant others and a primary reference regarding health. His individual agency has direct bearing on the outcome –the same way his passive stance brings about the family's demise in the first episode.

The central role of Jorge in the film reflects the key role of husbands in at-risk groups when it comes to obstetric emergencies. This is confirmed by quantitative and qualitative data from the field. Some 44% of women of childbearing age interviewed in April and 2008 for the MNH Project baseline survey in Xochis said their husbands had the most influence over their decisions regarding pregnancy care.[98] Health officials and health staff share this perception. A government health official in Chilpancingo said in this regard:

> [...] O sea, ellas, normalmente, lo que diga el marido. O sea, si ustedes le preguntan a la señora, "¿Señora, la vamos a llevar al hospital?", lo primero que hace es voltear a ver al marido... "¿Señor, la trasladamos?" "No, pues, sí,"... pero es él quien toma las decisiones. Falta mucho empoderamiento de la mujer, no hay empoderamiento de la

[97] Though his status is somehow diminished by the doctor's reprimand -a prime example of the construal of at-risk women and their spouses as children in need of paternalistic guidance.
[98] Doctors and nurses were the second most frequently reported source of influence (35%), while elderly women, such as mothers and mothers-in-law came in at a distant third place (15%). The exact phrasing of the question was as follows: *¿A quién le hace más caso en estas cosas del embarazo?*

mujer. Aquí todavía, en algunas comunidades, se cree que el marido no es esposo de sino que la mujer es propiedad.

On the other hand, Gabriela continues to be an unwitting but active Accomplice, Opponent, and Anti-Sender, who manipulates Jorge's not-wanting-to-do and not-having-to-do by reminding him of commonsense advice and the cost of leaving their household to seek skilled care (which reflects low self-efficacy and low intention in cognitive behavioural terms). She goes to the health centre in spite of her will and, once, there, her first reaction is to oppose Victoria when she wants to seek immediate help, because she is embarrassed to jump the line. Indeed, *Gabriela is very active as an opposing force* until she becomes aware of the stakes. The text implicitly construes her as an active Helper during the Control sequence, through the use of presuppositions: we assume that she has gone for a follow-up on her own will, that she has been taken the medicine, and that she will continue to do so. Finally, we see her lying down in her bed and properly *being cared for* in the week before delivery. Her transformation goes from lacking to having competence (having-to-do, knowing-how-to-do, being-able-to-do) in terms of maternal care, but she shows contradictory signs of "right" agency in that regard. Moreover, she is construed as agentive in the context of traditional roles, attitudes, and activities as a housewife. But she is portrayed as a dependent, child-like figure[99] in need of care and supervision from others when it comes to her own health.

When Jorge first takes Gaby to the health centre, they find different types of Helpers there. The first one is Victoria, the townswoman who spontaneously approaches Gaby, shrugs off her concerns about jumping the line and requests immediate help.[100] She is a

[99] She has childish gestures, puckers, giggles, barely makes eye contact with the female doctor, asks not to be scared, sighs in relief, reacts as a scolded child, is guided by a motherly figure (Victoria), stares at the ultrasound image with overstated amazement, etc. Her husband decides to take her to the health centre and later reminds her what happened with her sister when the doctor asks her about her family's obstetric history. I elaborate on this construal throughout the analysis.

[100] According to Amuzgo CIET team members from Xochis, this would be an unlikely occurrence if indigenous participants were involved in real life. In particular, Mestizo patients would rarely if ever spontaneously approach indigenous patients to offer help. This inter-ethnic distance would be even greater at the Ometepec regional hospital. Of course, there is role modelling at play in the video film; but the circumstances –participants, events, interactions- do not reflect the social reality of Xochis.

Donor[101] who gives guidance based on her own experience (her daughter, who was also pregnant, took seriously ill). She shows competence in terms of wanting-to-do, having-to-do, knowing-what-to-do, and being-able-to-do. This reflects awareness of the threat, positive attitude towards seeking immediate help, and strong intention to do it, in terms of cognitive behavioural constructs. She also gives reassurances of response efficacy: "*Vas a ver como ahorita te vas a sentir mejor,*" and she links this assertion to the goal[102] of her own actions: "*Le voy a avisar a la enfermera.*" Through the staging of this scene in the crowded waiting room, Victoria's intervention, and the implied outcome[103], the text tackles environmental barriers (long waits) and cultural and gender barriers ("*pena*" or embarrassment) frequently mentioned in research as perceptual and material hurdles dissuading women from going to government health facilities. In this regard, we can see Victoria's role as a key intertextual reference to the traditional order of discourse. She is another motherly figure, but in contrast with Jorge's mother, she brings in "enlightened" commonsense; moreover, she encourages deviation from "misguided" beliefs.

There are other Helpers who reveal the truth about the unknown disease and therefore contribute to save Gabriela. However, these Helpers are different from the townspeople who lend a hand along the way. They inhabit places of goodness and knowledge –the health centre, and most conspicuously the Hospital, a castle- where the Hero and his family must go to change their fortune. They aid Jorge and Gabriela in their quest against an evil they do not see and they do not understand. Through their knowledge, power (including the magic means of biomedical technology), and decisive actions, these Helpers rescue Gabriela and bring her –and the story- to a state of restoration. They secure the means of transportation, cure her (partial restoration), and accompany her

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[101] The Donor or Provider is a character who gives the Hero –or, someone closely related to the Hero, as in Gabriela's case- a magical resource or some particular wisdom. The Donor is usually encountered by chance. Propp V 2003, p. 39.

[102] Here, I use the term Goal in the sense of systemic functional linguistics, as the recipient of the actions of the Actor in a transitive material clause. Halliday MAK, Matthiessen CMIM 2004, p. 180. In this case, the Goal is the nurse.

[103] At the textual level, the last shots in the Waiting Room scene (first we see Victoria leaving to seek help, then the image dissolves from Gabriela to an anxious Jorge) transition to the first shot of the nurse weighing and measuring Gaby on a scale. On a logical plane, we can infer that Victoria's request was successful and Gabriela was given priority. This amounts to another intertextual reference, since many women complain about the speed and quality of care in government health services.

down the road of healthy pregnancy and safe delivery (final restoration). They are self-proclaimed Helpers, but in fact they are Heroes, since their participation is both necessary and apparently sufficient to save Gabriela and her baby. The male doctor at the health centre is a pre-eminent Helper/Hero. He takes care of the situation, scolds Jorge (because he is wiser), evaluates symptoms, asks questions in search for knowledge, uses magical forces and agents (biomedical technology, hospital, specialists), reveals and names the evil presence, offers help, and displays the full extent of his power by arranging the immediate transportation of Gabriela to the hospital. He shows competence at all levels and carries out actions that change the outcome.

Back in the home front and the traditional order of discourse, the comadre emerges as a real, active, strategic Helper/Donor. She gives Jorge and Gaby material and moral support, hails Jorge as a hero, and contributes another intertextual dose of "enlightened common sense" when she calls the attention to Jorge's spousal support and later says that divine intervention depends on individual agency. (I discuss these intertextual manipulations on 5.8 below) From a cognitive behavioural point of view, she contributes to raise awareness and to reinforce expected attitudes and behaviours *from within the traditional order of discourse*. Her age also adds value to this construal, since she brings a different social norm –heed medical advice, go to the health centre in case of doubt- from a generational perspective. Echoing the subject positioning of Victoria as an "aware elderly woman", the comadre is framed as an "aware young woman". She represents the best of traditional community life –social solidarity-, but she also believes individual agency and responsibility can shape the course of events.

The heightened presence of the baby is another salient trait in the second episode, which I discuss from a multimodal perspective on 5.11 below. Here, I will only state that the good health of the baby is confirmed as the Object and Receiver of the actions of the Sender, the Heroes, the Helpers, and the Speaker. This time, the baby is not only alluded to, but we also see his ultrasound image and we finally meet him in person, when he is delivered to Jorge in the waiting room at the hospital. Jorge and Gabriela's explicit reference to their "Jorgito" and their "Gabrielita", and redundant, accentuated mentions

from skilled health providers to the health of the child seek to reinforce expected attitudes, intentions, and behaviours. The images of the baby passing from the nurse's arms to his father's are meant both as a reward for Jorge's agency and a construal of response efficacy as a motivation to comply (seeking immediate biomedical assistance upon signs of alarm will most like save the mother and the child). In terms of safe motherhood discourse, maternal health is construed as encompassing the health of both the mother and the child, and safe birth is equated to institutional delivery.

5.7. The construal of oppositions

5.7.1. Traditional beliefs vs. true knowledge

I have already discussed the most explicit opposition between good and evil in "Heed the messages", where pre-eclampsia and eclampsia are construed as villainy preying on the unaware. Indeed, the disease is still like an evil spirit that manifests itself gradually, through omen-like signs -a dramatic device that intertextually resembles the animistic interpretation of disease in many traditional and non-traditional societies-[104] until we see its true face in the "Seizure" scene at the health centre. It is an evil force, an evil presence, rather than an evil human character. In a way, there seems to be no human agency in this villainy, and no human villainy in the story.

But there is another opposition, much less obvious yet equally powerful –and far more relevant for safe motherhood discourse and health risk discourse at large-, woven into the plot. This opposition is laid out during the first dialogue between Jorge and Gabriela (I have italicized verbally accented words):

[104] It is not unusual for mainstream Western media to portray disease as evil invested of agency. Thus, cancer, malaria, or aids can be depicted as a "silent killers" and often pitted against courageous individuals, as in "So and So (usually a public figure) lost his battle against cancer." This is particularly the case when a given disease is identified with death, as it happened with cancer, at least until recently. See Sontag S. *Illness as Metaphor*. New York: Farrar, Straus and Giroux, 1978. The creators of "Heed the messages" have drawn upon these metaphorical representations of disease to heighten the fear component of their message and to reveal "the face" of a hidden enemy with an alien name.

Jorge (leaning forward towards her, stressing his words, encouraging her to speak): *No* te sientes *bien*, ¿verdad?

Gabriela (shakes her head, looks towards the floor and then at him with a smile in her face; she speaks with a mix of muted reassurance and resignation): ¡Ay, Jorge! No es nada. Sólo es el *cansancio*. Hasta tu mamá dice que son los *achaques* del embarazo, que se pasan *pronto*.

At first, the unaware[105] viewer may perceive this as a passing reference to likely familial dialogue about pregnancy ailments. But there is more to it than meets the ear. The literature points to elderly women (mothers and mothers-in-law) and other women in the community as sources of advice and influence on pregnant women and their husbands.[106] Health officials and health staff take this influence for granted, as shown by data from interviews.[107] In their view, it is the cultural mould at work –and a powerful source of misconceptions regarding maternal and newborn care. I confirmed this interpretation while I was watching the video film with a government health official in Chilpancingo. Here is a segment of our dialogue:

Q: O sea que ustedes están llamando la atención sobre un conocimiento tradicional que es incorrecto...

A: En muchas de las ... es correcto. A ver, "dice mi mamá que es normal, pero no nada más la mamá, puede ser la suegra, puede ser la comadre, que es algo normal. O sea, en este caso ella es una mujer primeriza, como le decimos. Entonces de alguna manera se asesoran ellas con la mamá y le preguntan, por ejemplo, a la mamá o a la suegra, y le dice, "Oye, tú ya tienes cinco hijos, pues, ¿qué se siente? Y la señora da su experiencia, pues mira vas a vomitar, te van a dar mareos... Pero habría que diferenciar de mareos a

[105] I use this term in a double sense: unaware that these symptoms may be signs of a life-threatening illness and unaware of the opposition that is being construed on screen.

[106] Why have the authors of the video film chosen to mention Jorge's mother as the bearer of misguided commonsense? Gabriela could have instead said: "*My* mother says this is normal and it will soon go away". Partly because of the strong patriarchal structures in most indigenous communities and partly because newly wedded couples used to move in with the man's family until they were able to fend for themselves (to a certain extend, this is still the case nowadays), the young husband's mother is supposed to have much bearing on whether, when, and where her daughter-in-law will go for help or will deliver her children.

[107] However, only 15% of women of reproductive age interviewed for the MNH Project 2008 baseline said their mother or their mother-in-law was the most important influence regarding maternal care. Forty-four percent mentioned their husband and 35% said they paid the most attention to the doctor or the nurse. Of course, the mother-in-law can also have an influence through her son.

> mareos, porque no es lo mismo unas náuseas que un vómito constante. No es lo mismo un ligero mareo que un desmayo. No es lo mismo una ligera patada en el niño a que el niño esté inmóvil. No sé, entonces es, sí, hacer hincapié de que ojo que hay gente a tu alrededor que te puede asesorar mal. En este caso la asesoría estaba mal.

In the next scene, we see Jorge and Gabriela at lunchtime, inside their home, and we can assume that they have followed the commonsense knowledge voiced by Gabriela in the previous scene. We do not hear Jorge's reaction to Gabriela's comments, but we can understand this ellipsis in terms of logical meaning and cause-effect relations.[108] What happens in this indoor scene is the direct consequence of the previous scene –and of other unseen, implied elements in the story. This logical connection also allows us to understand what is going on in the following scene, where Gabriela has a seizure in a primary health care centre. The logical relation of cause-effect is crucial to the construal of the most important opposition in "Heed the messages": that between the traditional, indigenous, commonsense belief system of the Amuzgos –and of any other indigenous group, for that matter- and the biomedical "knowledge" system.

The text establishes an intertextual collision between two orders of discourse: Jorge's mother and her opinions are in indexical relationship with traditional belief systems that contradict epidemiological findings and biomedical knowledge.[109] In other words, Jorge's mother and her comments stand for the commonsense knowledge of the target audience at that place and time. In this case, Gabriela's use of reported speech when she refers to advice from her mother-in-law is both an intertextual and an interdiscursive device. By

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[108] Halliday says that we can split the ideational component into experiential and logical. While experiential refers to meaning as organization of the experience, the logical component refers to language as the expression of certain very general logical relations that apply to the way we read texts. Halliday MAK, Matthiessen CMIM 2004, p. 310-311. Cause-effect inferences are among these logical relations. As O'Halloran points out, this is of much relevance in film and video analysis, given the cause-effect relations in film narrative. O'Halloran KL 2004, p. 111.

[109] According to the MNH Project baseline survey, there is a low level of awareness of biomedical signs of alarm for pre-eclampsia and eclampsia. Only 28% of husbands, mothers, and mothers-in-law in Xochis and Tlacoachis mentioned headaches as the most important alarm sign during pregnancy; 12% mentioned swollen feet, 6% "pains", and 4% intense stomachache. The third most frequently sign was bleeding (8.5%), which is not related to pre-eclampsia. However, a very low proportion of all three groups said that women have to wait until these symptoms go away. Only 14% of mothers-in-law were of this opinion. Some 70% of elderly women and 60% of husbands said they should go to the health centre. All of which warns against assumptions, oversimplifications, and generalizations in public health communication.

quoting this familial source and showing the consequences of following her line of thought, the creators of "Heed the messages" have not only brought a text into another, but they have dragged an entire order of discourse (that of traditional knowledge about maternal health) and have placed it in a semiotic collision course with safe motherhood discourse. *Whom, and not what, to "heed" has become the textual, ideational and interpersonal focus of the video drama.*

This opposition between the systems of Belief and Knowledge is taken up later, at some key points in the narration. The first of these "non-declared" confrontations happens in the middle of the seizure scene, when two health workers enter the poorly lit room and try to hold Gabriela, while Jorge looks on hopelessly from the background and the percussion pounds heavily from the foreboding soundtrack to highlight the extreme gravity of the situation. A feminine voice in off lets us know that "the saddest part is that most of these deaths could be prevented if timely action were taken". Even when the opposition is not explicitly mentioned, we know why this is happening: Gabriela's seizure is the result of following the ill advice from Jorge's mother and wasting precious time before requesting skilled care. On a less direct, more connoted plane, the text seems to insinuate that 1,200 women die in Mexico every year because they heed the wrong experts. In other words, they are victims of a commonsense belief system that is brought into question.

The authors of the text use a well-known rhetorical device –which Lemke calls concessive-adversative[110]- to make their point while toning down the level of confrontation. They first state their partial agreement with something that has not been said before, but has been implied through the intertextual reference to the mother-in-law's interpretation of certain pregnancy ailments: "*La inmensa mayoría de los embarazos termina bien, con la mama y el bebé en buen estado de salud.*" Then, the

[110] Lemke JL 2002, p. 49-50. "This is the familiar 'Yes, but…' of many Argument genres," says the author. "The first element concedes a partial agreement with the previous move, the second element then offers a more important disagreement. Thematically, a link is created between the heteroglossically Opposed formations, showing that they contain some thematic proposition in common (the Concessive). But then a difference is highlighted, with the axiological stance favouring the speakers formation as right (the Adversative)." Teachers frequently resort to this rhetorical device when responding to students' challenges.

qualified adversative "*pero, desgraciadamente*" sets the stage for the confrontational "*esto no sucede siempre,*" which undermines the presumptive popular belief that "everything will turn out all right".[111]

In a non-fictional segment of the film, they next introduce the "objective" truth of scientific discourse[112], through maternal health statistics for Mexico as a whole, and they create a visual and linguistic link between Gabriela's story and these numbers. They do this in three different ways:

a) They progressively split the screen in multiple cells showing Gabriela's face, while a red sheathe gradually covers the frame and the voice in off talks about the number of maternal deaths in Mexico. This not only gives a more concrete idea of an abstract number, but also recreates Gabriela's story and her fateful outcome in each one of those cases through an operation of semantic reduction. This image operates as a visual synecdoche whose meaning is rendered explicit before our very eyes: this death embodies and represents all 1,200 deaths. However compelling, this semiotic manipulation may induce the viewer to think that all maternal deaths happen in the same circumstances, when in reality Gabriela's case represents one-third of the overall statistics.[113]

b) In the expression "la mayoría de *estas* muertes", the demonstrative pronoun has a double deictic function. On the one hand, it refers to the 1,200 maternal deaths that happen yearly in Mexico. On the other hand, it points to the events taking place on screen. But, here again, it may also refer to the 400 deaths from eclampsia, because the

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[111] In itself an oversimplified reading of indigenous beliefs regarding pregnancy, as I show with data from interviews in chapter 6.

[112] Lemke JL 2002, p. 42.

[113] It can be argued that, in the construal of this synecdoche, Gabriela's image denotes a specific class (deaths from eclampsia), which is being used to refer to a more general class (women who die during pregnancy, childbirth or puerperium). But the multimodal organization of the text makes it hard for the viewer to make this reading, particularly in a context of high illiteracy and innumeracy, as is the case in Xochis. For instance, the onscreen splitting effect happens while the voice-over talks about the overall stats of maternal mortality in Mexico, and it culminates with a mosaic of tiny images of Gabriela in the background, covered in red, while we see the overall number of maternal deaths in salient white lettering: "*Más de 1,200 mujeres mueren al año*". It is only after image that the voice-over refers to deaths from eclampsia as a subclass of all maternal deaths, and when this happens we no longer see Gabriela's face, but first the swollen feet, then the swollen hands, and finally the face of an unnamed indigenous woman.

anaphoric reference is not clear. As it happens with the synecdochal use of Gabriela's image, it may contribute to mislead the viewer into thinking that all 1,200 deaths occur in the same circumstances –either from eclampsia or because the victims did not seek immediate help, or a combination of both.

c) They insert a close shot of a young indigenous woman, who is not a participant in the fictional story and who is sitting in a hospital bed, with swollen hands and feet, while a doctor examines her. The onscreen text –*La mayoría de las muertes se pueden evitar si se actúa a tiempo*- is not only fully integrated with this image, but it stands out from a faded close-up of the woman, which then dissolves into the de-contextualized, conceptual close shot of Gabriela that opens the non-fictional segment of the film. Here, the editor's blend of dissolve and match-cut (through similar, partially disengaged close-ups of the two women) makes for strong textual cohesion between the fictional and non-fictional components of the video drama.

There are multiple semiotic purposes in this epilogue. Ideationally, the combination of diegetic (Gabriela's image) and non-diegetic materials (on-screen text, red colouring of the screen, background music, voice-over, linguistic content) aims to connect fiction and non-fiction. At the same time, it labels and "shows" the unseen enemy, and it puts Gabriela's story in perspective as a public health issue. From an interpersonal perspective, the epilogue connects the events on the screen with the lives of the viewers and, potentially, with the fate of the 1,200 death women. In that sense, it gives a "truthful", scientific explanation of what we have seen and it warns about the perils of ignoring the threat based on our commonsense and traditional beliefs.

The authors of the text have framed what we see on screen as the outcome of a misguided reading of alarm signs and the subsequent delay to seek help from skilled health providers. This point is brought home in the last sentence, through cohesive means, once again avoiding an explicit confrontation with the traditional order of discourse. The conditional component in "*La mayoría de estas muertes se podrían evitar* ***si se actuara a tiempo***" anaphorically connects with the first scenes of the video drama, which show Gabriela shrugging off Jorge's concerns and going about her chores in spite of her pain,

and then both of them having lunch while the drama begins to unfold –all of it because they heed commonsense explanations from life experience and traditional beliefs.

In the immediate textual context, we can read this counterfactual use of the conditional (imperfect subjunctive + conditional) as reproach.[114] This reading is supported by the thematic placement of the highly evaluative expression "*Y lo más triste es*" within the same clause complex. ("*Y lo más triste es que la mayoría de estas muertes se podrían evitar si se actuara a tiempo*".) Even though the impersonal "se" seems to dilute the attribution of responsibility, everything else in the text makes it clear that the victims are to blame for the tragic outcome. Not only that, but from the immediate textual context of the epilogue –*all* 1,200 deaths could be averted if the victims sought immediate help from government health services- we can infer that the women, their spouses, and their wrongful beliefs and cost-benefit evaluations, are the ultimate cause of maternal mortality in Mexico. In short, the victims are to blame for their own fate and for the dismal statistics of maternal death in the country. Of course, reverting this situation is also in their hands, as the voice-over reminds them during the second epilogue.

At the level of discursive practices, there is great ideational potential for misleading the viewer in this direction during the epilogue, as I have mentioned when discussing the metaphorical connection of Gabriela's image to the overall stats of maternal mortality and the deictic use of the demonstrative pronoun "*estas*" in "*La mayoría de estas muertes se podrían evitar si se actuara a tiempo*". This misleading potential is furthered by the semantic manipulation of statistical information and the organization of the clause complex where these numbers are nested. Ideationally, the voice-over implies that 400 women die yearly from pre-eclampsia and eclampsia in Mexico. But this figure is never mentioned. Textually, the statistical expression "one-third of these deaths" is used instead within a relational clause that refers to a subgroup of all maternal deaths in Mexico.[115]

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[114] For this interpretation, I have followed García de María's analysis of the Spanish conditional in terms of the Speaker's intention in the communicational context. García de María J. Condición e hipótesis: más allá de lo real y lo irreal. *Revista de Lingüística y Lenguas Aplicadas* 4:79-88, 2009. Available at http://www.upv.es/dla_revista/docs/art2009/06_Garcia_de_Maria_J.pdf.

[115] Technically, there is both hyponymy and meronymy between these clauses. There is hyponymy, because the 400 deaths from eclampsia are a subclass of the 1,200 maternal deaths. There is meronymy

Meanwhile, the voice in off and the visuals foreground and strongly evaluate the overall number of victims. Seeing this textual manipulation in the context of Xochis, we can speculate that many illiterate and innumerate women will likely understand that 1,200 women die every year in the same circumstances –death from eclampsia, death from not seeking help in a timely fashion, or a combination of both factors.

Is this an unintentional effect from the textual organization of the different semiotics? Maybe the authors of the text did not try to mislead the viewers into thinking that all maternal deaths are due to eclampsia. But the textual manipulation of the statistical language, the ambiguous deictic reference, and the synecdochal use of Gabriela's image, coupled with the semiotic salience of the overall number of maternal deaths also suggest that the authors of the text want to convey the idea that most maternal deaths could be prevented if women and their spouses acted promptly. In other words, the text implies that traditional beliefs and commonsense evaluations of cost and benefit are the reasons for *all* maternal deaths in Mexico. Put differently, this framing of maternal mortality numbers fits into –and "adds value" to- the semiotically muted opposition between Knowledge and Beliefs at the core of the film.

Elsewhere in the text, the multimodal device reinforces the construal of this key opposition. One such example is the contrast between Gabriela's casual and seemingly reassuring tone of voice and gestures when she talks with Jorge and mentions his mother's beliefs, and her worried expression as she glances at him while he is not looking at her in the lunch scene. For a brief second, it looks as if Gabriela wanted to say something to Jorge. This visual contrast –a typical semiotic code to signal internal struggle in telenovelas- tells the viewer that something is not quite right. Of course, at this point we also *know* there is a problem because we have seen Gabriela doubling in pain and trying to fit her shoes in her swollen feet. Her body is trying to tell her something and she reads those messages according to the belief system that has been

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(part/whole), because these deaths are one-third of the overall stats of maternal mortality. The textual use of a highlighted integral for the whole and a fraction for the part may dilute both the hyponymy and the meronymy, with a subtle but profound repercussion on the ideational content of the text. I have drawn the definitions of hyponymy and meronymy from Halliday MAK, Matthiessen CMIM 2004, p. 574-576.

passed onto her. But deep down she is not quite convinced. However, she keeps carrying out her spousal duties and serves Jorge at the table, without complaints.

At the same time, the various semiotic modes hint at a much more complex struggle at the level of sociocultural practices. Gabriela does not come forward because she does not want to disrupt the status quo of her family, her community, and her traditional upbringing. The stakes are high. Traditional roles and patterns –as interpreted by the makers of the video- are exposed in the first minutes of "Heed the messages" and called into question. Breaking away from the explanatory system and the unwritten rules of their culture may come at a price for Jorge and Gabriela –the creators of the video drama seem to admit- but sticking to them on certain crucial occasions may be even worse.

In a typical pattern of health risk discourse,[116] the creators of the video film let us know that both Jorge and Gabriela have their share of guilt for not "heeding" the right experts and not doing the right thing. In terms of structural dramatic components, they break *a rule of heeding* and this is the *cause* of their terrible ordeal away from what they thought was the safety of their home.[117] In fact, it is rather *heeding the wrong expert* –a false Helper- what initially dooms Gabriela and her child. On the other hand, when they abide by true (biomedical) Knowledge, they are able to identify the enemy, they find true Helpers, and they change the course of history –or, more in accordance with the intertextual reading of the video drama, they avoid what commonsense and tradition may construe as fate.[118] The difference between these two scenarios lies at the thematic and ideological core of the video drama.

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[116] See discussion in chapter 2.1.4, on p. 60-61.

[117] I have already mentioned the importance of the hero's attitudes towards rules and prohibitions in the turn of events, according to structural dramatic analysis.

[118] Seen from this perspective, "Heed the messages" is not only construed –both in content and form- as classic melodrama, but as a moral tale for the education of children, not unlike an Aesopian fable or Little Red Riding Hood. For instance, the clear contrast between the safety of the village and the dangers of the woods in the latter is matched by the opposition between the *apparent* safety of the home and the real safety of the hospital in the video drama. Like Little Red Riding Hood, Gabriela undergoes a tragic experience before being saved. In Perrault's version of the classic tale, the wolf emerges victorious. The Grimm Brothers, on the other hand, changed this ending (a hunter who kills the wolf is both Helper and Hero, like doctors and health workers in "Heed the messages"), and even wrote a sequel where the girl and the grandmother trapped another wolf. As we have seen, the creators of the video drama have built these different endings within the same narration.

The opposition between traditional Belief and medical Knowledge is further reinforced in the epilogue of the first episode through a close shot of a doctor's arm examining a heavily swollen woman's foot on a hospital or primary care unit bed, while a voice in off labels the hidden enemy and lets us know it is the leading cause of maternal death in Mexico, and the heavy percussion keeps pounding from the soundtrack -a redundant ground[119] that leaves no doubt about the severity of the threat. This shot not only indexes the presence of a doctor: it shows him at work. The vector of his arm drives the action, as much as the vector in the doctor's gaze and arm drove it on the front panel of the Carnet. He has direct agency as a Helper, and so do the health workers who rush inside the room when Gabriela has her seizure and later the nurse who weighs and measures her, and checks her blood pressure. He also has agency as an expert, which we know because we learn about pre-eclampsia from the Speaker while the doctor is on screen -this becomes all the more clear in the "male doctor" scene that comes in later in the narration. This power to explain, to speak numbers, to show them on screen, and to reveal the true nature of an unseen evil reveals another fundamental premise of scientific discourse: the "special truth" of scientific knowledge, "available only to those who have mastered the intricacies of scientific-technical discourse and practices that are often divergent from commonsense beliefs."[120] By way of contrast, we never see any traditional practitioner doing any kind of examination. Parteras and traditional healers are never shown or directly alluded to throughout the narration. The traditional belief system percolates as oral tradition, layers of saying, soft knowledge without empirical connection with the pregnant woman. Moreover, the implied bearer of this knowledge –Jorge's mother- has no direct agency on screen; she does not deliver the message herself but is quoted instead. She does not act, she is not a doer: she is quoted as having said.

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[119] Baldry and Thibault, following van Leeuwen, analyze the use of sound in terms of figure, ground, and field. The figure is the focus of interest (in this case, the voiceover) and it stands out against the ground and the field. The ground provides a context to orient the viewer and to contribute interpersonal evaluation (in this case, the dramatic music). The field is a group of a mbient sounds -the *soundscape*- and is not there to comment on the other semiotic modes or to call the attention of the viewer. Baldry A, Thibault PJ. *Multimodal Transcription and Text Analysis: A Multimedia Toolkit and Coursebook.* London and Oakville, CT: Equinox Publishing Ltd, 2006, p. 212.

[120] Lemke JL 2002, p. 42.

The privileged status of clinical practitioners is further brought to the fore when Jorge sees Gabriela violently shaking from head to toes, and after a first instinctive –and futile- reaction to protect her, runs to the door and shouts towards the next room: "Doctor! Doctor!" He does not call out for a nurse or for any other health worker, but he summons the expert, the authorized healer, the most "qualified provider" from safe motherhood discourse. It is a powerful, climatic *mise-en-scéne*[121], a dynamic construal of the opposition between Belief and Knowledge. Through a single medium shot that keeps the illusion of objectivity –the camera never zooms in on the participants- the film reveals the true face of the hidden evil and warns about the consequences of following traditional beliefs when faced with this formidable foe.

What happens within the frame is important here, but so is what lies out of sight, in the indexed space of the government health centre.[122] Jorge and Gabriela are alone and helpless in a closed –one could even say oppressive- room with little light[123], while the soundtrack blends the distant, desperate sound of his voice, the dramatic musical score, and the rattling of the metal structure of the stretcher in such a way that none of them prevails; but the mix highlights the gravity, isolation, and helplessness of the situation – and the ultimate failure of the Belief system to give a valid response. Faced with the unsettling view of his wife in convulsive spasms, and unable to protect her, Jorge turns around, opens the door and shouts to the next room: "Doctor! Doctor!" At a symbolic level, we can see his need to break away from tradition and to seek for help from

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[121] Mise-en-scène involves both *what* is put before the camera and *how* it presented (dramatized, photographed, etc.). According to Barsam, this concept "generally denotes the total arrangement of settings, costumes, lighting, sound, and acting –everything you see and hear on the screen, from frame to frame." Barsam R 2004, p. 122.

[122] Open frame is used to create tension between onscreen and off-screen space. Ibid, p. 128.

[123] From a clinical perspective, one could say that this is to avoid excessive visual and sonic stimulation to the sick woman, but close semiotic analysis of the full scene shows that there is meaning making intention in the dim lighting of the room. Also from a clinical standpoint, it would not be sound practice to leave a patient with Gabriela's symptoms alone, as a health practitioner who works in a third-level hospital specialized in obstetric emergencies in Chilpancingo pointed out: "*Una señora no se debe dejar nunca sola en una camilla. Mira, otro error medico [...] Si esa paciente se cayó, tuvo un traumatismo craneoencefálico [...] pero aquí, en este momento, ella tiene gran dificultad para respirar. En este momento, sí, ella se puede ahogar.*" This supports the reading of low lighting as a meaning-making device. Unintentional exposure of medical practice does not escape the trained eye. Two medical practitioners also noted that Gabriela should have been given intravenous therapy upon arrival at the health centre, a basic measure to stabilize the patient's vital signs. These observations point to medical malpractice, a key concern among public health officials and a major textual omission regarding maternal death in Mexico.

"qualified health providers". These helping hands are beyond the isolated environment of soothsaying and misconceptions. When the door opens, light comes into the darkened room together with the health workers, and we can glimpse –due to use of soft-focus- the archetypical wall of a health care centre in the background, where the word "Salud" stands out on a panel with otherwise fuzzy text. It is too late, though, as the image cuts to a close shot of Jorge consumed by anguish –and guilt- against a fuzzy, distant beam of light reflecting on the wall in the next room.

The use of open frame[124] in the extended shot contributes to the dramatic tension, because we know that help lies outside the closed room and we hope Jorge will open it sooner rather than later.[125] But the open frame is also functional to the staging of the opposition between Belief and Knowledge. When Jorge opens the door –and the frame- to call out for the doctor, he is calling out to a different view of the world, and when the health workers burst in, they bring this warning about pregnancy and its perils –and we learn the steep price of heeding the wrong experts in matters of life and death.

Here, there is an underlying assumption that many indigenous women will consult traditional healers and parteras, sometimes before seeing the doctor and often on a parallel track -which is confirmed by data from interviews in Xochis.[126] These indigenous experts operate within the traditional belief system. Their explanations, their advice, and their actions do not always adjust to government and biomedical rationality and expectations. Many of them treat symptoms of pre-eclampsia –sometimes eve seizures- before referring women to clinical practitioners and government health facilities. The

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[124] Open frames allow people and things to enter and leave. They are common semiotic devices in realistic films, because the frame is "a window on the world, a window that provides many views". On the other hand, neither characters nor objects enter or leave closed frames. Barsam R 2004, p. 128.

[125] This is a way to ratchet up suspense in a climatic scene and to get the viewer's attention for the moral and educational component in the epilogue. As Kincaid points out, uncertainty keeps the audience emotionally involved. "A good story," says the author, "is balanced between two equally plausible outcomes: what the audience hopes will happen and what it fears might happen." Kincaid DL 2002, p. 138.

[126] As it becomes clear from in-depth interviews, many indigenous women inhabit both explanatory and healing systems –the traditional and the biomedical- as do many healers. They all move within complex networks of references and mediations, where concepts from both worlds have an uneasy coexistence. While it is not my purpose to delve deeper into these dynamics, it is safe to argue that not all women stay at home and downplay their suffering. Many of them go to see the doctor; others seek the advice of healers and parteras; a great number do both.

government has made a great effort to reach out to these traditional practitioners and convince them –through a mix of education, persuasion, and coercion- to immediately refer pregnant women with symptoms like the ones described in the video drama. The video addresses this unnamed –but all too important- reality by highlighting the need to "heed" the right experts and seek their care. Once again, Jorge voices this opposition – and he acts as a role model- when he emphatically tells Gabriela that they will go to the health centre. None of them ever mentions parteras or traditional healers, and this rhetorical device keeps the confrontation under wraps.

The text offers an alternative worldview by naming the "real" cause of Gabriela's ailments and explaining the complex chain of physiological events involved in the process (particularly in the consultation scene with the male doctor). Labelling the disease with new names –pre-eclampsia- has the power of staking out a semantic foothold –a *concrete* discursive entity that we see unfolding on screen- in a world where people talk of, and believe in, *antojo*, *coraje*, *espanto*, and loss of the *nahual* or *tono*.[127]

The long, grim "Seizure" sequence engages indigenous discourses of maternal health at yet another levels. As discussed in the opening chapters, many indigenous women are reluctant to give birth in hospitals for a host of reasons, including the perception that pregnant women die in institutional settings.[128] The video film shows that Gabriela dies

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[127] During fieldwork, I witnessed several examples of this eagerness to offer a reinterpretation of traditional beliefs. One of these episodes happened during the intercultural design workshop for the MNH Project, in October 2007, in Acapulco. Amuzgo participants described what they thought happened when people lost the nahual or tono, and they explained how traditional healers would try to recover it. Upon hearing this, a clinical practitioner who worked in a third-level hospital in Chilpancingo quickly modified his Power Point presentation about pre-eclampsia and eclampsia and told the Amuzgo members of the audience: "*Nosotros creemos que lo que ustedes llaman pérdida de tono es esta enfermedad*", and he went on to show images of gravelly ill eclampsia patients in intensive care. "*Y cuando las mujeres tienen esta enfermedad, sólo se las puede salvar en un hospital, y lo mismo pasa con el bebé.*" A medical anthropologist who was also present answered by pointing to the different nature of both ailments: *"El tono es más bien una cuestión anímica, y usted habla de una cuestión fisiológica."* Coronado offers a similar example from Cuetzalan, in Puebla, where a hospital doctor said regarding cultural syndromes: "Es importante que uno los conozca explicarles y *hacerles ver* que algunas enfermedades *que ellos dicen* que es susto, empacho, tienen *otra curación.*" Coronado Suzán G 2003, p. 340.

[128] Public health stats bear somehow bear out these perceptions. As of October 2007, according to public health officials in Chilpancingo, 50% of maternal deaths at state level happened in hospitals, 15% during transportation, and 25% in the home. The number of hospital deaths had increased from previous years, which my sources said was partly due to the increase of arrivals in dire conditions. "*Eso también pasa porque llegan más, aunque no lleguen en buenas condiciones.*"

not because of what happens in the health centre or in the hospital, but *because she did not go there early enough.* In other words, by remaining in the private sphere of her home and the public sphere of traditional discourses on pregnancy and childbirth, she renders the public biomedical system helpless and puts herself and her baby in harm's way. It is the lack of institutional control that dooms her pregnancy.

However, this construal of maternal death from eclampsia glosses over the sticky issue of medical malpractice. As I mentioned above, this was a major concern for health officials in Chilpancingo, who had made another video for training purposes, based on standard procedures to handle obstetric complications. A government official said in this regard:

> [...] porque en muchas ocasiones el marido hizo lo correcto, el del centro de salud hizo lo correcto, y llegan al hospital y en el hospital no se hace lo correcto. Esto es importante. O sea porque pudo haber llegado la señora con mucha sangre perdida y si no haces esto en el hospital, que nos ha pasado, se muere en el hospital. Es por eso que se le enseñó esto es a la gente que está en los hospitales, la gente que le llega que sepa cómo debe manejarla.

Of course, it could be argued that educational videos targeting pregnant women and their husbands should focus on raising awareness about things the spouses can do to prevent women and children from dying –after all, this is not a documentary about maternal mortality in Mexico. But the heavy-handed discursive presence of guilt, blame, and spousal responsibility in "Heed the messages" raises serious ethical concerns vis-à-vis the silenced reality of biomedical malpractice.

When we go back to Jorge and Gabriela talking in the backyard, at the beginning of the second episode, the original exchange moves in a different direction and takes on a different meaning:

> **Jorge** (leaning forward towards her, stressing his words, encouraging her to speak): *No* te sientes *bien*, ¿verdad?
> **Gabriela** (shakes her head, looking towards the floor; then looks at him with a smile in her face; she speaks with a mix of muted reassurance and resignation): ¡Ay, Jorge! No es

nada. Sólo es el *cansancio*. Hasta tu mamá dice que son los *achaques* del embarazo, que se pasan *pronto*.

Jorge (leaning towards her and emphasizing his words): Con la *salud* no se *juega*

Gabriela: En *este* momento nos vamos al (additional emphasis) *Centro* de Salud.

Gabriela: No, está muy lejos. Y si nos vamos, ¿quién va a cuidar a los animalitos?

Jorge (again, leaning towards her and stressing his words): Yo prefiero cuidarte *a ti*... (caressing her belly and adding tenderness to his voice) *y al Jorgito*.

Gabriela: (Giggles and leans closer as she corrects him)... ¡*A la Gabrielita*![129]

[Jorge caresses her belly, while he holds her hand, and kisses her in the forehead, while she looks down again. Soft piano chords transition to the next sequence, which takes place in the waiting room, at the health care centre.]

This time around, Jorge takes an active stance and lets Gabriela know that they are not going to run any risks. He says that he will take her to the health centre and he makes good on his word, in spite of some additional hesitation on her part. His agency is construed with great care, and we see the full semiotic development of his role –together with the role modeling taking place- since the first lines of the exchange, which are now cast in a new light. We can also appreciate how he is construed as the voice of reason that opposes the Belief system. *His agency comes through opposition*, as follows:

-He is the one who encourages Gabriela to speak and tell him how she really feels –we know from previous scenes that she has been putting a smile while keeping at her chores, but she does not feel well. The way he does it carries additional weight. When he says "¿*No* te sientes bien, ¿*verdad*?," the thematic placement of the nuclear accent on *No* makes it a given, something he takes for granted. He *knows* she is not feeling well, and so does the audience. The rhetorical question at the end of his overture -*¿verdad?*-, delivered with empathetic manner and soft tone, conveys the idea that something is left hidden or unsaid. The opposition begins to unfold.

[129] When first Jorge and then Gabriela touch her womb and name the expected child with a diminutive, the text deictically signals the presence of another human being –a child to boot- who is, and should be, the object of as much attention and care as the mother. This may reflect the Speaker's assumption that parents, at least among the target audience, consider the foetus as a human being. It may also indicate that they *should* see the foetus in this light. This second reading connects the text with a fairly extended belief, at least among health staff in the region, that indigenous parents value the life of the mother more than the life of the foetus or the newborn. I elaborate on this point below.

-When Gabriela answers, she starts out by shaking her head and looking down, and then she stares at him an begins with a common interjection, "¡Ay, Jorge!", all of which indicates her conflicting emotions. We immediately confirm something is going on because she makes reference to *his* mother as the source of the commonsense belief guiding her reading of the strange symptoms that she feels. We can infer from her compliance that she does not want to disrupt traditional familial ways. The opposition is laid out. The experiential meaning from this reported order of discourse is interpersonally highlighted by nuclear accents on *nada, cansancio*, *achaques*, and *pronto*. The opposition is expanded to include some key misconceptions, from a biomedical reading of the same symptoms: that nothing serious is going on, that she feels like this because she is tired, that these are common ailments when a woman is pregnant, and that they will soon pass.

-He immediately states his opposition with a common metaphoric expression from Spanish –"*Con la salud no se juega*"- which has also become an oft-repeated slogan in medical consultation and in public health campaigns across the Spanish speaking world. With the same emphasis, and leaning towards her, he adds: "En *este* momento nos vamos al *Centro* de Salud," bringing into the conversation other crucial components of safe motherhood discourse: whenever in doubt, you should seek assistance from qualified health personnel. This assistance supposedly lies outside the traditional belief system.[130] Hence, the opposition is fully articulated through negative reinforcement of the subjective norm –that is, encouraging Jorge's deviation from the traditional interpretation of events, particularly when this reading comes from his mother.

-When Gabriela answers, she introduces two reasons, frequently mentioned in the literature, in dialogue with social workers, and in medical consultation, why indigenous women avoid going to government health centres and hospitals: long distances and

[130] Here, too, data from the MNH Project baseline survey shows an oversimplified view of people's attitudes and behaviours. Some 60% of husbands, mothers, and mothers-in-law said the doctor should be the first one to assist a pregnant woman facing complications from pregnancy, while 35% on average said they should see the partera first. However, the question does not mention specific complications, nor do the answers let us know what people construe from that expression or what they themselves would define as complications.

household chores –in this case, the latter related to tending domestic animals that contribute to the household economy. His answer –"Yo prefiero cuidarte a *tí*, y al *Jorgito*", he says as he leans towards her and puts his hand on her womb- confronts this reported discourse and further expands the safe motherhood argument to include the care of the mother and the child. In doing so, it offers a role model, a cost-benefit calculation, and a hierarchy of values –all of which reveals the underlying assumption that people in the communities may think and prioritize otherwise. This confrontation is deepened later in the story, when Jorge says that he was not able to bring Gabriela earlier for consultation because "we live far from here", and the doctor dismisses his explanation as a excuse –rather, as not enough reason for a delay. This implies that the authors of the video have underplayed the role of structural material circumstances hindering maternal outcomes among the most disadvantaged population groups in Mexico.

-There is yet another likely, implicit dialogue taking place when Jorge encourages Gabriela to be frank about her ailments and later takes her to the health centre in spite of her resistance. By doing this, the creators of the video film also seem to work on the assumption that indigenous women tend to conceal their suffering because they do not want to appear weak or frail in front of their men. A medical practitioner working in a third-level maternal health hospital in Chilpancingo reflected on this topic during our interview:

> Ahora, yo estoy seguro, sin hacer investigación, que muchas mujeres no le informan al marido que hay algún problema porque en las comunidades se acostumbra ... al marido le chocan las mujeres enfermizas, ¿no?... porque trabajé en comunidad, sé cómo son las señoras.

From a rhetorical standpoint, the text features the opposition between Belief and Knowledge without openly declaring "war" on the traditional and familial orders of discourse.[131] Instead, it opens a rift *within* these realms, co-opting the husband as an ally

[131] The use of Jorge's mother as the Opponent is also an interdiscursive reference to the world of telenovelas. Doraluz Vargas, editor of TV y Novela magazine, is quoted by Matelski as saying: "The themes [of telenovelas] are timeless [...] It's about the love between a man and a woman and the problems

and fostering the unity of the couple over the extended family in terms of decision-making –a major discursive implication at the level of sociocultural practices in rural Mexico.[132] This interpretation becomes all the more plausible when we consider potential alternatives. For instance, the scriptwriters could have featured the mother-in-law as an ally and the husband as an opponent; but this would have staged a conflict between the spouses and *between the husbands and the public health system.* From the actual textual choices, it is all too clear that the makers of video are trying to establish an alliance of power and solidarity by shoring up existing power structures –male dominance- and proposing an alternative model of decision making –spousal-centred- in the traditional and familial orders of discourse.

The "muffled" opposition between Belief and Knowledge –a confrontation, indeed- is staged at other key moments of the story. One of them occurs towards the end, while we see Gabriela and her comadre watching the ultrasound image of the baby and laughing together. Here, as in the first epilogue, the Speaker steps in, as a female voice in off directly addresses the viewer:

> Tu salud y la de tu bebé están en tus manos. Tienes que cuidarte durante tu embarazo, tu parto y los cuarenta días después de dar a luz. Que te duela la cabeza *no es normal.* Que se te hinchen la cara, las manos, los pies, *no es normal.* Si te mareas, ves lucecitas o escuchas zumbidos, *no es normal y no se va a pasar.* Lo más seguro es que tengas la presión alta y, probablemente, pre-clampsia. No lo dejes pasar. Ve inmediatamente a tu centro de salud. Hazle caso a tu cuerpo, hazle caso a la vida.

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that they have with their families." Matelski MJ. *Soap Operas Worldwide: Cultural and Serial Realities.* Jefferson, NC: McFarland & Company Inc., Publishers, 1999, p. 9.

[132] From a "realistic perspective", it is unlikely that husbands, in a rural indigenous setting, would make such an immediate decision to seek help from centre without consulting other female members of the family. A health official in Chilpancingo acknowledged as much: *"El marido es un marido que estaba ya sensibilizado y decidió llevarla. No consultaron a nadie más, no le preguntaron a nadie. Digamos, esto es representativo del contexto urbano."* This is another example of de-contextualization of the video drama. However, the discursive implications hold regardless of how accurately the film reflects the circumstances of the target audience or how successful it may be in sparking vicarious identification between male viewers and Jorge's character. Husbands are still engaged as potential allies and encouraged to break with familial sources of knowledge and traditional attitudes.

There are several important things in this paragraph, but I will only focus on the epistrophic repetition[133] of *no es normal* at the end of the third, fourth, and fifth sentences, and the addition of *no se va a pasar* at the end of the latter. Here, the script cohesively pairs the different signs of pre-eclampsia with assertive contradictions of each traditional belief shaping Gabriela's reaction at the beginning of the story. By placing the commonsense assertions at the onset and the adversatives towards the end of the film, after we have witnessed the fallout of the wrong advice, the producers of the video claim the high ground for biomedical knowledge, while avoiding an indictment of indigenous traditions and their bearers, in the context of increasing political talk about intercultural approaches to maternal care.

Also, by shifting from a third-party, impersonal narration of the events to a direct interpellation of the viewer in the second person (informal *Tú*, as in the Carnet), the engineers of the text reinforce the link between what we have seen on screen and the personal experience of pregnant women in the audience. In other words, they *cement* the identification of the viewer with Gabriela. At the same time, they both offer and impose an alternative, authoritative explanation to "heed" the messages of her body.

5.7.2. Private-public, danger-safety, self-control-control

The commonsense advice from Gabriela's mother-in-law is part of the traditional knowledge system that circulates in the *public* sphere of the communities –the traditional order of discourse about motherhood. But there is a crucial difference between the indigenous public sphere and the biomedical public sphere in terms of pregnancy and childbirth. Within the Amuzgo culture –and most indigenous cultures across the Americas-, public control has kept pregnancy and childbirth confined *to the private sphere*. Pregnant women consult with parteras and receive help from elderly women mostly in the privacy of their homes. Familial power dynamics are the managing devices

[133] Epistrophe is a rhetorical figure of repetition that occurs "when the last word or set of words in one sentence in one sentence, clause, or phrase is repeated one or more times at the end of successive sentences, clauses, or phrases." *American Rhetoric: Rhetorical Figures in Sound*. Online speech bank, 2009. Available at http://www.americanrhetoric.com/figures/epistrophe.htm. Accessed October 22, 2009.

that connect public and private realms. Control and self-control happen within the family. This was traditionally considered *the safest way* to handle pregnancy and childbirth. In the biomedical public sphere, a government-run machinery of experts and institutions demand submission to overt, explicit, systematic control in the public sphere. And familial power dynamics are reinforced or subverted, as the video film shows, to better serve the purposes of public government control. One of the most potent ideological implications in "Heed the messages" is related to this realignment of the private and public spheres through the construal of power dynamics within the family and within community life.

Throughout the text, there is a carefully construed multimodal relation of opposition-articulation between private and public spaces, coupled with related polarities (safety versus danger) and complementary dualities (control and self-control) from health risk discourse and safe motherhood discourse. Music is a key element in this construal of risk.

The video film opens with the title –"*Hazle caso a tu cuerpo, hazle caso a la vida*" -in unadorned, white sans-serif capital typeface fading in on a black background. The use of black and white in this opening image conveys a sense of unadorned realism and announces the seriousness of what we are about to watch. At the same time, the sharp contrast of white against black sets the stage for the dualities and confrontations woven into the narrative and the morality tale that lies at its very heart.[134] This effect is co-patterned and accentuated through the musical score. As we read the title, we hear two synthesized dramatic minor chords signalling the presence of danger from the outset, even before the narration starts to unfold -this is the first indication of the "threat" motif that I describe below. The intention is clear: these first few seconds of the video drama tell us *how we should read the text*, that is, *as a confrontation between what is right and what is wrong, what is safe and what is unsafe, and as a warning of all that is at stake.* In

[134] Most film theorists agree on these dramatic uses and likely connotations of black and white in filmmaking, which are particularly salient at a time when the vast majority of movies and telenovelas are shot in other colours. See, for instance, Barsam R 2004, p. 183-185, and Giannetti L. *Understanding movies. 10th edition.* Upper Saddle River, NJ: Pearson-Prentice Hall, 2005, p. 27.

other words, we should "heed" what is going to unfold on screen, because it is related to our body and to our life; and we should "heed" the warning that comes with it.

From a linguistic standpoint, the second person (informal) command in the title links two interlaced clauses with no strict relation of subordination. The thematic positioning of "*hazle caso*" in both clauses provides salience (heeding is the focus of the message), cohesion (your body and your life are connected, so heeding your body is heeding your life), and coherence (the title is a guide to understand the overall text).[135] In fact, the title is not self-contained, since it lacks the semiotic expansion that will come with the narration. In this sense, it is a slogan waiting to unfold. When the film is over, the viewer should be able to make a coherent reading of the text and, hopefully, to activate this meaning each time she sees or hears the slogan, most likely in connection with safe motherhood campaigns. Of course, the viewers will be invited to relate their own experiences to this interpretation –*but not to interpret them on their own.*

As the words of the title fade out, we hear the arpeggio of the guitar emerge from "behind" the opening chords. It is the beginning of what I call the "Harmony" motif[136] slowly gaining salience through volume, and immediately cueing domestic life, as the image fades in on a long shot –gradually zooming in- that shows Jorge and Gabriela's house from the outside, and we hear a rooster crowing and we then see it moving across the yard. It is a playful musical theme in major chords, orchestrated for acoustic guitars and synthesized strings, with a quick tempo, dominance of treble voices, and a rhythmic pattern that evokes a pastoral dance to connote the simple pleasure of family life and the joyful expectation of pregnancy. This theme is alternatively figure and ground when things go well –or rather *seem* to go well- in a private environment.

This musical motif lingers in the sonic foreground through the next shot of Gabriela washing the dishes (we also hear, as a field, the water running from the tap) and through

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[135] I further discuss the meaning and organization of this clause complex on 5.12 below.
[136] A motif is "a distinctive musical passage that is repeated (and varied) throughout a musical text". The motif reinforces and is reinforced by what we see in the images. Kalinak MK. *Settling the score: music and the classical Hollywood film.* Madison, WI: University of Wisconsin Press, 1992, p. 15-16.

a close-up of her relaxed expression of happiness, as she lifts her head and looks outside the kitchen window. The next shot reveals that she is looking at Jorge, who is going about his work in the backyard. The music follows a silent and satisfied Gabriela as she caresses her womb and then appears in the window frame and exchanges tender glances with Jorge, who has taken a break to paint a crib.

It is a minute and ten seconds into this portrayal of domestic bliss that we see Gabriela first wincing in discomfort –still to the dominant sound of the "harmony" theme- and then double in pain while she feeds the poultry. We now hear a disturbing stinger[137] -the irruption of some low-key, ominous music, first through a discordant bass note, then through the low drum and a slowed-down synthesized effect, laid over the arpeggios of the "harmony" motif. It is a disruptive sonic landscape. Both musical themes uneasily coexist for a few seconds, until the editor cuts to the interior of the house and we now see Gabriela, clearly worried and still in pain, trying to fit her shoes in her swollen feet. Here, the "threat" theme gains the foreground for some time, with a pulsing, menacing staccato that seems to accompany her efforts each time she bends down.[138]

The "harmony" motif comes back to the sonic foreground over a close-up of Gaby's arm, leg, and right shoe (which shows the viewer a detail of her struggle), and then over a medium long shot of Gabriela sitting on the bed and giving up on fitting her shoes with a puzzled, concerned expression. But now there is an intermodal contradiction: the music

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[137] Spande R. *The Three Regimes: A Theory of Film Music*. Unpublished essay, 1996. Available at http://robertspande.com/19037.html. Accessed October 26, 2009. The stinger is a typical code in film music, a high-pitch sound that usually signals danger and evil, and goes with sudden changes in the narrative. Here, the stinger underscores the presence of alarm signs and symptoms. Like in a horror movie, it lets us know that there is a hidden threat and that we should be worried. Once introduced, the stinger not only startles us, but it also symbolizes the fear and threat posed by the evil force, in this case, the disease - and thus becomes a development of the "threat" theme. "The stinger," says the author, is a direct representation of the action on the screen by the music. The action is scary = the music is scary." Because we know that the authors of the video want to warn their target audience about potentially harmful commonsense explanations of pregnancy ailments, we can read the equation in the opposite direction: *we hear scary music because we should interpret the action as scary, as something we should worry about.* This is an obvious but very important device for a video film aiming to warn illiterate people about the danger lurking in their own bodies and daily lives.

[138] The "threat" motif prepares us to expect narrative (and real life) complications behind the appearance of normality -in the diegetic space, it tells us that those complications are already there. It is a signal that points to other signals. It is also the motif of Evil-The Enemy itself. If anything, viewers have to be able to make this identification, and so they are cued with maximum redundancy.

talks of harmony, while actions, gestures and expressions all indicate that something is wrong. What is going on? The multimodal device is warning us that danger lurks behind the apparent safety of a private pregnancy, confined to the intimacy of our homes, and the peaceful appearance of everyday life.[139] This hidden danger, this evil presence, can shatter our dreams and illusions, and rob us of our future, fully embodied in Gabriela's pregnancy and further symbolized through images of Jorge working on his child's crib.[140]

This binary opposition is sustained along the two episodes of the film, through a multimodal approach where the melodramatic use of musical codes (typical of mainstream movies and telenovelas)[141] plays a fundamental role, both to create mood and to anchor narrative developments.[142] The interlocked pattern of "threat" and "harmony" dominates the first episode, with heavy percussion pounding as the danger becomes more evident, at the end of the lunch scene, until it reaches an unsettling crescendo when the evil force takes over in the shape of seizures at the health centre. The heightened percussion pattern –a stinger again- keeps anchoring the narration through the "rewinding" sequence and commenting on these images with a rhythmic accent on each

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[139] Seale says this is a common trait in media portrayal of health threats: "The incapacity of ordinary people to predict or control such threats or resist such evil is emphasized by these devices that contrast the ordinary experience of security and routine goodness with sudden episodes of devastation or wickedness at its most extreme." Seale C 2002, p. 33.

[140] This melodramatic multimodal warning device is in keeping with standard health story form in the media. As Seale points out: "The goodness or innocence of the threatened person is contrasted with the sheer malignance of some enemy, whose evil must be beyond understanding [...] The incapacity of ordinary people to predict or control such threats or resist such evil is emphasized by these devices that contrast the ordinary experience of security and routine goodness with sudden episodes of devastation or wickedness at its most extreme". Seale C 2002, p. 33.

[141] The contrasting sounds of "harmony" and "threat" are overemphasized. In the "harmony" motif, the first and last notes in the tonal chord of the melody are played with upward glissando towards a slightly higher pitch. This is set off against the low pitch of the bass and the drum in the "threat" theme, where the synthesized figure is slowed down artificially to increase the contrast and convey this sense of looming peril. This effect pulls us back and brings us down, as domestic life, represented by the "harmony" motif, struggles to keep going as usual. Kalinak explains this effect in her analysis of Bernard Hermanns' score for Vertigo's main title sequence, where the composer combines the effect of high and low pitch to create "dis-ease" in the listener. Kalinak MK 1992, p. 12.

[142] These conventions are powerful meaning-making tools, especially when the creators of a text want to orient the reading in a way that makes no room for alternative interpretations, as is the case here. Kalinak says in this regard: "A musical convention harnesses musical affect to specific and concrete meaning through the power of association. Musical conventions which become ingrained and universal in a culture function as a type of collective experience, activating particular and predictable responses [...] Composers [...] use familiar conventions to establish geographic place and historical time, and to summon up specific emotional responses predictably and quickly." Ibid, p. 12.

individual scene. An accompanying, still murky synthesized figure then transitions to the first dialogue between Jorge and Gabriela, where the second episode starts.

From this point on, the musical elements are realigned in a different way, as Jorge and Gabriela take an entirely different path. A third motif gently transitions from the moment that Jorge kisses Gabriela, at the end of their conversation in the backyard, to the first images of the couple at the health centre. This is a soft, low-tempo, descending piano figure that gradually but unobtrusively expands with a lush synthesized string arrangement, soothing our anxiety, while we see first Jorge and later Victoria trying to reassure Gaby that everything is going to go well. There is still a certain tension, because Gabriela is still suffering, but we somehow know –there are many hints, including the music-[143] that things will be different this time around. The spouses are in a safe environment and will soon be under proper –and timely- care. Everything is now getting under control. I call this third motif the "Control" theme. There is a minimal, vaguely menacing synthesized chord that returns for a second or so in this second episode, after the nurse asks Gabriela to give her a urine sample and tells her that she will now refer her to the doctor; as if to remind us that we cannot yet release the tension; but it is a faint echo of the "threat" theme and it does not carry enough weight to undermine a perception of safety and skilled care.

In the last part of the second episode, there is a reframing of the interaction between the public-private polarity and the notions of safety, control and self-control. When Gabriela's health is restored at the hospital, we witness a partial outcome –a partial restoration, both in dramatic and medical terms. But the story is far from over: there is a long road (four months of pregnancy) before the ideal resolution –and this is an outcome that we cannot take for granted, as the multimodal device lets us know.

[143] The moral of the first episode is that the tragedy could have been averted had Jorge and Gaby heeded the messages of her body and done the right thing, because most maternal deaths can be averted "if timely action is taken". We then see the rewinding of the images back to the crossroads where now Jorge decides to take Gabriela to the health centre. At the level of the logical metafunction, we are already prompted to expect a different turn of events, since it would not make any sense to see the same outcome twice.

The "control" motif reappears to contribute emphasis and cohesion to a powerful sequence of medicalized care that covers four months in Gabriela's pregnancy.[144] This hushed musical theme starts at the end of the scene where the male doctor tells Jorge and Gabriela "*No se preocupen, nosotros vamos a ayudarlos... Estamos a tiempo*". The same music then becomes a sonic figure over images of Gabriela undergoing ultrasound, and it stays in the sonic background when she talks with a female doctor during a follow-up visit three months later. During this conversation, Gaby gets good news about her own health and the health of her baby, and she reveals that her symptoms have been remitting. We can also infer that she has been taking her medicine to reduce her blood pressure as indicated; we learn that she will have to keep taking the pills because "the risk is not over yet"; and we know (from Gaby's gesture of scolded child) that she will do as she is told.

The "control" motif gives way to a mid-tempo pop figure dominated by the rhythm section (no threatening low bass this time), and later reinforced with synthesized voices in staccato, when Gaby gets the ultrasound image of her baby and stares at it, first in amazement –she is still at the hospital- and then overcome with joy while she lies in bed at home. This fourth musical theme, which comes on the heels of the doctor's warning about lingering risk and her request for Gaby to be "very alert" and to look after herself, keeps playing over the ultrasound image of Gabriela's baby and shots of Jorge sweeping the floor and later talking with their comadre, who enters the house to pay a visit and bring a meal she has been cooking. I call this fourth motif the "Watchful Care" theme, as it covers a narrative segment involving medicalized control, individual self-control, and spousal and familial solidarity (in this case, through the extended system of comadrazgo).

Finally, the "harmony" motif returns as the focus of interest while Gabriela and her comadre joyfully chat while they look at the ultrasound image of Gaby's baby. The music then yields the figure to the voice-over and provides interpersonal evaluation from the background, as we hear the moral of the story. When the narrator says: "*Hazle caso a tu*

[144] From her conversation with the nurse, we learn that she is in the fifth month of her pregnancy when she goes for help at the health centre; later, the female doctor at the hospital tells her that the baby has "the correct size for his eight months". Shortly after this consultation, Jorge tells their comadre: "el chamaco ya nace en esta semana."

cuerpo, hazle caso a la vida", we see a close-up of Gaby's newborn, and the music stands out once again, while the nurse gives the baby to Jorge and he looks down in ecstasy and then up with utter joy and thankfulness. The "harmony" theme, the undisputed sonic figure at this point, is now also the music of "restoration" –no longer at home, but in the public hallways of the hospital, where intimacy and safety are implied to coexist, as they did in the controlled and self-controlled environment of their last four months of pregnancy, both in public and private settings. This time, our heroes followed the rules, trusted the bearers of true knowledge and received their reward.

Key participant roles take on particular meanings when we place them in the context of this opposition and articulation between private and public spheres. Jorge's case is the outmost example of these shifts. In the second episode of the story, he takes initiative on the home front (opposing the traditional belief system and Gabriela's own views, taking her to the health centre, and later helping out with the house chores), but he is submissive in the public sphere of the health centre and the hospital (where he is alternatively portrayed as helpless, sheepish, obedient, repentant, and grateful). Precisely because of this active stance in the private sphere and his submission to public biomedical control, he is proposed as a role model.

In the context of the private/public framewok, we can draw an intertextual connection between the shot of Gabriela lying in her bed and staring at the ultrasound image of her baby, at the beginning of the "Self-control and solidarity" sequence, and the photograph on the front panel of the hospital version of the Carnet. At first sight, there are key textual differences. The image of Gabriela is a medium close shot, in oblique angle to the narrative vector following her gaze to the ultrasound photo. This creates some distance between the viewer and the represented world, but not enough detachment to pull us out of it. We are involved onlookers, as is happens through most of the film. The image is rendered in a naturalistic style and visual collocation of non-participant elements clearly denotes the immediate environment: Gabriela is in her own home.[145] On the other hand,

[145] See Appendix C, p. 578, and/or Appendix F (CD), image 8, for a more detailed multimodal description of this shot.

the picture in the Carnet is an extreme close-up of a recent mother and her newborn.[146] Through low modality, the designers have blurred the image of the participants and have excluded all other elements from the immediate context, thus rendering a timeless archetype rather than a specific moment in the life of two people with names and personal circumstances. This manipulation projects an idealized notion of privacy and intimacy in an institutional setting –from the overall textual context, we know the woman has given birth in a hospital.

However, the two images have much meaning in common. Experientially, they both refer to the same type of participants. We can connect Gabriela, a soon-to-be mother, with the recent mother on the Carnet; and there is a cohesive link between Gabriela's protruding abdomen, the ultrasound image of her child, and the newborn lying next to his mother on the front panel of the Carnet. Both Gabriela and the woman in the photograph are engaged in behavioural and mental processes (lying down; gazing; feeling safe, satisfied, in love with their children). The woman on the Carnet is construed as if she and her baby had the kind of intimacy associated with the privacy of the home. Gabriela and her unborn are in the home, but, as we know, under close medical watch. Both women are getting the skilled care they need. We can even draw a sequential articulation between the two images: Gabriela is framed in a context of self-control, institutional surveillance, and spousal and microsocial solidarity in the last week of her pregnancy. She has her child (and the responsibility for his/her life) in her hands. She has not yet delivered, but she feels confident and safe. The woman in the Carnet has safely had her child, and their relaxed, intimate communion is the result of her submission to medical care. She may as well *be* Gabriela, safely conjoined with her baby after birth. (There is a common absence, too, since both texts gloss over the critical stage of delivery in a hospital setting.) In sum, both images project a "natural" non-traumatic articulation between private and public pregnancy, control and self-control, in a medicalized continuum of care.

[146] See chapter 4.11 above for a detailed analysis of this image.

5.8. Engaging and co-opting traditional orders of discourse

There are other meaningful intertextual and interdiscursive links that reveal a "dialogue" with the orders of discourse of religion, traditional health care, family and everyday life. It is a highly engineered dialogue, where the authors of the video select bits and pieces of traditional orders of discourse to co-opt or contradict these domains, according to their goals. Here are some relevant examples from the film.

Halfway through the "Self-control and solidarity" sequence, we see Jorge carefully sweeping the floor while Gaby is resting in bed. Their comadre walks into the house with a pot in her hand and shows her surprise: "¡Ooora, ¿tú ya eres *mandilón*?",[147] she pokes fun at him, in a clear intertextual allusion to popular stereotypes of manly posturing in a social environment dominated by patriarchal structures and behaviours.[148] When someone acts as a mandilón, he is not confirming to traditional gender roles and expectations. Mandilones, in short, are the opposite of machos. Of course, the comadre is teasing Jorge; but the authors of the text use her to engage this discourse and to construe a counter-discourse of spousal solidarity. It is a delicate balancing act at the level of sociocultural practices, since the text proposes an alternative model of manly behaviour, but at the same time it co-opts the idea of male leadership when it hails Jorge as a hero for taking Gabriela to the health centre against her own wish and his mother's beliefs.

However, the melodramatic, overstated portrayal of Jorge's character, his teary eyes, childish expressions, and, most of all, the way he shows outward emotions and affection for his wife, does not reflect the micro-social reality of Xochis, where men are kept to themselves and rarely if ever engage in the kind of verbal and physical tenderness we see in the video drama –let alone in front of other people, as it happens in the presence of the

[147] In Mexico, the expression "mandilón" refers to a henpecked husband.
[148] Indeed, sweeping floors is not something a man would likely do in Xochis, regardless of ethnic identity. To this day, this is typically a woman's chore. If anyone is going to do it for a pregnant woman, it will be her mother, her mother-in-law, her comadre, or another female relative or friend.

male doctor in this scene. As a man, Jorge is out of context in Xochis –and so may be the melodramatic role-modelling strategy of the film.[149]

The single most interesting use of intertextuality happens later during the same dialogue between Jorge and his comadre (I have italicized verbally accentuated expressions):

> **Comadre** (entering the frame and the house through the door, showing an expression of surprise): ¡*Ooora*... ¿Tú ya eres *mandilón*?
> **Jorge** (holding his broom while he speaks): ¿*Qué pasó*, comadre? En vez de estarme criticando, debería *felicitarme*, porque la Gaby y el bebé ya están *retebien* (he sighs in relief). El chamaco ya nace en esta semana, con el favor de *Dios*...
> **Comadre** (interrupting him and adding emphasis with her right index finger): ... Con el favor de Dios y de *usted*, que también ha *cuidado* a mi comadre. Imagínese que no la *lleva* al *hospital*... capaz que ni la *cuenta*. Ahora sí que como dice el dicho (she gets more emphatic as she wiggles her finger), "*Ayúdate* que Dios te *ayudará*"... Aquí le traigo este guisado para que... (She tries to give the pot to Jorge, but she hits the broom with it. Jorge lets go of the broom and grabs the pot)... no se preocupe de *cocinar*. (She walks forward, toward the camera and Gabriela, while Jorge goes towards the kitchen).

The use of the popular saying "*Ayúdate que Dios te ayudará*" (Help yourself and God with help you along the way), emphatically delivered by a key Helper from the traditional environment, reveals an attempt to articulate alliance and opposition, power and solidarity. On the one hand, it projects the popular idea that God has a bearing on individual health outcomes. On the other, it implies that individual agency can –and must- make a difference. In fact, this popular saying is construed as a two-clause complex where "Ayúdate" is the main clause and "que Dios te ayudará" the subordinate clause that makes God's help dependent on self-help -one could also state, in negative terms: *Si no te ayudas, Dios no te ayudará*. One way or another, the meaning is clear: *There is no*

[149] As Barsam points out, "both cinematic conventions and individual experiences play significant roles in shaping the 'reality' depicted by films." Barsam R 2004, p. 32.

pre-scripted destiny when it comes to maternal health. People who take timely action can make a difference, even when faced with extremely dangerous complications.

Interpersonally, this reading sums up the moral of the story before we hear it from the voice-over during the epilogue. When she speaks, the comadre stresses -through inflexion and accentuation- the words "Usted", "hospital", "cuenta", "ayúdate" and "ayudará". We can read at least four of these five words in terms of agency and responsibility, control and self-control. By correcting Jorge's appreciation that Gabriela and the baby are fine "*con el favor de Dios*", and adding deictic stress to the pronoun *Usted* -the comadre accentuates the delivery of the word and points her index finger to Jorge-, the text places Jorge's agency as the New and makes it even more important than God's participation in the events, which are the Given. This is very relevant for meaning making, both in the context of the linguistic content of the exchange and what the text assumes as widespread, long-held beliefs about maternal health in traditional environments.

The closing shots in the last scene of the film take up this intertextual reference to the orders of discourse of religion and commonsense. Kinesic resources and gaze are of the essence here. We see Jorge cradling and kissing his newborn, and looking alternatively at the baby and at an indeterminate, higher off-screen point. All of his face shows an emphatic, reverential, almost childish expression that combines tenderness, delight, and gratitude. The first time he looks up, he briefly and gently shakes his head, smiles, and utters what looks like a silent "*gracias*". Jorge is thanking God for the outcome, but we know through cataphorical reference (his conversation with their comadre) that this is also the result of his agency in seeking skilled care.

Next, the comadre exhorts Jorge to imagine what could have happened if he did not take Gabriela to the hospital. There is a double layer of meaning here. The first one connects the word "hospital" with Jorge's actions –which made his participation equally or even more important than God's favour. The subordinated clause in the second sentence –*si no*

la lleva al hospital-, is an essential extension[150] not only of the first clause in that sentence *–Imagínese-*, but of the previous sentence, where she praises him for taking care of Gabriela. In other words, she commends him for having taken her to the hospital (and not only to the health centre). The writer of the text could have avoided this extension, but they wanted to make sure that this crucial point –this "new" New- would get across to the audience: that taking care of Gabriela, in the emergency, meant taking her to the hospital. It's only then that his agency is spelled out in the text. A chain of causes and responsibilities for the expected outcome now becomes clearer: Hospital (including experts and technology) + Jorge (a rewarded hero who followed the biomedical rules and trusted the right experts) + (God) = Safe Gaby + Baby. *If you heed the right experts and you act as they suggest, God will lend you a hand.*

But the second layer of meaning is even more important. When the comadre exhorts Jorge to imagine what might have happened if he did not take Gaby to the hospital, she is cataphorically leading the audience to *remember* –not to imaging- what indeed happened in the first episode –or the first version- of the story. A case of implicit multimodal cohesion occurs here, linking the illocutionary act in the comadre's utterance to the visuals, the sounds, and the explanations in the first part of the film. This implicit meaning refers to the mutual knowledge that the members of the audience now share with the Speaker. This textual macro-connection between different parts of the text realizes the awareness-raising dimension of health risk discourse, from a logical, experiential, and interpersonal perspective. It is a logical connection because it allows the viewer to connect with previous events in the text, in terms of cause and effect. It is experiential because it triggers images that will let us know what the text is talking about. And it is interpersonal because it involves the viewer through a "displaced" directive. On the surface, it is Jorge who has to imagine what could have happened; below the surface, it is each individual viewer who is being interpellated through the comadre's words.

[150] In systemic linguistics, an extension occurs when "one clause extends the meaning of another by adding something new to it." Halliday MAK, Matthiessen CMIM 2004, p. 405.

The manipulation of the text at this point also reveals a typical trait of health risk communication. The comadre says to Jorge: *Imagínese si no la lleva al hospital... capaz que ni la cuenta...* The third clause, *capaz que ni la cuenta* ("she might not have lived to tell it") is built around the phonetic stress on "*cuenta*" and the interpersonal evaluation (hedging) in "*capaz que*", which takes some distance with the eventual outcome of a different behaviour. Of course, this is perfectly justified within the context of a self-enclosed second version of the story; after all, Gabriela *is* alive and well. From a logical perspective, it makes sense for the comadre to speak to Jorge in such manner. She is only highlighting the importance of his actions. Moreover, the phrasing of the outcome in terms of a "possibility" ("*capaz que...*") is in keeping with epidemiological risk discourse, where maternal and foetal death are *associated with* eclampsia -but not the necessary outcome of the disease. Nevertheless, we –the audience- have already been exposed to the worst-case scenario, since the multimodal device leads us to think that Gabriela dies at the end of the first version. So, when the comadre says "*capaz que no la cuenta*", and she puts the stress on "*cuenta*", the intratextual reference functions as an expansion of the first two clauses, lest we forget what *actually* happened when Jorge did not take Gabriela to the hospital. It is in this triangulation between what the comadre says to Jorge and what the audience has seen and heard that the low evaluation of the "possible" outcome turns into something different, something "likely" and even "almost certain" to occur.[151] Once again, the fear appeal –and the danger component of risk- take centre stage. Individual viewers, represented by Jorge and Gabriela, are urged to be aware and act promptly or face the –more than likely- consequences.

Because of the semiotic construal of the second episode –and the overall message of the film-, the converse reading is also possible: that "heeding" the messages, acting promptly, and having a closely scrutinized pregnancy will *necessarily* lead to an ideal outcome –which echoes the "optimum safety" scenario from safe motherhood discourse,

[151] The co-patterning of semiotic resources clearly tips the interpersonal evaluation towards the most alarming interpretation. This is all the more relevant at the level of discursive practices in Xochis, where many women are illiterate and would not understand the probabilistic nuances in the Spanish version of the video. The multimodal device would then leave a stronger impression of extreme danger and almost certain tragedy should the viewer stray from the expected behaviour.

as discussed in chapter 2.4.[152] This reading would in turn invite –and be induced by- a different take on the expression "*Ayúdate que Dios te ayudará*". In effect, we could consider the subordinate clause "*que Dios te ayudará*" as an extension of the main clause "*Ayúdate*", in terms of action and consequence or cause and effect. In other words, if you help yourself (by "heeding the messages", acting promptly, and going to the hospital), God will grant you a safe outcome (for both the mother and her child). These readings speak to the inherent polisemy of any given semiotic resource –including popular sayings, as is the case here-, which calls for the "taming" of that semiotic potential within particular discourses. They also show how the re-semiotization of a given semiotic resource within an essential multimodal text has an impact across many other resources.

5.9. Ultrasound as foetal reality and interdiscursive device

The "Late pregnancy checkup" sequence opens with a close-up of Gabriela's naked abdomen and a doctor's (or a technician's) hands preparing her for obstetric ultrasound. Through a fair amount of visual detail and the soothing "control" motif, the engineers of the text construe the proceedings as painless and unobtrusive, an interdiscursive reference to reported women's dislike of invasive biomedical procedures.

Through successive dissolving (visual ellipsis), the editors show "cutaways"[153] of these expert hands as they gently spread gel and then move the transducer over the abdomen, while we begin to see the image of the foetus moving on a monitor screen in the background. Soft-focus and depth of field are crucial resources here, since they both allow and induce a logical connection between the events and casual agents on the foreground and the image of the baby on the monitor screen as the "real-time" product of these magical forces. This deep shot transitions to a close-up of Gabriela's head on a bed with white sheets. She glances outside the frame, towards the monitor, and insinuates a

[152] Based on their experience, health officials in Chilpancingo were convinced that timely treatment of patient with signs of pre-eclampsia would almost certainly avert the risk of death. "*Nosotros tenemos la idea de que la gente logre trasladar inmediatamente*" said a top health official at the state level during an interview for this thesis in October 2007. "*Con el simple hecho de trasladar y a la señora le metan líquidos, con ese simple hecho y que la traigan con líquidos en un traslado, la señora se salva.*"

[153] Kress G, van Leeuwen T 2006, p. 127. Cutaways are close-ups of objects "integrated into an action through the editing."

faint smile –happy to see her baby, but aware of the risks and, as a result of this awareness, still unsure about the outcome.

The final shot of this scene dissolves into a medium close shot of a female doctor talking with Gabriela in her office. At the beginning of their heavily one-sided interaction, [154] the doctor tells her patient: "*Todo va muy bien, Gabriela. Tu bebé tiene el tamaño correcto para sus ocho meses y su corazón late perfecto.*" Gabriela, whose face shows that she is anxiously awaiting the news, briefly sighs in relief. These images are logically connected with the preceding scene of the ultrasound procedure. The doctor's assertion is the result of true knowledge from this "magical" technology, and Gabriela accepts her words for what they are, a truthful, undisputable statement.

The scene ends with the doctor handing out an ultrasound image of the baby to her patient. "*Éste es el ultrasonido de tu bebé,*" she explains as we see a close shot of the image on the desk[155] [156] and we hear the "Watchful care" theme gaining prominence in the sonic background. The doctor's hand enters the open frame from the left, picks up the image and hands it over to Gabriela, whose hand enters the frame from the right. The panning of the camera from left to right –the only panning in the film- co-patterns this vector and highlights the transitive action. We hear the doctor command with a gentle but firm voice: "*Llévatelo*". The visual syntaxis follows a typical transactive pattern where the action, and the knowledge that comes with it, passes from the doctor to her patient. In other words, the doctor confirms the reality of a healthy pregnancy to the mother. At the

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[154] Throughout the exchange, the doctor asks questions, gives and demands information, corrects and warns her patient, commands her to keep taking her medicine (through disallowance and subsequent construal of a directive act in the shape of a categorical assertion in the immediate future tense, "*No, vas a seguir tomando la medicina*"), and finally exhorts her (*"te pido de favor"*) to be attentive and take immediate action should she feel the same symptoms.

[155] We see a full image of the ultrasound picture without much space around it. In advertising, this type of shot represents the object "as within the viewer's reach, but not as actually used". (Ibid, p. 127) In other words, the object, with all its semiotic potential (in this case, the picture, together with the factual knowledge it conveys and the reality it confirms) is within our reach.

[156] We can reword this clause as "*Esta imagen es de tu bebé*" or even "*Este ultrasonido es tu bebé*". Such reconfiguration retains the intended meaning in the original, that is, to identify the image with the baby. In any of these variants, the utterance provides a clear-cut example of "identifying relational clause", where some thing has an identity assigned to it (the identifier) by means of another (the identified) (Halliday MAK, Matthiessen CMIM 2004, p. 227.) Here, the ultrasonido is the identified and the baby is the identifier –or, more clearly, the identity.

same time, she is *passing responsibility* for the child's health onto the mother.[157] This is cohesively confirmed by the voice-over during the epilogue: "*Tu salud y la de tu bebé están en tus manos*" –which is quite literally so in the ideational construal of the video.

Gabriela takes the image with both hands and holds it with great care, as if she were holding her child; she lowers her head to take a closer look, and we next see the ultrasound picture fully occupying the frame. This shot dissolves into the next scene, where Gabriela is lying in bed, a reassured smile lighting up her face, as she stares at the ultrasound image on her left hand and she caresses her womb with her left hand. Four strong vectors lead the narrative pattern, one of them from her eyes to the image; a second one from her eyes to her womb; another one along her right arm to the womb; and the fourth one from her folded arm to the ultrasound image. They all form a rhomboidal pattern connecting the visual reality of the image with the embodied perception of the child in the womb. Gabriela turns her head to look at her grown belly, intensifies her caresses, and turns again to the picture, while she giggles and quivers with anticipation. We can tell from her gestures and facial expression that she has confirmed the reality of her pregnancy and the wellbeing of her child. This segment of the film plays out like a religious adoration or rather like the construal of a *biomedical ritual* –another semiotic foothold- within an already ritualized intercultural context. At the same time, the text presents ultrasound imaging as foetal reality and speaks to the expertise required to read and express this truth.[158] Technological knowledge is construed as certainty that confirms subjective perceptions and supersedes commonsense knowledge from the social world.[159]

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[157] "Ultrasound is thought to reduce maternal anxiety and to stimulate the parents' emotional 'bond' to the foetus," says Mitchell. "In this regard, it offers a means for influencing women into complying with prenatal care recommendations about food, cigarette, alcohol, and/drug intake." Mitchell LM. *Baby's first picture: ultrasound and the politics of fetal subjects*. Toronto: University of Toronto Press, 2001, p.4.

[158] Mitchell, among other authors, has exposed the uncritical acceptance of ultrasound foetal images as reality and "the links between this technologically mediated reality and the politics of gender and reproduction." A staple of prenatal care in the West, ultrasound is now increasingly commonplace in many countries around the world. "Wherever it is used," says the author, "it is adapted to fit with social imperatives and cultural meanings." Mitchell LM 2001, p. 4-5.

[159] However, this technology cannot *replace* women's own experience of their pregnancies. That is precisely why they are exhorted to be the sentinels of their own bodies.

Georges contends that foetal ultrasound "plays a privileged role in the process of generating authoritative knowledge in prenatal care for pregnant women and doctors alike,"[160] which leads to an active demand of foetal screening. This seems to happen because the visual component of ultrasound technology helps women "feel the reality of their pregnancies, reassures them of foetal health, and provides a pleasurable sense of contact with, and knowledge about, the foetus."[161] Hospital doctors confirmed this trend in Xochis and Ometepec. The following segment from an interview with a medical practitioner at the Ometepec regional hospital captures the range of issues at stake, such as increased ultrasound dependency for medical diagnosis:

> **A**: Algunas [pacientes] vienen con la esperanza de que luego a la primera se le va hacer un ultrasonido, y quizás en ese aspecto las tenemos mal educadas... pero, bueno la tenemos mal educada desde el médico de primer nivel. El médico del primer nivel le dice: "Vete a Ometepec y en este instante te van hacer un ultrasonido, te van hacer estudios y vas a pasar con el ginecólogo" [...] Ahora, aquí en la institución no tenemos una persona que se dedique nada más a hacer ultrasonido. Son los ginecólogos los que operan, dan su consulta y hacen ultrasonido. Y ahora, con el crecimiento del Seguro Popular, pues se les está dando citas [...] para tal fecha para que se le haga un ultrasonido. Pero esa persona viene mal informada: "En este instante te van hacer un ultrasonido, y que te den el papel donde lo están interpretando"... Y lógicamente que los doctores sí le ponen ahí "embarazo de veintitantas semanas de gestación, cefálico, con frecuencia cardíaca tanto, el líquido amniótico normal"... Sintetizan todo lo más, este, que debemos de saber y nada más, y dice: "Te debe dar un papelote grande, esto no sirve, vete a un particular"... A fuerza quieren la interpretación de una hoja ahí escrita que se hizo este ultrasonido, es de tantos voltios... tenemos ese problema.
>
> **Q**: ¿Con los médicos o con las pacientes?
>
> **A**: Bueno, más bien, más bien ya con las pacientes, porque la paciente llega - "¡Ultrasonido!¡Quiero ultrasonido!" -"Sí, mira, se te va hacer ultrasonido para tu próxima cita. Si tu vienes, aquí yo le pongo para que te anoten en tu libreta y te den tu cita" -"No,

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[160] Georges E. Fetal Ultrasound Imaging and the Production of Authoritative Knowledge in Greece. *Medical Anthropology Quarterly* 10(2):157-175, 1996, quote on p. 158.

[161] Ibid, p. 157. The scene of Gabriela lying on the bed and interacting with the ultrasound image and with her own body is the visual embodiment of this description –now construed as a necessary landmark of prenatal care.

pero es que el doctor dijo que no regresara si no llevo el ultrasonido" –"No, mira, madre", le digo. "Tu bebé está bien, aquí está la cabecita, mira tócala" -"Es que no encontraba la cabecita" –"Mira, aquí está la cabecita, ¿sí? ¿De acuerdo? -"Sí, doctor, entonces me lo hago hasta dentro de un mes"... Pero si yo concientizo así a esta persona, esa persona regresa al mes, y se va contenta porque ya identificó la cabeza de su bebé. Les pongo el estetoscopio, "Mira, aquí está el corazón, escúchalo..." Se lo pongo en el oído y ya ellas escuchan y se van felices. Con que uno les diga "Mira, aquí está la cabecita, aquí está el corazón", a esa persona se le olvida el ultrasonido.

Q: ¿Entonces por qué les hacen el ultrasonido?

A: Mire, lo que pasa es que nosotros, bueno no nosotros, el médico, los médicos que mandan para ultrasonido les dicen: "Sácame un ultrasonido para ver si viene bien tu bebé"... Óigame, hay que recordar que nosotros somos médicos y que el diagnóstico, yo siempre he dicho, el diagnóstico debe ser clínico. El laboratorio es un apoyo para confirmar lo que nosotros estamos diagnosticando.

Of course, the high-risk condition of Gabriela seems to warrant the use of ultrasound in the film; but the heightened semiotic presence of this procedure and the salience of the resulting ultrasound images across a narrative phase[162] of control and self-control in public and private spaces, all suggest other readings. I contend that this strong actantial presence of ultrasound as Helper and magical force or agent –in terms of dramatic theory- seeks to create and reinforce the idea that biomedical technology and biomedical procedures are *sources of true knowledge* –in the same way that "picking up the shadow" can confirm the loss of the nahual and help restore the original balance in a system of traditional beliefs. Something similar, albeit to a lesser extent, happens with images of urine testing. Put differently, true knowledge is fact-based, and we can only have access to these facts through biomedical know-how. As Georges points out,

> As authoritative knowledge is continually reinforced and reproduced through hierarchical social interactions, such as clinical encounters, other ways of knowing are delegitimized

[162] In multimodal analysis of film, a phase is "an intermediate level of analysis which is characterized by a relative semiotic homogeneity of selections and combinations of selections from the semiotic resource systems". In other words, "meanings made within that phase exhibit a high degree of sameness, at the same time that meanings made in other phases of the same text are different." Baldry A, Thibault PJ 2006, p. 49-50.

> and dismissed. [...] Technologies of many sorts play an important role in the performance and display of authoritative knowledge because of their symbolic (as well as practical) value, their association with experts, and their expression of power and other significant relationships between persons engaged in a community of practice.[163]

There are strong interdiscursive echoes here. Both quantitative and qualitative data from the MNH Project reveals that the most frequently required service from parteras in Xochis is no longer assisting women at birth, *but ensuring that the baby is well positioned in the birth canal.*[164] In order to do this, the partera feels the abdomen and, if necessary, repositions the foetus manually. Most medical doctors discourage this practice, which they deem potentially harmful for the unborn. In this context, the framing of ultrasound as a safe procedure that provides truthful information about the foetus indirectly alludes to –and confronts- these traditional practices. Pregnant women do not need parteras to tell them whether the baby "*viene bien*". Ultrasound, the text seems to suggest, provides tangible, visual evidence women can rely on -the mother has an iconographic representation of the unborn child in her own hands. (Nevertheless, this image requires expert interpretation, as is the case with the partera. This power is never in lay hands, regardless of the cultural context.)

But showing the "reality" of the baby does not necessarily imply that women will turn their back on traditional knowledge and practices, *even if they embrace this new reality.* In many cases, if not most, they try to accommodate the new knowledge in a broader social and experiential frame of reference, [165] as the following excerpt from an interview with a 44-year-old pregnant Amuzgo mother of nine indicates:

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[163] Georges E 1996, p. 158.

[164] Even women who opt for institutional delivery consult parteras in this regard.

[165] This could be seen as an example of what Bonfil and Coronado describe as intercultural processes of appropriation, whereby an ethnic group uses elements from another culture, adapting their meanings in the context of their own views and practices. "La apropiación", says Coronado, "es un proceso en donde un grupo –indio o mestizo- introduce algún significado cultural o elemento material de la cultura de los otros, transformando sus significados para ser controlados por los nuevos 'dueños'. En este proceso las nuevas formas culturales no se controlan por el otro grupo, sino que llegan a ser parte de la cultura propia". Coronado Suzán G 2003, p. 55. Bonfil talks about "appropriated culture" and defines it as follows: "Este ámbito se forma cuando el grupo adquiere la capacidad de decisión sobre elementos culturales ajenos y los usa en acciones que responden a decisiones propias. Los elementos continúan siendo ajenos al grupo no adquiere también la capacidad de producirlos o reproducirlos por sí mismo; por lo tanto, hay dependencia

Q: ¿Vas a ver a la partera cuando estás embarazada?

A: Sí, voy con la partera.

Q: ¿Por qué vas con la partera?

A: Para reposicionar al bebé, para que me revise si está en buena posición. Porque hay bebé que molesta y necesita reposicionar.

Q: ¿Qué te dice la partera?

A: No dice nada mientras el bebé está en buena posición. Cuando el bebé está en mala posición, entonces sí dice algo, pero no dice nada cuando no molesta el bebé.

Q: ¿Dice lo mismo que el centro de salud?

A: Lo mismo, la enfermera también revisa y cuando está en buena posición no dice nada.

Q: ¿Tú siempre haces lo que te dice la partera?

A: Sí, porque es lo mismo, respeto lo que dice la enfermera y lo que me dice la partera. Dicen lo mismo.

Q: ¿Es importante que la partera te acomode al bebé?

A: Es importante, porque ella mueve al bebé. Con los médicos es diferente, porque no mueven al bebé, sólo revisan. Y la persona que atiende a la embarazada (partera), ella cuida y mueve al bebé. Y con esto no te duele el pie, con esto no te pasa eso.

Q: ¿Platicas de acomodar el bebé con el doctor?

A: No, con el médico no. Cuando fui sólo estaba viendo con el aparato y me dice que está en buena posición, porque ellos ven y yo también vi que era cierto. Él me fue diciendo que se estaba moviendo, los pies, la cabeza, todo yo lo vi.

In chapters 6 and 7, I will further discuss the complex relationship between safe motherhood discourse and suggested practices, indigenous orders of discourse, and the embodied experiences of indigenous mothers.

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en cuanto a la disponibilidad de esos elementos culturales, pero no en cuanto a las decisiones sobre su uso." Bonfil Batalla G. La teoría del control cultural en los procesos étnicos. *Anuario Antropológico 86*. Brasilia: Editora Universidade de Brasilia/Tempo Brasileiro, 1988, p. 13-53; quote from p. 19-20. Although indigenous people cannot decide when to undergo ultrasound scanning, they can put pressure on health staff to demand this practice (as we have seen above) and, most importantly, they can articulate this new practice with traditional prenatal care on their own terms. At the same time, the adoption of ultrasound may represent a process of refunctionalization of prenatal practices among the Amuzgos. "El proceso de refuncionalización," says Coronado, "[...] transforma prácticas pasadas introduciendo nuevos significados o cambiando los significados de los elementos ajenos por su inserción en el contexto de los significados de la cultura propia." Coronado Suzán G 2003, p. 55.

5.10. The construal of subject positions and biomedical authority

The scene with the male doctor is a centrepiece for the construal of interpersonal meaning and subject positions, for the reinforcement of biomedical authority, and for the analysis of the video film at the level of sociocultural practices. In that regard, it functions as a core cluster in the overall text.

This is the culminating scene –and the longest one, two and a half minutes, from 7:34m to 10:05m- in the "Emergency consultation" sequence of the second episode, which also includes an opening scene between Gabriela and the nurse (from 6:15m to 7:27m) and a short, two-shot scene (7:28 m to 7:33m) of the urine protein test. The scene with the nurse, which I will not analyze in detail, opens with an establishing shot that clearly resembles the photograph on the front panel of the Carnet. But where the latter, through manipulation of linear perspective, shows the male doctor as if he were higher than the woman standing on the scale, the mise-en-scène in the video drama places Gabriela in a more "elevated" position than the female nurse.[166] This "higher" placement of Gabriela happens only twice in the film; the other significant exception comes towards the scene of Gabriela and Jorge in the kitchen, where we see her cooking for her husband and serving him at the table -perhaps an interpersonal evaluation of the diminished role that Jorge is playing with respect to the expected behaviour.

The urine test scene serves different purposes: on a textual level, it makes for cohesion between the nurse's request of a urine sample from Gabriela and the doctors' mention to the presence of protein in the urine as an indicator of pre-eclampsia. At the experiential level, it shows the "physical" reality of a diagnostic procedure that patients do not have the chance to see in real life. At the logical level, it establishes a sequential order of process and result (urine sample>urine test>protein in urine). At the interpersonal level, it

[166] By changing both the lens focal length and the distance between the camera and the subject, the photographer alters the perspective and the spatial relation between participants. In this case, the photographer has created a shallow image, flattening the distance between the different planes and making sure the doctor will appear taller than the woman.

highlights the importance of biomedical technology for maternal health.[167] Yet more crucially, this analysis points to the manipulation of discursive practices in order to offer an alternative system of beliefs, where true knowledge derives from hard biomedical data and *tangible, visible* procedures (hence the extreme close-up of the matching colours on the test strips and the rating chart) rather than from soft, intangible soothsaying without physical or chemical foundation. These images help ground the authoritative knowledge of the male doctor in the subsequent scene.

At the textual level, the establishing medium to medium-close shot in the "Male doctor intervention sequence" positions the viewer as an onlooker without creating too much distance with the depicted world.[168] The shot reveals a triangular composition[169] that organizes the mise-en-scéne, co-patterns the relations between the three participants, and sets up the stage for the editing pattern.[170] Arms and gazes provide strong vectors connecting the participants. The doctor is positioned on the left side of this triangle and he is the biggest and the tallest of the three. He is standing straight, has a commanding voice, and carries out most of the talking, which includes questions, answers, information, explanations, clarifications, rebuttals, assertions, directives, and commissive acts[171]. His left hand rests on the upper part of the stretcher and his right hand on the lower end; both hands return to this position whenever he is not using them to make a point. The two vectors of his arms and his hands encircle Gabriela, protecting her but keeping a distance. His head is the apex of the pyramidal layout. From this perspective, he looks slightly downwards onto Jorge, who stands on the right of the screen, and the vector of this gaze draws another side of the triangle. Jorge leans in turn towards

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[167] The airy, new age musical figure underscoring the actantial presence of biomedical technology contributes to the ideational and interpersonal meaning of these shots.

[168] In visual semiosis, simulated distances between viewers and participants are "transformations of the proxemic resources which regulate social-interpersonal relations between interactants." Baldry A, Thibault PJ, 2006, p. 197.

[169] For this analysis, I have drawn on Barsam's discussion on the relationship between composition and mise-en-scéne. Barsam R 2004, p. 127.

[170] The scene is edited in classic Hollywood style, as discussed by Giannetti L 2005, p. 145, and Monaco J 2000, p. 218. There is a establishing shot at the beginning, which sets the scene and captures the interaction for a few seconds, followed by reverse angle shots of the different participants at different points during the exchange.

[171] In speech act theory, commissives express an intention, a commitment to a future course of action. Verschueren J 1999, p. 24.

Gabriela, who is lying on a stretcher, his arms running alongside hers from behind, trying to hold on to his wife and protect her, the continuity of their bodies outlining another side of the "pyramid". With her right hand, Gabriela holds Jorge's right hand; she keeps her left hand on her abdomen, signalling her concern for the unborn child –and reminding us of the fourth participant in the scene[172]. There is no music in the scene and the voices of the participants –particularly the doctor's commanding tone- provide the sonic figure from beginning to end.[173]

The gaze system[174] remains the most dynamic visual resource throughout, because it marks the interaction and the power differential between the participants. Due to her position, Gabriela has to look up to make eye contact with the others. Conversely, both the doctor and Jorge have to bend their heads to look at her. As mentioned above, the doctor's eyes connect with Jorge's from a slightly higher position. Gabriela and Jorge's eyes continuously turn from one another to the doctor, underscoring their fears and reactions –and connoting both their impotence and their dependence from the authoritative expert. For most of the segment –and the scene as a whole-, it is the doctor who engages with his interlocutors through the gaze vector, while Gabriela and Jorge are mainly reactors.[175]

At the beginning of the scene, we see the doctor trying to occupy his place by Gabriela's side and briefly having eye contact with Jorge and nodding to acknowledge his presence. It is a split second, but it is enough to get an impression of his grave demeanour and to

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[172] This textual device (Gabriela touching or stroking her abdomen) is used almost every time she is on screen, as an ideational and interpersonal reminder of the presence of the baby and the mother's concern for the health of her child. Jorge also lays his hand on her abdomen when he says he is only concerned about her and their child, and the male doctor lightly touches her belly when he berates Jorge for endangering the life of the baby.

[173] There is yet another absence that would not go unnoticed in an Amuzgo context. Most interactions between medical practitioners and Amuzgo women are mediated by ad-hoc translators –nurses, TAPS, maintenance staff, neighbours, etc. Moreover, typical exchanges between Mestizo doctors and Amuzgo patients –translated or not- hardly ever resemble the fluid interaction we see on screen. This was confirmed with Amuzgo CIET team members who watched the film.

[174] Semiotic systems, such as those of lexicogrammar, phonology, kinesics, proxemics, gaze, etc.- are "systems of possible meanings and forms typically used to make meanings in particular contexts." Multimodal texts are "composite products of the combined effects of all the resources used to create and interpret them." Baldry A, Thibault PJ 2006, p. 18.

[175] For gaze analysis, I have drawn from Baldry and Thibault, ibid, p. 167-171.

catch sight of a grimace conveying social distance and hinting at disapproval. As he prepares to speak, Jorge nervously rubs Gabriela's arms, a look of anguish and eagerness in his eyes, while Gabriela holds his hand and her abdomen, screwing up her face and looking back the doctor like a frightened child.

The system of tenor is an essential driver of interpersonal meaning here. "*¿Cómo vamos, Gaby? "Te duele la cabeza*?", asks the doctor in a commanding, almost solemn tone, standing straight while he talks, and using the inclusive "us" so typical of doctors, the informal "tú", and the short form of her name –which implies a familiarity he does not have with a new patient- to address her, in a concise, crystal-clear example of power and solidarity. The discursive reproduction of prevailing, highly hierarchical sociocultural practices is in full display from the outset.

Gaby answers affirmatively –"*Sí, doctor*", with a deictical reference to his title[176] that reoccurs almost every time Jorge and Gabriela address the doctor, thus acknowledging his higher status and explicitly confirming the social distance between them. And she adds: "*Y me zumban los oídos, y veo manchitas de luz*", repeating the alarm signs that she has already mentioned to the nurse. The doctor next turns to Jorge and scolds him:

> **Doctor** (*he shows reproach in his voice and interpellates Jorge with his extended arm as well*): ¿Por qué has tardado tanto tiempo en traerla, Jorge?
> **Jorge** (*his look and his voice beg for understanding from the authority figure*): Es que el centro de salud nos queda bastante retirado, doctor...
> **Doctor**: Pues sí (he acknowledges briskly), pero eso no es pretexto (*rebuttal, categorical assertion, re-evaluation of Jorge's mention to distance as an excuse*). [*Jorge lowers his head*] Pones en riesgo la vida de Gaby y del futuro bebé (*he uses another categorical*

[176] The use of social deixis, from formal and informal second person pronouns to titles and "honorifics", signals social status and forms of respect. Verschueren J 1999, p. 21. This is not, per se, an indication of an ideological use of language. But Jorge and Gabriela explicitly address the doctor by his title *each time* they talk to him, except when Jorge asks "¿Es grave?". This is co-patterned with child-like gestures and facial expressions of new awareness (induced by the expertise of the doctor and his revelatory knowledge), gratitude, obedience, and subordination, and by the linguistic content of the interaction. The multimodal device not only evokes, but also *reinforces* the power differentials.

assertion; keeps a firm, admonishing tone; he slightly touches Gaby's belly and looks at Jorge, who does not return his gaze).

I have already discussed how this intertextual confrontation underplays access barriers to institutional health care in rural Mexico and in similar settings throughout the developing world, which the literature acknowledges as one of the main obstacles for getting timely care in maternal emergencies.[177] Even worse, it may create a logical dissonance with the viewer, since the doctor blames Jorge for the delay and makes Jorge responsible for putting Gaby and the baby at risk, when we know that Jorge took Gabriela to the health centre as soon as he confirmed that she was not feeling well. At the textual level, this can only be explained by reference to Jorge's reaction in the first episode. From an intertextual perspective, this discursive construal seems to reflect the prevailing idea among government health staff that husbands are opponents rather than allies, and that their antagonism stems from a host of reasons, including access barriers, underestimation of pregnancy risk[178] ignorance of alarm signs for obstetric emergencies[179], and wariness of medical prenatal checkups[180].

As a result, we can see an unresolved tension between the discursive construction of Jorge (and the husbands he stands for) as potential heroes and as opponents from the Speakers point of view. In clear contrast with the positive incentives to adopt the expected behaviour (such as rewarding the hero in the last segment of this episode), the construal of guilt and blame is deeply woven into the semiotic fabric of the text. This discursive effect is accentuated by Jorge's response when he is rebuked: he does not say anything and lowers his head instead –which can be construed as submission to the higher status of the doctor, as implicit recognition of guilt, or as both.

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[177] According to the MNH Project 2008 baseline survey, 21% percent of the women who had not gone for prenatal checkups in Xochis said distance was the main problem.

[178] In the case of Xochis, this may be an erroneous perception: almost 90% of husbands surveyed for the MNH Project 2008 baseline considered that pregnancy is a dangerous state. Of course, there can be different definitions of "danger" and "risk" and different evaluations of specific situations. I will elaborate on the husbands' views in chapter 6.

[179] The MNH Project 2008 baseline shows very low overall knowledge of biomedical alarm signs among husbands, elderly women, and women of childbearing age.

[180] Almost 60% of husbands interviewed for the MNH Project 2008 baseline said the doctor should be consulted in case of alarm signs or complications during pregnancy.

The scene most obviously plays as a medical consultation –and particularly, biomedical emergency consultation in primary health care-, drawing from the genre's structure and typical rhetorical formations, such as question and answers, diagnosis, explanations of cause and effect, treatment, etc.,[181] and including speech acts such as requests, commands, assertions, advice, and very important in this case, reassurance.[182] As in most consultations, the doctor controls the interaction, and this is the result of several interrelated factors, including patient anxiety and insecurity about their own health; institutionalized medical power to diagnose, indicate treatment, and give access to other resources within and without the health system; and patient lack of familiarity with a system of specialized knowledge[183]. All of these factors are present –and magnified- during this scene. Gabriela and Jorge arrive at the consultation in high distress; she is in pain and has symptoms that she has never felt before. The tension builds up after the nurse tells her that she has high blood pressure and requests a urine test. By the time they meet the doctor, they perceive that something is wrong, but they do not know what it is and how bad it can be. The doctor is a sage who will reveal their fates. The systems of gestures, kinesics, and gaze tell us that they are aware of at least one thing: they depend on the doctor's knowledge. Not only that: *the outcome of their dire situation is in his hands*, as we learn from the closing exchange. This knowledge differential is of utmost relevance to the discursive event. As I have already discussed, the film does not only aim at the prevention of pre-eclampsia and eclampsia, but it is also an attempt to re-educate the viewers into a biomedical system of knowledge and control. Of course, in this case medical dominance is compounded but the highly unequal social status of the participants, which is reinforced through the semiotic organization of the text.

After the initial exchange, the doctor momentarily interrupts his questioning of the patient and anticipates a likely diagnosis:

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[181] See, for instance, Ten Have P. The consultation as a genre. In B Torode (ed.) *Text and Talk as Social Practice*. Dordrecht/Providence, R.I.: Foris Publications, 1989, p. 115-135. Available at http://www2.fmg.uva.nl/emca/genre.htm#N_1. Accessed December 2, 2009.

[182] Freadman A. Anyone for tennis? In A Freedman, P Medway (Eds.), *Genre and the new rhetoric*. London: Taylor & Francis, 1994, p. 43-66.

[183] Hughes D. Control in the medical consultation: Organizing talk in a situation where co-participants have differential competence. *Sociology* 16(3):359-376, 1983.

Doctor (*looking at Gabriela, who stares up at him in angst, while Jorge nervously caresses her head and her arms*): Mira, Gabriela (*he commands her attention, then pauses and sighs*)... (*Adopts a didactic intonation*) A las mujeres que se les sube la presión durante el embarazo, generalmente les duele la cabeza (*he turns his head up, briefly looks away from her into the distance*), ven lucecitas (*he looks away again, while she grabs Jorge's left hand with her left hand and her abdomen with her right hand*), escuchan zumbidos (*he looks away for a third time*), o se hinchan, como tú. Los riñones dejan pasar proteínas a la orina... (*upon hearing this, Jorge hastily moves to the side of the stretcher, opposite the doctor, leans closer to Gaby and kisses her head; this displacement further articulates the triangulation between the protagonists*)
Mira (*he recalls her attention, highlighting his next statement*), cuando eso sucede, es muy posible que las mujeres tengan una enfermedad que se llama p re-eclampsia (*he stresses the word and adds emphasis with his left hand; Gabriela gets restless, looks at Jorge, and strokes her belly; Jorge looks at the doctor*).
Jorge (*first cut from the establishing shot to a direct, slightly high close-up of Jorge, who stares up at the doctor in apprehension; his voice, his teary eyes, and the expression of his face emphasizing distress as he realizes that this is the moment of truth*): ¿Qué es eso, doctor? (*He raises his eyebrows, drawing them together,*[184] *and holds his breath, in anguished anticipation.*)
Doctor (*cut to oblique, median close-up of the doctor, who looks at Jorge and grimaces as he thinks for a second, his pause adding suspense*): ...
Jorge (*cut to established close-up of Jorge, who breathes heavily and keeps a tense expression of anguish and fear*): ¿Es grave?
Doctor (*cut to established close-up of the doctor*): Pues, sí... (*He maintains didactic intonation*) La pre-eclampsia es una enfermedad especial que sólo le da a las mujeres cuando están embarazadas (*cut to direct, high close-up of Gabriela, who purses her lips, looks at Jorge, and tightens the grip on his hand*), durante el parto (*cut to close-up of Jorge; he purses his lips, lowers and shakes his head in dismay*), o después de que nace su bebé (*cut to established close-up of Gabriela*), en la cuarentena. (*Cut to close-up of the doctor, who looks at Jorge*). Mira (*he anticipates the relevance of the following statement*

[184] This movement of the eyebrows can express a mix of surprise, worry and fear, as discussed by Wierzbicka A. *Emotions across languages and cultures: diversity and universals*. Cambridge, UK; NY and Melbourne: Cambridge University Press, 1999, p. 195-201.

by renewing his command for Jorge's attention)... Si no se atiende de inmediato (*cut to close-up of Jorge, who looks worried and lowers his eyes towards Gabriela, but somehow immersed in his own thoughts*) y se permite que la enfermedad avance, (*cut to close-up of Gabriela, whose fast-paced breathing shows her agitation; she looks at Jorge and then at the doctor in angst*), la mujer puede presentar ataques de convulsiones, con pérdida del conocimiento (*cut to close-up of the doctor*), que puede ocasionar daños graves en la salud de Gaby (*cut to close-up of Gaby, who looks at Jorge*) o del bebé (*cut to close-up of Jorge, who is breathing in anguished agitation; he looks at the doctor and then away, to the right of the screen, out of the frame, as he purses his lips, signalling his helplessness, and maybe his remorse*).

This is a crucial segment in the story, where the doctor unmasks and names the hidden enemy. He is the one who has the knowledge and the power to detect and face the threat. Jorge and Gabriela are powerless: their commonsense beliefs are of no use in this world. The semiotic systems of tenor, gaze, voice, kinesics, and facial expressions, the uneven positioning of the three participants on the vertical plane[185] and the camera angle in close-ups (we see direct, frontal shots of Jorge and Gabriela, in an attempt to draw us into their fears; but we always see oblique shots of the male doctor)[186], all co-pattern and reinforce this power differential. Together with the one-sided linguistic exchange, this multimodal device foregrounds the interpellation taking place –with the doctor as the interpellator- and the crucial transition from unawareness and misconception to knowledge and awareness. It also cranks up the fear appeal through tactical pauses, facial expressions and non-linguistic verbal cues -like the doctor sighing at the beginning of his explanation- in order to convey the severity of the threat and to increase our perceived vulnerability. The editing contributes to the mounting tension. On the one hand, the editor highlights key references to looming danger by cutting to close-ups of Gabriela when the doctor says: "*que sólo le da a las mujeres cuando están embarazadas*"; "*o después de*

[185] In the scene with the nurse, Gabriela is always placed higher (on the scale) or at the same level (sitting on the stretcher) than the other female participant. In the scene with the male doctor, Gabriela is lying down and he is a towering figure that speaks to her from high above.

[186] In film theory and multimodal analysis, horizontal angles connote degrees of involvement or empathy, where directness implies empathy and obliqueness detachment from the participants and their world. Baldry A, Thibault PJ 2006, p. 195. From an interpersonal perspective, the text accentuates Jorge and Gaby's distress and draws us closer to them, while we hear –and see- the doctor displaying his knowledge and his power over the couple and over ourselves.

que nace su bebé"; "*la mujer puede presentar ataques de convulsiones, con pérdida del conocimiento*"; "*en la salud de Gaby* (close-up of Gabriela) *y del bebé*". This visual punctuation of the text deictically indexes the two main subjects of safe motherhood and identifies them as at-risk individuals, who are members of at-risk groups. At the same time, the editor gradually increases the rhythm of this segment of the scene by shortening the length of the close-ups,[187] as the doctor spells out the potential risks for Gaby and her child, and the tension peaks before it temporarily subsides when he finishes his explanation and Jorge looks out of the frame.

During this scene, as it happens throughout the text, the voice of the "lifeworld" –a childish indigenous lifeworld- is brought into play only to let the voice of medicine co-opt it and confront it on its own terms.[188] The doctor summons both voices, but the voice of medicine clearly prevails in his didactic exposition.[189] Thus, he uses everyday expressions to refer to perceivable symptoms –*dolor de cabeza, zumbidos, lucecitas, se hinchan, cuarentena*-, together with technical terms, elaborated expressions, and nominalizations that belong in a different register, such as *pre-eclampsia, proteínas, pérdida del conocimiento, "presentar" ataques, and "ocasionar" daños* –something that also happens on the Carnet. The Speaker preserves the probabilistic nature of health risk discourse by means of modality adverbs and expression, like *generalmente, es muy posible, es muy probable, la mujer puede presentar, and puede ocasionar.* However, this hedging is offset by other semiotic modes and by the contents of the first episode, where the viewer is presented with the worst-case scenario.

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[187] One way editors control the rhythm of a film is by changing the length of the shots in relation to one another. Barsam R 2004, p. 309.

[188] Medical consultation, according to Mischler, connects the "voice of medicine" and the "voice of the lifeworld", which represent, respectively, "the technical-scientific assumptions of medicine and the natural attitude of everyday life." Mishler EG. *The discourse of medicine: Dialectics of medical interviews.* Norwood, NJ: Ablex Publishing Corporation, 1984, p. 14.

[189] There is another way to make sense of the evident dislocation between the doctor's tone and vocabulary from a likely "real world" consultation in Xochis. Seen in terms of the relation between the Speaker and the viewer, the scene plays as a master class where the doctor explains what is going on, offers a framework for interpreting people's personal experiences, and issues a dire warning about the perils of thinking and acting otherwise.

This uneasy balance between probabilities and the certainty of good and bad outcomes is a distinctive trait of the overall text. We have seen one such example during the conversation between Jorge and his comadre (p. 255). Something similar happens with the onscreen text during the epilogue of the first episode. In salient white lettering over the faded-out image of an unnamed young indigenous woman with signs of pre-eclampsia (who is being assisted by health staff), we read: "*La mayoría de las muertes se pueden evitar si se actúa a tiempo*". This is an almost categorical assertion phrased as a cause and effect hypothesis: if A, then B.[190] True, one can interpret the impersonal "*se puede*" in terms of possibility ("*es posible*"), and then the hypothesis would sound more like "if A, then possibly B"; but in the multimodal context of the overall text, this reading is overwhelmed by the almost certainty of the safe outcome.

Another marker of biomedical language is the precise description of alarm symptoms –all of which we have already seen on screen- in terms of a complex, physiologically grounded pattern of cause and effects. The doctor explains that high blood pressure causes headaches, ear buzzing, changes in vision, swelling, weight gain, and kidney damage that in turn allows proteins to spill into the urine (the gaze resource system contributes to highlight these signs and to underscore the rhythmic pattern of the doctor's speech, as he briefly looks away from Gaby's eyes when he mentions some of these symptoms). All of this is very likely caused by a "special" disease called pre-eclampsia. If the disease progresses, it can bring about seizures and fainting fits, which in turn can cause serious damage to the mother and her baby. This complex causal chain of physiological events begs to differ with "soft" traditional explanations of unproven cultural syndromes (however, it can be every bit as arcane and it requires a cadre of experts or sages to guide this type of logical reading).[191] As I have mentioned above, this interdiscursive dialogue is also evident in the attempt to give visibility to as many signs of the disease and as many diagnostic tools and procedures as possible.

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[190] García de María J 2009, p. 80-81.

[191] In the context of Xochis, very few people would be able to follow the doctor's explanation, riddled as it is with biomedical jargon and complicated cause-effect chains. This holds for Spanish speakers as well. The use of probabilistic language is particularly challenging, since the Western notion of probability, which lies at the heart of public health risk discourse, is alien to the Amuzgo language.

The exchange between the doctor and our heroes then continues with a typical primary-genre format of question and answer, which in real-life consultation usually comes before the presumptive diagnose and the explanation:

> **Doctor** (*established close-up shows him looking again at Gabriela*): Gaby (*he pauses*)... ¿Sabes si tu mama, una tía o una hermana tuya han tenido problemas en su embarazo o cuando nacieron sus hijos?
> **Jorge** (*cut to established close-up nodding as he looks at Gabriela*): Tu hermana...
> Gabriela (*cut to established close-up, as she looks at Jorge, then nods, breathes in anguish, looks alternatively at the doctor and away, out of the frame, while she speaks*): Sí, doctor... mi hermana se murió cuando ya se iba a aliviar y (*she pauses, close to tears*)... el bebé también se murió.
> **Doctor** (*cut to close-up*): Y en tu familia, Gaby, ¿alguien ha sufrido del corazón o de los riñones, ha tenido presión alta o ha sido diabético? (*he adds emphasis towards the end*)
> **Gaby** (*cut to close-up, as she frowns, brings her eyebrows together, squint her eyes, and lowers the corners of her mouth, holding back the tears. We see Jorge's hand stroking her head*): Sí, doctor, sólo mi papá...
> **Doctor** (*cut to close up; he briefly stares at her in silence, like pondering the result of his questions and seeing the logic in the situation; then, he turns up his head, looks at Jorge, as if he were looking for the right words; then looks alternatively at Gaby and Jorge*): Bueno, miren... no quiero espantarlos (*he adds emphasis to the negation by shortly shaking his head*) [*Cut to close-up of Gabriela, who looks at him in apprehension.*] Con estos antecedents y con las molestias que tienes, (*cut to close-up of the doctor*) es muy probable que tengas pre-eclampsia. (*Cut to close-up of Jorge, who stares at the doctor, anxious and distressed*) y necesitas que te atiendan y te cuiden (*Cut to close-up of Gabriela, who looks alternatively at Jorge and the doctor*) inmediatamente en el hospital, Gaby. Allí tienen equipo (*Cut to close-up of the doctor looking at Gabriela*) y especialistas (he turns his head towards Jorge and nods) para tratar la pre-eclampsia.
> **Jorge** (*Cut to close-up as he looks at Gaby and up to the doctor, and then talks, his voice filled with anxiety*): ¿Y cómo le hacemos, doctor?
> **Doctor** (*Cut to close-up, as he looks from Jorge to Gabriela, takes a short breath, and then looks back at Jorge*): No se preocupen (brief pause)... nosotros (*Cut to close-up of Gabriela, whose face is still tense but less anguished, as she looks from the doctor to*

Jorge) vamos a ayudarlos (*Cut to close-up of Jorge; a heightened, childish expression of relief and thankfulness lights up his grief-stricken features and still watery eyes.*).
[*Cut to close-up of the doctor, looking alternatively at Gaby and Jorge*]. Le voy a avisar a la enfermera que hable al palacio municipal para llevar a Gaby inmediatamente (*he adds emphasis to the word with his voice and a nod of his head*) al hospital. (*Cut to close-up of Jorge, who bears the same expression and bites his lip to push back the tears, gripped by mixed emotions*). Estamos (*cut to close-up of Gaby, who finally smiles with closed lips*) a tiempo.
Gabriela (*same close-up, as she nods, looking at Jorge and then back at the doctor*): Sí, doctor... gracias.
Jorge (*cut to close-up, as he smiles from his still worried face, his watery eyes now glimmering with relief, and he nods as he says*): Gracias, doctor.
Gabriela (*cut to close-up, as she looks at Jorge, then to the other side, out of the frame, and breaths a deep sigh of relief*).
[*This last shot of Gabriela dissolves into the first shot of the ultrasound sequence, three months after the consultation with the male doctor.*]

From a clinical perspective, many of the questions for risk factors –family history of diabetes, high blood pressure, and maternal death- *should have been asked in prior consultations*. But Gabriela and Jorge's reaction strongly connotes their surprise –and their sudden awareness of the risks- and suggests they have never heard these questions before. Although health staff would want to know this crucial information in an emergency situation, chances are they would already have it from Gabriela's file or from her perinatal Carnet. Why is the doctor asking these basic questions at this point? One possible answer is that Gabriela has never gone for prenatal checkups in her five months of pregnancy. There are mixed indications in this regard. On the one hand, the doctor addresses Gabriela as "Gaby", as if she knew her from before, and he does not mention the fact that she has never been there. One would certainly expect such a reproach, in the context of the text; however, the doctor scolds Jorge for not "bringing her sooner" when faced with the alarm signs. And I have already discussed that Jorge's reaction upon learning of Gabriela's ailments seems to indicate that they are familiar with the health centre –choosing to go there is the Given; doing it immediately is the New. On the other

hand, Gabriela should have been asked about her family history and she should have heard about alarm signs had she gone for prenatal consultation before.

Taking discursive practices into account, it seems unlikely that the Health Secretariat would have approved a text that would expose a critical glitch in pregnancy control, concerning what should have been labelled as "high risk" pregnancy, in a pressing political context to avert maternal death.[192] Hence, the hypothesis of a first medical consultation gains ground. Either way, the most likely reason for the ideational content of the question and answer component of the consultation is the need to raise awareness of risk factors for pre-eclampsia and eclampsia. From an interpersonal perspective, this segment aims to interpellate individual viewers as potential at-risk individuals, who are members of genetically determined at-risk groups; hence the strong emphasis on the family history, which is once again conveyed in the shape of a worst-case scenario. This circumstance is rhetorically highlighted by using fear as the point of departure of the doctor's presumptive diagnosis. "*No quiero espantarlos*", he says, while the image cuts to a close-up of Gabriela's apprehensive look, and he goes on to say that it is very likely she has pre-eclampsia. Because he has described the threat as severe, and we have seen how bad it can get, we (the viewers) will likely construe the doctor's negative statement as what it is, a rhetorical move that means exactly the opposite: "You should be afraid."[193]

It is precisely this rhetorical strategy of going with the worst-case scenario that brings to the fore the guilt component of health risk discourse. Evoking the death of Gabriela's sister and her baby when she was about to deliver makes for a cohesive connection with the first episode of the film, with the doctor admonishing Jorge for taking too long to bring Gaby to the health centre, and with the comadre's exhortation to imagine what could have happened if he had not taken her to the hospital –and adding that death might

[192] Of course, health staff would notice this lack of fit between the story and the medical guidelines and procedures in place; but they are not part of the target audience.

[193] This happens twice in the film. When the female doctor tells Gabriela that the risk of pre-eclampsia is still there, Gaby says: "*No me asuste, doctora.*", and the doctor answers: "*No quiero asustarte, pero sí quiero que estés muy pendiente, te cuides y vengas si te sientes mal*". At that point in the narration, it is clear that the text has tried to raise awareness by presenting the viewer with a worst-case scenario and an emphatic, multimodal fear appeal.

have been the result. Because all of these circumstances and outcomes –delay, death, restoration, death again as a potential alternative scenario- are directly attributed to Jorge and Gabriela's behaviour, the death of Gaby's sister and her baby can coherently be interpreted as the result of her own behaviour and that of her husband. In other words, there is a coherent construal of guilt and responsibility in "Heed the messages". *The victims are to blame when things go wrong*. The fact that Gabriela's father has one of the risk conditions mentioned by the doctor contributes to this discursive effect -so much so that her answering "*sólo* mi papa" sounds like an attempt to attenuate the perception of individual and familial guilt for this overwhelming string of maternal tragedy.

The last part of the scene includes the most compelling construal of power and solidarity within the film. When the doctor informs Jorge and Gabriela that she must be immediately assisted and taken care of at the hospital, ("necesitas que *te atiendan y te cuiden* inmediatamente en el hospital", he says, stressing the words that point to "the care she needs"), Jorge voices a common concern among indigenous patients and their families: how to cover the costs. For a patient with pre-eclampsia from Xochis, this implies going to the second-level hospital in Ometepec and, depending on the severity of the case, a subsequent referral to Acapulco or Chilpancingo. At least one companion will likely have to stay for a few days in Ometepec. This is a complicated cost-benefit equation for people living in remote villages on a subsistence economy. At the beginning of the second episode of the film, the text partially alludes to this conundrum, when Gabriela asks who is going to look after their animals if she is not at home. Jorge dismisses her worries saying that he prefers to look after her and their baby. This rhetorical solution is much too obvious: the mother and the child are worth more than the chicken. But things are not that easy. A multiparous woman would have to leave her children. If she does paid work, her absence would halt that source of income. The husband would have to get help from the extended family or stop working for as long as his wife is away. The discursive construction glosses over these dramatic circumstances by simplifying the values at stake –particularly when it is not clear for the parties involved whether they are facing life-threatening circumstances- and using a convenient

but not universally representative archetype –a first-time mother who apparently does not have a paid job outside of the household.

So, when an overwhelmed Jorge asks the doctor "*¿Y cómo le hacemos, doctor*?", he is far from requesting instructions to get to the hospital. The doctor knows this and the audience too. This reference to the voice of the lifeworld is an attempt to address very real and pressing obstacles for at-risk women to get "the care they need". The doctor makes a tension-building pause that brings both the scene and the sequence to a climatic conclusion: "*No se preocupen... nosotros vamos a ayudarlos.*" On the surface, the first part of his statement is an exhortation, but expanded through the next clause and the subsequent explanation, it can be construed as an assertion –e.g., "*No hay de qué preocuparse... nosotros vamos a ayudarlos*". The doctor is describing a state of the world, through categorical modality. This construal is reinforced by what we see on screen: as soon as he says "*nosotros vamos a ayudarlos*", the image cuts to a close shot of Gabriela, whose features begin to relax, and then to Jorge, who smiles with a melodramatic expression of thankfulness and relief, as the doctor begins to lift a heavy burden from his shoulders. There is a double connotation here: Jorge and Gabriela are taking the doctor's description of the situation at face value (there is nothing to worry about) and they trust him (and the "*nosotros*" he is part of) to help them in a way that will allay their concerns. This perlocution[194] should extend to the viewers. They, too, should trust that everything is as the doctor says it is and will be. From this point on, the tension begins to unwind and the whole sequence gradually descends into a post-climatic trough dominated by the spelling out of the "nosotros" and how they are going to help.

The doctor's commitment is also an assertion that he is able to enact directives which will bring about desired change (and recursively make his first assertion and last assertions, that everything is under control and that they still have time, true): "*Le voy a avisar a la enfermera que hable al palacio municipal para llevar a Gaby inmediatamente al hospital. Estamos a tiempo.*" So, when the doctor says "nosotros", he is making a twofold

[194] The perlocutionary effect of an utterance is "what is done *by* saying something". Verschueren J 1999, p. 23. In this case, the doctor makes Jorge and Gabriela count on his commitment and his definition of the state of the world. The Speaker would do as much with the target audience.

indexical reference: "us" at the health centre and all of "us" who will participate in taking Gaby to the hospital (the health centre and the local government). And we can go as far as saying that there is a third "us" that includes the hospital where Gabriela will get the care she needs. In other words, there is a compressing "us" that ideationally zips up the full range of institutional support that Gaby will get. Equally important for the constitution of subject positions, the clause complex that goes from "*No se preocupen*" to "*estamos a tiempo*" points to the leverage of the doctor to make things happen at various levels of government and to make the world fit his words and to prove, at the same time, that his words match the world.[195] This clause complex realizes a commissive act through several transformative material clauses[196] in a cascade-like hypotactical (unequal) relation that reveals the scope of the doctor's influence to make things happen. In the main clause "*Le voy a avisar a la enfermera*", the actor (the doctor) commits himself to a process (*avisar*) that will impact a goal (*enfermera*). In the first subordinate clause ("*que hable al palacio municipal*"), the actor (nurse) will engage in a process (*hablar*) that will have an impact on another goal (*palacio municipal*). This implies the authority of the doctor to have the nurse call the local government. In the second subordinate clause ("*para llevar a Gaby inmediatamente al hospital*"), the implicit actor (municipal government) will carry out a process (*llevar*), under certain circumstances (*inmediatamente*) and to a certain destination (hospital, a Recipient) that will have an impact on both the goal (Gaby) and the recipient (hospital). This presupposes the existence of available vehicles and an emergency transportation system for obstetric complications, as well as the ability of the health centre to set that system in motion.

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[195] Searle uses "direction of fit" between words and world as a key criterion for the classification of illocutionary acts, that is, what we *do* when we say something. The main illocutionary point of assertions is to get the words to match the world; in the case of directives, promises and requests, it is the other way around. Searle J 1979, p. 3. The example that I have chosen shows that this directional principle, and the way it connects different utterances with one another, can play a key role in projecting and validating the power status of the speaker.

[196] In systemic functional linguistics, material clauses are clauses of doing and happening that refer to processes of change where an Actor does something that impacts the Actor (intransitive material clause) or a Goal (transitive material clause). Transformative clauses refer to changes that impact the Goal. An example of transitive clause would be "la enfermera (A) revisó (P) a Gabriela (G) en la sala de primeros auxilios (Circumstance)." Material clauses can have other participants. In "La doctora le dio la imagen de ultrasonido a Gabriela", "imagen de ultrasonido" is the Goal and Gabriela is the Recipient. In "Jorge pinta la cuna para su bebé", "cuna" is the Goal, while "su bebé" is the Client. Halliday MAK, Matthiessen CMIM 2004, p. 179-192. I have extended the uses of these categories and definitions to multimodal use of different meaning-making resources. Appendix C, p. 574-579, and Appendix F (CD), image 8, feature several such examples.

As I have mentioned, the doctor remains the initiating actor across the clause complex. He is thus construed as a willing and influential agent, capable of mobilizing a vast chain of resources. In principle, the use of the future tense makes this agency contingent on the *actual* occurrence of what the doctor promises. However, we have seen how the commissive act is presented as an assertion in future tense, that is, *as a matter of fact.* This textual manipulation assumes an audience without previous experience with government health services in obstetric emergencies. Of course, many viewers will have been there or will have heard from other people's first- or second-hand accounts. These events from the lifeworld will play a role in the reception of the film.[197]

Something similar happens with the construal of institutional help as the turnkey or a magical remedy for the multiple challenges facing indigenous women who have to leave their households in remote rural villages to request institutional medical care. There is no arguing that the help offered in the film is of critical importance, but many outstanding issues remain, as discussed above. The video drama glosses over them, as we next meet Gabriela three months after the meeting where the doctor pledged full institutional support. We know she is safe, at least from a biomedical perspective; but the three-month ellipsis is like a black box brimming with material and cultural concerns.

5.11. The unborn as a person, the person at risk

Close analysis of the film reveals an intricate construal of the unborn as a person and as a person yet to be, always projected as a key component of safe motherhood and maternal care. In terms of risk discourse, this unborn is framed as an object of care and not as a subject of interpellation (as is the case with the mother and the father). In this section, I will discuss key discursive dimensions emerging from this construal, based on a

[197] This is strongly suggested by the emergence of previous experience as a key dimension from the interviews in chapter 6. However, this is not a study of audience reception; I am looking into discursive dimensions emerging from the selected texts.

multimodal transcription of crucial references to the child throughout the film.[198] I will also touch upon other relevant topics revolving around the semiotic presence of the unborn and –later in the film- the newborn.

The semiotic construal of the baby anchors many of the core topics in the film. From the first time we see Gabriela on screen, we are made aware of her pregnancy, what it means to her, and what it should mean to the viewer. Even though her grown abdomen is the most obvious indication of her state, it is the co-patterned use of arms, hands, gaze, emblematic objects –such as the cradle-, and linguistic utterances what constantly reminds us of the child and, at the same time, channels material, mental and behavioural processes connecting the parents and the baby throughout the film. Clearly, the text makes us aware of the presence of another participant, one that is the object –a goal or a phenomenon, in terms of systemic linguistics[199]- of people's actions and thoughts, and a major topic in the text. The ideational and interpersonal awareness of the baby has several purposes –indexical, symbolic, interpellative, role-modelling-, but all of them are associated with key dimensions of safe motherhood and health risk discourse, and with emerging categories –such as the relative values assigned to the lives of the mother and the foetus, or rather the Speaker's perception of the values that members of the target audience place on these lives.

In the first scenes of the "Domestic life" sequence, Gaby is looking out the kitchen window, smiling, and gently grabbing her womb, while Jorge works in the yard and then paints the cradle. The co-patterned resources (gaze, hands on womb) connect all three participants from Gaby's point of view. We learn that she is happy with her role, with her family, and with her future. The child is construed as a symbol of future and hope. The

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[198] See Appendix C, p. 574-579, and Appendix F (CD), image 8, for detailed comments on the most relevant semiotic resources and how they are co-patterned in each case.

[199] Mental clauses refer to inner processes of feelings, emotions, and cognitions. The subject of a mental clause is called Senser, while that which is felt, liked, wanted, or perceived is called Phenomenon. In "A Gabriela le gustó la ecografía", Gabriela is the Senser and "ecografía" is the Phenomenon. Behavioural clauses are somewhere in between material and mental clauses. They express physiological and psychological behaviour that does not necessarily bring about any change in the world, such as smiling, staring, standing up, sitting down, lying down, etc. The "subject" is called Behaver. An example would be "Gabriela miró a Jorge y sonrió". For the definition and analysis of these processes, I have drawn from Halliday MAK, Matthiessen CMIM 2004, p. 197-210.

textual presence of blue and pink, together with Jorge's gesture, indicate that he wants a baby boy, while Gaby expects a baby girl. This stereotypical contrast -which in fact connotes their mutual attachment to the child- is reinforced later in the film. The baby is the Goal, Client, and Phenomenon of material and mental processes throughout the scene.

As she leans out of the window, Gabriela embraces this future, but there is a distance separating her from Jorge and the crib.[200] The next scene bluntly spells out this symbolic space between hopes and reality: Gabriela starts having severe pain and the "Threat" motif disrupts the harmony of domestic life. The foetus, brought to life in the previous scene, is now shaped as at-risk being. When Gaby has a seizure in the health centre, the voice-over tells us: "*La inmensa mayoría de los embarazos termina bien, con la mama y el bebé en buen estado de salud*", reminding us that two lives are at stake and naming the foetus as an unborn child. Right after this mention, the mother becomes the focus of the text by means of the voice-over and the visuals: "*En nuestro país, en sólo un año, más de mil doscientas mujeres mueren durante el embarazo, en el parto o poco tiempo después, en la cuarentena*". The Speaker goes on to state that pre-eclampsia and eclampsia cause one third of these deaths, and to regret that most of these fatalities could be averted through timely action. The baby is left aside, while the visuals construe Gabriela as a non-agentive archetype of maternal death and multiply her image on screen.[201] This is an all-important omission in the film and it reflects deep contradictions regarding the relative value assigned to the life of the mother and the baby in the order of discourse of public health. As I mentioned above, many health officials, doctors, and nurses feel that indigenous parents value the life of the foetus -and even the newborn- less than the life of the mother. A medical practitioner expressed his conviction that government health services and institutions are no different, as he pointed to under-registration of perinatal deaths[202] and lack of institutional pressure around these events:

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[200] Citing Merleau-Ponty, Baldry and Thibault observe that "movement is capable of creating an *abstract space* above and beyond the concrete physical space in which the movement takes place in space and time [...] Thus, the agent's body is the semiotic source of meanings that are directed towards the other and which seek to engage the other." Baldry A, Thibault PJ 2006, p. 203.

[201] See Appendix C, p. 574-575, for a more detailed description of this semiotic manipulation.

[202] According to this source, at the time of fieldwork it was still possible that a mother could leave a hospital without a death certificate for a miscarriage, a stillbirth, or a neonatal death; and it was possible for people in the region to bury a stillborn or a death newborn without being required a death certificate.

Informant: La muerte de la madre es más difícil. Es más difícil, ¿por qué?, porque se nos muere una mamá y nos llegan de nivel nacional, de nivel estatal en la jurisdicción de aquí, y nosotros mismos, sí... Entonces, ¿qué pasa?, cuando hay una muerte materna, la reporto y tratamos de sesionar lo más pronto posible, cuál fue la causa, y si la causa fue que no hubo material, ponemos que no hay material, ponemos todos los indicadores, desde primer nivel, segundo nivel... "no llevó buen control, su médico no se dio cuenta" Y cuando se sesiona en la jurisdicción, yo por lo menos he tratado de que nos avisen para llevar a los médicos involucrados [...].

Q: Ahora, pregunto, ¿se arma el mismo lío cuando mueren los niños?

I: No, no, es la primera vez con usted que estoy viendo que se están interesando en los óbitos y en los recién nacidos. Pero en la jurisdicción sólo sesionan muertes maternas, y nosotros aquí sí nos reunimos para ver, pero lo vemos desde el punto de vista del expediente: "¿Sabe qué, a este paciente no se le hizo esto y esto y esto..."

Medical jargon also gives support to these perceptions. The most frequent word used by medical practitioners to refer to the foetus in Xochis and elsewhere *–producto-* is far from signifying the presence of an unborn human being. In the film, most allusions to the foetus do not reflect this construal of the unborn; but the absence of any statistical mention to perinatal deaths, in a textual context with a cohesive set of multimodal references allowing –and encouraging- viewers to connect the fate of the mother with the fate of the child, throws into question the Speaker's standing in this regard.

Ideationally, there are many references connecting the health of the mother and the unborn throughout the text, including Gabriela's emotional evocation of the deaths of her sister and her baby. All of this should provide enough cohesion for the viewer to infer the likely death of many babies from eclampsia. However, there is no specific mention to perinatal deaths in a crucial scene that aims to raise awareness about the scope of maternal death as a public health issue. Interpersonally, this critical omission takes emphasis away from the child that has otherwise been given dense semiotic prominence throughout the text. Whatever the reason for this contradictory approach between the narrative and the informational components of the video drama –one could argue, for

instance, that there are no reliable statistical records of perinatal deaths-, it reveals implicit priorities at the level of discursive and sociocultural practices.
This uneven construal has other ethical implications at the level of discursive practices, since the video drama interpellates the target audience with a key dimension of safe motherhood discourse –the equal value of the lives of the mother and the child- through ideational and interpersonal content that does not seem to reflect prevailing views among key stakeholders, including government as the Speaker.[203]

The baby retakes center stage in the first scene of the second episode. Here, Jorge, Gabriela and their child and deeply linked through the co-patterned systems of linguistics, kinesics, and gaze. The spouses sit outside their home, holding hands, the contours of their bodies shaping a heart-like figure. Jorge leans forward towards her, extends his left arm, and places his hand over Gaby's womb. "*Yo prefiero cuidarte* ***a ti... y al Jorgito***", he says, looking alternatively at his wife and her womb, and verbally accentuating the deictic references. "***Y a la Gabrielita***", she replays playfully, drawing closer to his face. The system of gaze and the vector running along Jorge's arm, together with his utterance, gives equal importance to the lives of Gabriela and their baby. The unborn child is named with a diminutive, first after his father and then after her mother. This "relief" exchange further signals the presence of another human being; it also connotes that baby girls are as welcomed and valued as baby boys, an interdiscursive reference maybe based on the assumption that people in rural communities –where most of the target audience comes from- place a higher value on the coming of a male child. As a religious minister working in Xochis observed:

> [...] Así que muchas veces, pues, los papá quisieran bebés porque los va a ayudar en el monte, van a cuidar los chivos, van a cuidar el toro, van a la milpa. Entonces las mujeres no les sirven más que para lavar ropa y hacer tortillas, ¿sí? Sin embargo, hay veces que los hombres prefieren varones. ¿Por qué? Por su trabajo de ellos, por el campo, por... y aquí no podemos hablar por sucesión, de algún apellido ¿no? Pero sí por su trabajo,

[203] Moreover, the text tends to blame the victims for endangering the baby (construed as a sentient human being waiting to be born), when those who channel the blaming device (e.g., the doctors in the story) may not share this discursive conception of the unborn.

> ¿verdad? Dice, "una niña qué me va a ayudar... no, yo quiero un niño, quiero un bebé para que cuide, para que esto, para que el otro... Por eso el papá siempre quiere varón, pero por su trabajo, no porque "aaay el varón va a llevar mi apellido, y mi apellido va a ir creciendo aquí en esta comunidad"... No, no, no, ellos lo hacen por esa razón... cuantos más niños es mejor porque les va ayudar más, van a trabajar, van a ir a ir a esto a lo otro, y las niñas pues no.

During the conversation with the male doctor, the latter only attempts to touch Gabriela when he scolds Jorge for taking too long to bring her to the health centre. "*Pones en riesgo la vida de Gaby y del futuro bebé*", he says, as he places his right hand almost touching Gabriela's womb and briefly looking in the same direction. Gaby, too, strokes her belly when she hears the doctor mention her child. This double deixis both signals and accentuates medical and maternal concern, reinforcing expected roles (the doctor is professionally making a point, Gabriela reacts instinctively). This is the only occasion when the unborn child is openly qualified as not-yet being ("*futuro bebé*"). Later in the same scene, the doctor warns Jorge about the threat of pre-eclampsia to both the mother and the baby. We are later exposed to a worst-case scenario of individual risk factors, when Gaby recalls that both her sister and her baby died during delivery. This rhetorical strategy aims to extend the perception of threat –both in terms of vulnerability and severity- to the baby, who is framed as at-risk individual and part of an at-risk group.

I have already discussed the key actantial and semiotic role of the ultrasound images across the "Late pregnancy checkup" and "Self-control and solidarity" sequences. We can see these segments of the film as part of a single phase with strong internal cohesion, where biomedical technology –and ultrasound imaging in particular- are construed as hard facts we can count on to confirm both the existence and the good health of the baby. The makers of the text use behavioural processes (Gabriela lies down, first in the hospital and then at home), mental processes (she looks at the images of her baby, confirming his existence and his good health) and relational clauses of identification ("*Éste el el ultrasonido de tu bebé*", "*A poco que es el Jorgito*", "*Éste es el ojito*") to cohesively co-pattern the same meaning across different scenes.

The first of these two interlinked scenes ends with the doctor passing knowledge –and responsibility- to Gabriela, who stares at the image of her baby in awe, while the second scene features Jorge and Gabriela revealing fact-based, true knowledge about the baby to their comadre. This is a key dimension emerging from the overall ultrasound phase, one that heralds the generation *of a new type of shared knowledge* in an intercultural environment where at-risk women are construed as prone to misguided beliefs. Ideationally, there is a direct, visual connection between mother and child (even though she has been carrying him in her womb for eight months). Tangible, visual knowledge from biomedical technology (Gaby can both *touch and see* the image of her child) confirms the embodied –though uncertain- experience of motherhood. Both literally, as she leans forward to the image, and figuratively, Gabriela gets closer to her child. The phase ends –and transitions to the epilogue- with the voice-over of the Speaker taking up the sonic figure (from the "Watchful care" motif) and deictically addressing the viewer for the first time: "*Tu salud y la de tu bebé están en tus manos...*" At the textual level, the multimodal device reaches maximum redundancy: gaze, smiles, hands, voice-over, even the field (though the voices are inaudible) deictically index the baby (a visible, tangible baby) as at-risk being and subject of care. Interpersonally, the text resembles the Carnet in that they both interpellate the viewer/reader as at-risk mother who is responsible for her own health and the wellbeing of her child.

During the second scene of this phase, Jorge says to their comadre: "*... la Gaby y el bebé están retebién... y el chamaco ya nace en esta semana*". The second clause of this utterance, anchored in categorical modality and a sense of immediacy (*"ya nace en esta semana*") presupposes the safe birth of the child under medical surveillance. This is confirmed from the very first image of the "Reward" scene, where we see a closed, tight frame fully occupied by a healthy baby boy wrapped in a white blanket and cradled by a nurse in white uniform. The archetypical image (sharp focus on the baby and the nurse, couched in immaculate white, against an indefinite background) dissolves from the last shot of the "Anticipation" scene, glossing over the circumstances of childbirth in a hospital setting, which is feared by some indigenous women and embraced by others. The tight close-up of the child in the nurse's arms confirms a safe delivery in good, trusted

hands (skilled care) and proposes a close bond between public health and at-risk families. The heightened whiteness –itself the culmination of several cohesive references to this colour across sequences in the second episode- points to safety and cleanliness in hospital environment. Textually, the dissolve of the previous shot to the tight close-up of the baby also suggests a topical relationship, as it continues and fully realizes the equation between ultrasound image (Given) and baby (New) and it presents the healthy baby as the outcome of awareness, parental agency, control, self-control, and solidarity, all of which are discursive landmarks of the second episode (and the overall text).

The mother is physically absent from this scene. This is a significant choice, because it leaves the emblematic intimate space of the immediate afterbirth first to the nurse and then to the father. One possible reading, consistent with the analysis in terms of dramatic theory, is the decision to highlight the role of the heroes: Jorge and government health staff. After all, it was Jorge who had no hesitations regarding institutional care. This reading is supported by another detail: the intimacy of this moment is not de-contextualized, as it happens in the hospital version of the Carnet. When the nurse hands the baby over to Jorge, the use of deep focus makes it clear from an ideational perspective that the happy denouement is taking place in the public space of the hospital.

5.12. Revisiting a metaphor

In 5.7.2 above, I said that the title of the film is a guide to understanding the overall text. I also said that this is not a self-contained statement, since it lacks the semiotic expansion that comes with the fictional and non-fictional components of the text. Having analyzed key elements from the film, I will now revisit the meaning-making potential of the title.

The film opens and closes with the same exhortation: "*Hazle caso a tu cuerpo, hazle caso a la vida*". Taking into account all three dimensions of the discursive event, we can appreciate the semiotic density and metaphorical potential of this clause complex. We have the different nuances of the verbal idiom "*Hacer caso a algo o a alguien*", which implies at the same time "*prestar la atención que merece*" (pay attention to someone or something), "*obedecer, ser dócil*" (obeying, being submissive), "*acceder o asentir a lo*

solicitado" (do as requested), and "*conceder credibilidad a rumores, noticias, etc.*" (grant credibility to rumours, news, etc.).[204] All of these apply here. This semiotic range anchors the metaphorical and metonymical use of the overall clause complex –the thematic placement of "*Hazle caso*" at the beginning of both clauses adds to this effect.

For instance, the filmmakers urge the viewer, through the first clause, to pay attention to their body. Of course, we need the semantic expansion that comes with the film to understand the metonymical use of the word "*cuerpo*" instead of a certain set of bodily symptoms (headache, ear buzzing, swollen feet, sharp abdominal pain, etc.) But would it be enough for the viewer just to pay attention to these symptoms? As we know, Jorge and Gabriela somehow do this in the first episode of the film: He notices that she is not feeling well, and she implicitly acknowledges as much, but she says that it will soon pass and he goes along with it. We also know what happens next. Based on the purpose of the video, it is not enough to pay attention to your body: you have to "grant credibility" to a certain interpretation of these bodily messages, which the text construes as signs of alarm for a potentially deadly disease. The interpretation of our bodily messages is experiential, social, cultural, and –if anything- multifaceted. Through our own experience, we tend to assign meaning to what is going on in our body, but mostly *we are told* how to interpret those signs. We ask others to tell us what is going on –e.g., girls typically ask their mothers when they see their first menstrual blood. Socially, we ask those who are authorized to interpret –parteras, healers, clinical practitioners- and those whom we trust in this regard -friends, family members, online health and fitness advisers, etc. Or we simply hear it around us. Much of this knowledge is culturally grounded. Throughout a good part of our life, we take for granted these interpretations, which become part of commonsense. Personal experience also comes into play: we confirm this interpretation through our own embodied experience. And, as I have discussed in chapter 2, there are also explanations when the sanctioned interpretation fails to account for real life

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[204] I have drawn the different senses of the expression from the online dictionary of the Real Academia. "Caso">"Hacer caso a alguien, o a algo". *Diccionario de la lengua española, 22nd edition modified*. 2009. Real Academia Española online. Available at http://buscon.rae.es/draeI/SrvltConsulta?TIPO_BUS=3&LEMA=caso. Accessed December 27, 2009. All of these senses apply when using the expression with Spanish speakers in Mexico.

outcomes: scapegoats, blaming devices, fate, religion, bad luck, "one-in-a-million" statistical aberrations, any or all may come into play.

These meanings are so pervasively around us and so deep within ourselves that we retrieve them automatically. So, for a new interpretation to take root, the previous one has to be uprooted. And one way of doing this is to discredit the source of that knowledge. Which is what happens in "Heed your body": the authors of the text exhort the viewer to turn their attention away from traditional sources of cultural, commonsense knowledge, and to pay attention and grant credibility to what they see and hear on screen, to go by the new interpretive framework, and to trust the authorized, authoritative bearers of this "true" scientific knowledge. We can now re-read the same clause: "*Cuando sientas estos síntomas, no le hagas caso a lo que te dicen que no es nada y que pronto va a pasar. Haznos caso a nosotros*". One can also read: "*Créenos cuando te decimos que los servicios de salud del gobierno y el municipio te van a ayudar, que en el hospital te van a salvar, y que allí vas a tener un parto seguro para ti y para tu bebé*".

From a behavioural and sociocultural perspective, there is more going on. The text is not only interpellating the viewer to see things in a certain way and to trust that this will translate in a safe experience of motherhood. The filmmakers want the viewer to act as they are told whenever they experience what they now should know are signs of alarm. The full semantic range of "*hacer caso*" is now in display. Heeding your body entails paying attention to certain feelings, interpreting them as symptoms of a potentially deadly disease, and seeking immediate assistance from government health services. But, as we have seen from the multimodal analysis, "heeding" also means *agency* to take distance from the traditional social norm and *submission* to government health staff and "skilled", biomedical practitioners. Overall, it means the viewer should be able to and reinterpret and reorient knowledge, attitudes, behaviours, social roles, alliances and oppositions as framed within the film. As I have mentioned in 5.7.1 above, *whom* to heed, and not what to "heed", is the interpersonal focus of the video drama.

Something similar happens with "*hazle caso a la vida*" in the second clause. We know it is impossible to heed life in a literal sense. Life is too broad a concept and it needs textual

and contextual grounding. Upon viewing the film, we can see the metonymical association, which is linked with the meaning of the first clause: if you pay attention to your body's messages, and if you read them correctly, you will realize that these are the messages of life at risk. Technically, there is no relation of subordination between these clauses. Rather, the second clause expands the meaning of the first one, both in terms of elaboration ("Heeding your body is heeding life") and enhancement, which can in turn be read with respect to manner ("Heeding your body means heeding life") or cause and effect ("If you heed you body, you will heed life").[205] Moreover, if you "heed" and obey the right experts (second episode of the film), you will be able to avert your own death and you will help to reduce maternal mortality in Mexico (first episode). This complex chain of metaphorical meaning is hammered home through the voice-over in the final epilogue: Heeding your body (and acting accordingly) is in your hands, and so is life.

These metaphorical manipulations both distill and contribute to the re-educational, re-socializing effort of the film, so pregnant women and their husbands start interpreting and organizing their views and practices according to the medical science behind safe motherhood discourse and the policies and priorities of the Mexican government.

5.13. Conclusions

"Heed the messages" is a multi-generic, interdiscursive text that draws heavily in terms of content and structure from secondary genres or macro-genres[206] such as edutainment telenovelas, medical consultation, non-fictional health education videos, and health risk communication; from primary genres or micro-genres, such as explanations, instructions,

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[205] Elaboration and enhancement are two kinds of clause expansion within a clause complex. In elaboration, one clause specifies, clarifies, or exemplifies the meaning of another. In enhacement, a clause qualifies the meaning of another by reference to time, place, manner, reason, purpose, etc. Halliday MAK, Matthiessen CMIM 2004, p. 394-395 and 410-411.

[206] The distinction between primary and secondary genres comes from Bakhtin. Secondary genres are complex scientific, artistic, legal, journalistic, political, and technocratic ways of organizing types of activities (in this case, health promotion and education) from a communication standpoint. Secondary genres "absorb and re-contextualize primary genres from a range of semiotic modalities into their own forms and for their own purposes". Baldry A, Thibault PJ 2006, p. 43. Martin calls them "macro-genres". Martin JR. Analysing genre: functional parameters. In Frances Christie, J.R. Martin, *Genre and institutions: social processes in the workplace and school.* London, New York: Continuum, 2000, p. 3-39, reference on p. 16..

reports of statistical information, and exemplums; and from different orders of discourse –religious, familial, public health, and traditional views of motherhood and maternal care. This complex configuration has three interconnected purposes. First, it suits the immediate educational goals of the text –changing knowledge, attitudes, and behaviours for the prevention of pre-eclampsia and eclampsia among at-risk groups. It also serves the implicit goal of identifying safe motherhood with public control and private self-control of maternal health in a medicalized continuum of care. Finally, it reveals a more ambitious goal of re-orienting the target audience away from traditional views and sources towards a biomedical understanding of health. This wider re-educational effort, almost an attempt at acculturation,[207] has profound ideological implications in an intercultural context like the one in Xochis. The mix of elements from different orders of discourse implies confronting and/or co-opting indigenous stakeholders, views, and practices to suit government purposes.

Moreover, this re-educational drive is not an offshoot or an unintended consequence of the video drama, but an essential component and a pre-requisite for the success of the immediate educational and behavioural goals. In other words: for the message to "get across" and have a bearing on people's knowledge, attitudes, and behaviours, a broader change is needed in the way indigenous people understand the world, relate to one another, and defer to the authoritative knowledge and expertise that the government endorses and promotes in the public sphere. As Petraglia points out:

> Narratives are not sequences of isolated information; indeed the distinctive feature of narratives is their embeddedness in broader, cultural narratives. [...] Thus, intervention in narratives is rarely about the simple replacement of an inaccurate belief with a more accurate one. When narratives are successfully recast, the new meaning modifies not just a single fact, but also the fact's relationship to all the other facts in the narrative; it effects

[207] Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members. At the group level, it involves changes in social structures and institutions and in cultural practices [...] Because acculturation takes place after an individual's initial socialization into his or her original culture, it may be viewed as a process of *resocialization*, or *secondary socialization*." Berry JW. Acculturation. In Joan E. Grusec, Paul David Hastings (eds.), *Handbook of socialization: theory and research*. New York: The Guilford Press, 2007, p. 543-558.

> a change in one's worldview. [...] The best use to which narrative intervention might be put is similar to the aims of narrative therapy –to induce a significant shift in one's worldview and the way the person understands a range of significant relationships and reemploys past experience and future expectations.[208]

I cannot tell whether this overarching meaning-making effort will contribute to the success of "Heed the messages" as a cognitive behavioural intervention. As I said before, this is not a study on the efficacy of safe motherhood communication –although I have mentioned issues of de-contextualization in a rural indigenous setting that would undermine this effort. But the discursive analysis of the film reveals an attempt to induce a shift in worldviews among the target audience.

This is very much in line with core generic traits. Lozano argues that edutainment telenovelas are conscious, ideological attempts at re-creating myths, "in ways that explore options, expose contradictions, and suggest new ways of doing things"[209] This video drama aims to undermine traditional indigenous narratives about pregnancy and childbirth and to create a new mythical narrative where elements of the traditional order of discourse are re-contextualized and subordinated to a biomedical interpretation of pregnancy and childbirth. "To invent a myth –says Lozano- is to construct an ideological instrument and to deny the cultural ground of mythological thought".[210] Taking into account data from interviews in the field, I would argue that the producers of the video take aim at mythic thought *precisely because it is culturally grounded.* They believe that using scientific information to raise awareness through authoritative sources can not only debunk the misconceptions at the heart of the myth, but also usher audiences in a new explanatory model they can apply to their experience in the "lifeworld".

In a similar way, the film sets up a moral framework for individual and familial responsibility with respect to maternal health. Here, too, we can trace the mythic resonance from telenovelas:

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[208] Petraglia J 2007, p. 500.
[209] Lozano E 1992, p. 213.
[210] Ibid, p. 216.

> The domestic, intimate, and interpersonal stance of melodramatic serials privileges an "ethical" approach to the construction of drama. Melodramatic serials emphasize matters of morality over matters of action, as much as mythical narratives emphasize the logic of interaction and patterning over the logic of action and resolution. In both cases, the mythical structure is to be found not in the circumstantial events but in the forms of relationships and interactions. The myth is the very structure of options and choices.[211]

Options and choices are woven deeply into the fabric of this text. So much so that viewers are left with the responsibility of an open ending in their hands –a pivotal construal opposing individual agency to mystic fate.

Following the Mexican edutainment tradition, the video film construes behavioural relations of cause and effect between people's actions and health consequences, and it makes individual and collective attributions of blame and responsibility. In this regard, the film presents a classic moral tale that rewards the alignment of the participants –and the viewers- with biomedical explanations and a Western view of the world, and punishes cultural, commonsense readings of maternal health and traditional beliefs and expertise. Drawing from mainstream behavioural research for the prevention of maternal mortality, the text features cognitive constructs like self-efficacy and response efficacy, and subjective norms, reflecting a Western and mainstream Mestizo assessment of the values and options at stake. The film also bears key markers of health risk discourse, such as awareness raising (of alarm signs and risk factors for pre-eclampsia and eclamsia), fear appeals (both in terms of severity of the threat and vulnerability to it), and the promotion of individual responsibility and trust in biomedical experts.

The risk paradox I discussed in chapter 2.2.4 is nested in "Heed the messages". On the one hand, the video film conveys the idea that pre-eclampsia can happen to anyone –a hidden enemy lurking under the surface of a normal pregnancy. On the other hand, it explicitly construes a group of at-risk women –or rather, women at higher risk- by making Gabriela's case a worst-case scenario in terms of risk factors.

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[211] Ibid, p. 210.

Throughout the text, there is a carefully construed multimodal relation of opposition-articulation between private and public spaces, coupled with related polarities (safety versus danger) and complementary dualities (control and self-control) from health risk discourse and safe motherhood discourse. And even though it acknowledges material constraints -like access to government health centres- and cost-benefit evaluations in a near-subsistence economy, the film ultimately dismisses these concerns by prescribing solutions based on government value priorities, pointing the finger to traditional beliefs as the most serious obstacle to maternal health.

As was the case with the Carnet, the multimodal textual device is reinforced at the level of discursive practices, in this case, through the controlled use of the "media"[212] to ensure a heavily guided reading of the text in mandatory prenatal chats. With respect to sociocultural practices, the film creates and reinforces a series of subject positions and identities, using interpersonal meaning to construe relations of power and solidarity. The main indigenous participants are framed -and the members of the target audience interpellated- as children in need of paternalistic guidance and supervision from biomedical practitioners. Participants and viewers are demanded agency to break away from traditional beliefs and submission to embrace authoritative medical knowledge.

The unborn is construed both as another person and as a person yet to be (future baby), always projected as a key component of safe motherhood and maternal care. In terms of risk discourse, this unborn is framed as an object of care and not as a subject of interpellation. The spouses are held responsible for his or her life. The text also alludes to the equal value of the lives of baby boys and baby girls, an interdiscursive reference likely based on the assumption that some among the target audience place a higher value on the coming of a male child.

[212] In chapter 3.5.2.2, I refer to channels and physical distances as the "media" of the discursive event. They are part of the collective system of situational resources for the use of language, also known as register.

Commonsense and cultural knowledge are confronted or embraced in order to fit the immediate goals and the overarching re-educational purposes. The creators of the text construe muted, oblique oppositions between traditional beliefs and knowledge and also between "misguided" commonsense (e.g., Gabriela's, her mother in law's) and "enlightened" commonsense (Victoria and Gabriela's comadre). Along the same lines, relations of power and societal roles are reinforced or subverted to better serve the purposes of public government control. Jorge is hailed as a hero for deviating from social norms within his family and taking Gabriela to the government health centre. He is framed in a positive light both for deviating from the macho archetype (he keeps abreast of her pregnancy and helps with the household chores) and for doing what is expected from him in spite of his wife's will. Male influence and dominance over women is not a problem here, as long as it is a positive, "enlightened" dominance. On the other hand, Gabriela's agency is framed in a negative light when she voices traditional beliefs about her own bodily experience; whereas she is encouraged and rewarded for self-controlling her pregnancy and being obedient and submissive in a medicalized continuum of care.

The video film bears many traces of individualistic health risk discourse as has been described and documented elsewhere; but it also has a collective dimension that is not typical of lifestyle-oriented health discourse. This collective component has several layers of meaning: it is an acknowledgment of certain structural barriers that affect people's decisions; it is also an admission that giving pregnant women "the care the need" calls for a concerted effort from family, community, health services, and the government. This is all about solidarity. At the same time, the collective component reproduces, reinforces and at times challenges existing power relations between different social and ethnic groups; requests men and women in the communities to change their views and behaviours in order to tackle a politically defined national priority; interpellates men and women to take individual action in the private sphere of their homes to set in motion a wider set of collective events; and ultimately makes the victims of social inequities responsible for changing this state of affairs –or, at the very least, for not being an obstacle in this collective endeavour. This is all about power. Such combination of solidarity and power is at the very heart of "Heed the messages".

Chapter 6: Analysis of field interviews

6.1. Introduction

In this chapter, I will explore how indigenous women and men use key dimensions of government safe motherhood discourse, as well as elements from different orders of discourse (e.g., family, community, religion, traditional health care) to make meaning in relation to pregnancy, childbirth, puerperal and perinatal practices. I will also analyze selected segments from interviews with other stakeholders, such as government health officials, government health staff, and religious leaders, to stress certain discursive influences and articulations, and to fill out the overall discursive picture that feeds into the ideological complex of maternal health and motherhood.

Data on this chapter come from in-depth interviews with 14 women of childbearing age (some were pregnant and some had recently delivered at the time; most were backstrap-loom weavers who had little formal education and scant or no knowledge of the Spanish language) and 12 husbands who, in all but one case, were not related to the female participants. All interviews were carried out in different locations within the municipality of Xochistlahuaca, between September 2007 and September 2009. All but one were done in Amuzgo by trained Amuzgo community health promoters and later translated and transcribed by an Amuzgo medical practitioner and an Amuzgo anthropologist from Xochis working for the MNH Project there. All units of analysis are therefore translations, except where indicated. To protect the identity of our participants, I have changed all their names here. As I mentioned in chapter 3, these interviews aimed to capture the following: a) key dimensions of safe motherhood discourse, including health risk components; b) explicit and implicit references to indigenous concerns regarding pregnancy, childbirth and the postpartum period, as identified from the literature and key informant interviews; c) explicit and implicit references to other institutional orders of discourse concerning maternal and perinatal care.

Although women are the primary target of the communication pieces analyzed in chapters 4 and 5, I have included data from interviews with men for two main reasons: a) they are also part of the target audience in the video film; b) according to the MNH Project baseline study, they are the single most important source of direct influence over pregnant women.[1] I have also used data from interviews with five health officials from Chilpancingo and Ometepec and two religious leaders from Xochis. I personally carried out these interviews (most Spanish, one in English), except for one that was done by the coordinator of the MNH Project in Xochis.

I have followed two major references for the analysis of these interviews. The first one is Lupton's work on everyday discourses about the emotional self[2] and women's discursive construction of their pregnancies[3], and Lupton and Barclay's research on discourses of fatherhood[4]. In the latter, the authors summarize their approach:

> Our intention in this study was to elicit these men's practices and feelings in relation to their experiences of becoming fathers, and to seek to explore the ways that they may take up, negotiate, reshape or reject the discourses on fatherhood emerging from popular and 'expert' texts and other sources.[5]

In the same vein, I have explored how indigenous women and men "take up, negotiate, reshape or reject" safe motherhood discourse from government sources, and how they incorporate elements from different orders of discourse (e.g., family, community, religion) in the process. This approach entails "mining" for discursive traces on selected units of analysis, rather than taking people's words at face value. Which does not mean that people will necessarily lie or conceal information during interviews, or that they will concoct the complex, purposeful, and targeted discursive engineering we have seen in chapters 4 and 5. It rather means, as Lupton and Barclay observe, that

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[1] According to the still unpublished 2008 MNH Project baseline, the husband was the single most important influence on pregnancy-related decisions for some 45% of respondents.
[2] Lupton D. *The Emotional Self: A Sociocultural Explanation.* London, Thousand Oaks, and New Delhi: Sage Publications, 1998.
[3] Lupton D 1999c.
[4] Lupton D, Barclay L 1997.
[5] Ibid, p. 7.

> ... the ways in which people articulate their responses about a particular topic are always the product of the resources they have available to them, including the pre-existing discourses that are circulating within their own sociocultural setting, acting in conjunction with people's personal biographies and the unconscious level of meaning. Participants in any research study will take up particular ways of expressing their opinions and recounting their experiences that are inevitably shaped through social and cultural processes and meanings.[6]

I have not approached these interviews as if they would yield a deeper truth about maternal health in Xochis than other research methods, but rather in search of a particular kind of insight: how people make sense of maternal and perinatal care, what discourses they draw from and what this tells us about the underlying social processes. As Lupton observes in her study of everyday discourses on emotions in men and women:

> The focus of an analysis such as this is not so much on to what extent the participants are conveying an 'objective' reality, but how they express their understandings and experiences of reality incorporating both contradictory and overlapping discourses. It is assumed that there is a commonly shared pool of discourses to which people have access and upon which they draw when describing their experiences. This pool of discourses is not static, but is subject to constant flux in response to broader sociocultural events and trends. The focus of the discourse analysis is in identifying which particular discourses tend to be used by people when 'making sense' of phenomena and conveying narratives of their experiences to others."[7]

In practical terms, "the emphasis of the analysis is upon the structure of people's explanations, the words, phrases, concepts and belief systems they use to describe phenomena and beliefs and represent their experiences, and the other texts they draw upon in their explanations."[8] Along these lines, I have examined how the different

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[6] Ibid, p. 94.
[7] Lupton D 1998, p. 40.
[8] Lupton D, Barclay L 1997, p. 94-95.

discourses and representations of risk and related ideas interact in people's own words, and how sometimes these texts are transformed into something new.

My second major source of inspiration is the grounded theory approach that dominates qualitative research since the 1960s. When I say "source of inspiration", it means that I have drawn from this set of methods, not that I have searched for grounded theory in a classical, orthodox manner. This would not have been a sound course of action, because looking for grounded theory is an inductive endeavour, where theory emerges mostly from the data,[9] while I have used mainly existing theory and pre-established categories from the literature, key informant interviews, and discursive analysis of government communication materials –fear, danger/threat, responsibility, blame, trust, advisors, etc. However, I have used grounded-theory tools in order to mine and arrange the data into conceptual categories, to explore core thematic relationships, and to establish certain connections between the different dimensions of safe motherhood discourse and textual elements from locally based orders of discourse (culture, religion, traditional health care, the expected roles of men and women in maternal care, etc.).[10]

By using grounded theory techniques, I also allowed for the emergence of new categories within the structured context of the interviews. In this case, emerging categories are not pre-established or purportedly induced through the questionnaire.[11] For instance, *hacer caso* (heeding) is a pre-established, induced category, because we asked in a very specific manner –*¿A quién le hace más caso en estas cosas del embarazo?* On the other hand, *débil* (weak), *fuerte/fuerza* (strong/strength) and *pujar* (pushing at delivery) are all emerging, non-induced categories, even if they were already in the literature.

Sometimes it is hard to draw the line between both types of categories. We asked about cultural syndromes such as espanto, antojo, and coraje, and therefore we will consider

[9] Álvarez-Gayou Jurgenson JL 2003, p. 90.
[10] This is an important conceptual clarification: the notion of "category" should not be seen as a synonym for "dimensions". *Some*, but not all, categories are key dimensions of safe motherhood discourse.
[11] Martínez Miguelez says that "true categories", that is, those categories that will reveal the logic behind individual and group behaviour in any given social environment, will most likely not be preconceived categories, but will emerge from the data. Martínez Migueles M. *Ciencia y arte en la metodología cualitativa*. 2004. Ciudad de México: Editorial Trillas, 2007, p. 76.

them pre-established, although some participants brought them up before being asked about them. Religion, on the other hand, is a purely emerging category, because we never asked about religious issues in relation to pregnancy and childbirth[12]. In practical terms, here is how I went about the analysis:

-First, I codified the units of analysis into different primary categories (PCs).[13] These categories are conceptual labels that group together and describe key concepts or ideas from cross sectional analysis of the data. From a discursive standpoint, categories relate to experiential meaning, that is, meaning as thematic organization of experience –what participants talk about, who is involved, under what circumstances.[14]

-Units of analysis are typically segments of interviews where participants talk about topics or situations with a certain thematic unity. These textual segments can include a range of content, from narrations of personal experiences or the experiences of others to people's views of maternal care practices in the community. The length of a unit may be defined by the response to a particular question, though some units may extend over more than one question and answer, or the opposite may happen, that is, a single answer may contain more than one unit of analysis. Pre-established and emerging categories also play a role in shaping units of analysis. At the same time, any unit of analysis can be classified into one or more categories.[15] Although many authors suggest labeling PCs with words and expressions used by the participants, I have not been able to do so here, because I worked with translated transcriptions of the interviews. Whenever possible, I labeled PCs with words and expressions from these translations.[16]

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[12] We only asked about religious affiliation at the beginning of the questionnaire, among other questions intended to draw a sociocultural profile of the participants.

[13] Other authors call them descriptive categories or substantial categories, as opposed to theoretical categories. Substantial categories are used to conceptualize data, whereas theoretical categories are used conceptualize the relation between substantial codes, allowing for the elaboration of hypotheses towards an emerging theory. Álvarez-Gayou Jurgenson JL 2003, p. 96.

[14] In this chapter, I will only define those analytical concepts and tools that have not been described in previous chapters.

[15] Hernández Sampieri R, Fernández Collado C, Baptista Lucio P. *Metodología de la Investigación*, 3rd. Edition. Mexico City, McGraw Hill, 2003.

[16] Although there was considerable back and forth with the translators to discuss their selection of words in Spanish, particularly regarding major categories, they may have used different words to account for similar

-I looked into the different units of analysis within each of the main categories to see what concepts, views, and experiences they were linked to. For instance, what types of dangers and threats are grouped inside this conceptual box? What kinds of discourses resonate within the emerging *Dicen* ("they say")? What do people refer to when they talk about prevention? I have done this selectively, because the amount of data exceeds the scope of this thesis; but the results give an idea of the complexity of the issues at stake from the perspective of our participants, which largely exceed government and biomedical concerns about maternal risk.

-I chose examples from categories that were closely connected with the objectives of my research. In particular, I used units containing narrations, views, and expressions that show how people make meaning by drawing from different types of discourses. I have also selected representative examples of key emerging categories.

-Finally, I have done some work at the level of theoretical categories (TCs), which helped me map out conceptual connections between primary categories.[17] For this, I followed *discursive connections* between categories, as they appear within people's responses. From a discursive perspective, what interests us is not so much an enumeration of risks and related ideas, but how people make meaning with them?

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ideas and expressions from the interviews. That is why I have often labeled categories based on overall ideas that are common to different units of analysis.

[17] Theoretical categories can emerge from inductive analysis –i.e. integrating PCs into larger topics and subtopics. Hernández Sampieri R, Fernández Collado C, Baptista Lucio P 2003, p. 595-596. Typologies are a classic example of theoretical categories. These typologies can either reflect how people classify other people, objects, events, etc., or they can be based on the researcher's criterion. Taylor SJ, Bogdan R. *Introducción a los métodos cualitativos de investigación: la búsqueda de significados*. Trad. from the English original by Jorge Piatigorsky. Barcelona, Buenos Aires, Mexico City: Paidós, 1987, p. 162-163. In this case, I have mostly used pre-established theoretical categories from key informant interviews and the literature. For instance, the category "Advisors" (people who advise the pregnant woman or tell her what she should do; people the woman has learned from or whom she heeds regarding maternal care) was introduced in the questionnaire. Some PCs within these TCs came from the literature and key informant interviews (e.g., people in the family, the husband, the doctor, the partera), whereas others emerged from people's answers (*las mujeres que han tenido muchos hijos, los muertos/los que vivieron antes que nosotros; dice la gente/me dicen/dicen que...*).

Following Fairclough, as in previous chapters, I have recursively worked between the different levels of the discursive event reflected in any unit of analysis: textual level, discursive practice, and sociocultural practice, taking into account observations from the field, key informant interviews, quantitative data from the 2008 SM baseline survey, and frequent consultation with our transcribers/translators. In particular, I have looked for intertextual and interdiscursive traces of key dimensions of safe motherhood discourse and other relevant discourses. At all times, I have tried to reflect the different forces at play and I have paid attention to how our participants use overlapping and contradictory discourses. In particular, I have tried to show how these discursive dynamics reveal the tensions and articulations between traditional and biomedical views, and the struggles around stability and change at the level of sociocultural practices. In sum, I have tried to explore not so much what kind of risks people perceive as *what they do to make sense of these risks* and what discourses they use in the process. As a result, different views of risk emerge, each one with multiple discursive articulations.

Following Lupton and Barclay, I have done both cross-sectional analysis and intra-interview analysis.[18] By focusing on common elements from different interviews, I have looked at major themes and patterns at the community level. On the other hand, I have paid attention to the way different discursive categories combine and interact within a single interview -for instance, in the narrative reconstruction of personal experiences. Among other things, this intra-interviews focus shows how most participants draw from different discourses when they make meaning in relation with maternal health and motherhood and reveals an unstable ideological complex and a shifting sociocultural landscape. Since I share Fairclough's observation that coherence lies with the interpreter of any given text,[19] it is in that sense that I will speak of coherence here –that is, if and how the different, often contradictory discourses nested in people's words, make for coherent reading and what this tells us about stability and change within the ideological complex.[20]

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[18] Lupton D, Barclay L 1997, p. 119-141.
[19] See p. 111 above.
[20] Intra-interview analysis requires careful consideration of the participant's personal and micro-social circumstances. In qualitative analysis, a participant is always a person plus her circumstances.

In chapter 3.6.1.3, I explained the conceptual and practical reasons for using structured questionnaires with open-ended questions. Working with inexperienced interviewers posed some challenges in this regard. For instance, I could not solve the lack of timely follow-up questions that would encourage participants to elaborate on key topics. This happened all-too-often during the interviews. On the other hand, unscripted follow-ups made for telling, insightful moments that enriched the analysis; I point to a few such cases below. We also had limited time and few trained resources to complete the interviews. Most interviewers had part-time jobs that were obvious priorities in a near-subsistence economy. As a result, follow-up interviews were soon ruled out.

We built specific tactics inside the questionnaires, in order to work with pre-established categories or dimensions of risk discourse and safe motherhood discourse. Tackling the complex semiotic components in the notion or risk is a premiere example of this approach. As I have discussed in chapter 2.1, public health communication stresses the "threat" or "danger" component of risk over the probabilistic nature of the statistical concept of risk. At the same time, as it became clear from the exchange with our Amuzgo collaborators in Xochis, the Amuzgo language does not have a word for risk in terms of "odds", "chances", or probabilities. Asking about risk, in this case, implied asking about threats or dangers.[21] In order to capture the idea of the likelihood of an event, we included questions about the need for prenatal control, perceptions of vulnerability, and making plans for delivery, among others intended to touch on different aspects of risk. We also asked for and made room for answers on personal experience, feelings, and views; contrasts (what do you think of this compared to that?), personal preferences, perceived social norms, and prevalent attitudes and behaviours in the community. We also searched for explanations and causal logic (typically, questions about why things happen), because these responses can provide insight on how people make sense of personal experience, the experience of others, and events in their communities.

[21] Bilingual health staff sometimes use the notion of "dangerous symptoms", "dangerous signs", or "dangerous conditions" in order to discuss maternal risk. Thus, someone could say during consultation: "If you have this symptom or this problem, it may be dangerous, because it can lead to this or that other problem or disease".

Because of the large amounts of data and the translated –hence mediated- nature of the texts, I have done a less delicate analysis of the use of language in these interviews, compared to the detailed approach in chapters 4 and 5.[22] I have used some tools and concepts with a good degree of confidence, mostly at the level of intertextuality, interdiscursivity, and experiential meaning, which allows looking into a crucial component of discourse analysis in an intercultural context, that is, the coexistence of different fields and orders of discourse in people's answers. I have made a more restrictied analysis of other semantic elements, given the nature of the translated texts.[23] This task involved frequent consultation with the translators of the original interviews.

6. 2. Notions of risk

The notion of maternal risks, in terms of threats and dangers, is very much present among the Amuzgos, and this finding holds even considering that our interviews took the dialogue quite clearly in that direction.[24] Childbirth, in particular, is seen as fraught with risk. On the other hand, many biomedical alarm signs were frequently seen as common ailments, and government views about how to lower maternal risk not always coincide with the views of Amuzgo women and men in the communities. An though many of our participants spontaneously referred to risk factors and at-risk groups in ways that ressemble the logical thinking of modern epidemiology –i.e., the correlational, rather than causal, link between a risk factor and a health problem-, their description of these factors and problems not always reflected biomedical concerns, as we can see from the following

[22] Despite some coordination between translators, there remain differences and inconsistencies that further limit the scope of the discursive analysis.

[23] I have secured a fair degree of confidence when it comes to the main idea within a unit of analysis, most experiential meaning, some logical meaning, and intertextual and interdiscursive references. I have carefully and occasionally said something about interpersonal meaning (for instance, something like "*no estoy segura, pero creo que…*" would indicate low evaluation from an interpersonal perspective). I have also examined utterances as representations of different types of processes (material, mental, verbal, relational, etc.) and certain components of the clause as message (theme and rheme), and I have analyzed some aspects in the rhetorical organization of certain texts. But I have not attempted to discuss the linguistic construal of the responses beyond this point.

[24] Some 87% of husbands and 78% of elderly women surveyed for the MNH Project 2008 baseline said pregnancy is a dangerous state, which belies the oft-assumed idea that indigenous peoples do not follow biomedical advice because they do not perceive the perils in pregnancy and childbirth.

exchange with Elcira, a puerperal 37-year old illiterate mother of seven from Llano del Carmen, who links being multiparous with a high risk –an almost certainty, in her words-[25] of having antojo:

> **Q**: ¿Cómo te das cuenta de que tienes uno de esos problemas?
> **E**: ¿El antojo? Pues se da uno cuenta por los síntomas, las molestias; no se vive feliz, se siente incómoda. Si no se tiene nada al principio, después de dos o tres hijos se presentan las molestias.

On the other hand, our participants were concerned with the position of the baby inside the maternal womb, with cultural syndromes (coraje, antojo, espanto, loss of the nahual), miscarriage and abortion, and female lack of strength during childbirth. Overall, perceptions of pregnancy risks include but largely exceed biomedical views. In Appendix D,[26] I have condensed the different types of risks mentioned by indigenous women of reproductive age and men from different communities in Xochis, as well as perceived eventual outcomes and reasons why these things happen. Even though some participants said –usually at the beginning of the interview- that they did not see any risks in pregnancy, most of them brought up a series of perils and uncertainties, as shown in the following exchange with Josefina, a 36-year old mother of six from Xochis Cabecera, who can speak, read, and write some Spanish, and who had recently given birth at the time of the interview:

> **Q**: ¿Puede haber peligros o problemas para la mujer embarazada?
> **J**: No
> **Q**: ¿Por qué no?
> **J**: No hay peligro cuando sólo está embarazada y no está enferma de otra cosa.
> **Q**: ¿Qué otra cosa le puede pasar a la mujer durante el embarazo?
> **J:** Puede fallecer si no está sana durante el embarazo
> **Q**: ¿Son cosas graves, entonces?

[25] This certainty is not unlike the framing of frequencies, rates, and even odds, as "facts" in public health communication –as discussed in chapter 2.1.1. Taking into account María Emilia's words, we could say that women are more likely to feel symptoms of antojo during their third or fourth pregnancy. However, she expresses this likelihood through categorical modality, as if it were a certain outcome, a fact.
[26] Appendix D, p. 580-606.

J: Son cosas graves. Si no está su bebé en buena posición no podrá parir naturalmente.

Q: ¿Estos problemas les pasan a muchas mujeres aquí en el pueblo?

J: Sí

Q: ¿Piensas que estas cosas te pueden pasar a ti?

J: Sí, creo que me puede pasar a mí cuando mi hijo no está sano o mi salud es débil.

Q: ¿Por qué hay mujeres que tienen problemas cuando están embarazadas?

J: Porque a veces es por falta de comida para que sus hijos nazcan sanos. A veces lo que pasa es por falta de dinero, por eso hacen coraje [...] por eso se enferman sus hijos.

Josefina qualifies her initial response with a condition: there are no dangers when the woman "does not have any other disease", or "is not otherwise sick". But she feels a woman can die if she is not healthy or if her health weakens while pregnant, a frequent complication –a threat- with a potentially deadly outcome that makes her feel vulnerable. This unit of analysis illustrates the convenience of interpreting people's answers in the immediate context of the narration and the cross-sectional context of the interviews. When asked to give an example of bad things that can happen, Josefina mentions the wrong position of the baby in the womb (transverse or oblique foetal lie), the single most frequent concern among our participants and a deadly threat to both the mother and the child facing delivery (cross-sectional analysis). When she later says that these things can happen if her son is not healthy, we can link this fear with her previous reference to the wrong position of the unborn child (intra-interview). Of course, transverse or breech position can be interpreted as an obstetric complication from a biomedical perspective; but in the words of our participants it emerges as an *ever-present risk* for the mother and the child. Moreover, we can say, from this and all other interviews, that a) a wrongly positioned foetus is part of an at-risk group of babies; and b) a mother with a wrongly positioned baby is herself at risk. Since our participants state that unborn babies may switch positions rather frequently, we can conclude that both the babies and their mothers are framed as being at risk and requiring prenatal control from doctors and parteras alike.

Josefina's reference to "weak health" is also of interest in the cross-sectional context of our interviews, to the point that I have treated "weakness" as a category unto itself. Bad things happen to weak women or women of weak health, because they are particularly

vulnerable to sickness and other health threats. In other words, weak women are at greater risk of taking ill or having complications during pregnancy and childbirth. There is a certain connotation of blaming in this view, like an "original sin" that makes some women weaker than others. There are also discursive traces of a generational divide: older women were stronger, tougher, more resilient and more agentive women, at least in terms of maternal health –which is certainly not a minor component of indigenous women's lives and expectations. These traces run along the following exchange with Ana, a multiparous woman who had recently given birth in Cozoyoapan:

> **Q:** ¿Y qué es lo que le está prohibido hacer a una mujer en el embarazo? ¿Qué es lo que dice la gente o lo que has escuchado?
> **A:** Como no levantar objetos pesados, como caminar mucho. La gente mayor dice que eso es mentira, porque ellas cuando daban a luz iban al monte y regresaban cargando cosas pesadas, pero nunca tuvieron problema en el embarazo, nunca. Pero la persona débil simplemente no lo puede hacer. En mi caso yo no lo puedo hacer; me quedé aquí, no salía, sólo aquí andaba, me cuidaba mucho.

In her last answer, Josefina mentions a complex chain of material constraints and health threats linking structural barriers with the health of the mother and the child. At the same time, she points to a deep connection between the pregnant woman and her unborn baby, a salient trait of the indigenous order of discourse on motherhood and maternal health (which I have captured as a category, "Mother-child"). Moreover, we can see that her child is framed as her ultimate concern. Asked why some women have problems when they are pregnant, Josefina says that "sometimes, it is for lack of food so their children can be born healthy", framing lack of food, an emerging category, as a risk factor for malnutrition and an unhealthy newborn.[27] In the second part of her answer, Josefina says

[27] To illustrate the overall categorizing procedure, I have coded this unit of analysis under "What the pregnant woman eats" (*Alimentación de la madre*), "Malnutrition" (*Desnutrición*) and "Lack of food" (*Falta de comida*), among other categories. In this case, Malnutrition is a pre-established category, because we asked our participants whether a pregnant woman should eat more or less than usual, or as much as usual; whereas "lack of food" is an emerging category, because some participants brought it up in their answers even though no question referred to this problem. In a second stage, I have axially coded "Lack of food" and "Malnutrition" as "Risk factors" . "Lack of food" also links axially with "Poverty" (another risk factor) and this with "Structural barriers". Malnutrition can also be related to lack of food and poverty, but it may also be the outcome of a personal decision to eat less in order to have an easier delivery.

that, sometimes, lack of money makes the woman sick with coraje, which in turn affects her children.[28] Here, the path from structural barriers to negative maternal outcomes is even more explict. This takes responsibility away from the woman and places it on the material conditions in which she lives. Both lack of food and lack of money relate (cross-sectionally) to the material life conditions of the Amuzgos and to a widely held perception of themselves as being poorer than the Mestizos. This is an important discursive component from the indigenous order of discourse, which has been incorporated into government safe motherhood discourse, as we have seen in chapter 5.

The very first part of Josefina's answer hints at a linguistic pattern that looms large on the whole notion of pregnancy risks from an indigenous perspective. When the interviewer asks her why she thinks there are no perils for pregnant women, she answers: "There is no danger when she is only pregnant and not otherwise sick". Both in English and Spanish, the answer may strike as being deeply contradictory; but we know, from the review of the literature, that many indigenous groups in Mexico refer to a pregnant woman as someone who is sick. This is also the case among the Amuzgos, where most people say *estoy enferma* or *está enferma*, that is "I'm sick" or "she is sick", when they want to say "I am pregnant" or "she is pregnant".[29] This wording may reflect the view of pregnancy as an inherently constraining, debilitating state, which is suggested by the following exchange with Catalina, an unschooled 37-year old going through the *cuarentena* after bearing her fourth child:

> **Q**: En el embarazo, ¿comes igual, más o menos que de costumbre?
>
> **C:** En el embarazo, la mujer no tiene mucha hambre, come poco, no come lo que se debe.
>
> **Q**: ¿Por qué le pasa eso a la mujer?
>
> **C:** No sé, yo pienso que es por el embarazo... el embarazo impide comer mucho.

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[28] Josefina frames coraje both as the outcome of stress from material deprivation and the cause of illness in the mother and the newborn. One can say, based on cross-sectional analysis of the data, that indigenous women see themselves as more prone to catching coraje because they are poorer than Mestizo women. In fact, many participants express their perception of coraje as an indigenous-only disease, which Mestizos neither suffer nor believe in or understand –and therefore are unable to cure.

[29] According to Moisés Zeferino de Jesús García, a linguist and translator from Xochis, unschooled people say "I'm sick", while schooled men and women use the Amuzgo equivalent to "I'm pregnant". The expression "I'm sick" was by far the most frequently used by participants in our interviews.

Q: ¿Trabajas igual, más o menos que de costumbre cuando estás embarazada?

C: No, se trabaja poco. A veces no se hace nada porque no se puede. Se trabaja poco porque el bebé lo impide.

Q: ¿Qué cosas no debes hacer durante el embarazo?

C: No se deben levantar objetos pesados, muchas cosas ya no se pueden hacer. Se enferma la mujer, pierde la felicidad, eso le impide realizar cosas.

Most of our data tends to confirm what some authors have suggested on this matter, that is, "the parallel with illness may lie in the fact that both illness and birth are stressful times associated with ritual and physical danger."[30] For many of our participants, pregnancy *entails* danger, particularly in relation with childbirth.[31] Belisaria, a 24-year old puerperal woman and mother of three, with post-secondary education, describes pregnancy in terms of uncertainty and herself as being at risk, even though she says pregnancy-related problems are not frequent in her village and she has not had any problems in the past.

Q: ¿En el pueblo hay mujeres que tienen problemas en el embarazo?

B: Aquí no

Q: ¿Crees que tú puedes pasar por esos problemas?

B: Si, lo he pensado

Q: ¿Has pasado por algo de eso?

B: No, nada

Q: ¿Por qué crees que te puede suceder algo?

B: Porque una persona no sabe como va a terminar su embarazo, ya que una mujer se embaraza por nueve meses y en esos nueve meses no sabe cómo terminará todo.

Most men –87%, according to the MNH Project baseline survey- are of a similar view, regardless of age. Horacio, a 63-year old from Guadalupe Victoria, thinks of pregnancy in terms of risk and uncertainty (the latter, in itself a risk factor for coraje):

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[30] Cosminsky S 1986, p. 76.

[31] I have reflected these views by creating a theoretical category that I have labelled "Pregnancy *as* risk".

> [...] porque conforme avanzan los meses de embarazo debe de tener más cuidados. Mientras pasan los días, ella se vuelve más débil y ya no puede levantar objetos o realizar trabajos pesados. Como aquí las mujeres tejen telar de cintura en el embarazo, la mujer ya no debe realizar este tipo de actividad. Estas son algunas de las cosas que pasan. Mientras más se acerca el día del parto va empeorando, aparecen varios síntomas como la pérdida del apetito o se enferma de coraje. El coraje viene de la incertidumbre que ella siente, de no estar segura que dará a luz sin complicaciones.

In some cases, this perception is based on unspecified comments from others. Jacinto, an 18-year old man from Llano del Carmen, who had elementary school education and was expecting his first child at the time of the interview, is a good example of this generic awareness of pregnancy as fraught with severe threats:

Q: ¿Tú piensas que puede haber peligros o problemas cuando una mujer está embarazada?
J: Sí, es peligroso
Q: ¿Por qué es peligroso?
J: Puede fallecer
Q: ¿Por qué?
J: No sé, pero es peligroso.
Q: ¿Cómo sabes estas cosas?
J: He escuchado
[...]**Q**: ¿De qué se puede enfermar la mujer embarazada?
J: No sé de qué se pueda enfermar, pero sí sé que puede morir. Yo creo que se enferma si no acude al hospital.
Q: ¿Conoces alguna señal o molestia que pueda indicar problemas graves?
J: Sí, cuando está triste
Q: ¿Qué hay que hacer en esos casos?
J: Se le pregunta qué tiene, y se tiene que llevarla al hospital.
Q: Cuando se pone triste, ¿qué es lo que tiene?
J: Dolor de cabeza o de panza.
Q: ¿Por qué ocurren estos problemas?

20 **J:** Porque no acuden al hospital

21 **Q**: ¿A quién le pasan?

22 **J:** A las mujeres que no acuden al hospital.

23 **Q**: ¿Sólo a ellas les pasa?

24 **J:** Sí

25 **Q**: ¿Alguien tiene la culpa de que pasen estas cosas?

26 **J**: Sí, el esposo.

27 **Q**: ¿Por qué?

28 **J:** Porque no la lleva al hospital

29 **Q**: ¿Estos problemas les pasan a muchas mujeres aquí en el pueblo?

30 **J:** Sí

31 **Q**: ¿Por qué crees que pasan esas cosas?

32 **J:** Porque no van al hospital

I have used the word "awareness" above, because it is a key dimension of behavioural models and public health communication campaigns. Based on the above exchange, we can say that Jacinto is aware of pregnancy *as* risk. Like Jorge in the video film (Jorge the Sender from the second episode), he doesn't have a clear knowledge of what these threats involve form a biomedical perspective; but he shows "englightened common sense" and knows they have to seek help from the right experts. If we substitute "hospital" for "health centre", we find in Jacinto's assertive and normative language the attitudes that should pave the way for Jorge's reaction in the second part of the film. He doesn't know what kind of disease can affect the pregnant woman, but he is aware that she can die; he doesn't know what the alarm signs may lead to, but he knows that he must talk to her when she is sad, and, most significantly, he knows that he must take her to the hospital when she shows certain signs, like headache or stomach pain. In fact, the hospital is the single most salient topical theme cutting across his answers. He believes the woman gets sick *because* she does not go to the hospital ("*Yo creo que se enferma si no va al hospital*", lines 11-12, and then he reiterates this belief on line 32). Furthermore, only women who do not go to the hospital have problems, and this turns them into a high-risk group (lines 19-24) and makes their husbands responsible for the adverse outcome (line 26). The hospital seems, from his words, the best guarantee of a healthy pregnancy.

In short, Jorge seems aware enough that he will do what is right from a biomedical standpoint. And he seems permeated by a "coherent" type of discourse. However, later in the same interview, he says that a pregnant woman should not wash herself with cold water because her blood grows weaker; should go to the health centre because they can tell her if the baby is well positioned within the womb, but should also go to the partera to correct this position; and should go to the healer, "because he can cure her when she has antojo or espanto". Jacinto's awareness shifts and expands with our interview, in a way that encompasses biomedical and traditional concerns. On the one hand, all of this confirms that multiple views and discourses of risk coexist in the community, and therefore government discourse lands on fertile ground in terms of "awareness". On the other, it poses a challenge to government policies and goals, since it is anything but clear that women and men from the communities will follow a single course of action facing these threats. Jacinto seems to follow seemingly contradictory explanatory models and he seems to trust authoritative figures from both worlds.

Cross-sectional analysis of the data frequently reveals the same pattern: most people view pregnancy and childbirth in terms of risk, though they may not be particularly aware of biomedical risks, they may interpret a series of symptoms in a different way, or they may be focused on a single dominant concern, like the position of the baby inside the womb.

But while Jacinto's views echo the voices around him and the expectations of things to come, other people's views of risk are strongly influenced by their personal biographies;[32] these people re-interpret government discourse in a different way. Francisco, who lived in Llano del Carmen and whose wife was pregnant at the time of the interview, talked about a previous miscarriage and likened pregnancy to his own experience as a worker in the countryside:

> Las mujeres que han tenido varios hijos dicen que no es necesario ir al hospital por experiencia de ellas y porque cuando el destino está escrito que el bebé nacerá bien, pues

[32] Personal biographies are narrations of previous experiences, where what counts is not so much what really happened as how people construe those events.

así sucederá. Pero uno nunca sabe lo que pueda suceder. No en todo momento sucede eso. Como yo soy campesino y a diario uso el machete, yo me puedo confiar de mi destreza con el machete, pero en cualquier momento puede sucederne un accidente [...] Es lo mismo con la mujer, porque ella vino al mundo con la capacidad de dar a luz, pero nunca sabe de las posibles complicaciones que le pueda ocurrir.

Many discourses interact here. Francisco brings into his answer the voices of multiparous women who say there is no need to go to the hospital for delivery, based on their own experiences and their belief that fate dictates the outcome of childbirth –in this case, he frames fate in terms of positive expectations. He then resorts to an interpretation of his own experience as a farmer to confront and undermine this perception of self-efficacy. He, too, trusts his ability to perform in that which he is skilled for, and he draws a parallel with a woman's inherent capacity to give birth. Both are capable of doing what they were born to do (give birth) or became able at doing (using the machete), but neither can tell what may happen for sure. This first-person account of the limited value of experience and his warning about self-efficacy as a double-edge sword fits like a glove in safe motherhood discourse. Francisco openly confronts traditional discourses of pregnancy and childbirth from his own personal experience, whereas government texts do it in a muted, indirect way.[33]

Something similar happens with José, 32-year old man from Xochis cabecera, with high school education and no religious affiliation (he said he had yet to choose one), who had one child and was expecting a second one at the time of the interview:

Q: ¿Es necesario que la partera atienda a tu mujer durante el embarazo?
J: Sí, cuando se aproxima la fecha del parto, porque la mujer embarazada corre riesgos, es delicada. Al levantar objetos pesados o leñas puede abortar. La señora (partera) lo que hace es acomodar el bebé. El embarazo es riesgoso, yo sé porque a

[33] As we have seen in chapter 5, "Heed the messages" brings these variables into play through the doctor's questions about Gabriela's family clinical history and Jorge and Gabriela's recollection of past maternal tragedies.

mi mujer le sucedió.

Q: ¿Me puedes platicar cómo pasó?

J: Se nos murieron tres bebés. Mi mujer siempre fue al centro de salud porque tenía cita, la citaban una vez al mes durante el embarazo. Ella siempre cumplió, pero no sirvió de nada. Al final mi mujer parió aquí en casa porque no tuvimos tiempo de llegar al centro de salud.

Q: ¿Quién atendió el parto?

J: La señora, la mamá de Santiago (la partera).

Q: ¿Qué fue lo que pasó?

J: El bebé nació bien, no estaba enfermo, se veía bien, mamaba bien. A los pocos días se enfermó de coraje, la llevamos al centro de salud pero no lo curaron.

Q: ¿Cuánto tiempo vivió?

J: Tres semanas. El otro hijo vivió sólo un día y otros dos fallecieron en la panza de mi mujer.

Q: Cuando tu mujer se embarazó del bebé que vivió un día, ¿iba al centro de salud durante el embarazo?

J: Sí

Q: ¿No le avisaron que tenía problemas?

J: No, allá sólo le ponen un vidrio en la panza para ver el movimiento, por eso no dicen nada cuando está enferma la mujer, porque no saben. Yo pienso que con las inyecciones que le ponen a los bebés lo que causan es daño, porque el día en que nació la llevamos para la inyección y desde aquel momento comenzó a sentirse mal. Parecía que tenía saliva en la garganta que le tapaba. Yo pienso que las inyecciones causan más enfermedades y esto ni los propios médicos lo saben. Es un plan del gobierno para terminar con los indígenas porque ya no tolera que le reclamen. El gobierno busca la forma de exterminar con los indígenas y las inyecciones son parte de esa estrategia. Mi bebé estaba bien cuando nació, pero después de las inyecciones comenzó a sentirse mal.

Q: ¿De qué era la inyección?

J: Era la inyección que les administran a los bebés.

Q: ¿Tu mujer no hacía trabajos difíciles durante el embarazo?

J: No, no

Q: ¿Tu mujer va a controlarse al centro de salud durante el embarazo?

J: Siempre va

Q: ¿Por qué?

J: Porque ellos la citan. En las reuniones les dicen a todas las mujeres que cuando se embaracen deben de ir al centro de salud. Ella iba y cumplía con todo lo que le recomendaban, porque cuando no se cumple y pasa algo los médicos dicen que es culpa de ella por no ir. Porque ellos preguntan luego si la mujer ya fue al centro de salud. Pero ni ellos pueden salvar, no tienen asegurado el destino, sólo Dios sabe. Por eso, aunque vaya al centro de salud, cuando el destino ya está definido no hay nada que hacer.

Q: ¿Por qué nació muerto el otro bebé?

J: Aunque iba periódicamente mi mujer en el centro de salud, nunca le dijeron que estaba mal el bebé. Yo dudo mucho que revisen el estado de salud... puede ser que ni ellos lo sepan. Entonces, ¿qué tan cierto es que ellos pueden ayudar? No lo sé. En mi familia han muerto cuatro hijos míos, y con el último fueron cinco; al último lo atropelló un carro.

Here, too, pregnancy is a besieged state, and maternal health is framed, mirroring government discourse, as a continuum of care for both the woman and her child. José contends that "pregnancy is a dangerous state" (line 4) and that the pregnant woman *corre riesgos, es delicada* (lines 2-3) –in other words, she is an at-risk women. He puts the emphasis on miscarriage, a dreaded outcome. But he does not speak from hearsay; he derives his discursive authority from personal experience: "I *know* because it happened to my wife" (lines 4-5). Then, he goes on to talk about the death of two of his newborns and two other babies in the womb. If his conception of maternal and perinatal health as an experiential unit –in terms of ideational content- gives strong cohesion to his narrative vis-à-vis government discourse, his intertextual reference to government interpellations (lines 37-44) and his wife's positive response in terms of expected behaviour (lines 41-42) makes his blaming of government health staff (lines 47-50) all the more coherent. His narration becomes a cautionary tale. From a behavioural perspective, response efficacy is turned into discursive boomerang: "*Ella siempre cumplió, pero no sirvió de nada*" (lines 8-9). We can therefore construe José as Jorge, the husband in the movie, if things had taken a wrong turn at the hospital, something government officials acknowledge as an all-

too frequent event. He also blames health staff for not being able to anticipate the newborns' health problems, even though his wife periodically went for prenatal control.

José's reconstruction of his tragic experience shows that he, too, values the core dimensions of trust and expert knowledge at the heart of government safe motherhood discourse –in fact, a cross-sectional analysis of the interviews experientially reveals mirroring values in the traditional order of discourse. This is a crucial commonality of concerns, because trust in medical experts and government is laid to waste in José's cautionary tale. Health staff at the health centre failed to anticipate and later to cure what he labels as a case of coraje. Twice he states both things with categorical modality: "*El bebé nació bien, no estaba enfermo, se veía bien, mamaba bien. A los pocos días se enfermó de coraje, la llevamos al centro de salud pero no lo curaron*" (lines 14-15) "*No, allá sólo le ponen un vidrio en la panza para ver el movimiento, por eso no dicen nada cuando está enferma la mujer, porque no saben*" (lines 23-24). On lines 48-50, he restates this idea, this time with a marked sense of mistrust: *Aunque iba periódicamente mi mujer al centro de salud, nunca le dijeron que estaba mal el bebé. Yo dudo mucho que revisen el estado de salud... puede ser que ni ellos lo sepan.*

We know from the discussion in chapter 2.2.4[34] that no amount of prenatal screening can foresee all potential complications at childbirth -or with the newborn, as may have been the case here. However, the strong discursive connection between prenatal control and safe outcomes that we saw from the analysis in chapter 5 –including the construal of health staff as the ultimate experts in maternal health and institutional services as the only skilled care- may induce the type of negative –confrontational- reading that José draws from his own experience.[35]

Something similar happens with screening technology, which is pitched as a magical agent of truth –seeing entails knowing- in the video film. José undermines this discourse

[34] See p. 75-76 above.
[35] In other cases, personal biographies (the narration of previous experience) ratify government discourse. One way or another, personal biography is an all-important category emerging from the cross-sectional analysis.

–understandably so- from his own experience. "They only put a glass on her belly to see the movement" (of the baby), he says of ultrasound scanning, and that is why "they do not say anything when the woman is sick, because they don't know." Through the generalization of his own experience, José contests ultrasound imaging and strips it of its magical power to speak the truth.

Trust in government fares even worse in José words. Logical meaning and intertextuality feature powerfully here (lines 23-32). Even with lower evaluation than elsewhere in the text (*pienso, parecía*), he derives a logical sequence of cause and effect between taking a healthy newborn to a government health centre and the progressive deterioration of the child's health, ending in death, after being vaccinated. He concludes that vaccines cause diseases and he exempts health staff from responsibility. On lines 27-31 we can see the irruption of a discourse that could be linked, at the level of sociocultural practices, with the repressed autonomous indigenous movements in Xochis, as described in chapter 1.[36]

The experiential coexistence of several discourses is very telling of how people make meaning, mediated by personal experience, in an intercultural context where a new discourse –safe motherhood discourse- tries to make way for new practices and policies within the ideological complex of motherhood and maternal health:

-On lines 1-5, we find ideational traces of pregnancy risks and pregnancy *as* risk, particularly related to the position of the baby in the womb, a common concern in both government health discourse and the traditional order of discourse, with a very different framing of what should be done and who should do it. José explains, as a matter of fact, and not of option or choice, what has become the most frequently requested service from parteras.

-On lines 6-10, we see an intertextual reference to government health discourse, and close surveillance and control of pregnant women (a pre-established category from the cross-

[36] See chapter 1.1.4.1, p. 32-33.

sectional analysis). There is also mention to personal experience and material barriers: José presents homebirth as the result of circumstantial constraints and not of choice.

-On lines 14-15, 23-24, and 48-50, as we have seen, José claims the authority of personal experience to undermine government discourse regarding safety and skilled care in institutional settings. This also work s as a blaming device that offsets the individual interpellation –and the blaming therein- extracted from government discourse through the use of intertextuality on lines 41-44. José responds to this fingerpointing by blaming the government (lines 24-31) and drawing from a discourse of indigenous obliteration that may be linked to longstanding indigenous grievances in Xochis.

-On lines 40-44, José puts into words the intense pressure he perceives from government surveillance policies and discourse of prenatal control. When this discourse does not live up to the expectations it has created –as measured through the lens of personal experience-, he brings in notions of fate and religion (also voiced by many other participants) and not clinical or structural explanations to give meaning to this failure. When fate is set in, there is nothing health staff can do; only God knows. His logical conclusion makes for a highly coherent reading in an intercultural context with competing authority claims: *Por eso, aunque vaya al centro de salud, cuando el destino ya está definido no hay nada que hacer.* José was one among a few to bring up divine intervention and the all-powerful, unassailable influence of fate, which sometimes are presented as one and the same, to make sense of adverse maternal outcomes. Carolina, a young woman from Llano del Carmen who was expecting her first child after a previous miscarriage, said along these lines:

> **Q**: ¿Por qué crees que puede fallecer una mujer embarazada o el feto mismo?
> **C**: Pues fallece porque así lo dispone su destino, porque aunque acuda a un hospital hay enfermedades que aparenta estar bien pero de un día para otro se enferma nuevamente, síntomas como falta de visibilidad o dolores de cabeza, y eso lo puede llevar a la muerte. Ningún médico puede hacer nada cuando Dios así lo dispone.
> **Q:** ¿Lo mismo sucede con el recién nacido?
> **C**: Lo mismo sucede, a veces no vive más de un día en este mundo.

Health authorities dread this conclusion, and they go to great pains to change it through public health discourse, as we have seen from the analysis of the video film in chapter 5. Moreover, the government contends that God's intervention is contingent on human agency on the part of pregnant women and their spouses. God's influence stops at the door of the health centre or the hospital, so to speak. There is an acute counterpoint here, one that concerns the relationship between knowledge and power, as well as pre-established (agency) and emergent (fate, religion) categories. We appreciate how traditional and religious discourse can be harnessed for different purposes and combined to divergent effects. (Below, I analyze yet another case where religious discourse and government safe motherhood discourse combine in the words of a female participant to reinforce biomedical views).

One way or another, it is clear that traditional and religious orders of discourse are a default background and essential components of the ideological complex, while safe motherhood discourse operates as a recent incorporation that can co-opt but not entirely dominate pre-established discourses –let alone the way people will use them to make meaning in their lives.

6.3. Cultural syndromes, maternal health, and social circumstances

As we have seen from chapter 2.3.2,[37] culturally bounded syndromes such as espanto, antojo,[38] coraje, and the loss of the nahual are present across indigenous groups throughout the Americas. They also feature as feared risk factors and frequent complications for maternal and perinatal health among the Amuzgos. From a discursive perspective, they all imply a close holistic connection between the pregnant woman and her child, and between the two of them, the familial and the social environment, and the

[37] See p. 86-88 above.
[38] Antojo may be the most widely shared with non-indigenous groups. However, there are specific discursive connotations linking antojo with ethnic identity and maternal health emerging from our data; I discuss them below.

material circumstances of their lives. Women who suffer from cultural syndromes are at higher risk of adverse outcomes and so are their children.

In the same way that both same motherhood discourse and traditional discourses lay out a continuum of care, people view cultural syndromes as a *continuum of threat* for the mother and the child, from before conception to the cuarentena. Moreover, the consequences of these cultural syndromes carry over from one stage of motherhood to the other. A mother who loses her nahual before being pregnant is at higher risk for pregnancy complicatons, and an unfulfilled antojo can affect the child at birth, as expressed by Jacinto:

> **Q**: ¿Hay algún peligro para el niño recién nacido?
> **J:** Sí
> **Q:** ¿Cuál?
> **J:** Se puede enfermar
> **Q**: ¿Has escuchado de algún caso?
> **J**: Sí
> **Q**: ¿Me puedes hablar sobre el caso?
> **J:** Era un bebé que al momento de nacer vivió unas horas, después falleció. Falleció porque su mamá se había enfermado de espanto.

The continuum of threat from cultural syndromes looms large over the mother and the child. A mother who gets coraje or is otherwise subject to stressing social and emotional processes after childbirth can affect the newborn –who is particularly at risk at that early stage. Alfredo, a 23-year old father of two from Colonia Progreso, who could read and write some Spanish, brought this up during our exchange:

> **Q:** Si se enferma el recién nacido, ¿alguien debe revisarlo? ¿Dónde y cuándo deben revisarlo?
> **A**: Si no es muy peligroso, debe de ser su mamá, y si es grave en el hospital. También hay medicina indígena; si se enferma, se puede usar la medicina indígena.
> **Q**: ¿En qué casos se puede usar?

A: Cuando se enferma, porque hay niños que se enferman, les da por no comer bien, no crecen.

Q: ¿Por qué se enferman?

A: Puede ser porque la mamá no le caiga bien a alguien, o porque tiene miedo de algún animal ponzoñoso, por eso el niño al nacer no come bien, nace flaco. Por ejemplo, si la mamá odia al perro, la cura contra esa enfermedad puede ser quemar la basura de la casa, juntarla y quemarla y el humo tiene que pasar encima del bebé [...] Hay otra enfermedad peligrosa, el coraje. Cuando el niño sale con la mamá a la calle y pasan por una casa donde las personas están discutiendo, se enferma de coraje, y cuando esto pasa, si no se busca medicina, puede morir.

Many issues converge here. From lines 9-15, Alfredo discusses different possible explanations for the newborn being sick. All of them are expressed in terms of cultural syndromes, and all of them involve the mother. For instance, someone may not like her ("*Puede ser porque la mamá no le caiga bien a alguien*"), in which case she is the Phenomenon in a negatively charged emotional process with an anonymous Senser;[39] or she may be afraid of something ("*porque tiene miedo de algún animal ponzoñoso*"), in which case she is the Senser in an emotional process conveying fear (espanto) of a concrete Phenomenon in her environment. On lines 10-12, he elaborates with an example: if the mother "hates" the dog (where hate could imply extreme disgust or even fear), this negative emotion (that disease, "*esa enfermedad*") can make her child sick. This effect on the newborn is implicit though nonetheless clear in the explanation, because Alfredo says, on line 12, that the smoke from burning the garbage has to pass over the baby. In both cases, the mother is a necessary participant in the child's illness; in one case, she is directly responsible because of her emotions (Mother→Fear→Child); in the other, she is the recipient of negative emotions, for which she may be to blame or not (Anonymous Senser→Dislike→Mother→Child). One way or the other, there is a causal chain of events with a negative impact on the newborn health. This causal connection can only be explained in terms of an inextricable holistic link, even from before conception,

[39] Mental processes (and clauses) represent the inner workings of our experience, such as cognitions and emotions. These processes always have a human participant, the Senser, who feels, thinks, wants, or perceives a Phenomenon, that which is felt, thought, wanted, or perceived. The Phenomenon can be another person, a group, a thing, a fact, etc. Halliday MAK, Matthiessen CMIM 2004, p. 201-205.

between the mother and the child, and a *continuum of responsibility* from the mother to her child.

From lines 12-15, Alfredo then talks about coraje, which he qualifies as a dangerous disease, so much so that the child can die. In this case, coraje is framed as social in nature and not related to the mother: they walk in front of a house where people are arguing and, because he is still frail, the newborn takes ill. As with the other examples, Alfredo presents a situation where negative forces throw people's lives out of balance, and particularly *the lives of others*, in our case, the weakest, most defenceless members of the community –a high-risk group in epidemiological terms. By doing this, he brings into his explanation a discourse of individual and social responsibility concerning maternal and perinatal health. In fact, the traditional order of discourse seems to be more emphatic than safe motherhood discourse when it comes to the holistic connection between the mother, the child, and the environment they live in.

We can also appreciate in this example the challenges facing mainstream safe motherhood discourse in the intercultural environment of Xochis. Among other things, there is a problem within the main components of the ideational meaning. From a logical standpoint, Alfredo's explanation is at times in keeping with modern epidemiological thinking on maternal and perinatal health: he links different variables, draws cause and effect chains, and takes into account environmental stressors. Negative emotions and social tensions affect the pregnant mother, which in turn has an impact on the child (he has lowbirth weight, does not eat well, and as a result, does not grow up strong). At times, he clearly strays from this path: two strangers arguing would rarely be considered the cause of sickness in a child whose mother happens to walk by their house. Experientially, it would be hard for many doctors to identify some expressions in Alfredo's account –"*si la mamá odia al perro*", "*juntar y quemar la basura de la casa y el humo tiene que pasar por encima del bebé*"- as belonging in the field of maternal health. Alfredo's way of thinking clearly bears the marks of different discourses and practices, which he combines in a certain way (from lines 2-4, he lays out a tripartite

system of newborn care, where the mother, the hospital, and traditional healing all have their place). In other words, he makes his own coherent rearrangement of these elements.

According to our participants, believing in and suffering from cultural syndromes is something that happens within the in-group; hence, dealing with cultural syndromes is off limits to biomedical practitioners.[40] These logonomic restrictions are as powerful as the ones that government and biomedical discourses try to impose on their own turf. Roque, a 52-year old illiterate father of two from Arroyo Limón, says in this respect:

> **Q**: ¿La madre trasmite la enfermedad del espanto y del nahual?
> **R**: Sí.
> **Q**: ¿Y por qué no van al hospital para curarla?
> **R:** Porque para ellos no existe la enfermedad del espanto y del nahual. El hospital sabe que hay enfermedades que causan dolores en los pies, en la panza, y recomiendan inyecciones. Para ellos no existen esas enfermedades. Ahora lo que hacen es imitar; ya tienen una inyección que dicen es para el coraje. Pero no es cierto; lo que tiene esa inyección es vitamina que fortalece la sangre, pero no cura del coraje.

This example illuminates the struggle between two logonomic systems and how biomedical practitioners try to breach the logonomic rules within the traditional order of discourse. From Roque's words, we can see how government health personnel attempt to co-opt and subdue traditional discourse –in this case about coraje. This happens at the level of experiential meaning: doctors and nurses, or maybe government cultural advisers, identify that coraje belongs in the field of maternal health within the traditional order of discourse. As Roque points out, they do not believe in coraje –furthermore, they think that believing in coraje and other cultural syndromes delays people from seeking timely and skilled care. There is no room in biomedical knowledge for coraje, except as a meaning-making device, a symbolic hook, if you will. So, they do what the government

[40] This is consistent with Franco Pellotier's discussion about retributional murder based on nahualism, which I mentioned in chapter 1. The author states that this explanation does not explain or lead to violence between Amuzgos and Mestizos, because it is only part of the indigenous worldview. This is also confirmed by Zulema's account, below. She does not get any of these cultural syndromes because she functions within a biomedical explanatory model concerning pregnancy ailments.

does with other notions from the traditional order of discourse in "Heed the messages". Or what a hospital doctor tried to do during an intercultural seminars in Acapulco –as I said in chapter 5, he tried to show a group of Amuzgo men and women from the communities what losing your tono *really* was, with support from images of an intubated woman who suffered from eclampsia, saying it was so serious a disease that it could only be cured in a highly specialized medical environment. Deep down, these attempts at semiotic co-option reveal the underlying conviction that indigenous people are like children and, therefore, a similar approach to meaning making (using white lies, circumventing but not contradicting their childlish views, using their favourite toys and ideas to establish a common code) might work with them. But this manipulation is likely to fail, as we see from Roque's answer: "*Ahora lo que hacen es imitar, ya tienen una inyección que dicen es para el coraje. Pero no es cierto.*" Yes, coraje and pre-eclampsia and other biomedical syndromes belong in the same field of maternal and perinatal health, but they coexist uneasily, because they come from different worldviews, with their own experts, diagnostic devices, explanatory systems, treatments, supportive discoursive devices, and logonomic rules.

This is nowhere clearer than in the words of Zulema, a pregnant 31-year old mother of two from Arroyo Pájaro, who had six years of elementary education and spoke no Spanish:

Q: ¿Una mujer se puede enfermar de antojo, nahual o espanto en el embarazo?
Z: No sé, porque yo no me curo de eso, yo siempre voy al centro de salud, yo no me enfermo de eso.
Q: ¿La gente de aquí se enferma de eso?
Z: Sí
Q: ¿Qué le puede pasar cuando se enferman?
Z: Ellos dicen que si no se curan de esas enfermedades abortan
Q: ¿Sabes cómo se da cuenta la gente de que está enferma de esas cosas?
Z: Van con el brujo y él les dice de qué están enfermas

Zulema, unlike most of our participants, said she did not believe in cultural syndromes. But, here again, *how* she says this is most telling from a discursive point of view. On line 1, the interviewer asks her whether a woman can take ill with antojo, espanto or loss of her nahual. She answers by admitting her lack of knowledge, in a sociocultural context where even younger people know that these things happen among the Amuzgos and can affect a pregnant woman and her child. How come she does not know? On line 2, she says why: "*Porque yo no me curo de eso, yo siempre voy al centro de salud, yo no me enfermo de eso.*" We can slightly alter the order of the clauses in this clause complex, to get a good glimpse behind her answer: She neither gets sick nor is cured from any of these syndromes *because* she goes to the health centre. Again in a different order, she is not diagnosed with any cultural syndrome, hence she does not suffer from them. Moreover, she looks at them from a distance, like an alien set of concerns, as interpersonal meaning suggests: "no me curo *de eso*... *no me enfermo de eso*". We can see a biomedical explanatory system, with its logonomic framework, at work, and Zulema moving within its boundaries. On line 4, the interviewer asks her whether "people around here" do suffer from cultural syndromes. She acknowledges this *happens*. In other words, these are processes of happening and personal experience filtered through a meaning-making device. On line 6, the interviewer wants to know what can happen when others take ill. When she answers, on line 7, Zulema downplays the certainty of what she shares with the interviewer: "*Ellos dicen...*", pointing to a collective, anonymous Sayer in the community. Finally, on line 8, the interviewer asks her whether she knows how people realize they are sick with one of these syndromes, and her answer confirms the same kind of connection behind her own knowledge –or lack thereof: they consult with a traditional healer and he tells them they are sick; in other words, the explanatory system, the discursive framework, and the worldview behind them, as much as the sources of this knowledge, determine what people see *happening* to them and what it means.

In terms of maternal health, Zulema does not seem to inhabit two worlds; in fact, she could be a successful story from the perspective of government safe motherhood communication. She goes for prenatal control, she trusts her health centre, she delivers

her children in the hospital, and she deviates from the social norm insofar as she seems to inhabit only one worldview. Nevertheless, the two worlds –provided that we can talk about two worlds *at all*- are not isolated from each other. Most people move back and forth across the borders, using resources from the different health systems and making meaning though an articulation of semantic elements from different orders of discourse. This crisscrossing comes to the fore in the words of Eulogia, an illiterate 44-year old woman who was expecting her tenth child when we met her in her home of Xochis Cabecera:

Q: ¿Puede haber males de antojo, coraje o espanto, o problemas con el nahual durante el embarazo?
E: A veces sí es cierto. Nosotros, como vamos a la iglesia grande *[the site of the official Catholic church in Xochis, as opposed to the followers of a traditionalist branch of Catholicism, both described on p. 24]*, creemos que puede pasar. En el embarazo se llegan antojos de carne de chivo, pero a veces no es cierto; no es cierto, y se debe por la debilidad de la sangre. Hay personas que no comen bien y la sangre se debilita; se debilita, por eso les sucede.
Q: ¿Cómo sabes si tienes uno de estos problemas de antojo, espanto o nahual?
E: Se hace la cuenta, sólo así se sabe qué tiene la mujer. La gente que llamamos *Nn'a^{n} caula'*, ellos saben cuando la mujer está enferma del nahual o de antojo y buscan la medicina. Así es como le hacemos y con la medicina se cura. Hay personas que sí es cierto les pasa, hay otras que no les resulta.
Q: ¿Qué haces en esos casos si te pasa a tí?
E: Pues, busco a la persona que me saque la cuenta y si me dice que tengo esa enfermedad hago la medicina que me digan. Y si no cura esa medicina, vas al hospital donde se busca la cura.

On line 3-5, she makes a complex interpersonal evaluation of the threat and impact of cultural syndromes during pregnancy. First, she says "*a veces sí es cierto*", which implies: a) that this is not always the case ("*a veces*"), b) that this may indeed be the case ("*sí es cierto*"); and c) that she is acknowledging, behind our question, a controversial status of the "reality" of cultural syndromes ("*es cierto*"), even if the interviewer has not

made it explicit. The whole of her answer, plus the thematic placement of "a veces" tell us that she takes some distance from the universal validity of these claims.

Then, she identifies herself as part of a subgroup –a large majority at that- within the community: "*Nosotros, (los que) vamos a la iglesia grande*". People in this group believe these things may happen. There was no follow-up question to inquire further into this association, but it seems that Eulogia is aware of the different religious affiliations and what they imply in terms of traditional beliefs. One thing is clear from this and other interviews: our participants construe the so-called cultural syndromes as circumscribed to an ethnic in- group ("*nosotros los amuzgos*") or a subgroup within the population ("*nosotros, los que vamos a la iglesia grande*").

Interpersonal meaning is equally salient on lines 6-8, where Eulogia admits that women may crave for goat meat, but then says this is not always true. She repeats this negation ("*no es cierto*"), as if arguing with someone, which is additional evidence that she keeps some distance from the universal validity of antojo claims. In her view, "weakness of the blood" is often the problem (this condition is cited by other participants), because some people "do not eat well". The relational/existential clause "*hay personas que no comen bie*n" states this situation as a fact[41] and frames a group of people whose behaviour puts them and their babies at risk –though the responsibility is only implicitly connoted through agency. There is no further reference to the reasons behind the lack of proper nutrition in Eulogia's response; other participants link antojo and malnutrition with poverty, as I mention below.

Discourses of expertise, knowledge, and power take centrestage from lines 9-17. On line 10, Eulogia makes it clear –as most participants who touch on this topic- that the only way to know whether people are suffering from cultural syndromes is to seek out the

[41] Some 40% of all women of bearing age surveyed for the MNH Project 2008 baseline in Xochis said they ate less than usual while they were pregnant.

healer who will then diagnose and cure by traditional means.[42] She herself proceeds in this way and follows the expert advice from the healer (lines 15-16),[43] but she admits that this sometimes may not work. Moreover, on lines 12-13 she implies that the outcome of the traditional treatment may confirm whether it was a case of cultural syndrome or not: "*Así es como le hacemos y con la medicina se cura. Hay personas que sí es cierto les pasa, hay otras que no les resulta.*" If this happens, if the explanation from the traditional order of discourse does not work, then she moves out of it: "*Y si no cura esa medicina, vas al hospital donde se busca la cura.*" In other words, she acknowledges the culturally bounded nature of these syndromes and the expert authority ("*La gente que llamamos Nn'a^{n} caula*"; "*así es como le hacemos*"). But, contrary to Zulema, she also implies the subsidiary role of Western biomedical medicine, as a second option when traditional remedies fail –this does not entail there is a biomedical cure for cultural syndromes; it rather means some people look for diagnosis, treatment, and explanations within a traditional framework, and only when this proves fruitless, they move outside of this domain. This is the root of governmental and medical attempts to co-opt and subordinate the traditional order of discourse, in an attempt to change people's first options and priorities for pregnancy care. Such strategy is unlikely to succeed, because practice and meaning making are deeply intertwined.

6.4. Repositioning the baby in the womb

I have already mentioned how transverse or breech position can be interpreted as an obstetric complication from a biomedical perspective. From the women's point of view, it is as an *ever-present risk*, a dangerous loss of balance that threatens the mother-child diad

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[42] Some women trust their own embodied experience. When asked how she knew whether she had one of these syndromes, Catalina said: "*A veces lo sabemos nosotras mismas por los síntomas y buscamos hoja de coraje; se muele y se baña con esas hojas, así ayuda, esa medicina indígena ayuda.*"

[43] In the Amuzgo language of Xochis, traditional healers are called *N'na^{n} calua'*, where *N'na^{n}* means people and *Calua'* possibly cockroach. Literally translated, this would mean something like "cockroach person" or "cockroach people". They are also called *Ts'a^{n} na nncwjei' cwenta*, that is, "*la persona que saca la cuenta*" in Spanish, or the person who figures out or diagnoses the illness. These healers diagnose through physical examination and interrogation of the patient, and also using cards or a basket, or even drawing blood from the patient's hand, for purposes of divination. Some experienced parteras, though not most of them, are recognized as healers and perform these duties with their patients. Valtierra Gil, G. *Análisis de entrevistas a parteras: tipos de enfermedades tradicionales, diagnóstico y curación.* Valtierra Gil G. Unpublished report from the MNH Project.

and needs close monitoring and corrective action. I have also stated how a wrongly positioned foetus is portrayed as part of an at-risk group of babies and a mother with a wrongly positioned baby as herself at risk. Therefore, assessing the position of the baby and repositioning as needed are powerful reasons for prenatal control from doctors and parteras alike. But there is yet more from a discursive perspective. Here is what Santiago, a doctor in the Xochis hospital, interviewed in Spanish, had to say on this matter:

1 [...] Entonces las valoraciones aquí son, por ejemplo, si viene pélvico obviamente es
2 un factor de riesgo y eso no lo podría atender una partera, ¡aunque sí llegan a
3 atenderlas! Nosotros aquí también... Pero, ¿qué pasa con ese producto pélvico? ¿Y
4 si se atora de la cabeza, quién lo va a sacar? De aquí a que la pases a la ambulancia,
5 de aquí a que vaya la ambulancia, o fallece el bebé o fallece la mamá. Entonces,
6 ¿qué prefieres, que nazca aquí o que nazca en un lugar donde creas tú que le van a
7 solucionar su problema mediante una operación cesárica? ¡Pues, obviamente en el
8 hospital! Que vaya, ¿no? Tiene un riesgo alto de que ese ese embarazo termine en
9 una cesárea; no le podemos resolver ese problema aquí. Pero si viene pélvico
10 siempre le mandamos a decir "favor de enviar a su paciente a la semana 36", para
11 que los médicos del hospital general ya la vayan conociendo, le vayan pidiendo sus
12 exámenes, la vayan valorando y le vayan dando fecha para operarla, si es que ellos
13 determinan que la van a operar. Y si determinan que le van a dar parto, tiene que ser
14 un parto vigilado las 24 horas... todo el tiempo que transcurra el embarazo. Si ven
15 que tiene problema, la operan de emergencia, ¿ah?, pero en un lugar donde tengan
16 poder resolutivo [...]

On lines 1-3, Santiago talks about risk assessment and mentions breech position as a risk factor -which also shows that confusion between risk factors and obstetric complications is not only a matter of lay perception. On line 2, we see a first connection with two other discursive categories: "Expert" and "parteras". Our source sets the limits for what a partera would be able to do or should do –in this case, "*no podría*" could also be read as "*no debería*". As most clinical practitioners think, she should not deal with a baby in a breech position. Then, he uses high evaluation –through his tone of voice, which I have captured with exclamation marks- to state that parteras do assist deliveries in these

conditions. His evaluation may indicate bewilderement, respect, or perhaps that this is a daring, wreckless undertaking. The latter seems unlikely, since he then adds, in a lower tone of voice: "*Nosotros aquí también (lo hacemos)*". This is an important admission, because the Xochis hospital is not prepared to perform c-sections. At the time of fieldwork (the situation had not changed in May 2010) this hospital had a surgery room and a specialist, but it was not equipped to carry out complex procedures. Pregnant women with unborn babies in a breech position were usually referred to the Ometepec hospital, where doctors can handle the patient as he describes lines 9-16, and eventually practice a c-section.

On lines 3-5, our informant presents the worst-case scenario: What happens if the baby's head gets stuck? Who is going to pull him out? And he mentions frequent delays leading to tragic outcomes in such cases –which he states with categorical modality: "*o fallece el bebé o fallece la mama*". Drawing from his experience, knowledge, and views of risk, he sets the stage for the rhetorical question-and-answer device on lines 5-9: "*Entonces*," he says, logically linking his worst-case scenario with his rhetorical question: "*¿qué prefieres, que nazca aquí o que nazca en un lugar donde creas tú que le van a solucionar su problema mediante una operación cesárica?*" The logical implications are inescapable *within this discursive framework*: "*¡Pues, obviamente en el hospital! Que vaya, ¿no? Tiene un riesgo alto de que ese ese embarazo termine en una cesárea; no le podemos resolver ese problema aquí.*" (Based on what I discussed above, the indexical "*aquí*" refers to Xochis, as opposed to the Ometepec hospital). High evaluation through emphatic delivery and thematic placement of "*pues, obviamente*" point to the inevitability of this line of reasoning, ruling out other considerations. He then goes on to describe a solution where both experiential and logical meaning construe a procedural discourse featuring prenatal monitoring and control, expert knowledge, and skilled care in a well-equipped institutional environment with a safe obstetric outcome, most likely through c-section. Rhetorically, he opposes this situation to partera-assisted homebirth, by highlighting the differences, in terms of knowledge, resources, and power, all of which he sums up on lines 14-16 ("*si ven que tiene un problema, la operan de emergencia, ¿ah?, pero en un lugar donde tengan poder resolutivo*").

Our source leaves out an important piece of information that would change the overall framing of the situation from the traditional order of discourse: most parteras deal with breech presentation *before* childbirth, by repositioning the baby with their hands,[44] usually during the last three months of pregnancy. Government health personnel discourage this practice –even when they think it may work, as we can see from an interview with Alicia, a government health worker who explained, in Spanish, how she trained parteras in the region[45]:

S: [...] Entonces les digo "mejor las paramos -y vénganse lo vamos hacer así, así, así-" y les ponemos de diferente posición el bebé y le enredo el cordón umbilical – "mira esto puede pasar si tú ya me lo quieres enderezar"-, porque también tenemos parteras que nos dicen "pues viene atravesado, yo como quiera, pare; venga sentado, venga atravesado, sale".

Q: ¿y sale?

S: Yo no sé a veces cómo le hacen, la verdad, pero sale (risa). Sí, pero, bueno...

Q: ¿Y ellas te explican cómo sale?

S: Ellas dicen que las mantean... les ponen abajo como una sábana, le giran la cadera a la señora, las alzan, no sé en qué, que se mueve el bebé; no sé, pero a veces sale el bebé... casi la mayoría de las parteras logran ese nacimiento

Q: ¿O sea que ellas les explican a ustedes cómo hacen las cosas también?

S: ¡Sí! Sí, luego que las mantean, o luego nos dicen que las soban, las soban y ahí es donde nosotros decimos que no deben hacerlo. Es donde yo les pongo el bebé y les enredo el cordón; pongo doble circular o una circular –"y mira qué pasa si tú lo quieres voltear, qué va pasando", ¿no?- y van viendo ellas que se va...

Q: Se va...

S: ... estrangulando el bebé. Y se quedan: "Es que nosotras por fuera no vemos cómo está el nene adentro..."

J: ¿Ellas hacen todo desde afuera?

S: Ajá, yo digo que sí, es avanzar poco a poco

[44] According to the 2008 MNH Project baseline, only 5 parteras out of 66 surveyed in Xochis and Tlacoachis had never attempted to reposition the foetus from a breech or transverse lie position.

[45] I have selected this unit of analysis because our source trained parteras according to biomedically-oriented government guidelines and, therefore, her answers reflect mainstream views and discourses on the re-positioning of the baby –a key emergent category- and TBA work and knowledge in general.

Questions of knowledge and power are in full display here, as we get a glimpse of the uneven exchange between the nurse and the parteras. On lines 1-3, Alicia explains how she discourages the parteras from repositioning the baby by using dolls and other props and showing how the umbilical cord can get wrapped around the baby's neck. In other words, she presents them with a worst-case scenario and undermines their tactile knowledge by mock-up visual display of potential negative effects they not see because they unfold inside the womb. This relates to the "ultrasound as foetal reality" discourse analyzed in chapter 5. Some people in the community are of a similar view. José, who would not trust doctors with his newborns, says in this regard: "*No (mandaría a mi mujer con la partera) porque ella no puede ver la posición del bebé; en cambio, en el hospital sí se puede con el ultrasonido.*"

On lines 4-6, our source brings in the voice of parteras asserting their ability to deliver a child regardless of his position inside the womb. She quotes them in a way that reflects their pride in their own skills, though her intention, in the immediate context of her first response, is perhaps to show that some parteras engage in dangerous practices without knowing (without seeing) they may cause harm. As with Santiago, her evaluation may also indicate a mix of concern, amazement, and grudging respect. This is nowhere clearer than on lines 6-7, where the interviewer asks her if the baby comes out in the end, and she says: "*Yo no sé cómo le hacen, pero sale (laughing). Sí, pero, bueno...*" This single utterance packages frontline medical discourse on TBA knowledge: a) most health staff do not know how parteras get results without biomedical knowledge or going against it (in fact, not knowing is the thematic anchoring of Alicia's utterance, something she repeats at the end of line 10); b) they acknowledge that parteras do deliver babies in complicated situations (*pero sale*); c) they take some distance from this evidence (in this case, Alicia laughs, which carries interpersonal meaning in the context of her explanation) and then says "*sí, pero, bueno...*", insinuating her misgivings and pulling away from a conclusive statement about the partera's knowledge and ability to pull off complicated deliveries.

The interviewer insists on knowing whether the parteras explain how they manage to deliver a wrongly positioned foetus. Alicia now paraphrases the parteras and transforms a material process –i.e. *ellas mantean al bebé*- into a verbal one: "*Ellas dicen que las mantean*, etc." By doing this, and placing "*ellas dicen*" in a thematic position, she again distances herself from the validity of the reported knowledge. On line 10, she says "*no sé con qué*" and then "*no sé*", further downplaying TBA knowledge and revealing that she has not tried to see –let alone learn- how the *manteo* works. In other words, there is no serious attempt to understand this practice –even though Alicia admits: "*casi la mayoría de las parteras logran ese nacimiento*"-, but an active, systematic policy to discourage it. We can validate this conclusion from lines 13-16, where Alicia again presents a worst-case scenario, *which she frames as the inevitable, universal consequence of the partera's work,* through mock-up visual evidence*: "Y mira qué pasa si tú lo quieres voltear, qué va pasando, ¿no?, y van viendo ellas que se va [...] estrangulando el bebé."* Verbs and verbal expressions like "*mira*"and "*van viendo*" have a complex experiential nature, since they not only refer to seeing as the main activity that is going on, but also as "seeing" in terms of learning –thus, "*mira*" could be interpreted as "learn" and "*van viendo*" as "they start learning"- and true knowledge. Put differently, the experience of seeing in class should override the experience of using their hands in consultation. This example confirms that health authorities try to construe a subordinate subject position for parteras –i.e. students who must get rid of harmful habits-, undercutting their status as experienced practitioners.[46] It also shows the mindset behind the definition of "skilled care" and the role of TBAs in safe motherhood guidelines, as discussed in chapter 2.4.[47]

[46] Hinojosa arrives at a similar conclusion in his study of biomedical training of Maya midwives in Guatemala. Health officials, says the author use biomedical material in obligatory formal training "to undermine the midwives' knowledge base". And he adds: "Encounters between midwives and formal health personnel reveal an ongoing privileging of biomedical knowledge, one that preserves asymmetrical relationships between these practitioners." Hinojoa SZ. Authorizing tradition: vectors of contention in Highland Maya midwifery. *Social Science & Medicine* 59:637-651, 2004. From her observation of biomedical training of traditional healers in Cuetzalan, Puebla, Coronado says in this regard. "Desde el punto de vista institucional, la lmedicina tradicional se beneficia gracias a que a los curanderos tradicionales se les entrena para trabajar en la forma 'correcta', es decir, con mejores prácticas higiénicas y con el conocimiento médico occidental, para evitar que 'hagan daño'." Coronado Suzán G 2003, p. 336.

[47] See p. 93-96 above.

From the interviews with Santiago and Alicia we can see why women construe the repositioning of the baby as lying outside the biomedical realm. Doctors do not do it, and, equally important from a discursive perspective, *they do not know how to do it.* Most women seek the partera to ensure that their baby remains well positioned inside the womb for childbirth prevention and readiness –something that holds for prenatal control as a whole-, as a means of preventing c-sections and vaginal cuts, and as a solution for pregnancy ailments such as swollen feet, lower abdominal pain and leg pain. They link the position of the baby with childbirth risk, perinatal health, embodied experience (*vivencia del propio cuerpo*),[48] mother-child connection, response efficacy, skilled care (from parteras), and combined use of traditional and biomedical services. Some of these connections emerge in the following exchange with Dionisia, a young, illiterate mother of two in Xochis Cabecera, who had recently given birth in the local hospital, because she thought, based on her own experience, that it was safer in case of complications:

Q: ¿Vas a ver a la partera cuando estás embarazada?
D: Sí, voy para que me revise la posición del bebé para que nazca bien.
Q: ¿Qué te dice la partera?
D: No me dice nada cuando el bebé está en la posición correcta; también me dice que ella recogerá el bebé, me da indicaciones.
Q: ¿Te dice lo mismo que en el centro de salud?
D: Yo veo que no, es un poco diferente. No es lo mismo lo que dice ella y lo que dice un médico. No se parece.
Q: ¿Tú siempre haces lo que te dice la partera?
D: Sí, cumplo lo que me dice, siempre sigo sus indicaciones. Le hago más caso a ella porque ella sabe cuando está en buena posición. Ella sabe más.
Q: ¿Platicas de acomodar el bebé con el doctor?
D: De lo que me ha pasado, me he dado cuenta que, aunque les pidas que acomoden

[48] By embodied experience I mean "people's subjective, felt experiences of their bodies in action", and how they project these experiences through language. Gibbs contends that our embodied experience "provides part of the fundamental grounding for language and thought." Gibbs Jr. RW. Embodied experience and linguistic meaning. *Brain and Language* 84:1-15, 2003; quotes on p. 2. People's accounts of embodied experiences of pain, labour, knowledge or awareness through body messages (e.g., "*una sabe*", "*una se da cuenta*"), the baby moving or not moving in the womb, etc., follow under this category, which is different from "personal biographies", that is, the semantic construal of previous experiences.

14 el bebé, no es posible porque no saben cómo hacerlo. Ellos saben hacer la cesárea
15 porque no saben cómo acomodar el bebé.
16 **Q**: ¿Qué te dice el médico de acomodar el bebé?
17 **D:** Él me revisa, pero una sabe cuando no está en buena posición.
18 **Q**: ¿Vas al centro de salud para que cuiden tu embarazo?
19 **D**: Sí, siempre voy, y también busco a la persona que me acomoda el bebé.
20 **Q**: ¿Por qué vas al centro de salud?
21 **D**: Porque ahí pueden hacer la cesárea.

This representative sample shows how indigenous women use a combination of traditional and biomedical resources, blending practices and discourses to that effect. Dionisia consults with the partera for a specific purpose –to reposition her baby-, which in turn should lead to an expected outcome: a good delivery. Within the traditional order of discourse, repositioning is frequently connected with the prevention of c-sections and vaginal cuts. However, Dionisia prefers delivering in the health centre *because they can perform c-sections* (lines 20-21) -later in the interview, she says she would rather have her children in a hospital setting, because doctors can perform c-sections in case of complications ("*porque si hay complicaciones, inmediatamente hacen la cesárea*").[49] She clearly draws from the available pool of resources –and competing worldviews- as she sees fit to narrow the margin of risk facing childbirth. From this perspective, repositioning the baby is part of a multilevel preventive strategy. Many women in Xochis, particularly younger ones, combine maternal health resources in similar ways.

Dionisia's choice of provider also tells about her attribution of knowledge and power. She heeds the partera when it comes to the position of the baby in the womb because she

[49] Some doctors, as well as some men and older women in the communities, contend that younger women prefer c-sections to normal delivery. A clinical practitioner in Ometepec said in this regard: "*Bueno, yo he visto poco miedo a la cesárea. Hay muchas mujeres que llegan: 'Oiga, ¿y no me pueden hacer cesárea? No quiero el trabajo de parto' [...] Lo he visto en primerizas y en multigestas, en las que ya tuvieron más de 3, 4 hijos, ya al último andan con cierto miedo que ya no quieren el trabajo de parto y que ya mejor prefieren una cesárea*". Horacio, a 63-year old man from Guadalupe Victoria, talked of what he perceived as a generational trend: "*Ahora, los jóvenes de hoy, como ya abundan los hospitales, ellos ya no usan tanto esta medicina, ya hasta se pueden operar por miedo al parto natural, ya pueden hacerse la cesárea.*" However, all the women in our sample said they preferred normal delivery to c-section, which they saw as more difficult, harder to recover from, and more likely to leave long-term sequels. Only Dionisia mentioned c-sections as a supporting resource that made her feel safe in case of complications.

is the one who knows best and who can do something about it; but she does not trust her with delivery (see lines 4-5) because she has fewer resources at her disposal in case of complications. The doctor, on the other hand, does not know how to reposition the baby. In fact, doctors do not know *because* they can perform c-sections. Dionisia further erodes the doctor's knowledge about the position of the baby on line 17. In effect, the doctor examines her, but she knows all the same ("*pero una sabe cuando no está (el bebé) en buena posición*"). We can tell from the adversative clause that she places knowledge from her own embodied experience above clinical criteria.

6.5. Childbirth risks and fears

As I have mentioned, our participants see childbirth as fraught with peril. Moreover, the uncertainties surrounding delivery are frequently mentioned as the most serious threats to pregnancy.[50] This is not new among the Amuzgos, as we see from the following exchange with Horacio, a 63-year old man from Guadalupe Victoria, whose discursive sources precede the irruption of Western biomedical thinking in the community:

> **Q:** ¿El cuidado que se le brinda a la mujer viene de años atrás o es reciente? En tu caso, ¿fue tu papá o tu mamá el que te inculcó estas cosas?
> **H:** Mi abuela, la escuché cuando se lo dijo a mi madre. Ella le dijo que era peligroso dar a luz sin el debido cuidado, porque se corre el riesgo de contraer alguna enfermedad que le podría llevar hasta la muerte. El parto es delicado y peligroso.
> **Q:** Es peligroso...
> **H:** ... peligroso, porque cuando algo sale mal corre el riesgo de fallecer.

In other words, childbirth may be normal, but it is dangerous. However, not everyone makes sense of and responds to this danger in the same way. After all, some 60% of pregnant women in Xochis were delivering in their homes at the time of fieldwork for

[50] I consider Childbirth Risks as a pre-established theoretical category from the literature, whose contents came from specific questions aiming in this direction. On the other hand, childbirth as the main risk in pregnancy emerges from the first question in our questionnaire, "Are there any risks in pregnancy?", and from spontaneous references from out participants.

this thesis.[51] True, these numbers show a sharp decline of home births from around 1990;[52] but this is still a high proportion going against the grain of maternal health policies, under enourmous pressure from government programs and health services. What do people say when they talk about institutional delivery versus childbirth in their homes? What discourses do they draw from and how do they use them?

Some people see delivery with parteras as a risky affair –even though many seek the partera to reposition the baby for birth-, based on previous experience, hearsay, or pressure from heatlh services. One common concern among these participants (linked with pre-established categories from safe motherhood discourse) is that parteras cannot handle certain obstetric complications and women may not be able to get to the hospital in time if this ever happens. Others are wary of parteras pressing in the wrong place and hurting the baby or parteras asking women to push when they have no strength left. Fear of pain and lack of strength to push in labour are powerful emerging categories.

Not being able to push is a frequent fear that women construe as lack of autonomy. On the other hand, being strong, knowing how to push, being able to do it, and successfully delivering a child are perceived as signs of female agency and success.[53] In women's accounts of their experiences, anxieties, and expectations, not being able to push is linked with a host of variables, such as big babies, unskilled parteras, disabling positions for labour and delivery, and not knowing how to push. Fear is also related to these categories and discursive connections. To some participants, being afraid cripples the woman facing delivery; in other words, it implies a loss of agency. Talking about childbirth risks, Belisaria said: "*Es más peligroso para la madre, porque cuando ya se acerca el momento*

[51] According to the MNH Project 2008 baseline, 61% gave birth at home (51% assisted by parteras, 6% by a close relative and 4% by themselves), while 39% delivered in health units assisted by doctors or nurses (26% in hospitals, 9% in private clinics, and 4% in health centres).

[52] Andersson N, Martínez E, Villegas A, Rodriguez I 1989. According to this publication, the frequency of institutional deliveries in Xochis was lower than 2 out of 10 in the late 1980s. According to an unpublished 1998 CIET study, 8 out of 10 women in Xochis still delivered their children at home at the time, most of them assisted by a partera. These findings, together with data from this thesis, show the impact of aggressive government policies during the last ten years.

[53] This is another good example of the use of categories and axial codification. "Pushing" is an emerging PC, which feeds into "Being strong", a theoretical category (TC), which in turn is a sign of "Agency" (TC). All of them seem related to (women's) "Autonomy", a core or axial category (AC) emerging from my research, insofar as there is a multi-stakeholder discursive struggle around women's autonomy.

del parto y no puede aliviarse se le acaban la fuerza en ese momento y eso le da miedo a la mujer." Even being ashamed (*tener pena*), a frequent feeling among indigenous women when they must talk about private matters with someone who does not belong to their inner circle of family and friends, and often given as reason not to give birth in institutional settings, is framed as a constraint on a woman's ability to deliver a child. This perception of agency and self-efficacy[54] is an important reason why, even though she follows biomedical advice and goes to prenatal control in government health centes, Catalina prefers to deliver her children at home:

> **Q**: ¿Todos tus hijos los tuviste en casa?
>
> **C**: Sí, todos nacieron en mi casa.
>
> **Q**: ¿Por qué no te alivias en el centro de salud o el hospital?
>
> **C:** Porque *no tuve complicaciones, no sufrí*; por eso *me confié*, por eso los tuve en casa..
>
> **Q**: ¿Dónde crees que es más fácil aliviarse, en tu casa o en casa de salud?
>
> **C**: Es lo mismo, *depende de la mujer.* Si no se *esfuerza* en *pujar* se *complica*, aunque la mujer vaya al hospital. Ellos no te ayudan mucho. Depende del *esfuerzo* de la mujer; si *puja fuerte nace el bebé bien.*
>
> **Q:** ¿En qué posición prefieres aliviarte?
>
> **C**: Pienso que es mejor en casa. Pienso que tengo *más valor* para *esforzarme*; en cambio, en el hospital me daría *pena* que me estuvieran viendo.

Personal experience (*"no tuve complicaciones, no sufrí"*), personal effort and responsibility (*"depende de la mujer", "si no se esfuerza en pujar", "depende del esfuerzo de la mujer", "si puja fuerte", "tengo más valor para esforzarme"*), self-efficacy (*"me confié", "tengo más valor para esforzarme"*), and response efficacy (*"si*

[54] I use the term agency with two slightly different though closely complementary meanings. In sociological theory, agency is the ability to act on one's will, which is opposed to structural factors (social class, religion, gender, ethnicity, etc.) constraining that ability (See, for instance Barker C. *Cultural Studies: Theory and Practice.* London: Sage, 2005, p. 448). This notion of agency is very close to the concept of self-efficacy from behavioural theories discussed in chapter 2; in other words, the perception that one can carry out a desired –or expected- action under certain circumstances. At the same time, I use the concept of agency from functional linguistics, that is, the force (usually an actor or an agent) that brings about the development of a material process (e.g., self-care, prenatal control, giving birth) through time. An agent or an actor is the one who "does the deed" or brings about a change. Halliday MAK, Matthiessen CMIM 2004, p. 179, 283. In the context of discourses about motherhood and maternal health, agency often implies choice and responsibility.

puja fuerte nace el bebé bien") interact here, in a way that echoes health risk discourse, except that the result of the interaction goes against a core idea from safe motherhood discourse: that all women should deliver their children assisted by biomedical practitioners. In fact, doctors and nurses cannot do much ("*ellos no te ayudan mucho*"), because everything depends on the woman's effort and ability to push. This ability –this agency- ensures a safe delivery, no matter of where it takes place. These things lacking, complications ensue. Put differently, complications are mainly the result of an undermined confidence, of a diminished autonomy. And Crecencia feels that delivering in a hospital setting would do just that by activating her shame, hampering her courage, and undercutting her strength.

The ability to push and the related perception of agency (self-efficacy) may be framed in a myriad ways (e.g., most feel stronger if they deliver in vertical positions, though one participant said she would rather lie down), but one thing is clear: all women perceive that being able to choose the circumstances of delivery gives them more strength, an expression that features four times in Eulogia's brief but vivid explanation:

> Yo refiero ponerme de rodillas porque así me da *fuerzas*, como cuando hay un palo donde sostenerme, me da *fuerzas*. Y hay personas que los acompaña el marido, agarrando el marido les da más *fuerzas*. Para mí, estando sola siento que tengo más *fuerzas*.

The above example tells us there are many ways of construing a safe delivery. For example, we can consider the perceived risk of delayed, overdue delivery, and of not being able to deliver, as stated on Appendix D. When we asked our participants what could happen as a result, most agreed that w omen suffer, that both the mother and the baby may die, and that doctors may resort to c-sections or vaginal cuts. But the agreements ended at that point. When we asked how to prevent this from happening, people offered a wide range of responses, often combining traditional and biomedical practices, and sometimes keeping them apart. Some would rather see the doctor for prenatal control and ultrasound scanning, because they thought this narrowed the likelihood of delayed or failed delivery; yet others (or maybe the same ones) would make

sure the partera positioned the baby for birth. There were those who identified institutional birth with more options (medicine, c-section) in case of complications, and thought it was their responsibility to make sure these resources were at hand. But there were those who thought, often based on their own embodied experience, previous experience of services, or the experience of others, that being responsible meant staying at home. Here is another excerpt from our interview with Eulogia:

Q: ¿Dónde te aliviaste la última vez y con quién?
E: En casa, con la persona que cuida a las embarazadas, ella levantó el bebé.[55]
Q: ¿Dónde vas a aliviarte la próxima vez y con quién?
E: Yo creo que en casa, con la persona que se dedica a eso, la persona que levanta el bebé. Ella me cuida. Si no se puede, bajo al hospital, donde me pueden ayudar.
Q: ¿Por qué no te alivias en el centro de salud o el hospital?
E: Porque yo no quiero ir, yo no quiero ir... Se me hace difícil, como te dije. Ellos no toman el tiempo del parto, se pasa el tiempo; pero nosotras ya sabemos, sabemos el tiempo del parto, uno sabe cuando se aproxima el parto. Y ellos lo que hacen es, aunque ya es tiempo del parto, dicen que falta, y en eso a mí se me complica. En cambio, la partera ya sabe cuándo es el tiempo adecuado y yo me esfuerzo para dar a luz. En cambio, allá sufro más con ellos.
Q: ¿Dónde es más fácil aliviarse, en tu casa o en casa de salud?
E: Yo creo que en casa, porque yo sé cuál es el tiempo y no puede pasar el tiempo necesario porque puede fallecer. Como en mi caso, si voy al hospital y ellos no se apuran, quiere decir que yo misma estoy matando a mi bebé. Y en mi casa el parto es normal.

Eulogia, like other participants, thinks of institutional birth as a second-line option, a subsidiary resource ("*si no se puede, bajo al hospital*"), in case of complication, emergency, or inability to deliver at home. When the interviewer asked her why she does not deliver her children in a hospital or health centre, she used interpersonal meaning (in this case through negation, repetition, and the use of an expressive statement) to strongly

[55] The literal translation of "partera" from the Amuzgo language to Spanish is "*la persona encargada de cuidar a las embarazadas*" (the person who looks after the pregnant woman) o "*la persona encargada de levantar el bebé*" (the person who picks up the baby).

emphasize her own feelings as the primary explanation: "*Porque yo no quiero ir, yo no quiero ir...*" she says on line 7. Then, on lines 8-10, she elaborates on her reluctance by affirming her own embodied experience against the contradicting interpretation of government healths staff. Moreover, she says, this denial of her own embodied experience (telling her it is not yet time to deliver, when she feels otherwise) is what *complicates* things for her. In other words, she construes this contradiction, this medical dismissal of how she interprets (heeds) the messages from her own body, as a threat to her own health and that of her child. On lines 15-16, she says: "*Como en mi caso, si voy al hospital y ellos no se apuran, quiere decir que yo misma estoy matando a mi bebé.*" Eulogia explicitly construes going to the hospital and exposing herself to delays in labour as killing her baby with her own hands. Thus, the responsible thing to do is to stay at home: "*Y en mi casa el parto es normal*", that is, according to her own reading of her body with support from the partera, who provides skilled, knowledgeable care. On lines 10-12, there is perfect summary of this collaboration, as opposed (she explicitly and rhematically states the contrast) to what happens in an institutional setting: "*En cambio, la partera ya sabe cuándo es el tiempo adecuado y yo me esfuerzo por dar a luz*". The knowledge and experience of the partera, her own embodied experience, and her personal effort: these are the ingredients of a normal delivery, a responsible way to face childbirth. Going to the hospital is a second-line option, in case she cannot deliver at home (line 5).

Later in the interview, Eulogia turns her own case into an instance of a larger pattern, a given state of affairs, by asserting the higher value of maternal embodied experience vis-à-vis doctors' lack of (embodied) knowledge when it comes to childbirth. Not knowing, not understanding, implies a fundamental lack of empathy that makes institutional delivery so difficult for women like Eulogia: *"Es difícil porque los médicos no saben que es un parto; en cambio, nosotras, que ya hemos tenido hijos, entendemos.*" Drawing from this construal, she infers the reason why women die giving birth in hospitals: *"Muchas mujeres se mueren en el hospital porque ellos no saben."*

The following exchange with Josefina is another example of how women can draw from previous experience, embodied experience, and key dimensions of safe motherhood discourse to construe their own vision of a healthy pregnancy and a safe childbirth:

Q: Antes del parto, ¿ya sabes si todo va a salir bien?
J: Cuando comienzan los dolores del parto yo pienso muchas cosas, porque no sé si todo saldrá bien. No sé tampoco si mi hijo viene bien o mal. Porque a veces pasa que nuestros hijos nacen con problema, se atora la placenta o el cordón umbilical y ahí está la dificultad. Cuando comienzan los dolores no sé si saldré viva o no.
Q: Entonces ¿tú crees que puede haber problemas en los partos?
J: Así es. Es difícil, porque a veces aunque se puje no se puede parir, y si no se previene el hijo es el que sufre más; puede morir en la panza el bebé.
[...] Q: Aquí en el pueblo, ¿hay muchas mujeres que tienen problemas en el embarazo y en el parto?
Q: Sí
J: ¿Crees que estos problemas te pueden ocurrir a ti?
Q: Sí, yo creo que sí, porque mientras más hijos se tenga se va acabando la fuerza. Llegará un día que ya la mujer no podrá parir.
Q: ¿Por qué pasan estos problemas en el parto?
J: Se necesita un médico para que haga una radiografía, para que revise si la mujer tiene un problema en el embarazo.
Q: ¿Y tú puedes hacer algo para que todo salga bien en el parto?
J: Puede ser acudiendo periódicamente al hospital y siguiendo al pie de la letra las indicaciones.
Q: ¿Tú haces planes con tu marido por si hay problemas en el parto?
J: Sí, hacemos planes por si algo nos ocurre. Cuando comienzan los dolores, mi marido prepara y busca dinero para llevarme al hospital. O cuando es en mi casa, porque en mi casa también puedo parir y de hecho así ha sido.
Q: ¿Tus padres y tu marido, dónde quieren que te alivies?
J: Ellos aceptan mi decisión. Si yo les digo que en casa, será en casa; si es en el hospital, entonces será ahí. Y una vez me pasó cuando di a luz mi hija, me pasó feo, me dio calentura, me llevaron al hospital. Estando allá no di a luz adentro del hospital sino afuera ¿Por qué? Porque los médicos no me quisieron atender. Por eso

lo que hablamos aquí debemos de cumplirlo, cumplir nuestras obligaciones. Los médicos deben de recibir a las personas amablemente. Eso fue lo que me pasó y cuando lo recuerdo me da coraje.

Q: ¿Por qué ya no te recibieron?

J: No me recibieron porque me dijeron que tenía que ir hasta Ometepec. Me dijeron que faltaba tiempo para parir y yo sabía muy bien que ya era tiempo por el intenso dolor. Entonces me sacaron del hospital. Me estaba acompañando la partera; por eso ella me atendió debajo de un árbol que está parado cerca del hospital; por eso me esforcé pujando hasta parir a mi hija.

Q: ¿Dónde te aliviaste la última vez y con quién?

J: Me atendió una partera pero ella ya no vive, ya no está.

Q: ¿Por qué ella?

J: Ella me atendió porque las enfermeras y los médicos ya no me quisieron recibir. Ellos me dijeron que ya no porque era necesario que fuera hasta Ometepec porque allá me pueden hacer cesárea.

Q: ¿Dónde vas a aliviarte la próxima vez y con quién?

J: Ahora, con todo lo que me ha pasado, he puesto como regla parir en mi casa, y mis últimos hijos los hes tenido en mi casa. Porque me duele la cabeza ir al hospital y que no me reciban. [...] Si algo me pasa que sea en mi casa. Porque las enfermeras ya no te reciben y si hay alguna complicación y me muero, mejor que sea en mi casa, porque ahí hay medicina también.

Q: ¿Dónde es más fácil aliviarse, en tu casa o en el centro de salud?

J: Yo creo que en casa.

Q: ¿Por qué?

J: Porque en casa sabe uno a qué hora es el tiempo de parir. En cambio, en el hospital el trato es feo, te levantan los pies e inyectan agujas en los brazos, y eso al final de cuentas no ayuda.

This complex unit of analysis shows how Josefina negotiates between different worldviews, using her own embodied knowledge and her previous experience with public health services as guiding principles. In the first half of the exchange, we find key dimensions of health risk discourse and government safe motherhood discourse. From lines 2-5, we see how the opening (thematic) and closing placement of her embodied

experience ("*cuando comienzan los dolores del parto yo pienso muchas cosas*", "*cuando comienzan los dolores no sé si saldré viva o no*") both bookend and support the notion that delivery is a dangerous affair. That first sentence includes common concerns from a biomedical standpoint and from the perspective of our participants (position of the baby, retained placenta, and cord accident). In sum, her labour pains open a period of risk and uncertainty. Even pushing may not be enough –although she does not say it, we can coherently connect this fear with the threat of a wrongly positioned baby in the birth canal. In terms of health risk communication, she is aware of the severity of the threat (the baby can die), the scope of the problem (it happens to many women in her town), and her own vulnerability (lines 7-13). She brings up a biomedical risk factor (having had many children), which makes her part of an at-risk group: multiparous women who will increasingly and inevitably lose their strength and their ability to bear children (lines 13-14).[56] Still, she prefers to deliver her children at home. Very much like in Eulogia's case above, the negative connection between her own embodied experience and a critical incident in the Xochis hospital[57] opens a rift between her conception of childbirth and safe motherhood discourse. The Xochis hospital episode, in particular, seems to have pushed her away from the idea that hospitals are tantamount to safe delivery and skilled care. From a discursive perspective, what counts in this case is not so much what really happened as they way Josefina construes those events. Some components of her narration stand out in this regard:

a) Her own embodied experience, her own knowledge was disregarded ("*Me dijeron que faltaba tiempo para parir y yo sabía muy bien que ya era tiempo por el intenso dolor*", on lines 34-36). This exposes a fundamental issue at the level of discursive practices: Telling women to heed the messages of their bodies always implies heeding *an interpretation* of those messages. Safe motherhood discourse implies heeding biomedical experts; women's views often entail heeding their own knowledge and

[56] As this and other examples show, being multiparous is sometimes framed as an advantage –women are experienced, not afraid- and sometimes as a disadvantage or a risk factor. Ana, for instance, shares Josefina's concerns in terms of the diminishing ability of multiparous women to give birth on their own: "*Está bien dar a luz el primero, y puede ser hasta el tercero, en la casa. De ahí en adelante no está bien, porque a la mujer se le va acabando la fuerza*".

[57] As mentioned in chapter 3, participants' narrations of critical incidents are particularly insightful from a discursive perspective, since they show how people draw from different discourses, including embodied knowledge and personal biography, to make meaning under extreme circumstances.

embodied experience, or even the knowledge of traditional experts such as healers and elderly women. The resulting collisions reveal a conflict of knowledge and power around women's bodies, behaviours, and subject positions.

b) Hospital staff did not deliver on their obligations, that is, on the promise of quality care which is at the core of government safe motherhood discourse ("*Por eso lo que hablamos aquí debemos cumplirlo, cumplir nuestras obligaciones. Los médicos deben de recibir a las personas amablemente,*" on lines 29-31). It is worth noting how Josefina considers her conversation with the interviewer as part of an implicit dialogue with the government, most likely based on the explanation she received at the beginning of the interview. Her deictic reference to what is being discussed ("*lo que hablamos aquí debemos cumplirlo*") points in that direction. It also reveals how the government's appeal to women's agency and sense of responsibility has backlashed: Josefina kept her part of the deal (what was *in her hands*, as we have seen from chapters 4 and 5), but the government did not follow through on their commitment. It is also worth noting the strong connection between her previous experience and her current embodied experience. On line 31 she says: "*Eso fue lo que me pasó y cuando lo recuerdo me da coraje*". This connection shapes her attitude towards government health services and her intentions concerning institutional delivery versus homebirth.

c) Josefina's disappointment with government health care is compounded by the fact that she felt illtreated and literally excluded from the service. She makes a clear attribution of agency from doctors and nurses in her recounting of that episode, in a series of mental, verbal, and material processes ("*Porque los médicos no me quisieron atender*", on line 29; "*no me recibieron porque me dijeron que tenía que ir hasta Ometepec*", on line 34; "*entonces me sacaron del hospital*", on line 36; "*porque las enfermeras y los médicos ya no me quisieron recibir,*" on line 42). As a result of all this, there is a breach in trust with far-reaching consequences. She has decided to deliver at home, regardless of the outcome: "*si hay una complicación y me muero, mejor que sea en mi casa*" (line 49).

d) It was the combination of her effort and her knowledge of her own body with the partera's skillful handling of the emergency that resulted in a successful delivery under a tree, outside the Xochis hospital (lines 37-38), even though the doctors wanted

her to have a c-secton in Ometepec (lines 43-44).[58] Needless to say, the effect of this experience and its interpretation blows a hole under the waterline of key safe motherhood notions such as expert advice and skilled knowledge.

e) On lines 46-50, we can see how the combination of previous experience, interpretation of her own embodied experience, and attitude towards government health service has led Josefina to make a conscious choice: have her children at home. It is more than a choice, it is a rule, and she has lived by it (line 46). This strong normative language (an assertion that also carries the illocutionary force of a commissive act), together with her previous mention to the Xochis hospital failing to fulfill their obligations, reveals a sense of agency and responsibility that she also demands from government health services.

f) Ideationally, she associates giving birth at home with the availability of medicine (she likely refers to traditional medicine) and, most significantly, with the ability to act on her embodied experience: "*Porque en casa uno sabe a qué hora es el tiempo de parir.*"

In sum, Josefina shares the safe motherhood view of childbirth as inherently dangerous; but she does not perceive institutional delivery as conjuring the threat. In fact, she seems to say, there is no safe place to deliver a child. In such context, she chooses to cross that dangerous river trusting her own embodied experience and making some contingency plans (lines 22-23).

Of course, previous experience can make a woman choose institutional delivery. Such is the case of Ana, who thinks her ability to deliver a child is limited at home and enhanced in the hospital:

1 **Q:** En tu caso, ya diste a luz en tu casa y en el hospital ¿Dónde crees que es mejor o
2 se debe de dar a luz?
3 **A:** No lo sé... Creo que en el hospital es mejor, a diferencia de la casa donde cuando

[58] Government health staff may have been reluctant to deal with an apparently complicated delivery in a context of great political pressure on government health services to prevent maternal deaths.

sientes dolores intensos lo único que se puede hacer es pujar, sólo pujar, sólo se esfuerza una y así se acaba la fuerza cuando se llega el momento de la verdad. Eso es lo que provoca complicaciones

Q: ¿Quién te dice que debes de pujar antes?

A: Pues la partera. Recuerdo que vivía una señora que venía a cuidarme. Era una señora con mucho conocimiento. En mi primer parto no se pudo caer el cordón umbilical porque casi jala con fuerza al feto, por eso se rompió y se quedó atorado el cordón en el vientre. Sufrí mucho, me tuvieron que llevar de emergencia al hospital. Lo bueno era que estaba mi madre. En aquellos días estaba la enfermera Élida, me regañó y yo le dije que era el cordón; ella me dijo que no, que era la placenta lo que estaba adentro y me dijo que aquella vez tuve suerte.

From lines 3-6, Ana asserts her belief about a general state of affairs (it is better to deliver at the hospital than in her home), based on her own embodied experience. Here again, being able to push at the right time ("*el momento de la verdad*") is a core component of women's perception of agency facing childbirth. However, the circumstances that constrained her ability to push in a timely fashion were quite different from those evoked by Josefina. It was the partera, not the doctors, who failed to handle the situation and undermined her womanly strength. Also worth noting, from lines 12-14, she describes a situation that bears some resemblance with the consultation sequence in "Heed the messages": the nurse dismisses her explanation, which was in turn probably influenced by the partera ("*yo le dije que era el cordón; ella me dijo que no, que era la placenta la que estaba adentro*"), scolds her ("*me regañó*"), and implicitly blames her for her botched attempt to deliver at home ("*me dijo que aquella vez tuve suerte*"). The attribution of knowledge and power in the emergency is all the more emphatic when we take into account that Ana thought highly of her partera ("*Era una señora con mucho conocimiento*", on lines 8-9).

Yet, Ana's choice of institutional delivery came after her failure to give birth at home. Other women choose to give birth in hospitals as a first option, under greater influence

from safe motherhood discourse and biomedical views. This is what Belisaria –a younger woman with more years of formal education- said on this point:

Q: ¿Tus papás y tu esposo donde quieren que te alivies?
B: En el centro de salud.
Q: ¿Por qué?
B: Porque ahí voy a salir bien yo y el bebé va a nacer bien, por eso ellos quieren que ahí me alivie
Q: ¿Este último bebé donde lo tuviste y quien te atendió?
B: En el hospital, y me atendió una doctora
Q: ¿Por qué te aliviaste ahí?
B: porque... bueno, de lo que me preguntabas hace rato que dónde querían que me aliviara... pues mi esposo quería que yo me aliviara en el hospital, para que todo salga bien para nosotros.
Q: ¿Si tuvieras otro hijo, donde te aliviarías y quién quieres que te atienda?
B: Si tengo otro, en el hospital
Q: ¿Por qué?
B: Porque ya me acostumbré a ir ahí, y aparte de que no tengo problemas, me atienden bien
Q: ¿Por qué no quieres aliviarte en casa y que te atienda una partera?
B: Porque para mí ellas sólo te acompañan... siento que no te ayudan en nada, y no me gusta que ellas me atiendan.
Q: ¿Por qué no te gusta?
B: Porque no les tengo confianza; sé que en la casa puedo aliviarme, pero no les tengo confianza
Q: ¿Dónde es más fácil aliviarse, en casa o en el hospital?
B: En el hospital
Q: ¿Por qué?
B: Porque ahí hay todo lo que se necesita para tí y para el bebé
Q: ¿Cómo qué cosas hay?
B: Medicinas para el bebé

We see from lines 1-5 and 9-13 (where she makes an explicit anaphoric reference to the first of these segments) that subjective norm plays an important role in her decision, both in terms of perceived expectations (lines 1-5) and intention to comply (9-13). From a discursive perspective, the most significant aspect of these excerpts is what they reveal in terms of intertextual meaning. From the categorical modality of her answer on lines 4-5 ("*porque ahí voy a salir bien yo y el bebé va a nacer bien*") and the means-end structure of her explanation on lines 10-11 ("*pues mi esposo quería que yo me aliviara en el hospital, para que todo salga bien para nosotros*"), we can infer that her closest relatives take for granted the favourable outcome of institutional delivery both for the mother and her child, a key trait of safe motherhood discourse. From lines 23-28, she gives additional reasons why it is easier to give birth in the hospital. Her answer follows a similar line of thought: "*ahí hay todo lo que se necesita para ti y para el bebé*". Both ideationally and interpersonally, Belisaria conveys the idea of a comprehensive, riskless, one-stop solution, very much along the lines of government health communication campaigns.

On lines 6-7 and 14-16 we can see the imprint of previous experience with health services (she had her last child in the hospital, assisted by a doctor, and feels well looked after). Perhaps more crucially, on line 15, we have a hint of another emerging category, "Getting used to" ("*Acostumbrarse*"), which somehow shows how people can make room for new practices within long-established cultural molds and, conversely, how living in a traditional ethnic environment does not translate as adopting all the cultural mores.[59] Then on lines 18-22, Belisaria uses strong interpersonal language and expressive force to convey her lack of trust in the parteras: "*sólo te acompañan*", "*no te ayudan en nada*", "*no me gusta que ellas me atiendan*", "*no les tengo confianza*". It is a deeply ingrained feeling, though she does not mention any critical incidents in her life and there are no signs in the rest of her interview that might indicate coercion from government health

[59] Zulema, for instance, does not consult with parteras because she is not used to it ("*no estoy acostumbrada a eso*"). Marcelina gives the same reason for not consulting with traditional healers. Eulogia does not follow the advice of elderly women to rest for three months and works normally after childbirth ("*y de todos los hijos que tuve así me acostumbré*"). Catalina says she goes for prenatal checkups at the health centre because she has always done so ("*voy porque siempre he ido; siempre voy cuando me embarazo, nadie me obliga a ir*"). Anthropological research shows that people often use this type of language when they refer to deep-seated habits and long-established mores.

services to stay away from parteras. This case, like many others, warns against hurried generalizations and dicotomies. Not everything in people's views and behaviours can be neatly explained by cohesive sets of overarching patterns, policies, and discourses. Belisaria seems to act as her family expects when the time comes for her to deliver her babies. But elsewhere in her interview she takes a good distance from these expectations and from other sources of advice. Here is what she says about prenatal control:

Q: ¿Siempre haces lo que te dicen tus familiares?
B: La verdad que no.
Q: ¿Por qué no?
B: Porque a veces no me cuido, ésa es la verdad.
Q: ¿Por qué dices que no te cuidas?
B: Porque no siempre voy al centro de salud mes a mes como me dicen; no me cuido porque a veces aunque me digan que no levante cosas pesadas yo lo hago
Q: ¿Estas cosas las platicas con tu esposo?
B: Sí.
Q: ¿Qué te dice él?
B: Él se espanta, me dice que vaya al centro de salud. La mayoría de las veces me manda y a veces no voy.
Q: ¿Vas a ver a una partera durante tu embarazo?
B: No.
Q: ¿Por qué no?
B: Porque en la mayoría de las veces, cuando estoy embarazada, me pongo de mal humor. Me molesta que alguien me toque, que alguien me agarre la panza; me molesta saber que mi bebé no está bien acomodado o que no viene bien, así que mejor me espero hasta que él nazca.
[...] **Q:** ¿Quién te aconseja en el centro de salud?
B: El médico que lleva tu control
Q: ¿Siempre haces lo que te dicen ahí?
B: No.
Q: ¿Por qué no?
B: Porque no me gusta exagerar sólo porque estoy embarazada. Además, yo sé que el bebé está bien porque se mueve, por eso sé que está bien.

27 **Q**: ¿Vas a ver a algún médico privado?
28 **B**: Sí voy.
29 **Q**: ¿Por qué?
30 **B:** Porque a veces en el centro de salud ellos no siempre te atienden como se debe;
31 por eso voy a ver a un médico particular para escuchar su opinión
32 **Q**: ¿Qué te dice el médico particular? ¿Te dice lo mismo que en el centro de salud?
33 **B**: Sí, es lo mismo.
34 **Q**: ¿Siempre le haces caso a lo que dice el médico privado?
35 **B**: No, ni al médico privado ni al centro de salud.
36 **Q**: ¿Por qué?
37 **B**: Porque cuando estoy embarazada no hago nada malo; por eso sé que mi
38 embarazo va bien y no hay algo peligroso.
39 **Q**: ¿Por qué sabes eso?
40 **B**: Mientras vea yo que no me pasa nada o no hago nada que me ponga en riesgo, sé
41 que las cosas están bien.

Could this be the same Belisaria? If we applied a deterministic, over-simplified approach to people's views and behaviours, and we had read what she had to say about childbirth, chances are we would not anticipate these responses. The same would hold if we read this segment about prenatal control first and we were then asked what to expect from her views about childbirth. Can this be the same person, subject to the same sociocultural influences? Throughout this unit of analysis, we see how Belisaria distances herself from the advice, concerns, and expectations around her. She sometimes heeds influential others (husband, doctors), but *always* heeds her own reading of what is going on inside her womb –and as a result she does not go by traditional and biomedical expectations of prenatal control. The ideational content and expressive force of her utterances highlight the importance of her embodied experience in her choices and in the overall narrative of her pregnancy: "*porque... me pongo de mal humor*" (lines 16-17); "*me molesta que alguien me toque, que alguien me agarre la panza*" (line 17); "*me molesta saber que mi bebé no está bien acomodado*" (lines 17-18); "*no me gusta exagerar*" (line 25); "*yo sé que el be bé está bien porque se mueve*" (lines 25-26); "*mientras vea yo que no me pasa nada o que no hago nada malo que me ponga en riesgo, sé que las cosas están bien*"

(lines 40-41). Even when she echoes voices from elderly women ("*no me gusta exagerar sólo porque estoy embarazada*"), she deviates from expectations of partera-driven traditional control and she copes with the threat of a wrongly positioned baby in a very different way: "... *así que mejor me espero hasta que él nazca*" (lines 18-19).

Clearly, previous experiences and embodied experiences of pregnancy, childbirth and puerperium play an important role in women's attitudes, behaviours and intentions –and that is why there is a political and discursive struggle to shape the interpretation of these experiences *before and after* they occur. Other women have their babies with private practitioners –twice as many chose private clinics over government health centres. In the following example, Elena, a pregnant 18-year old mother of three from Cozoyoapan, explains her choice in terms of previous experiences, quality care, empathy, and cultural awareness from her private doctor, which she rhetorically opposes to a negative image of government health services:

Q: ¿Tus padres y tu marido, dónde quieren que te alivies? ¿Por qué?
E: Ellos siempre me dicen que vaya con el médico, como el médico Suárez. Él me revisa bien cuando doy a luz. Nosotros no vamos al hospital del gobierno que hay en el pueblo porque ellos no preguntan en el momento de llegar, no te atienden inmediatamente, no te preguntan qué necesitas. Porque a ellos no les importa, porque no son ellos los que sufren. Ellos andan viendo otras cosas, no trabajan lo que deben, no cumplen con su responsabilidad.
Q: ¿Dónde te aliviaste la última vez y con quién?
E: Con el médico que siempre vamos, él me atendió en el parto y dejó que entrara el papá de mis hijos [...] Yo tengo más confianza cuando él me atiende. Creo que se debe porque él cumple con su trabajo; el dinero que gana es para él, no es como en el hospital de gobierno, donde no atienden rápido porque es gratis.
Q: ¿Dónde vas a aliviarte la próxima vez y con quién? ¿Por qué?
E: Con el médico que siempre me cuida, con el médico Suárez, con el que conoce la gente de aquí, porque sabe cuidar a la gente, a las mujeres en el parto. Pienso ir con él porque permite que entre el papá de mis hijos y tiene una enfermera. En cambio, en el hospital de gobierno no dejan que entre el papá del bebé; sólo ellos quieren

estar con la persona. [...] Ellos no atienden bien el parto. Como me pasó a mí... una vez fui al centro de salud del gobierno y no me atendieron. Me dijeron que regresara otro día porque faltaba para el parto y yo sentía fuertes dolores. Ahí me di cuenta que ellos no quieren trabajar bien, no cumplen con su responsabilidad.

Q: ¿Por qué no te alivias en tu casa y con partera?

E: Porque me da miedo si tengo complicaciones en mi casa y no está un médico. Si voy con un médico, él tiene toda la medicina que puede usar, me puede inyectar suero. Y en la casa... no sé cómo es el parto en casa porque siempre he ido con el médico privado.

There are two striking discursive features in this unit of analysis and they both operate together: at the textual level, Elena frames good quality care through the rhetorical opposition between the positive traits of the private practitioner and the negative traits of government health services. At the interpersonal level, she repeteadly uses negation to describe what the latter lack in relation to her expectations –and to what government safe motherhood communication promises in their idealized construal of maternal services, as discussed in chapter 5. Here is what the speaker says of doctor Suárez, and how she construes an opposition with government health services:

-"*Él me revisa bien cuando doy a luz*" (lines 2-3, where she expresses a perception of skilled care, based on her own personal experience).
-"*Sabe cuidar a la gente, a las mujeres en el parto*" (line 15, where she talks of a state of affairs, based on what seems to be shared perception of skilled care). She sees quite the opposite in government services: "*No atienden bien el parto*" (line 18); "*a ellos no les importa, porque no son ellos los que sufren*" (lines 5-6); and "*no preguntan en el momento de llegar, no te atienden inmediatamente, no te preguntan qué necesitas*" (lines 4-5). She elaborates by referring explicitly to her own personal experience: "*Una vez fui al centro de salud del gobierno y no me atendieron; me dijeron que regresara otro día porque faltaba para el parto y yo tenía fuertes dolores*" (lines 18-20). In this last account of her personal tribulations, we can perceive the same kind of frustration expressed by Josefina at health staff contradicting a woman's reading of her own embodied experience.

-"*Y dejó que entrara el papá de mis hijos*" (a frequent concern from within the culture that she repeats on lines 9 and 17). She makes a point of comparing the prevailing policy at hospitals and health centres: "*No dejan que entre el papá del bebé; sólo ellos quieren estar con la persona*" (lines 17-18).

-"*Él me atendió en el parto*" (line 9); "*siempre vamos con él*" (line 9), "*yo tengo más confianza cuando él me atiende*" (line 10), and "*siempre he ido con el médico privado*" (line 25-26), all of them revealing a well-established trusting relationship based on positive experiences.

-"*Él cumple con su trabajo*" (line 11), where we see, as it happened with Eulogia above, a strong emphasis on obligations and responsibilities, and a perception that government health staff do not deliver on the promise of quality care which is at the heart of government safe motherhood discourse. She makes this comparison explicit on lines 6-7 ("*Ellos andan viendo otras cosas, no trabajan lo que deben, no cumplen con su responsabilidad*") and 20-21 ("*Ahí me dí cuenta que ellos no quieren trabajar bien, no cumplen con su responsabilidad*").

- "*El dinero que gana es para él*" (on line 12, echoing a frequent cross-cultural assumption of profit and self-interest as the motivation behind better health care from private services).[60] She opposes this perceived motivation to what happens in government health services: "*No atienden rápido porque es gratis*" (line 12). This perception undermines the intended message in "Heed the message" and other government communication efforts aimed at dispelling the notion that poor people have to pay to get maternal care in hospitals and health centres. According to our data, some had not received this information, others were not sure it would be true, and yet others, like Elena, were not sure this was a good thing.

-[Es] "*el que conoce la gente de aquí*" (lines 14-15). Here, she points to the need of a trusting relationship with the community, one that surely has developed throughout the years. As I discussed in chapter 2, trust in clinical practitioners has been the bridge

[60] Módena points to the same discursive connection between profit, self-interest, and quality care among indigenous populations in Veracruz state. "El pago de honorarios médicos se percibe como garantía de mejor atención." She frames this observation in the context of an ideological complex dominated by a capitalistic approach to health care. "Esto, junto con la idea de que son los fármacos los que curan, ubica la atención de la enfermedad en la lógica de la reproducción capitalista que se produce y reproduce, obviamente, en otras instancias sociales". Módena ME 1990, p. 216.

between public health priorities and people's need for guidance and support in the Western world of health risks. But the doctor-patient relationship gets short-circuited in government health services in remote rural villages with majority of indigenous population, like Xochis, where Mestizo doctors are passing through –to fulfill medical residency requirements- and turnover is very high.

-"*Tiene una enfermera*" (line 16), "*tiene toda la medicina que puede usar y me puede inyectar suero*" (lines 24-25), where she highlights the availability of a female nurse and all the needed biomedical resources. We can derive an implicit opposition, both from her previous references to government services and from our knowledge of the immediate context (hospitals and health centres have nurses and IV solutions). In other words, Elena is saying that Dr. Suárez has the same resources that she would find in the hospital or the health centre, but he also has many qualities lacking in government health units.

Although the doctor would not be able to handle a severe complication, she seems to feel that this holding medical environment, rather than government health services or highly specialized hospitals, guarantees a safe delivery. This interpretation is confirmed in another segment of our interview:

Q: Antes del parto, ¿ya sabes si todo va a salir bien?
E: Sí, me doy cuenta antes del parto que saldrá bien. Yo voy con el médico privado; él me dice que acuda cada ocho días antes del parto, él me revisa el desarrollo del bebé, porque hay bebés que se voltean y cuando se aproxima el parto hay dificultades. En mi caso, cuando se aproxima el parto sé que todo puede salir bien, sé que el parto saldrá bien porque hago todo lo que me dice el médico, las medicinas que me receta las cumplo.
Q: ¿Tú haces planes con tu marido por si hay problemas en el parto?
E: No hacemos planes. Como dije hace un momento, un mes antes del parto, cada ocho días se debe de acudir con el médico y él revisa hasta el momento del parto, no hacemos planes. No hacemos planes porque confiamos en Dios para que todo salga bien en el parto.

Close prenatal control from her doctor and compliance make her feel safe facing delivery (lines 2-3 and 4-7). Even though she is aware of potential complications (line 4), she *knows* that everything will be all right in her case *because* she complies with the doctors instructions (lines 6-7) and because she trusts God will help her have a safe delivery (lines 11-12). Trust in her doctor and trust in God also go hand in hand here, as they do in "Heed the messages". In the same way that other participants feel that trust in God and trust in themselves (not being afraid, knowing how to push, making a personal effort) will guide them through safe delivery in their homes (see Elcira's example below), Elena brings her faith to a combination of medical control and self-control.

Except for her references to biomedical resources, Elena's description of Dr. Suárez's qualities, her own personal experience and trusting relationship, as well as his standing in the community, strongly ressemble the kind of language used by other participants to describe their relationship with the partera. It is also how government safe motherhood discourse presents, and would like its target audience to construe, women's relationship with government health services. What she says on lines 23-24 of the first excerpt ("*porque me da miedo si se me presentan complicaciones en casa y no está un médico*") and then on lines 25-26 of the same unit of analysis ("*no sé cómo es el parto en casa porque siempre he ido con el médico privado*"), this "healthy" fear, this perception of safety in the doctor's hands, this absolute reliance on his abilities and their close connection come delivery time, this embodied experience of familiarity with his clinic would be the ideal outcome of safe motherhood communication efforts in Xochis and in rural and indigenous Mexico in general, judging from the analysis in chapters 4 and 5 - except for the fact that, in Elena's case, this is not happening with relation to government health services, and she makes a point of it.

As it has also been widely reported by researchers all over the world, our data shows a direct association between homebirth and structural barriers -lack of money being the most frequent concern. To some of our participants, when there is no money, there is no choice. Carlos, a 41-year old father of four from Plan de Pierna, who had three years of elementary education and could speak and read some Spanish, referred to this lack of

options in a very assertive way. Despite being aware of childbirth risks and favouring institutional delivery, he alone assisted his wife while she had their children at home:

Q: ¿Antes del parto ya se sabe si todo va a salir bien?

C: No se puede, sólo en el hospital pueden saberlo.

Q: ¿Dónde se alivia tu esposa y con quién?

C: Aquí en casa, yo le ayudo a mi esposa.

Q: ¿No viene la partera?

C: No

Q: ¿Por qué no?

C: Porque cobran mucho

Q: ¿Nadie atiende el parto?

C: Yo mismo, lo hago yo solo.

Q: ¿Siempre es mejor que se alivie así?

C: No, yo pienso que es mejor en el hospital.

Q: ¿Por qué?

C: Porque la pueden atender en caso de complicaciones

Q: ¿Dónde no debe aliviarse?

C: No debe ser en casa, pero no queda de otra cuando no hay dinero. Pero ahora ya no cobran porque el programa de Seguro Popular cubre los gastos.

Delivering alone, without assistance from doctors or parteras,[61] can also be linked with a woman´s sense of agency, something that goes against the grain of government safe motherhood discourse, where agency tends to be portrayed as the ability to comply with biomedical expectations, irrespective of social norms and traditional beliefs. In the following segment of our interview with Juliana, a pregnant mother of three from Llano del Carmen, agency to give birth by herself is wrapped around a strong narrative presence of her own embodied experience:

Q: Tú dices que, como has tenido muchos hijos, sientes que no es tan difícil aliviarse; pero ¿cómo sabes eso? ¿Tu mamá te lo dijo, o fueron otras mujeres?

[61] Only 4% of all women surveyed for the MNH Project 2008 baseline in Xochis had delivered their most recent child under these conditions.

J: No, sólo tienes que darte cuenta del niño... cuando ya te empiezan los dolores, cuando ya llegó el momento de que te den los dolores a cada rato, entonces tienes que pujar hasta que nazca y con eso está bien. Así han nacidos estos niños. Ese niño [she points to one of her children] tardó, estuve tres días con dolores, me pasó muy feo. En la mañana del cuarto día dijimos que iba a ir al centro de salud, pero todo estuvo bien. Como a esta hora del tercer día él nació. Ya iba a oscurecer y ya estábamos preparándonos para irnos al centro de salud... ni modo si me iban a operar para que pudiera nacer... pero todo pasó bien y solamente con él me pasó eso. Todos mis hijos ahí están, y con ellos yo sola he estado [at the time of birth] Ni él que es hombre [she refers to her husband], no digas que me acompaña cuando me voy a aliviar, pues es difícil... yo me he aliviado sola de tres de mis hijos.

Juliana says her knowledge comes from her embodied experience, and she vividly conveys this experience through words from lines 3-5: "*Sólo tienes que darte cuenta del niño*," she sums up, using a expression that emerges from across our data ("*darse cuenta*") as a powerful indicator of embodied experience and, at the same time, using low evaluation ("*sólo*") to state that this is all that is needed for a woman to give birth. She does it again at the end of her step-by-step description of what it is to give birth, on line 5: "*... y con eso está bien*". But, at the same time, she implies a great deal of agency and pride in her ability to deliver by herself, particularly from lines 11-13: "*Todos mis hijos ahí están, y con ellos yo sola he estado*", "*ni él que es hombre, no digas que me acompaña*", and "*yo me he aliviado sola de tres de mis hijos*". Three times in her narration she uses personal deixis to offer extratextual evidence (the presence of her children) of her knowledge from personal experience and her agency as the source of her success: "*Así han nacido estos niños*", on line 5; "*Ese niño tardó*", on lines 5-6; and "*todos mis hijos ahí están*", on line 11. This kind of rhetorical connection between her embodied experience and the immediate extratual reality tends to undermine the idea of unmanageable risk inherent in safe motherhood discourse. She reinforces this idea from lines 5-10, where she refers to a critical case of obstetric complications, only to highlight the final result (again, as a consequence of her agency) and to lessen the impact of this single case –and perhaps the likelihood of future occurrences- in the context of her overall maternal experience: "*... pero todo pasó bien y solamente con él me pasó eso*".

6.6. Self-care, a far-reaching imperative

As is the case with government safe motherhood discourse, imperatives of control and self-control feature prominently in people's words, usually linked with notions of responsibility and blame. In Xochis, risk control in relation with maternal and newborn health seems to have happened traditionally within the private and "semi-public" realms. By semi-public, in this case, I refer to the public manner of the traditional order of discourse, through legitimized bearers of traditional knowledge, such as brujos and parteras, close relatives, other people's advice, and hearsay. These forms of control did not take place openly in the public sphere of political institutions or the media, or through organized campaigns of public health promotion and communication in the communities –let alone in wider jurisdictions-, as is the case in contemporary Western societies. In government safe motherhood discourse, there is a very public interpellation to individual and collective responsibility for self-control that was absent in traditional societies. In chapter 5, we have already seen how government discourse embraces and tries to co-opt traditional semi-public forms of self-control to improve maternal and perinatal health surveillance. Here, I will analyze how these different views and discourses interact in people's words, and what are the ideological implications, for instance, in terms of subject positions, logonomic regulations, and power and solidarity.

The idea of self-control is strongly present in people's words. The key term in the Spanish translation is *cuidarse*, which entails self-care: being careful, taking care, looking after oneself. Women must be very careful during their pregnancies and the cuarentena, and they must take care of themselves *and their babies*. Appendix D shows how self-care or lack thereof is crucially linked with many risks, potential outcomes, and preventive measures. Self-care is associated with a range of norms and behaviours, including nutrition and work during pregnancy, satisfying cravings for food, going for prenatal control, not lifting heavy objects, not drinking, not smoking, not jumping from high places, not having sexual relations, not exposing oneself to scaring or stressing circumstances, avoiding self-medication, and not going out when there is a lunar eclipse.

To be clear: not everyone has the same concerns. Some people, for instance, think going to the doctor is important, others do not see it as a priority. There is much variation in people's responses about how much women should eat when they are pregnant and why. Self-medication, on the other hand, is widely viewed as a threat and a likely explanation when things go wrong –something a woman brought upon herself. Periodically checking the position of the baby in the womb, and re-positining as needed, are paramount concerns. People also agree that women should avoid heavy work after childbirth.

As I mentioned above, some women initially said they saw no risks in pregnancy, but later qualified this view in different ways. Lack of self-care features prominently among these disruptive factors, since it may lead to sickness, coraje, bleeding and miscarriage, postpartum hemorrhage, and newborn malformations, among other things. In other words, nothing should happen if women took good care, as Zulema, a 31-year old mother of two from Arroyo Pájaro, echoing what she "has heard", said during our interview:

> **Q:** ¿Crees que pueda haber algo peligroso que le pueda pasar a una mujer mientras está embarazada?
> **Z:** No sé si hay algo que pueda pasar
> **Q:** ¿Para ti no es peligro que una mujer esté embarazada o que tenga un problema o se enferme?
> **Z:** Para mi no hay problemas
> **Q:** ¿Hay alguna enfermedad que sea peligrosa para una mujer?
> **Z:** Si ella no se cuida, entonces se puede enfermar.
> **Q:** ¿Qué le puede pasar?
> **Z:** No sé
> **Q:** ¿No sabes lo que puede suceder?
> **Z:** Sí, mira, si una persona no se cuida, eso es lo que hace que ella aborte. Si hace algún trabajo pesado, eso es lo que yo he escuchado…

In many cases, being careful is directly linked to bearing a healthy baby as the outcome, even more than it is to the mother's health per se, as it transpires from this exchange with Alfredo:

Q: ¿Tú piensas que puede haber peligros o problemas cuando una mujer está embarazada?

A: La mujer debe de cuidarse para que no se enferme su hijo.

Q: Está bien, pero, ¿tú piensas que puede haber peligros o problemas cuando una mujer está embarazada?

A: Puede haber problemas. Si no se cuida, puede abortar. Debe de cuidarse para que el bebé nazca sano. También el hombre debe de cuidarla; no debe de golpearla para que no afecte el hijo.

Q: ¿Cómo sabes estas cosas? [...] ¿Conoces a alguien que haya pasado por problemas o peligros en el embarazo?

A: Sí, puede haber problemas. Es peligroso porque hay mujeres que abortan involuntariamente.

Q: ¿Conoces a alguien con ese problema?

A: He escuchado que hay gente que tiene esos problemas, sobre todo cuando no se cuida.

The dynamic of the exchange is very telling. The interviewer repeats the first question, because he is not satisfied with the response, perhaps expecting an answer that will focus on the mother's health.[62] However, Alfredo reiterates his concern for the child, elaborates (he says that the woman may have a miscarriage) and expands on his first explanation by including the father's duty to care for the woman –not hitting her- *so the child will not be affected.* The connection between lack of self-care and miscarriage continues to dominate Alfredo's responses until the end of this exchange. We see a similar pattern during the interview with José (in this case, the woman must not self-medicate, a frequent cross-sectional concern, because she can harm the child in her womb):

[62] Here, we see the limitations of working with a structured questionnaire and an inexperienced interviewer who is too concerned about getting a specific answer from a preset range of contents that, for whatever reasons, he has come to expect. At the same time, the reiteration of the first question adds value to what the entire sequence, because it reaffirms the participant's concerns and the core components of his view. This is also a good example of why we need a flexible approach to qualitative research. In this case, I have defined the unit of analysis as a sequence of questions and answers that allow for the conceptual development of the main ideas and the emergence of related categories and discursive dimensions.

Q: ¿Puede haber problemas graves durante el embarazo?

J: Sí, claro, cuando la mujer se enferma es muy delicado porque puede enfermar al hijo también.

Q: ¿Qué problemas puede haber?

J: Puede haber problemas graves. Debe de cuidarse mucho, no debe de tomar cualquier medicamento porque puede perjudicar al bebé. Es sumamente com plicado.

Child-oriented self-care discourse also appears coupled with prenatal control, closely mirroring government safe motherhood discourse and the link between control and self-control in health risk discourse. Here is an example from our interview with Belisaria:

Q: ¿[Tus familiares] te dicen que vayas o que no vayas al centro de salud?

B: Ellos me dicen que vaya, todos ellos me preguntaban si yo ya había ido al centro de salud...

Q: ¿Por qué te preguntaban eso?

B: Porque es algo con lo que yo debo tener mucho cuidado, porque sé que en mi vientre está creciendo un bebé y eso es no es cualquier cosa, eso es la cosa más importante que una mujer tiene.

A complex instance of intertextuality and interdiscursivity unfolds here, interlacing several key dimensions of safe motherhood discourse, such as prenatal control, self-control, responsibility, awareness, heeding, and caring for the unborn child. In her first answer, we can see how her closest relatives take an active stance in the normative reproduction of safe motherhood discourse: not only did they tell her to go for prenatal control at the health centre, but they asked her weather she "had already gone" there, which implies a direct interpellation in terms of responsibility. When the interviewer asks her why they wanted to know, Belisaria's answer bears the traces of safe motherhood discourse and related discourses from the community. From the cross sectional analysis of our data we can say, with a good degree of confidence, that she is paraphrasing likely familial conversations, public health slogans, religious sermons, and popular expressions that reflect both the role of women and the value apportioned to the health of pregnant women and their children. One such example is the use of the verb saber in the first

person and in the immediate context of a normative precept ("*sé que en mi vientre está crecienco un bebé y eso no es cualquier cosa*"), which echoes the knowledge=awareness component of behavioural communication campaigns and the didactic, commanding tone of the video film. From that perspective, Belisaria is aware of the importance of her child –who is already growing as a sentient being. But she is also aware of what that child *means* in her life –it is the most important thing she has- and of her responsibility for his good health -"*su salud está en tus manos*" reverberates at this point, as much as "*no es cualquier cosa*" brings the voice of familial and religious concerns. All of these voices, speak in strongly normative terms through Belisaria, who reproduces multiple social interpellations of power and solidarity and construes her subject position as a *heeding, self-caring, controlled woman*, where self-caring implies policing her own body and caring for herself and her child –better yet, so her child can be healthy. Men also voiced these expectations, as is the case with José:

> **Q**: ¿A quién hay que hacerle más caso en estas cosas del embarazo, el marido, al doctor, al curandero, a la partera, a tu madre, a tu suegra?
> **J**: Yo pienso que debe de ser igual, los consejos del médico, de su marido, de su papá, los consejos de todos ellos debe de respetarlo.
> **Q**: ¿Por qué?
> **J** En el caso de su esposo, debe de respetar sus consejos porque es su pareja, y ella no puede escuchar las opiniones de otra gente porque no viven con ella.
> **Q**: ¿Por qué debe de respetar la opinión del médico?
> **J**: Porque estamos hablando de embarazo; el médico es el especialista, lleva el chequeo. En el caso de su mamá, ella sabe porque tiene experiencia; sus consejos son valiosos.

At the level of experiential meaning, we can see how José construes a heeding woman who submits to different types of external authority: a) her husband's, because it is his inherent right as a partner who lives with her (this is clearly the most authoritative figure from an interpersonal perspective, since José asserts a strong logonomic, territorial interdiction in the private sphere: "*y ella no puede escuchar las opinions de otra gente porque no viven con ella*"); b) her doctor's, because he is the expert and the one who polices her pregnancy in the public space; and c) her mother's, because her authority

comes from experience. Together, spousal rights, medical expertise, and elderly experience conform the logonomic framework for a heeding, self-caring, responsible woman to carry out her pregnancy.

As it transpires from the previous examples, mentions to self-care are laced with guilt, blame, and the call for individual responsibility, all of which strongly likens it to the self-control dimension from safe motherhood discourse. All these elements have a strong interaction in the following excerpt from our interview with Elena:

Q: ¿Puede haber peligros o problemas para la mujer embarazada?
E: Sí
Q: ¿Por qué sí?
E: Porque hay mujeres que no se cuidan, se avientan de lugares altos o se sientan en una banca alta y una mujer embarazada debe de cuidarse, no debe de brincar en lugares altos, debe de cuidarse hasta para caminar.
Q: ¿Qué puede pasar?
E: Le puede pasar como te dije de la mujer que se sienta en una silla alta o se tira de un lugar alto. Si se sienta en una silla alta se le puede hinchar los pies, las venas se le hacen visibles, se le hinchan. Ahí está el peligro cuando va a parir. Cuando ella se embaraza le dolerán las venas, no podrá caminar por el dolor, le dolerán las venas.
Q: ¿Son cosas graves?
E: Sí, son un poco graves. Debe de tener cuidado... Como me pasó a mí, no me cuidé, me subí a la hamaca y estaba alto, dañé mi pie, se me salió una vena. Y dicen los médicos que es peligroso a la hora del parto. Se me puede romper una vena que tengo en mi parte íntima y corro riesgos de morir. Los médicos me dijeron que tengo que operarme.
Q: ¿Estos problemas les pasan a muchas mujeres aquí en el pueblo?
E: No a todas, porque hay mujeres que se cuidan como yo me cuido; pero me descuidé, me subí en la hamaca alta y se me torció el pie. No les pasa a todas las mujeres, sólo a algunas.
[...] **Q:** ¿Por qué hay mujeres que tienen problemas cuando están embarazadas?
E: Porque muchas de nosotras no nos cuidamos, no nos cuidamos a diario. Paseamos descuidadamente.

It is interesting to see how the framing of self-care, responsibility, personal experience, and guilt progresses throughout Elena's narration, and how these categories feed off one another. In this case, contrary to Zulema's answer –where she sees no problems for pregnant women, unless they bring them upon themselves-, our participant says *there are* problems because women bring them upon themselves. Also, while Zulema seems to use a conditional construction to allude to the eventual disruption of normalcy -*Si ella no se cuida, entonces se puede enfermar*-, Elena makes an assertive statement with high evaluation and categorical modality: Yes (there are dangers), she says, on lines 4-5, "*porque hay mujeres que no se cuidan, se avientan en lugares altos o se sientan en una banca alta...*" She presents this as a fact, as a state of affairs, with thematic placement of direct causality (*porque*), and clear attribution of responsibilities. There are no doubts in terms of logical meaning: These careless women are the cause of problems during pregnancy: they have an active role in behavioural processes ("*se sienta en una silla alta o se tira de un lugar alto*"), disregarding sound advice and increasing the risk of adverse outcomes; therefore, they are the ones to blame when bad things happen. Whereas Zulema talks about an eventual occurrence –*si ella no se cuida*-, Elena says this is indeed the case: "*Hay mujeres que no se cuidan*". Her use of language represents an existential process and, at the same time, a classifying one, since she points to a particular type of women: those who bring about problems buy putting themselves at risk in pregnancy.

Personal experience seems to be the mediating factor that makes the difference in terms of wording and risk perception between Zulema and Elena. Zulema has heard about it; Elena knows bad things can happen because they have happened to her. Normative language and guilt coexist on lines 13-17. She first states an impersonal warning, which carries multiple voices from different orders of discourse: "*(La mujer) debe tener cuidado*". Then, she elaborates on this statement by shifting the person deixis and citing her own experience to confirm the soundness of the self-care imperative.[63] Here, again, we can find the footprints of blaming, guilt, and negative retribution framed as a

[63] Exemplification is a form of elaboration, whereby a clause or a clause complex "develops the thesis of the primary clause by becoming more specific about it, often citing an actual example". Halliday MAK, Matthiessen CMIM 2004, p. 398.

cautionary tale -*Como me pasó a mí, no me cuidé... dañé mi pie, se me salió una vena*- including an intertextual reference to an authoritative voice that she makes her own on lines 14-17. On lines 19-20, she restates the existential process whereby she construes two types of women –self-caring women and careless women-, even though this time she includes herself among the first group –*porque hay mujeres que se cuidan como yo me cuido*-, framing her problems as a misstep –*pero me descuidé*- that bears serious consequences (*se me puede romper una vena que tengo en la parte íntima y corro riesgo de morir*, she says on lines 15-16).[64] Safe motherhood discourse looms large here: pregnancy risk, however minimal, *is always a serious threat.*

On lines 23-24, Elena changes the person deixis again to include herself among the careless women: "*Porque muchas de nosotras no nos cuidamos, no nos cuidamos a diario.*" This recurrent deictic shifting reveals her ambivalence vis-à-vis the social finger pointing that goes on around her, as well as the powerful implications of the self-care discourse from the community order of discourse, coupled with the self-control dimension from safe motherhood discourse. How can we tell? There is a particular argumentative structure that unveils the discursive presence behind Elena's words: she turns her own personal experience –*me descuidé*- into an instance of a pre-existing discourse of self-care: *hay mujeres que no se cuidan.* In other words, a pervasive, easily retrievable social discourse of self-care and self-control provides a strong explanatory framework for things that happen in our lives and the lives of others.[65]

This particular unit of analysis also shows the strength of the associated ideas of guilt, blame, and individual responsibility, which are the result of people's reworking of

[64] From a clinical perspective, it is not clear what would be the connection between "*torcerse el pie*" (which probably alludes to spraining her ankle) and *romperse una vena en la parte íntima.* But this only goes to show how the particulars of clinical alarm signs and symptoms get blurred in people's narrations, while they feed into a heightened perception or risk.

[65] Vannini says in this regard: "An important way in which discourse works is by turning a specific reality into an instance of a larger case. For instance, when someone tans with a high frequency –say, everyday of the week- that person is bound to be labelled a 'tanorexic' or 'tanaholic'. Discourse then works by turning a specific reality into an instance of the larger discourse of addiction." Vannini P. Social Semiotics and Fieldwork: Methods and Analytics. *Qualitative Inquiry* 13(1):113-140, 2007, quote on p. 134-135.

multiple –and sometimes contradictory- voices, in their attempt to make sense of social circumstances and personal experiences concerning motherhood and maternal health.

Self-care, individual responsibility, and blaming share a direct and very strong discursive connection with self-medication during pregnancy. Women can resort to traditional medicine, on their own or –preferably so- with guidance from parteras, healers, and elderly people; but they are clearly discouraged from using Western medicine, particularly without input from clinical practitioners.[66] Self-care is frequently linked with avoiding self-medication; failing to do so is widely viewed as a shortcut to miscarriage, induced abortion, and harm to the newborn. A dark cloud of blaming and guilt hangs over these behaviours and their likely outcomes. Here is Ana, a multiparous mother from Cozoyoapan, who had recently given birth at the time of the interview:

> **Q:** ¿Y cómo cuidabas tu embarazo?
> **A:** Pues en mi caso, después de comer se me inflamaba el vientre; pero yo no tomaba patillas (TN[67]: Alka-Seltzer) porque sé que no está bien. Es peligroso por el embarazo. Lo mismo la pastilla aspirina. Yo no lo hice... Lo que hice fue ir a consulta con el médico en el hospital, porque cuando se toma alguna pastilla sin consultar al médico se corre riesgos. Por eso se suceden los abortos, por eso yo iba al hospital. Hay mujeres que sí lo hacen y lo que provocan es un aborto.[68] Yo sólo así me cuidaba.

Religious discourse also has a strong bearing at the level of discursive practices when it comes to self-care and self-control. Women must look after themselves and be very careful *from before* getting pregnant. A religious leader in Xochis put it bluntly during our interview: "*Y yo se los digo hasta descaradamente...* [He raises his voice, mimicking

[66] Judging from our data, this is a domain where biomedical expertise seems unchallenged. Only doctors know how to properly use Western drugs.
[67] TN: translator's note.
[68] Miscarriage features as a major emerging category. Notions of danger, threat, medication and self-medication, individual and familial responsibility, blaming, guilt, domestic violence, antojo, susto, coraje, and loss of the nahual, among others, are linked with it. Blaming is greatly intensified when it comes to abortion. The word "abortar" (both in the sense of "to have a miscarriage" and "to have an abortion") does not exist in Amuzgo. According to one of our translators, who is also a clinical practitioner, people usually say things like "*el bebé se puede salir*" o "*puedes sacarlo*", or even "*quiero sacar a mi bebé*", when they want to have an abortion. When someone talks about somebody else's abortion, they frequently say things like "*esa mujer mató a su hijo*".

his own tone] *'Muchacha que abre las piernas está condenada a tener hijos'."* This self-care imperative assumes that women have a choice in these matters, in a cultural context where they are still expected to bear children at a young age. Of course, the validity of the preacher's one liner hinges on several presuppositions: a) that nothing can be done, or should be done, in terms of contraception; b) that nothing can be done, or should be done, to stop a pregnancy; and c), upstream on this line of thought, that having sex is meant for procreation. The first of these presuppositions, and the bearing of religious discourse on this matter, comes to life in our exchange with Juliana:

> **Q:** Cuando te diste cuenta de que estabas embarazada, ¿cómo te cuidabas?
> **J:** Pues, mientras no conozcas las letras (TN: no sabe leer) no sabes cómo; haces sólo lo que escuchas. Ahí tú como mujer eres la que se debe cuidar. Así como hay reuniones con el padre (TN: sacerdote), él dice sobre cómo hace la gente. Hay personas que se meten medicina, se meten inyecciones, y él te dice que eso es una culpa tuya (TN: pecado),[69] y es diferente a que tú sola te cuides cada mes que te pasa lo malo (TN: menstruación). Hay dos formas de que te pase eso... Una es que te baje sangre y otra que te baje algo blanco y eso es lo que te dice que ya recibiste a un hijo (embarazo). Eso pasa cuando no estás preparada para recibir a tu hijo y sólo te das cuenta de que ya estás embarazada.

At the other end of the maternal health spectrum, self-care is connected with postpartum and newborn care, as it happens in safe motherhood discourse. Self-care means that the mother should look after herself and her child. Dionisia, who lived in Cabecera and had recently had her second child, voiced a common view of maternal responsibilities:

> **Q:** ¿Cómo debe cuidarse la madre después del parto?
> **D:** Debe de estar sentada o acostada, tener muchos cuidados, no levantar objetos pesados. Debe de cuidarse mucho porque de lo contrario puede ser un problema.
> **Q:** ¿Qué problemas pueden ocurrir?
> **D:** Puede ser porque la sangre es débil, da mareos, dolor de espalda, cuando no se cuida. Puede tener hemorragias también.

[69] There is no literal translation for the word "pecado" in Amuzgo. People talk of "*culpas*" instead. Here is what one of our translators said in this regard: "*Tú te estás hacienda una culpa, estás pecando. Incluso para decir que vas a ir con el padre a confesar tus pecados, se dice como que vas a ir a decir tus culpas.*"

[...] **Q**: ¿Qué cuidados hay que tener con el recién nacido?

D: Se debe de cuidar, se debe de checar que no esté enfermo. Si está enfermo, llevarlo al hospital para que lo revise el médico.

[...] **Q**: ¿Alguien tiene la culpa si el recién nacido tiene problemas?

D: La madre, yo pienso que la madre porque no lo cuidó, es lo que veo yo.

Q: ¿En este pueblo mueren muchos niños en el embarazo, en el parto o recién nacidos?

Q: Yo veo que así es. Es por el descuido.

The self-care imperative holds across a wide range of views, practices, and discursive influences. Women are expected to look after themselves –and their babies- regardless of their choice of advisors and providers. When connected with institutionalized prenatal control, the self-care imperative fully translates as self-policing as described in chapters 2 and 4. In the following example, Calixto, a 29-year old father of three from Arroyo Limón, brings together self-control, institutional control, medical authority, heeding, responsibility, and blame:

Q: ¿A quién hay que hacerle más caso en estas cosas del embarazo, al marido, al doctor, al curandero, a la partera, a tu madre, a tu suegra?

C: Al doctor.

Q: ¿Por qué?

C: Porque hace buenas recomendaciones. Muchas veces, cuando la mujer no hace caso a los médicos, después sufre las consecuencias. Por eso las regañan cuando no cumplen.

There is perhaps no better example of how sophisticated the notion of self-care can get than the following excerpt from our interview with José:

Q: ¿Las mujeres embarazadas deben comer más, menos o igual que de costumbre?

J: Yo creo que debe de ser medido, no debe comer más ni menos. Debe comer en la mañana, en el medio día y en la tarde. Debe de comer de acuerdo a su dieta pero no debe de excederse porque puede subir de peso y en el parto yo pienso que puede tener complicaciones.

Q: ¿Ella sube de peso? ¿O es el bebé el que engorda?

J: Bueno, pienso que es ella la que sube de peso, pero también el bebé sube de peso.
Entrevistador: ¿Por qué piensas eso?
Entrevistado: porque se excede en la comida
Q: ¿Las mujeres embarazadas deben trabajar igual, más o menos que de costumbre?
J: La mujer debe de trabajar lo que se debe, pero tampoco debe de estar todo el tiempo dormida, porque estar dormida durante el día es nocivo para la salud. Si se mantiene sin trabajar la sangre se detiene y pierde la condición física. La mujer debe de hacer quehaceres de la casa, pero no debe de levantar objetos pesados.
Q: ¿Qué trabajo puede hacer?
J: Como barrer, también puede preparar comida.
Q: ¿Qué cosas no deben hacer las mujeres durante el embarazo?
J: No debe de levantar objetos pesados, no debe de andar en bicicletas porque es peligroso, puede abortar.

We could call this unit of analysis "José's risk hedging", and hedge he does, summing up different lines of thought about how a pregnant woman should look after her health and the health of her child. On line 2, he says that women should eat "moderately, neither more nor less" (there are women who think they should eat more to have more strength in labour, while others feel they should eat less to have an easier delivery). On lines 2-3, he gives a meal schedule for women to follow. On lines 3-5, he says that they should follow their diet, but they should not eat in excess because they could have complications when the time comes to give birth. On lines 11-12, he says that a pregnant woman must do "the proper" amount of work, but he cautions against her sleeping all the time, because this is bad for her health. On lines 13-19, he elaborates on this statement by saying that she can do house chores, like sweeping and cooking (which the video film suggests someone else should do, particularly in the late stages of pregnancy), but she should avoid riding a bike and lifting heavy objects, lest she may have a miscarriage. Of course, no one but the woman can find the right balance: too little work and she will lose her good shape; too much and she may lose her child. Here, self-care matches (in form, if not strictly in content) the classical demand for active, rational, and judicious self-control in lifestyle-focused health risk discourse. It is hardly a surprise, since José has likely been exposed to

this type of discourse in high school biology classes and chats by government health staff, as mentioned by key informants from secondary schools in Xochis.

Indeed, self-care is a sweeping mandate. If there is one thing that a pregnant woman and a recent mother should do, that is being careful and looking after herself –and the child she bears. Alfredo, the 23-year-old father of two, sums it up in very few words:

> **Q:** ¿Tú hablas con tu esposa de las cosas del embarazo?
> **A:** Sí.
> **Q:** ¿Tú qué le dices?
> **A**: Que se cuide.

From these examples emerges a discursive *continuum of self-care* that places squarely on women's shoulders a great deal of responsibility –and blame- for maternal and perinatal health, from the circumstances that lead to her pregnancy right through to the outcome of the cuarentena. Mirroring safe motherhood discourse, self-care is linked with preventing negative outcomes, interpellating individual women as responsible for their own health and the health of their children, and creating a subject position of self-caring, cared-for and controlled women in a continuum of care with strong normative contents and logonomic regulation at the level of discursive and sociocultural practices. Government-sponsored safe motherhood discourse and health staff try to encourage self-control within this discursive space, made up from the symbolic interpretation of embodied experiences traditional beliefs, religious imperatives, biomedical discourse, and social norms.

6.7. Spousal solidarity, material barriers, and ethnic identity

Of course, pregnancy is not only a matter of self-care. Maternity, and all that is at stake, makes women the focus of attention in the private sphere of the family, what I have called the semi-public domain in the community, and the public sphere of health care. Cross-sectional analysis of our data showed an underlining imperative to give pregnant women and recent mothers an equivalent of what global safe motherhood discourse calls

"the care they need". This care comes –or rather should come- from various stakeholders, most notably parteras, doctors, husbands and close family. Husbands, in particular, are deemed responsible for providing material and moral support, and for showing leadership when needed, which was also the case in "Heed the messages". This imperative can feed on a range of discourses, from spousal love and companionship to penal responsibility, as we can see from the following exchange with Elcira:

E: [...] Si él me quiere, no me deja, pero si no me quiere, me deja y se va a trabajar. Me puede dejar sola, sin saber si mi hijo nació bien o mal. Antes del parto él se preocupa, me lleva con el médico, en todo momento me lleva con el médico; si es ya unos días antes del parto corro riesgos. Así es como vivimos nosotras.
[...] **Q:** ¿Hablas con tu esposo de estas cosas?
E: Sí, lo hablamos, hablamos de cómo vivir bien.
Q: ¿Qué te dice él?
E: Me dice cómo vivir, cómo cuidar el embarazo, qué medicina tomar, no buscar sola una medicina. Él está al pendiente, no permite que levante objetos pesados. Si él permite eso es delicado. También es delicado para él... Él sabe que puede llegar a la cárcel porque permitió que la mujer hiciera alguna cosa indebida. Por eso el hombre después tiene la culpa y está obligado a buscar la medicina. Así es como vivimos nosotras... no sabemos cómo viven otras mujeres.

The spousal imperative rings loud in this text, drawing from different orders of discourse. On line 1, Elcira links spousal love to companionship and care facing delivery through a hypothesis phrased as a double conditional statement: physical presence before and during childbirth is evidence of love: "*Si él me quiere, no me deja; pero si no me quiere, me deja y se va a trabajar*". This high demand overrides other obligations, like the need to work in the pressing economic context of the Amuzgo people. Although Elcira speaks of men in general, she does it in the third person singular, bringing a close personal dimension and a strong interpersonal evaluation to her words: "*Me puede dejar sola, sin saber si mi hijo nació bien o mal.*" On lines 2-4 we can infer she now talks about her own husband, linking her discourse of spousal solidarity with a safe motherhood imperative of institutionalized skilled care aiming to lower the risk inherent in childbirth. "*Así es como*

vivimos nosotras," she says referring to a collective of Amuzgo women, an implicit mention of ethnic identity that she reiterates on lines 12-13, this time also alluding to the exogrup: "... *no sabemos cómo viven otras mujeres.*"

From lines 5-10, Elcira further develops the idea of spousal solidarity based on the narrative of her own experience. When the interviewer asks her whether they talk with her husband about maternal care, she expands the meaning and scope of this engagement, again in normative terms: "*Hablamos de cómo vivir bien*". Then, she gives a detailed elaboration on this meaning, where she portrays the husband in higly normative processes of saying ("*Me dice cómo vivir, cómo cuidar el embarazo*, etc.") and doing ("*Él está al pendiente, no permite que levante objetos pesados*"), which clearly resemble the role played by Jorge in the second episode of the video film. Of particular interest is her mention of her husband telling her not to seek out medicine on her own, on lines 8-9: "*Me dice... qué medicina tomar, no buscar sola una medicina*", which connects with a frequent and heightened concern about self-medication as a cause of miscarriage, both within the same interview and across our dataset.

Finally, on lines 10-12 we can trace the impact of governmental discourse about spousal responsibility, as well as the multi-level pressure to avert maternal deaths. Her husband knows that he will be to blame if he fails his duty either by action *or inaction.* "*Él sabe que puede llegar a la cárcel porque permitió que la mujer hiciera alguna cosa indebida,*" says Elcira, echoing a coercive discourse that will not be found in public health communication, but will likely and conveniently be funneled through government health centres, local authorities, and hearsay –very much like the coercive presence of Oportunidades looms large over women's submission to prenatal control in government health units.

As we can hint from the above, caring for pregnant women is also linked with notions of material barriers and ethnic identities. In the following excerpt, Jesús, who lived in Guadalupe Victoria and whose wife was pregnant at the time of the interview, draws

from local discourses of spousal responsibility, inherent manly identity ("*uno como hombre*"), and ethnic self-awareness when asked about care during pregnancy:

J: [...] Uno como hombre debe cuidar a su mujer. Es diferente entre nosotros los indígenas, que somos pobres, no tenemos quien nos ayude, trabajamos diferente. La gente rica, la gente que vive bien, ellos siempre tienen quien los ayude y sus mujeres salen bien... Pero nosotros tenemos mucho trabajo; pero tú como hombre debes saber que las mujeres cuando están embarazadas no deben trabajar ni partir la leña, no deben cargar bulto, y además cuando no queremos que les pase algo malo que haga que no pueda parir, entonces se debe tomar unas hojas...
Q: ¿Qué cosas no deben hacer?
J: No deben hacer trabajos difíciles. Tú como hombre debes buscar cómo ayudarle.
Q: Ahora, ¿tú cómo hombre hay algo en lo que le ayudas?
J: Sí, siempre hay algo en lo que le puedes ayudar
Q: ¿En qué le ayudas?
J: Cargando las cosas pesadas. Uno es él que las carga, haces todo lo que ella debe hacer. Si no hay quien te ayude a ti con tu mujer, cuando ya parió pones la olla en el fogón, bajas su nixtamal, lo pones en el suelo, juntas su lumbre, también cuidas el agua caliente que se usa cuando ya parió.
Q: Digamos que falta para que se alivie, que sólo está embarazada. ¿Tú le ayudas a tu mujer cuando está embarazada?
J: Sí, le ayudo porque así debe ser. Porque, fíjate, pobre de ella cuando está embarazada... pobres de ellas cuando están embarazadas... Se ve que caminan lento, que están enfermas, delicadas... Tampoco debes golpearla sólo porque estás tomado.

It is worth comparing the discursive framing of spousal solidarity in this example with the framing of the same topic in the videofilm. As we have seen, the film incorporates, and responds to, a seemingly prevalent discourse of macho posturing and lack of spousal involvement in the woman's pregnancy. Jesús also frames spousal solidarity as an imperative of manly identity ("*uno como hombre debe cuidar a su mujer*"). From an experiential standpoint, both Jesús and the creators of the "Heed the messages" refer to the same set of ideas and the same field of experience: the role of the husband in maternal health. But the discursive sources and implications are quite different. Whereas the film

portrays Jorge as a hero because he goes against the grain –that is, the accepted definition of manly behaviour-, the textual organization of Jesús's response –his thematic placement of what a man *is*, and the rhematic nature of what he should do- makes it clear that there are at least two interpretations of what is expected from the husband. In fact, cross-sectional analysis reveals the same emphasis from both men and women on what is expected from a man as a husband, as the father of the woman's children –*el padre de mis hijos* is a very common way for women to refer to their spouse- and as a man.

Of course, there are important points of articulation between government safe motherhood discourse and this views from within the community. What really differs here –see lines 1-4- is Jesús's framing of that imperative *within an emerging discourse of indigenous identity and associated material circumstances*. The husband must get involved in his wife's pregnancy not because of a universal imperative of manly solidarity pushing to break through traditional views of manhood (as the film frames it), but because of the material constraints facing indigenous peoples: Rich people, people who can make a good living, always have someone to help them and, because of this, their women fare well in pregnancy, childbirth and beyond. "*Pero nosotros tenemos mucho trabajo*," he says, where the first person plural deictically points to those who are not rich, a frequent reference also connected with indigenous identity across our data set. Here, men's lack of involvement could be interpreted as the result of material circumstances and not so much of traditional notions of gender roles. In other words, they do not have a real choice.

Jesús's explanation also translates in terms of health risk discourse: Indigenous people in Xochis are poor and this puts them at higher risk of adverse maternal outcomes than their Mestizo counterparts. True, the video acknowledges material constraints –Jorge asks *¿Cómo le hacemos, doctor?,* and the doctor spells out how the government health system is going to help-, but Jesús draws *a direct link* between ethnic identity and poverty, and between both variables and maternal health. This conception of indigenous ethnicity as a social determinant of health and a risk factor for maternal and perinatal health –including

spousal engagement in maternal care- is indeed pervasive within the government health system, though none of these arguments feature in safe motherhood texts.

From lines 4-16, there is more textual evidence that Jesús does not frame this reference to the indigenous condition as a justification. On the contrary, he says that indigenous men should help their wives *because* they are poor and have no external help. It is worth noticing that he presents his explanation as a series of directives within an assertive speech act: "*Pero tú como hombre debes saber que las mujeres cuando están embarazadas no deben trabajar ni partir la leña, no deben cargar bulto, etc.*" Because he uses the second person (*tú*) coupled with a command (*debes*), it may seem that the primary illocutionary point is that of a directive.[70] But Jesús does not really want to make the interviewer behave in a certain way; he is rather asserting how things are or should be among Amuzgo men; he is really saying: "An Amuzgo man, because he is poor, ought to –or is expected to- help his wife through pregnancy and through recovery". This interpretation is confirmed on lines 13-16, where the assertive nature of Jesús's words comes to the fore.[71] Spousal solidarity emerges here as a life strategy to cope with the material disadvantages of being Amuzgo and being poor, which are framed as one and the same thing.

On lines 19-21 there is further evidence of pregnancy perceived as a risky, delicate state that undermines women's health. We also see the framing of a singular reference as part of a larger view and a pre-established category, as Jesús quite consciously switches from the singular (in this case, an archetype) to the plural (an at-risk group): "*Pobre de ella cuando está embarazada... pobres de ellas cuando están embarazadas... Se ve que caminan lento, que están enfermas, delicadas*". Finally, there is a valuable piece of information on line 21, where Jesús says that men should not hit pregnant women "only because you're drunk". Implicit meaning is the key here. Jesús's utterance presupposes

[70] In classic pragmatics, the illocutionary point is the main purpose in any given utterance. Searle J 1979, p. 3. If Jesús were talking to another husband and he told him "*debes ayudar a tu mujer*", we could say that he has issued a command or a request, depending on other circumstances (whether he is talking to someone he has authority over, etc.)

[71] Jesús gives a very detailed account of what a man does or should do to help his wife. It is a wide range of activities –short of sweeping floors. This somehow confirms the melodramatic excesses of "Heed the messages" in the context of the Amuzgo culture, as our fieldworkers observed in chapter 5.

alcoholism and spousal violence in the community, insofar as he does not bring these issues as new information, but rather as part of a restrictive norm concerning a seemingly frequent behaviour, that is, a man getting drunk and hitting his pregnant wife or coercing her into having sex.[72] [73] Belisaria hints in the same direction when she says: "*El marido no debe de causar muchas molestias a la mujer, aunque sea un bebedor; pero no debe de hacerlo tanto porque no está bien, ella se podría enfermar.*" Elcira also points to these circumstances in terms of pregnancy risks and spousal responsibility in pregnancy care: *"También el hombre debe de cuidar a la mujer... Si llega borracho a casa que se meta a la hamaca, que se duerma y no moleste, porque sabe que la mujer está enferma. Debe de tener mucho cuidado porque no es cualquier cosa cargar un bebé. Así es como vivimos nosotras; no sé cómo viven otras mujeres."*

From the cross-sectional analysis of our data, spousal responsibility seems to be linked with maternal health beyond safe motherhood discourse. It also overrides issues of ethnic awareness and structural barriers. Roque says in this respect:

> **Q:** ¿Alguien tiene la culpa de que pasen estas cosas [pregnancy problems]?
> **R:** Sí, la mujer se enferma de coraje porque la hacen enojar. Cuando el esposo no le da dinero para la casa, cuando se va a emborracharse y no pone atención a las necesidades de la casa.
> **Q:** ¿Estos problemas les pasan a muchas mujeres aquí en el pueblo?
> **R:** Sí

Ideational meaning sheds light on the discursive connection here. Roque links the occurrence of a cultural syndrome (coraje) with negative spousal behaviour: by getting

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[72] Presuppositions are parts of meaning that must be taken for granted in making sense of someone we read or hear. It is a conventional means of expressing implicit meaning. They require, as does all implicit meaning, a common knowledge or a common background. Verschueren J 1999, p. 25-27. In the context of this interview, it could be the case that Jesús takes for granted a common background with the interviewer, another man from Xochis. But it could also be the case that he sees this as part of common knowledge, without regard to ethnic or community boundaries, as he reflects on the topic of conversation.

[73] According to the 2008 MNH Project baseline survey, 5% of all women of reproductive age had been beaten during their last pregnancy. As is usually case, this numbers could underrepresent the real prevalence of spousal abuse, since women may feel embarrassed, shocked, or unsafe when answering this question.

drunk, not caring about the needs of his household and not providing for the family, the husband makes the woman ill with coraje. According to Roque, this is a frequent problem in his town, one he does not explicitely associate with poverty or ethnic identity. Of course, this does not mean that he sees no connection between these variables –after all, he lives in a place where almost everyone is Amuzgo and poverty is the norm. What we can say, from a discursive perspective, is that he primarily draws from a discourse of individual responsibility and spousal manly responsibility when asked if anyone is to blame for a pregnant woman's ailments. In other words, spousal responsibility overrides other possible considerations. Many women are of the same view. Belisaria thinks it may be more likely for Amuzgo women to have problems during pregnancy because some husbands do not care when their wives take ill:

> **Q:** ¿Crees que las mujeres amuzgas tienen más problemas en el embarazo y en el parto que las mestizas?
> **B:** Eso depende, yo pienso que es más fácil que nosotras las amuzgas nos enfermemos, porque hay hombres que no les importa cuando sus esposas están enfermas, y los mestizos no, ellos siempre van al centro de salud, siempre toman medicinas.

Belisaria frames the situation of Amuzgo women –and the responsibility of their men- by comparing with what happens among Mestizos. The situation of Mestizo women is different for two reasons. Belisaria explicitly states one of them: they seek help from the health centre and take Western medicine. The other reason remains implicit: their husbands have an active role on this matter. There is a yet more general presupposition behind her words: men have power over their wives and, therefore, can be an enabling force or an obstacle for maternal health. Here, we can appreciate the interplay between Belisaria's views and key intertextual references in the videofilm in chapter 5.

Ethnic and poverty awareness, key issues from Jesús's interview, surface frequently from the cross-sectional analysis of people's responses.[74] In the following example, Elena

[74] This emergence is a good example of the methodological approach; it also confirms the adequacy of the combined toolkit. Ethnic and poverty awareness resulted from the axial combination of data from a pre-established PC ("Amuzgas y mestizas", explicitely induced through the questionnaire), a pre-established

identifies herself with two groups, pregnant women and Amuzgo women. The first group is the most comprehensive one, and all its members share a universal experience of hard times and pain in labour. A subgroup of Amuzgo women fare worse because they do not have material resources to get timely assistance in case of emergency and because they get worse quality of care from government health services:

> **Q:** ¿Piensas que las mujeres indias tienen más problemas que las mestizas durante el embarazo?
> **E:** Todas las mujeres pasamos por momentos difíciles en el parto. Lo que cambia en el caso de las mestizas... en nuestro caso, como indígenas, hay indígenas que se mueren por complicaciones porque no tienen dinero para ir al hospital y los médicos no las atienden. En el hospital de gobierno no atienden bien y con el médico privado es diferente, pero el problema es que nos falta dinero. Los mestizos sí encuentran dinero y acuden a los mejores hospitales. Con el dolor de parto es lo mismo que sentimos todas las mujeres.

Following a cross-sectional pattern, Elena sees Amuzgo women as part of a higher-risk group. Her reasons, however, differ from those given in government health services. While public health officials and staff tend to see indigenous women at higher risk because of their size, culture, young age, larger number of previous pregnancies, and lack of ability to communicate in Spanish, Elena links this higher risk with poverty and worse quality of care from government health services. Like Jesús, Elena believes there has to be agency in poverty –in this case, looking for ways to consult with a private doctor. She points in the direction of the poor for not overcoming these obstacles:

> [...] Sí es difícil porque hay mujeres pobres que no tienen dinero. Todas estamos en la pobreza, no tenemos dinero para vivir; pero donde no queremos pasar por algo trágico buscamos la manera de llegar con el médico privado. Como hay médicos que paga el gobierno no atienden a la mujer y hay bebés que son demasiados gordos y complican el

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axial category ("Structural barriers", which was comprised mostly of emerging categories, such as "poverty" and "access to health services"), and the other purely emerging from the data: "Us, We" ("*Nosotros, nosotras*"). The latter encompasses a series of identities, manifested through inclusion (nosotros, nosotras) and exclusion (ellos, ellas), to explicitly and implictly stress group identity or belonging, often combined with other identity markers –e.g., "es lo que hacemos *aquí*". I will only refer to ethnicity and socioeconomic status here.

parto, puede nacer pero nacerá muerto y no podrá nacer porque no se apuraron sus familiares para buscar la forma de operarse.

Here, the inclusive "we" in "*todas estamos*" and "*no tenemos*" refers to the subgroup of pregnant Amuzgo women, while yet another subgroup (those who do not want to be exposed to a tragic outcome) emerges in assertive-normative modality. Elena identifies herself with this third group. At the same time, she expresses her belief that poor people can do something to overcome their circumstances and have a safe pregnancy, provided that they choose to do so –a discursive implication that connects with the "choice" dimension in government safe motherhood discourse and health risk discourse as a whole. Marcelina, a 32-year old illiterate mother of five from La Ciénaga, echoes Elena's words as she puts aside money for an eventual obstetric complication while delivering at home: "*Porque soy pobre, por eso prevengo cualquier complicación. Si no puedo parir en casa, voy al hospital.*"

As we have seen, there can be a disconnection between government framing of structural barriers within safe motherhood discourse and people's views of their own situation –and the underlining discourse of poverty and Amuzgo ethnicity. The gap seems to close through another discursive mediation: that of agency and responsibility. Indigenous people can and must do something to overcome structural barriers to maternal health. They are expected to take action and trust government health services to help them in giving their children an even start in life. But trust may be in short supply, particularly among older women, as the following exchange with Elcira suggests:

Q: ¿Crees que las indígenas tienen más problemas que las mestizas en el embarazo?
E: Las mujeres indígenas, porque somos pobres, no tenemos dinero, y los mestizos tienen dinero. Si van a un hospital público y no los atienden, se van con un médico privado donde la reciben enseguida. Ahí les pueden hacer la cesárea si hay complicaciones. Porque tienen dinero, buscan dónde las puedan atender inmediatamente, no esperan la respuesta del hospital del gobierno, lo que diga el presidente de México, como el caso de nosotras, las que estamos en el Seguro Popular, donde nos dicen que vayamos al hospital cuando nos embaracemos. Yo no

sé si será cierto, pero nos dicen que en caso de una cesárea el seguro cubre todos los gastos. Es lo que dicen las mujeres que van. Unas me dicen que es verdad, otras me dicen que es mentira. Yo no sé hasta dónde es cierto; lo sabré cuando me toque estar en esa situación. Si llega el momento en que no pueda parir, tendré que ir al hospital, entonces veremos qué tan cierto es. Porque esto es apenas hace diez años que los médicos atienden en caso de un embarazo con complicaciones, porque ya se dieron cuenta que muchas fallecen. ¿Por qué fallecen? Porque aunque ya les llega el tiempo del parto en el hospital no las reciben si no se tiene dinero; aunque tienen ambulancia no te llevan, ellos las usan. La mujer, estando allá, no le da tiempo de discutir con ellos porque se siente el dolor, el hombre busca el carro, puede pedir el carro en el ayuntamiento.

Q: ¿Por eso tú no vas al hospital?

E: Sí, por eso no voy.

Here, too, structural poverty seems to be constitutive of Amuzgo identity vis-à-vis the Mestizo minority in Xochis, and this has direct bearing on maternal outcomes. On lines 5-8, Elcira makes a distinction between Amuzgo and Mestizo women, connecting the material and the symbolic, structural poverty and meaning making. Because they have money, Mestizo women do not "wait" (depend) on government hospital or the President's word (which she identifies addressing Amuzgo women and behind safe motherhood communication). She then compares with the situation of another subgroup of pregnant women -"*nosotras, las que estamos en el Seguro Popular*", an in-group identity that overlaps, to a certain extend, with her being a poor Amuzgo woman. The "material" (lack of money, being part of a government program) and the symbolic are deeply intertwined here. At the level of discursive practices, it is the women in this group who are targeted through safe motherhood communication campaigns *because* they have government health insurance. She feels interpellated to seek biomedical care in public hospitals, while Mestizo women, because they have money, don't have to "wait" (depend on) these services or what the President has to say. In other words, they have more autonomy at all levels. Of course, we can argue that Mestizo women are more influenced by biomedical discourse and, therefore, may have *less* autonomy in terms of discursive practices, but this interpretation would not take into account the sociocultural context in

Xochis. Elcira links poverty, ethnicity, government control (through government health insurance for the poor) and autonomy, and perceives that all these factors make Amuzgo women the target of government interpellations and, at the same time, less autonomous in every respect.

Trust, or lack thereof, also looms large in this unit of analysis, and we can see a feedback loop between these perceptions and the framing of trust in government safe motherhood discourse in chapters 4 and 5. On lines 8-12, Elcira brings three different voices into the equation: the voice of government saying that all costs will be covered if the woman needs a c-section; the voice of those women who say this is true, and the voice of those who say it is not. There is much "saying" here,[75] and it looks like Elcira prefers to suspend judgment until she is in the position to see for herself –one among many references to previous experience and embodied experience from the cross-sectional analysis of our data. In fact, from lines 13-21, we can tell that she does not give equal value to all these voices. At the level of sociocultural practices, she accurately relates what the government says to the political emphasis on maternal death in recent times ("*esto es hace apenas diez años*"), and she uses interpersonal meaning ("*hace apenas*") not only to mark the contrast between decades of neglect and recent policies, but also to suggest that ten years is a short time to change deep-seated discrimination in government health services[76] –which she spells out from lines 15-19. We did not ask if Elcira had already watched the videofilm, but it was clear that it would take much more than the authoritative assurance of the doctor to Gaby and Jorge ("*Nosotros vamos a ayudarlos*"), and the couple's teary thankfulness to revert years of mistrust. In the political context of Xochis, this is a frequent discursive combination –as we have also seen from our interview with Roque- with direct impact at the level of discursive and sociocultural practices.

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[75] "They say" ("dicen") is another emerging category that includes all refereces made by our participants to hearsay, popular knowledge, common sense, and unidentified sources.

[76] Ten years is a long time from the perspective of any government, long enough for government officials to expect an impact from their policies and to get political credit from these initiatives. However, María Elcira's response confirms that people may see "the government" as an overarching entity, a series of institutions and programs, and a state of affairs beyond a specific time-period or party rule. This may be particulary so from the standpoint of disadvantaged groups with longstanding grievances, based on individual and collective experiences, as is the case with the Amuzgos in Xochis.

It is also worth noting that Elcira's mention on lines 13-15 is the only explicit trace - across our entire dataset- of a participant's awareness of maternal health as a growing public health concern over the last decade. Some other participants said this was a problem in their community only in response to a specific question in this regard. As we have seen, people see many risks in pregnancy and childbirth, but few see it as a major public health issue.[77]

The link between ethnic identity, poverty, and self-awareness also emerges[78] as the cause of cultural syndromes like antojo and coraje, perceived as frequent and potentially serious threats to maternal and perinatal health by the Amuzgos –and indigenous peoples throughout the Americas. Such is the case in the following excerpt from our interview with Carlos:

> **Q:** ¿Dónde se curan el espanto?
> **C:** El espanto es una enfermedad que no se cura en el hospital. Se debe recoger la sombra del enfermo.
> **Q**: ¿Cómo sabes estas cosas?
> **C:** Es la creencia que tenemos los indígenas, y le pasa a mucha gente del pueblo. La gente se pregunta: ¿Por qué no les pasa a los mestizos? Porque ellos viven diferente a nosotros, tienen buena alimentación. En cambio, los indígenas no la tienen porque no les alcanza el dinero. A veces sufren de antojo, antojo de carne de chivo, y después de comerlo se curan.

Carlos's answer to the second question offers some valuable clues from a discoursive perspective. He first acknowledges the cultural-bounded nature of certain syndromes: "*Es la creencia que tenemos los indígenas*". This low-evaluation of their own beliefs is a typical discursive trait across our data, which I will discuss in greater detail below. He

[77] This is a key issue in health risk communication, frequently associated with low perceptions of threat vulnerability.
[78] Here, I use "emerge" in the same sense as "emerging categories": although "Antojo" is a pre-established category, in this case it came up spontaneously during the interview, and so did the articulation with Amuzgo ethnic identity and poverty.

then proceeds to support the validity of this belief with the assertion of a collective experience: "... *y le pasa a mucha gente en el pueblo.*" Then, through a typical verbal process, he brings in the voices from the community. While Mestizo government health staff and officials cannot understand why indigenous people *believe* in this things, the Amuzgo wonder why these things do not *happen* to Mestizo folk. In other words, there is a tension between the framing of cultural syndromes as mental processes (beliefs, cognitions) on the one hand and as material processes of happening on the other, which is the way people experience these problems. In the context of this section, and of Carlos's words, I will put the emphasis on material processes, because they relate to the Amuzgo perception of ethnic identity and their awareness of being at risk for an ethnically bounded type of threat. Carlos grounds this connection on the material circumstances of the Amuzgo people vis-à-vis the Mestizos, in a clear-cut "Us versus Them" construal: "*Porque ellos viven diferente a nosotros, tienen buena alimentación. En cambio, los indígenas no la tienen porque no les alcanza el dinero.*" Here, we found a close connection between antojo, poverty, and malnutrition, which reflects an endemic reality across Guerrero state, as discussed in chapter 1,[79] and mirrors epidemiological thinking based on socioeconomic determinants of health. In the last part of his answer, there is another assertion of the material nature of these processes and an indication of response efficacy: *"A veces sufren de antojo, antojo de carne de chivo, y después de comerlo se curan."*

6.8. Prenatal control

As we have already seen, the idea of prenatal control is present in the community, often as a combination of biomedical and traditional views and practices. I will focus here on the connections between prenatal control and some other categories, such as self-care, spousal solidarity, trust, responsibility, coercion, and safe childbirth.

Many women link prenatal control –positioning the baby, going for periodical checkups- with childbirth readiness and safe delivery. Some even think prenatal control helps with a

[79] See chapter 1.1.4.1, p. 18-22.

safe delivery *at home*. In other words, they seem to perceive prenatal control as both necessary and sufficient for a safe childbirth. Josefina, who does not know whether she will be dead or alive at the end of labour, and who has nonetheless made a rule of delivering her children at home, is one such example:

> **Q:** ¿Por qué pasan estos problemas en el parto?
> **J:** Se necesita un médico para que revise, para que haga una radiografía, para que revise si tiene un problema en el embarazo.
> **Q:** ¿Tú puedes hacer algo para que todo salga bien en el parto?
> **J:** Puede ser acudiendo periódicamente al hospital y seguir al pie de la letra sus indicaciones.

Eulogia, too, seems to believe that close prenatal control leads to safe childlbirth, even though she delivers her children at home:

Q: ¿Vas al centro de salud porque tienes ganas o porque te obligan?
E: Como te dije, voy porque mi marido quiere que me revise un médico, por si algo me pasa no digan que el papá de mis hijos no me mandó. Él me dice que vaya a revisión.
Q: Te vuelvo a preguntar si vas al centro de salud porque tienes ganas o porque te obligan...
E: Voy porque quiero ir, porque necesito que me revisen. Como dicen, cuando alguien envejece necesita más atenciones. Es difícil si algo me pasa a esta edad, por eso quiero ir, porque ya estoy grande. Ellos me revisan por si el bebé tiene problemas en la panza. Por eso voy.
Q: ¿Qué te aconsejan en el centro de salud?
E: Como te dije, debo ir por si se presentan complicaciones en el parto. Debo recibir tratamientos porque ya estoy grande, corro riesgos de tener complicaciones en el parto. Por eso necesito medicina. También me dicen qué medicinas hay que usar.

On lines 2-3, Eulogia's words reveal what is going on at the level of sociocultural practices, where traditional roles and government pressure have a deep impact on women's compliance with institutionalized prenatal control. The intertextual reference

that accounts for her husband's motivations, on line 3, is the key meaning-making resource here: "... por si algo me pasa no digan que el papá de mis hijos no me mandó". This is a particularly telling explanation, because it brings to life the abstract notion of interpellation. I will break it down into different components.

First, there are two levels of intertextuality operating here; the first one tells us what her husband thinks (he does not want to be responsible in case something happens to her), while the second one points to the source of the interpellation ("*no digan*"), where the implicit, unnamed Sayer likely refers to government health staff, government safe motherhood communication, hearsay, or all of them.

We find a second component of the interpellation in "*no me mandó*", which conveys the implicit idea that the husband should be agentive in his expected role within the couple and send his wife to prenatal control. We have seen a similar construal in "Heed the messages". In other words, the husband perceives he is held accountable –interpellated- and takes action to avoid being blamed.

On lines 5-6, the interviewer reiterates her question, probably because she feels that it has not been answered correctly, thus seeking a "personal" definition from Eulogia, not one that reflects an external influence.[80] From lines 7-10, Eulogia gives another answer, where health risk discourse and her personal perception of risk interact. "*Voy porque quiero ir, porque necesito que me revisen,*" she says on line 6, and the expressive illocutionary force in her words ("*quiero*", "*necesito*") could very well be taken at face value. However, her intertextual reference on lines 7-8 ("*como dicen, cuando alguien envejece necesita más atenciones*"), points to external sources who lay out the idea that older women are at a higher risk and therefore need closer medical control. We now know that this kind of discourse has a bearing on her decision: she feels vulnerable and in need of greater expert control. We should not conclude that her perception is only based

[80] Here, again, we reap unexpected benefits from using a structured questionnaire with unexperienced interviewers who want to make sure they are doing things by the book. If the interviewer had not repeated the first question, we would have only had her first answer, which may have reflected her main motivation to comply with prenatal control. However, the fact that she does not give the same answer when asked a second time sheds more light on the complex set of factos bearing into a woman's decision.

on health risk discourse; but we can infer that the notion of risk factors –already present in the community- has a positive feedback loop with safe motherhood discourse and has an impact on people's views and behaviours. We confirm this reading on lines 8-10: "*Es difícil si algo me pasa a esta edad, por eso quiero ir, porque ya estoy grande. Ellos me revisan por si el bebé tiene problemas en la panza. Por eso voy*".

We should also interpret all these links in the immediate textual context of Eulogia's full interview. Here is a woman who complies with prenatal control for a variety of reasons, and who thinks doctors can tell her if something is wrong... but she delivers her children in the home, with support from her partera. She shows the same pattern in the makeup of her subjective norm, satisfying her husband's expectations and allaying his fears while she is pregnant, but deviating when it comes to delivery (both her parents and her husband want her to have her children in the hospital). Government health officials and health staff find it hard to understand this apparent contradiction. However, we may be able to find a partial explanation if we consider that some people may perceive close prenatal control as *leading* to safe childbirth. Government safe motherhood discourse may contribute to influence people's views on this matter. From lines 12-14, we find further evidence to support this hypothesis. "*Como te dije*," says Eulogia, "*debo ir por si se presentan complicaciones en el parto. Debo recibir tratamientos porque ya estoy grande, corro riesgos de tener complicaciones en el parto. Por eso necesito medicina.*" The normative tenor of her utterance (expressed through the directive force of certain words like "*debo*" and the categorical modality of certain clauses, like "*debo recibir tratamientos porque ya estoy grande, corro riesgos de tener complicaciones en el parto*") reveal the external influence and, at the same time, her conviction that submitting to this close monitoring, getting the recommended treatments, and taking the prescribed medicines she will have a safe delivery in her home (what we would call high response efficacy in behavioural terms).

Eulogia's intertextual reference to her husband's motivations concerning prenatal control allows us a glimpse into people's perceptions of coercion. Coercion is a powerful category cutting across our data, often linked with fear and blaming. It frequently

materializes as pressure from government programs and health staff on women to go for prenatal control[81] and deliver their children in hospitals and health centres; as intensified surveillance from the Ometepec health district to identify pregnant women for prenatal control; as follow-up visits after childbirth to make sure recent mothers will take their newborns for medical checkups;[82] and as warnings to parteras to comply with biomedical practices and refer patients for prenatal checkups and in case of obstetric complications. In this case, I will focus on the use of Oportunidades to threaten women into prenatal control. Elena mentions this pressure as a powerful drive to comply:

> **Q**: ¿Vas al centro de salud para que cuiden tu embarazo?
> **E:** Sí, voy. Una vez al mes me citan, ahí me revisan, me checan si el bebé tiene bien el corazón, ellos escuchan, me revisan la panza.
> **Q**: ¿Por qué vas?
> **E**: Para que ellos me indiquen qué medicina aplicarle. Nosotras, como recibimos dinero de Oprtunidades, nos dicen que debemos de ir una vez al mes.
> **Q:** ¿Vas porque tienes ganas o porque te obligan?
> **E:** Voy porque, como dicen, en el caso de nosotras, que recibimos Oportunidades, debemos ir. Nos dicen que las embarazadas están obligadas a ir. En mi caso, me obligan; no voy por gusto, porque yo no acostumbro ir con las enfermeras del hospital, porque no atienden inmediatamente; por eso nosotras vamos donde nosotras pagamos.

Men also perceive the coercive use of Oportunidades as a key variable that has drawn women towards institutionalized prenatal control, as we confirm from the following exchange in Spanish with Camilo, from Guadalupe Victoria:

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[81] When I asked the head of maternal health at the Ometepec health district if women went for prenatal checkups of their own accord, he said: *"No, no, gente...con más cultura, podríamos llamarle así, o más educación, sí acude sola; pero gente indígena no, es más difícil que acuda a control. Las obligamos a través del programa Oportunidades o acudimos hasta su domicilio para que esté en control* [...]"

[82] Here is what the same authority said when I asked if women took their newborns for clinical evaluation within the first week of childbirth, as indicated in government health guidelines: *"El 50% acude voluntariamente, pero el otro 50% no está acudiendo. De ahí que se le esté pidiendo al personal de salud que realice visitas domiciliarias para vigilar al binomio madre-hijo que no tenga ninguna infección, ningún problema. A través de estas visitas domiciliarias, o si no se les manda a traer con familiares o con otra persona para que reciba la atención médica [...]"*

Q: ¿Las mujeres van al centro de salud a controlarse el embarazo por su cuenta o porque las mandan o las llaman?
C: Orita, como orita de este tiempo, se va mucha mujer de embarazada, se van a casa de de salud, porque nomás vienen por Oportunidades. Porque alguna mujer embarazada, si no va a casa de salud, le van a quitar su Oportunidades. Entonces, ella tiene miedo...tiene que ir cada mes, se presenta a la casa de salud. Si no llega, le van a poner equis en la... ¿Cómo se llama esa tarjeta? El carnet... le van a poner equis en el carnet y un mes ya no va llegar su Oportunidades. Esto de este tiempo, pero antes no, no iba la gente a casa de salud, no...eso apenas empezó, antes no.
Q: ¿Las mujeres van porque están obligadas, no porque estén convencidas?
C: Ajá, eso nomás. Porque hay mucha gente que le da pena... pó orita se le quita la pena porque quiere recibir lo que le toca de Oportunidades. Aunque poco, nomás trescientos, igual por eso va.

The use of time deixis on lines 3 ("*orita, como orita de este tiempo*") and 8 ("*esto de este tiempo, pero antes no, no iba la gente a casa de salud, no... eso apenaza empezó, antes no*"), gives a clear idea about the impact of Oportunidades on people's behaviour. We don't know from Camilo's words whether women are effectively penalized, but the threat looms large in his narrative ("*le van a poner equis*", on lines 6-7, and then again, "*le van a poner equis en el carnet y un mes ya no va a llegar su Oportunidades*"). From lines 11-13, Camilo describes the decision women make in terms of cost and benefit: "*hay mucha gente que le da pena... pó orita se le quita la pena porque quiere recibir lo que le toca...* ").[83] The scope and implications of this pressure should not be underestimated, particularly when there is aggressive surveillance within the health district, with agreement and some participation from religious leaders in the communities. Here is what a traditionalist Catholic minister, interviewed in Spanish, had to say in this respect:

> [...] Lo mismo hacemos en estas cosas del embarazo, recomendamos... Mira, las mujeres embarazadas, vayan por favor, con esta oportunidad del gobierno de Oportunidades y

[83] The coercive imposition of prenatal checkups through anti-poverty programs such as Oportunidades –and the way some of our participants construe indigenous adaptation in terms of inevitability, cost and benefits- is a good example of cultural imposition, as described by Coronado. "La imposición [...] refiere a la introducción de prácticas sociales y culturales nuevas, sin dejar que el grupo receptor las controle". Coronado Suzán G 2003, p. 53.

todo eso, caray, es un programa que yo lo admiro, ¿verdad? Si se toma en cuenta lo que el gobierno quiere, para mí es una cosa fabulosa ¿Por qué? Porque obligan a la mujer por medio de esa economía que le dan, aunque sea una porquería de economía, porque trescientos pesos, ¿qué va a hacer una mujer con trescientos pesos? Bueno, pero no hablemos de eso porque no es el punto; pero sí conviene que eso sea una parte, un estímulo para que la mujer vaya a visitar su centro de salud, y ya sabemos que la mujer cuando está embarazada, pues, necesita mucho hierro, mucho calcio, mucha vitamina, mucho lo que fuere, ¿no? Entonces, es bueno que asistan, es lo que recomendamos.

As with institutional childbirth, other participants talk of prenatal control in clinical settings as something they got used to, already part of their mores. Here is what Zulema says on this point:

Q: Te voy a preguntar algunas cosas de las parteras. ¿Vas a ver a una partera cuando estás embarazada?
Z: No, no voy
Q: ¿Por qué?
Z: Porque no estoy acostumbrada a eso, yo prefiero ir al centro de salud
Q: ¿Vas al centro de salud para que te atiendan en el embarazo?
Z: Sí, voy
Q: ¿Por qué?
Z: Para que me digan cómo cuidarme, para que me den medicina y eso me ayude
Q: ¿Vas al centro de salud porque quieres o porque te obligan?
Z: No voy porque me obligan, sino porque estoy embarazada
Q: ¿Quién te dice qué hacer en el centro de salud?
Z: El doctor
Q: ¿Siempre le haces caso al doctor?
Z: Sí
Q: ¿Por qué?
Z: Porque eso me ayuda
Q: ¿Vas a ver aun doctor privado?
Z: No voy
Q: ¿Vas a ver aun brujo cuando estás embarazada?

Z: No, tampoco voy

Q: ¿Por qué?

Z: No voy porque no sé si sea realmente cierto lo que esa persona me va a decir

Q: ¿A quién le haces más caso en estas cosas del embarazo?

Z: A la persona que está en tu casa, él te dice que vayas

Q: ¿Por qué le haces caso a esa persona?

Z: Porque él está en la casa, él es el que te dice que vayas o, si ve que estás enferma, él te lleva

Q: ¿Quién es esa persona?

Z: El papá de mis hijos

[...] **Q**: ¿De que otras cosas hablas con tu esposo?

Z: Yo le digo que estoy embarazada. Él me dice que si me pasa algo, si me duele la espalda o si tengo una molestia, me dice que no es necesario que lo espere para que yo le diga a él lo que me pasa, me dice que yo debo ir al centro de salud.

On line 5, Zulema explains that she does not consult with the partera because she is not used to it ("*no estoy acostumbrada*"). I have mentioned this expression before. Not being used to doing something refers to a lack of habit, but also hints in a direction of default practices ("*costumbres*"), internalized and *felt* as such, which we can verify in the immediate context of her answer ("*yo prefiero ir al centro de salud*") and other answers in the same text. On line 10, the interviewer asks whether she goes to the health centre because she wants to or because she is forced to do it –here, the question looked into the coercive use of government anti-poverty programs like Oportunidades. "*No voy porque me obligan, sino porque estoy embarazada,*" she answers. There is a fundamental presupposition in her words: being pregnant *implies* going to the health centre for guidance and control (she spells this out on line 9, and then on lines 12-17, where she says that she heeds the doctor because doing so helps her). This is the ideal outcome of the re-educational effort discussed in chapter 5, and it goes hand in hand with her response on line 23, where she says that she does not consult with the healer because she does not know if he will say something "true". The clash between true knowledge and belief and the battle for trust reverberate here, all condensed in a single line. The doctor is

the trusted expert who speaks the truth; the healer belongs in a different world, one that is around her but she keeps at arms length.

Also linking with these categories is the role of her husband, whom she depicts as the drive-belt between control and self-control, and the bridge between two worlds and two orders of discourse. On the one hand, she highlights and reaffirms his authoritative role in the traditional order of discourse: He is "the person who is in your house" ("*la persona que está en tu casa*", on line 25) and "the father of my children" ("*el padre de mis hijos*", on line 30), two expressions commonly used by Amuzgo women when referring to their spouses and their roles. These attributes are the source of his authority: she heeds him *because* she is the person who is in her house and the father of her children. On the other hand, he is the one who keeps a close eye on her pregnancy and makes sure she goes for prenatal control: "*él te dice que vayas*", on lines 25 and 27, or "*si ve que estás enferma, él te lleva*", on line 27, where he has agency through verbal (directive) and material processes. Equally important from a safe motherhood perspective, Zulema feels authorized, even compelled by her husband to seek biomedical support if she should ever feel bad while he is away (lines 32-34). Here, again, we see the husband as the agentive, logonomic force bridging and enabling the twin mechanisms of control and self-control. It is a perfect example of power and solidarity reshaping the ideological complex and the subject position of the woman when it comes to maternal health. It is this new world that the Mexican government envisions as the ideal outcome of safe motherhood discourse: A world where the doctor and the husband coexist as significant others and hold the same views. A world where the woman does what her husband wants and her doctor expects her to do for her own sake. A world where institutionalized prenatal control is a given in the woman's mind and the husband non-traumatically oversees –from a traditionally sanctioned role- the articulation between control in the public sphere and self-control in the private realm.

The drive-belt role of the husband, as envisioned in safe motherhood discourse, also emerges from our interview with Francisco in Llano del Carmen:

Q: En el parto y en el posparto, ¿quién es la persona que toma las decisiones de lo que se vaya a realizar, usted solo, ella o los dos?
F: Pues cuando ella se siente mal, como con dolor de cabeza, ella me avisa y yo le digo que vaya al hospital y que le diga al doctor lo que le pasa, sin vergüenza. Porque yo creo que aunque sea doctor no puede saber lo que tiene el paciente si el paciente no lo dice. A partir de ahí, el médico diagnostica la enfermedad, ya sea dando una pastilla o recetando medicamentos. Es lo que creo yo.
Q: Cuando hay opiniones contrarias, como por ejemplo si el doctor le dijera a Cele que debe ir al hospital por alguna enfermedad que tiene, y sus conocidos les dicen que no es necesario, o lo mismo le dice su suegra, ¿a quién le harían caso?
F: La verdad es que cuando ella se enteró de su embarazo, ella me dijo que tenía vergüenza de ir al hospital. Yo le pregunté por qué; le dije que todas las mujeres daban a luz y ella no tenía por qué sentir pena o vergüenza. Es normal. Le hice saber que lo mismo pasa en caso de un accidente. Si tiene una herida en cualquier parte del cuerpo, se deja de lado la vergüenza, porque no es cosa de juego. Lo mismo con el parto, porque para eso son los hospitales.

On lines 3-4, and then on lines 11-16, Francisco's depiction of the spousal interaction and his role in decision-making is in perfect sync with the beginning of the second episode in the videofilm. In the intertextual recreation of their dialogue, he gives much prominence to his attempts to overcome her resistance. We can almost hear Cele saying, very much like Gaby in the film: "*Ay, no, que me da pena*!" In fact, the film's allusion to Gaby's *pena* addresses a common feeling among many indigenous women, who are reluctant to go to prenatal control or to deliver their children in government health units. The filmmakers use Victoria, a townswoman, to allay those fears, perhaps under the assumption that indigenous men are wary of male doctors seeing their women. This is not the case with Francisco, who uses several meaning-making resources to convey his feelings about the negative effects of women's *pena* and to recreate his dialogue with Cele. On line 4, he makes it clear that this is the main obstacle he has to overcome when she does not feel well. From lines 5-7, he states his belief –the expressive nature of the speech act is marked at the beginning and at the end of this segment, through "*yo creo*" and "*es lo que creo yo*"- of how lack of communication with the doctor can hinder the

doctor's ability to make an accurate diagnosis. This emphasis on his beliefs reveals strong interpersonal evaluation on the topic of *pena* and connotes the effort he makes to convince his wife. What happens between lines 11 and 16 confirms this interpretation. When the interviewer asks him whom they would heed in case of conflicting advice on hospital care, Francisco goes back to the main source of controversy –his wife's feelings of shame, perhaps influenced by other members of the family- through the thematic placement of a disclosing statement: "To tell you the truth..."("*La verdad que...*", on line 11). Then, he uses a series of assertive and normative statements that reveal the nature of his discourse and, equally important, the way he articulates it as a rebuttal of traditional views, with a target audience in mind: his own wife. He reminded Cele that "all women give birth" (an assertive comment on the state of the world, a natural law, on lines 12-13) and told her that there was no reason for her to feel ashamed (another assertive/normative act aiming at his wife's ingrained feeling, on line 13). "*Es normal*," he tried to appease her with another allusion to a natural, universal law. And then he compared with a situation where he thinks she would –she should- feel no shame: "*Lo mismo pasa en un caso de accidente. Si tiene una herida en cualquier parte del cuerpo, se deja de lado la vergüenza*". And he adds, "*porque no es cosa de juego*", almost mirroring Jorge's lines on "Heed the messages". He finally returned to the core semantic component of his argument ("*lo mismo pasa con el parto*"), now endowed with the normal, natural qualities of an accident, something that just happens in life, "*porque para eso son los hospitales*". Here, at last, he makes explicit another implicit component of his argument: pregnancy problems, like accidents, must be dealth with in hospitals.

If I have taken the time to analyze the ideational, interpersonal, and textual resources in Francisco's account, it is because his persuasive effort, which takes place in the private domain of his home, mirrors the complex semantic engineering of public health campaigns. Francisco is the dream husband of "Heed the messages", minus the melodramatic tone of the fictional Jorge. He is not only aware and re-educated, but also a Helper, a leader, an agent of change. Carlos, whose wife delivers their children at home, without external assistance, also voices the twin imperatives of control and self-control, harnessing both traditional and biomedical resources:

Q: ¿Es necesario que la partera atienda a tu mujer durante el embarazo?

C: Sí, debe de atenderla cuando se aproxima el momento del parto. Ella también acomoda la posición del bebé durante el embarazo.

Q: ¿Tu mujer va a controlarse al centro de salud durante el embarazo?

C: Sí, una vez al mes, desde que se embaraza acude.

Q: ¿Por qué?

C: Va porque le revisan la sangre

[...] Q: ¿Tú hablas con tu esposa de las cosas del embarazo?

C: Sí

Q: ¿Tú que le dices?

C: Ella me avisa cuando ya está embarazada, yo le recomiendo que no deje de ir al centro de salud.

Q: ¿Qué más le dices?

C: Que se cuide

We can hear the impact of the same imperative, from the woman's point of view, in Dionisia's words:

Q: En tu familia, ¿con quién platicas de tu embarazo?

D: Con mi esposo, con él platico lo que me pasa. Si estoy enferma, acordamos para ir al hospital. Es lo que hacemos.

Q: ¿Qué consejos te da tu esposo?

D: Me dice que debo de ir al hospital para no enfermarme más.

Q: ¿Te dice que vayas al centro de salud?

D: Sí, me dice... me dice que vaya y que no deje de ir.

Q: ¿Tú siempre haces lo que te dice tu esposo?

D: Sí, siempre cumplo con lo que me dice.

Q: ¿Por qué haces caso?

D: Porque no es correcto no cumplir; eso puede llevar a la muerte a la mujer.

Q: ¿Qué es lo que más te dice?

D: Me dice que debo cumplir todo lo que me dicen en el hospital.

This unit of analysis, as much as the excerpt from our interview with Zulema, shows how safe motherhood interpellations reach the woman through her husband. Both examples bring to life the findings from the SM household survey regarding the important role of Amuzgo men as trusted advisors. Dionisia's words also point to her husband's a strong perception of response efficacy from government health services and how she impresses this idea on her, which we can tell from her normative language and use of interpersonal meaning on lines 5 ("*debo ir al hospital para no enfermarme más*"), 7 ("*me dice que vaya y que no deje de ir*"), and 13 ("*me dice que debo cumplir todo lo que me dicen en el hospital*"). Most significantly, we can appreciate how she construes not heeding her husband (and the biomedical discourse he channels) as a potential cause of death, on line 11: "*Porque no es correcto no cumplir; eso puede llevar a la muerte a la mujer*".

In the same way that religious discourse played an important role in connection with childbirth narratives, choices, and expectations, we can find it weaving its away around notions of biomedical prenatal control, as it happens in the following conversation with Marcelina in La Ciénaga:

Q: ¿Puede haber peligros o problemas para la mujer embarazada?
M: Sí, es peligroso.
Q: ¿Por qué es peligroso?
M: Cuando no está en buena posición el bebé, puede morir la mujer.
Q: ¿Qué puede pasar?
M: Puede provocarle la muerte... ella debe de ir al hospital con los médicos para que la revisen. Sí son cosas graves.
Q: ¿Estos problemas les pasan a muchas mujeres aquí en el pueblo?
M: Sí, hay mujeres que les pasa, algunas se mueren porque no quieren ir al hospital.
Q: ¿Piensas que estas cosas te pueden pasar a ti?
M: Sí, yo pienso que sí, puede llegar un día en que Dios me abandone cuando deje de adorarlo.
Q: ¿Por qué piensas que te puede pasar?
M: Porque soy un ser humano. Pienso que Dios ayuda mucho, es el ser supremo, ayuda más que el médico. Dios es más poderoso, también bendice la medicina.

Here, we find some of the ideas that I have discussed in previous sections, such as a salient concern with the wrong position of the baby in the womb, linked with a perception of severe threat to the mother's health (lines 3-7). On line 6, Marcelina uses normative language to say that women need to go to the hospital so doctors can check the position of the baby, spontaneously stating her preference for biomedical practitioners (later in the the interview, she mentions that she does not consult with the partera). Then, on line 9, she says obstetric complications are frequent in her town and, here again, she echoes the voices of government officials and medical practitioners when she asserts that some women die because they do not want to go to the hospital. But the most interesting discursive association unfolds from lines 11-15. On line 11, she expresses her perception of vulnerability to the threat in terms of likelihood not related to biomedical factors. Marcelina feels these things can happen to her if she stops adoring God and, as a result, God abandons her. Cohesion and coherence loom large here. Someone reading from a biomedical standpoint might find these statements lacking in cohesion and rather incoherent. However, there is anaphoric cohesion insofar as Marcelina thinks that straying from her faith in God will put her at risk of adverse maternal outcomes. And we can perfectly find coherence when we consider that she may be associating women's agency in seeking biomedical care with God's assistance; put differently, women must help themselves for God to help them. (If they do not, God may let go of their hands, which in turn would prove they did not adore him.) Cataphorically, we can confirm the cohesive and coherent properties of the text on lines 13-15. There, Marcelina first says that these things can happen to her because she is a human being (line 14), confirming that she is at risk primarily not as a pregnant woman, but as a person who is subject to God's will. It is her relationship with God that precedes and hovers over her condition as a pregnant woman. On lines 14-15, she acknowledges that God helps (or punishes, as we have seen) more than the doctor. Finally, on line 15, she says that God also blesses medicine, an all-too important reference in terms of the overall cohesion and coherence of the text, harking back to lines 19 and 20; in other words, some women die because they do not seek a blessed biomedical resource. Not going for prenatal checkups, not *wanting* to go for prenatal checkups, is also straying from God's will. The inescapable corollary: women bring these evils upon themselves.

This combination of agency, prenatal control, and women's relationship with God (or with a natural order of things) also comes to the fore in Elcira's words:

> **Q:** ¿Por qué hay mujeres que tienen problemas cuando están embarazadas?
> **E**: Porque no se acuerdan de Dios; se acuerdan de Dios cuando ya tienen algo. Sólo se dedican a ir al hospital con el médico, no van cuando están embarazadas, cuando apenas se está desarrollando el embarazo. No se acuerdan de Dios, escucho que ellas van para operarse, luego que la mujer o que el niño ya falleció, ¿Por qué? Porque se hacen rogar. Nosotros vivimos en este mundo, amanecemos, atardecemos, pero en todo el tiempo Dios está con nosotros. Ahora sólo quedaron sus enseñanzas. En aquellos tiempos, él mismo curaba a la gente; hoy en día debemos llamar a Dios diariamente. Es lo que yo pienso. La gente que les pasan esas cosas es porque Dios las mide porque no lo llaman. Como te dije, cuando le llega la hora a la persona no hay nada que hacer, porque le llegó la hora, aunque vayan al hospital o en la casa... cuando Dios decide el día y la hora no hay nada que hacer. Él ya decidió recibir tu alma.

Here, again, we are warned against oversimplifying and keeping two worlds apart. Elcira, who delivers her children at home, and who draws from traditional practices and discourses, believes, like Marcelina, that women who fail to seek prenatal care early in their pregnancies are toying with the sacred order of things: These women do not think about God, who is the ultimate source of power over their destinies. God tests their agency during pregnancy, which is construed as agency to have faith, agency to take care of themselves and to use all available resources, including prenatal care. As with Marcelina, there is a will, a behavioural choice in those women who end up having problems: "*se hacen rogar*".

However, for all the reverberation of government safe motherhood discourse across our data set, for most women, prenatal control entails a combination of traditional and biomedical resources. Although she goes for prenatal checkups and she delivered in the hospital, we have seen how Dionisia consults with the partera about the position of her baby inside the womb –clearly, making distinctions in terms of knowledgable, skilled

care. And not always the interaction between the woman and her husband and trusted advisor leads to the health centre by default, as it is the case with Josefina and her spouse:

Q: En tu familia, ¿con quién platicas de tu embarazo?
J: Con mi esposo, con él platico lo que me pasa, dónde me duele o cualquier enfermedad que tengo, con él platico estas cosas.
Q: ¿Qué consejos te da?
J: Pues él me dice, me ayuda, me pregunta si es necesario ir al hospital o si sólo se necesita la medicina indígena.
Q: ¿Te dicen que vayas al centro de salud o que no vayas?
J: Él me dice que primero busquemos medicina indígena, después al hospital, y ahí veremos cuál es la buena.
Q: ¿Por qué hacen eso?
J: Lo hacemos porque por experiencia sabemos que a veces la medicina indígena puede curar y la misma enfermedad dirá si no puede la medicina indígena.
Q: ¿Tú siempre haces lo que te dicen en la familia?
J: Al principio le hago caso, porque ellos me dicen que medicina indígena usar; después me mandan al hospital... porque nuestros abuelos vivieron con la medicina indígena, así también nosotros debemos vivir.

Josefina and her husband do not reject biomedical care, but they see it rather as a second option. They construe this choice by articulating four types of discourse: a) the importance of embodied experience (lines 5-6), as the husband seems to trust Josefina to decide whether they should go to the hospital or try traditional medicine; b) a normative framework, based on respect for traditional mores, where indigenous medicine is the first choice (lines 8-9, 11-12, 14-16); c) the role of the husband as drive-belt between this framework and pregnancy care (lines 8-9); d) previous experience, knowledge of the lifeworld, and response-efficacy (lines 11-12). Of particular interest is Josefina's remark on line 12 ("*y la misma enfermedad dirá si no puede la medicina indígena*"), because it points to yet another way of heeding bodily messages and, ultimately, back to the woman's embodied experience (in this case, her own dialogue with the symptoms and the

disease) as the best way of knowing whether it is time to move outside of the traditional way of doing things. .

By and large, women recognize the different health systems and their explanatory models, and they use them in a variety of ways, as I have mentioned in different sections of this chapter. They also draw from different discourses and from their own personal experiences to make meaning of these uses and to explain their decisions. Our interview with Narcisa, a 22-year old pregnant mother of one from Cozoyoapan, who had elementary school education and could speak and read some Spanish, is a good example of these interactions:

Q: ¿Vas a ver a la partera cuando estás embarazada?
N: Sí, voy a veces para que me acomoden el bebé, porque dicen que todos los meses debe de revisarse, debe de meter la mano en la panza para ver si está bien el bebé, si no está atravesado para que cuando nazca no le pase nada.
Q: ¿Qué te dice la partera?
N: Ella dice cuando el bebé está atravesado. También dice las cosas incorrectas que hace uno, por eso el bebé sufre de problemas. O puede decir que el bebé está en buena posición.
Q: ¿Te dice lo mismo que en el centro de salud?
N: Lo mismo, lo mismo que dicen los médicos y lo que dicen las personas que atienden a las parturientas.
Q: ¿Tú siempre haces lo que te dice la partera?
N: Sí, le hago caso porque ella acude a pláticas sobre las embarazadas, porque es el trabajo que ellos hacen; como la información que reciben los médicos, es la misma que reciben ellas.
[...] **Q**: ¿Platicas de acomodar el bebé con el doctor? ¿Qué te dice el doctor?
N: Le platico, le digo que ya me acomodaron el bebé, que ya lo pusieron en la posición correcta; me dice que es necesario que lo acomoden. Y el también debe de revisar si está en buena posición, como lo hizo la partera.
Q: ¿Vas al centro de salud para que cuiden tu embarazo?
N: Sí, voy una vez al mes porque me dicen los médicos que debo ir a las citas; la mujer embarazada debe acudir a la cita; si no va una vez, significa que no debe

culpar a los médicos después, porque ellos hacen la cita una vez al mes para revisión, para ver su alimentación, para ver si come bien, porque la pesan en el hospital, checan si está bien, si no le duele, si no le pasa nada como mujer, eso le preguntan. Hay personas que están bien en uno o dos meses de embarazo, pero a los tres o cuatro meses, cuando el bebé va pesando más, ya no es la misma que antes. El médico le pregunta si está viviendo bien.

Q: ¿Vas al centro de salud porque tienes ganas o porque te obligan?

N: Voy porque quiero, porque quiero que mi hijo nazca sano como se debe, limpio. No quiero pasar por momentos difíciles, por eso voy.

Q: ¿Qué te aconsejan en el centro de salud?

N: Es lo mismo. Me dicen que me cuide, también el médico dice lo mismo, dice que se cuide uno porque de lo contrario puede sufrir un accidente o puede pasar otra cosa mala, se debe de cuidar al caminar o al levantar cualquier cosa pesada o hacer algún trabajo pesado, porque una es consciente que está embarazada.

Q: ¿Tú siempre haces lo que te dicen en el centro?

N: Sí, lo cumplo porque de lo contrario me puede pasar así, si no cumplo con lo que me dicen los médicos.

From lines 9-15, Narcisa says that doctors and parteras basically tell her the same things, because they all get the same information about maternal care. Moreover, she heeds the partera *because* she goes to biomedical training sessions (line 13).[84] From an ideational perspective, this indicates a certain consistency in the field, which would emanate from the underlining biomedical discourse. But we get a different picture when we look at this text as a whole. From lines 1-8, it becomes clear that Narcisa seeks the partera to watch for the position of the baby and to re-position as she sees fit. The intertextual reference on lines 2-3 ("*dicen que todos los meses debe de revisarse*") does not likely come from government health services or government safe motherhood discourse, and neither does the assertive, normative statement on line 3 ("*debe meter la mano en la panza para ver si*

[84] This is a good example of the concrete impact of ideological articulations around the biomedical training of traditional health providers, which I discussed in chapter 3.3. There, I mentioned how traditional healers viewed biomedical training as a means of getting government authorization for their practice and further cementing their status in the communities (Coronado Suzán G 2003, p. 337). Narcisa's partera is also legitimized by biomedical training and gives biomedical-like advice, but she keeps practicing external versions to re-position the baby in the womb. This shows that safe motherhood discourse overlaps and co-opts the order of discourse of traditional maternal care; but the opposite also happens when traditional providers harness government discourse and resources for their own purposes.

está bien el bebé"). If anything, TBA training discourages parteras from re-positioning. However, on lines 16-19, Narcisa paraphrases her conversation with the doctor, where he reaffirms the traditional discourse –"*me dice que es necesario que lo acomoden*"- and tells her that he, too, must check the position of the baby, to keep an authoritative control over the whole process. Here, we can see a different approach from the clinical practitioner to matters of knowledge and power, engaging both orders of discourse insofar as he perceives their combined power in terms of prenatal control. The partera, in turn, goes for biomedical training, takes what seems to fit with traditional views, particularly about self-care, and continues to perform what her patients and herself consider an essential practice for pregnancy care. All three actors –Narcisa, the doctor, and the partera- negotiate different worldviews in a delicate balance that reinforces their own interests without altering the core values and subject positions at the heart of prenatal control. Neither the doctor nor the partera tamper with essential logonomic rules from the other's world. In fact, they reinforce these rules through a strategy of solidarity and power that foregrounds the need to heed biomedical and traditional experts and to articulate control and self-control. Both the doctor and the partera –and their respective orders of discourse- have a dialogue full of agreements that resonates in Narcisa's words. Both recommend she check with them once a month. Both claim their right –and do not undermine the other's- to police the woman's body. Both encourage the woman to seek control with the other.[85] And both remind her that she must look after herself and her child ("*Me dicen que me cuide, también el médico dice lo mismo, dice que se cuide uno porque de lo contrario puede sufrir un accidente o puede pasar otra cosa mala*", on lines 33-35, where we recognize fear appeals used as a common behavioural conditioning device).[86] On lines 6-7, we can hear the partera blaming the woman when she does not police her own body ("*también dice las cosas incorrectas que hace uno; por eso el bebé*

[85] This is particularly the case with parteras: 77% of women of childbearing age surveyed for the MNH Project 2008 baseline in Xochis said their partera had told them to go to the health centre for prenatal control. These women were twice as likely to have gone for five or more prenatal checkups (which constitutes adequate prenatal care, according to official guidelines from the Mexico Health Secretariat) than women whose parteras did not advise them to go to the health centre during their pregnancies.

[86] This is a good example of interethnic negotiation, as described by Coronado. "El proceso de negociación implica que los grupos involucrados tienen alguna fuerza para imponer su posición, pero al mismo tiempo tienen razones, fines o intereses para evitar la confrontación." Coronado Suzán G 2003, p. 54. In this case, negotiation takes place between individuals rather than groups; but we are also afforded a glimpse of the impact and implications that such a process could have at a larger scale.

sufre de problemas"). The doctor does his part on lines 27-28 ("*me pregunta si estoy viviendo bien*").

There are other key dimensions of safe motherhood discourse and health risk discourse built into this text. On lines 21-23 and 30-31, Narcisa gives different reasons why she goes for prenatal care at government health units. On lines 21-23, she says the doctors who request her compliance put pressure using responsibility and guilt appeals. On lines 30-31, she says she complies because she wants to, because she does not want to go through "difficult times" when she delivers, and because she wants her child to be born "healthy and clean". As was the case with Zulema above, Narcisa's second answer (lines 30-31) contains basic presuppostions: that institutionalized care and delivery are healthier and cleaner than partera-assisted homebirth, and a sure way to avert risk. This reference echoes the construal of clean delivery (*parto limpio*) in government safe motherhood discourse and clinical jargon. In her words, this attribution also has a direct intertextual connection with what their closest relatives expect from hospital care:

> **Q**: ¿Tus padres y tu marido, dónde quieren que te alivies? ¿Por qué?
> **N**: Ellos quieren que sea en el hospital, porque en el hospital se limpia toda la persona. Ahí revisan, piden medicina como suero, o cualquier medicina que adelante el parto... por eso prefieren que vaya al hospital.

This construal of institutional delivery is confirmed by her choice of providers: while she trusts parteras to re-position her baby, she does not seek their assistance for childbirth.

> **Q:** ¿Por qué no te alivias en tu casa y con partera?
> **N:** Porque hay mujeres que cuidan a la embarazada que sólo aprietan, y sólo hace más peso encima del bebé, y yo no quiero, porque el bebé puede sufrir algún accidente. Porque hay mujeres que cuidan las embarazadas que hacen bien su trabajo y otras que hacen feo con la parturienta: las agarran y les aprietan donde no deben de apretar. Y los médicos que estudiaron ya saben cómo cuidar.

Clearly, Narcisa draws from a complex blend of social discourses on expertise. Since she gave birth to her only child with a clinical practitioner, her construal of the partera's delivery skills does not come from her own embodied experience. At the same time, she admits the need for a different type of knowledge to diagnose cultural syndromes:

> **Q**: ¿Puede haber males de antojo, coraje o espanto, o problemas con el nahual durante el embarazo?
> **N**: Puede ser cuando la mujer sufre de antojo, puede causarle comezón en la piel. O puede ser cuando se asusta en algún lugar o por el coraje, cuando siente coraje porque sus hijos la molestan mucho, o su marido; o puede ser también cuando la mujer sufre de sangrado cuando tiene antojo. Es la costumbre que tenemos de este lado [...] Muchas cosas le pueden pasar... puede dolerle la cabeza o hincharse los pies o hincharse en todo su cuerpo, porque es peligroso cuando está embarazada...
> **Q**: ¿Cómo sabes si tienes uno de estos problemas?
> **N**: Te das cuenta cuando en esos casos la persona que sufre de antojo se va a que le saquen la cuenta, para que la revise la persona que sabe si tiene antojo o coraje o si tiene alguna otra cosa que sienta coraje. La mejor manera de enterarse es que te saquen la cuenta para que sepan que es lo que tienes.

As I have discussed before, our participants are conscious of the ethnically bounded nature of certain syndromes –"*es la costumbre que tenemos de este lado,*" says Narcisa- and the need for diagnosis and solutions from within their in-group. Drawing this line does not seem a matter of age; Narcisa is 22 and she trusts biomedical knowledge at the critical time of childbirth ("*Los medicos que estudiaron ya saben cómo cuidar*"). But she would seek "people who know" to confirm whether she has any of the syndromes that people get "on this side" ("*La mejor manera de enterarse es que te saquen la cuenta para que sepan qué es lo que tienes*"). Contrary to what happens with her doctors and her partera, this ethnically bounded knowledge presents a critical challenge from a biomedical perspective, insofar as many people will first consult with the in-group experts and then seek an answer "on the other side".

6.9. Responsibility and blame

Going back to the last numbered exchange with Narcisa, we can see from lines 21-23 how responsibility and blaming come to the fore and point to intense political and community pressure around maternal health. On line 21 she gives a first-person account of why she goes for monthly checkups ("*Voy una vez al mes porque me dicen los médicos que debo ir*"). Then, she elaborates on this explanation from a general perspective, using the type of normative language that she probably heard at the government health centre: "*La mujer embarazada debe de acudir a la cita; si no va una vez, significa que no debe de culpar a los médicos después, porque ellos hacen la cita una vez al mes para revisión*," which in turn echoes a common feeling of apprehension among health staff facing intense government scrutiny and family and community pressure when things take a wrong turn.

This is one among many examples of pervasive, across-the-board presence of discourses about individual, group, and collective responsibility coupled with blaming in our dataset. In many cases, we explicitly asked about responsibility and blaming, based on the literature and key informant interviews. In many others, there was a spontaneous emergence of these topics, linked with multiple other categories, from women's agency to spousal solidarity; from prenatal control to self-care, including care of the child in the womb and the newborn; from government health services to parteras. This chapter already contains a good number of examples, where we see the interaction of discourses on responsibility, and how people use them, reinforce them, or challenge them. Here, I will add a few significant ones. The first one comes from our interview with Juliana, in Llano del Carmen:

> **Q**: Dice la gente que una mujer embarazada tiene que cuidar lo que come, tiene que tener cuidado con el trabajo que hace. ¿Tú cómo lo ves? ¿Te cuidas de eso?
> **J:** Pues mira, yo no, porque siempre trabajo. ¿Cómo le vas a hacer si eres pobre, si todos los días necesitas algo de comer con tus hijos? No se puede estar solo sentada, tienes que trabajar un poco; pues siempre trabajo, tejo... (telar de cintura, backstrap loom)

In a few lines, the above exchange shows how discourses operate on people and how people manage these influences in their daily lives. The interviewer explicitly brings discourses from the traditional and biomedical order of discourse into the conversation. She opens the exchange with an intertextual device, by thematically positioning the social nature of the interpellation: "*Dice la gente*". The subordinate clauses in the verbal complex specify what these social beliefs and expectations are: that a pregnant woman should watch what she eats and the type of work she does. In other words, the interviewer tells Juliana what people think a responsible pregnant woman should do. Then, she asks Juliana about her views and practices.

Juliana opens with the rhematic placement of a colloquial expression –"*pues mira*"- that anticipates an admission, a confrontational stance, a deviation from what has been laid out in the question as a social norm (in our case, a widespread discourse about self-care during pregnancy). She then says *what she does*, not what she thinks ("*Yo no, porque trabajo*"), referring to the default circumstances of her life. Then, she engages the social discourse about responsible maternal behaviour with a reference to lived structural barriers (her own poverty) and, within that context, with another discourse on responsibility: her contribution to the household economy and her obligation to her other children. She does this through a rhetorical question conveying the underlying idea that she has no choice, or rather that the only responsible thing to do, under the circumstances, is to keep working. "*No se puede estar solo sentada, hay que trabajar un poco*," she asserts with normative language; "*pues siempre trabajo, tejo*," she concludes reaffirming what norm she goes by. In Juliana's words, we see how she juggles the different expectations and discourses brought into her life at a particular juncture. We also appreciate the material effects of discourses –in this case, discourses on responsibility- and how much pressure they enact on indigenous women in Xochis.

This example links with the discussion of women's role in household life and family economy in chapter 1.[87] Amuzgo learn to perform household duties, help in the farm, and

[87] See chapter 1.1.4.1, p. 26-29.

start weaving at a very young age. By doing all this, they learn how to be a woman in the Amuzgo society.[88] This early commitment and manifold contribution to their household's economy seems to develop a strong family-oriented work ethic among women, which is reflected in community expectations and may have implications for maternal health.[89]

In most women's accounts, responsibility is closely connected with agency facing labour and delivery –something I touched on when discussing home childbirth versus institutional delivery. Here is what Eulogia answered when we asked her why some women have problems during pregnancy:

E: Como dije, eso pasa porque hay mujeres que tienen mucho miedo a dar a luz, miedo a pujar, y hay mujeres que no. Esas cosas tenemos que pasarlas nosotras como mujeres que somos. Se debe de perder el miedo cuando llega la hora porque es necesario. Aunque sea en el hospital, se necesita esfuerzo personal para dar a luz.
Q: ¿Has escuchado algún caso así?
E: Sí, hay personas que les pasa, sobre todo a las que dan a luz por primera vez. En cambio nosotras, las que ya tenemos más experiencia, sabemos de qué se trata.

To understand the true salience of this issue in the context of Eulogia's words, we must take into account that she is answering a question about *pregnancy* problems, not specifically about childbirth. Moreover, she anchors her first response by the thematic placement of the anaphoric "*as I said*" ("*como dije*"), which points to a previous segment of the conversation and then cataphorically stresses the impact of women's fear of pushing and labour in adverse maternal outcomes. The two existencial clauses in that same statement separate pregnant women in two groups -those who are afraid and those

[88] Aguirre Pérez IG 2007, p. 30-35, 43. Although a growing number of female children and teenagers may be attending elementary, middle and high school, they have to juggle their educational obligations with household chores and farm work.
[89] In the MNH Project 2008 baseline survey, almost half of elderly women perceived that townspeople expected pregnant women to work as much as usual, compared to 14% of husbands who perceived the same. And while 75% of men thought people expected pregnant women to work less than usual, only 50% of elderly women had this perception. One possible explanation for these gender differences is that women have internalized familial –and community- expectations to the point where they sustain these unwritten norms more so than men do. This interpretation holds even if we consider that some respondents may have answered based on their own beliefs rather than on what they think others around them believe. I will return to these issues with one specific example in chapter 6, and then in the discussion of the results.

who are not. The first group is at higher risk because of their fear. On lines 2-3, she makes a normative assertion ("*esas cosas tenemos que pasarlas nosotras como mujeres que somos*") that highlights an inherent, inescapable responsibility of a woman *as a woman* ("*como mujeres que somos*"), very much as Juliana had spoken of self-care as an imperative of female identity ("*ahí es una como mujer la que debe cuidarse*") and Jesús had referred to spousal solidarity in terms of inbuilt manly identity ("*uno como hombre*").[90] Zulema, too, echoes this interpellation from the traditional order of discourse, channeled through her husband and closest advisor:

> **Q**: ¿En tu casa, con tu familia con quien platicas sobre tu embarazo?
> **Z:** Con nadie, solo con el papá de mi hija
> **Q:** ¿Qué te dice, que consejos te da?
> **Z**: Me dice que no me ponga triste ni me preocupe, que por eso soy mujer y debo tener hijos

On lines 3-4, Eulogia reiterates the idea that women have to overcome fear so they will not alter the natural order of things ("*se debe perder el miedo cuando llega la hora porque es necesario*"). Then, on line 4, she makes an implicit allusion to women who may choose to give birth in the hospital under the idea that they will suffer less or that they will need less effort to deliver their babies, as mostly elderly women suggested during one-on-one interviews and group discussions. She writes off this idea and stresses the imperative of female agency and responsibility: "*Aunque sea en el hospital, se necesita esfuerzo personal para dar a luz*". On lines 6-7, she links fear with lack of experience in first-time mothers, as opposed to the knowledge of those women who have given birth several times, as is her case –she includes herself in this group, thus validating her words with her own embodied experience. Elcira, too, resorts to her own experience to highlight a woman's ability to overcome fear and commend herself to God, in an intimate communion that constitutes the natural order of things:

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[90] I placed both units of analysis within an emerging category, "*Como mujer, como hombre*" ("As a woman, as a man"), which includes different references to what people perceive as built-in gender traits or what is expected from women and men in terms of inherent gender identities –or subject positions, from a discursive perspective.

Q: Antes del parto, ¿ya sabes si todo va a salir bien?

ME: Sí se salva la mujer. Cuando llegan los dolores se le habla a Dios, porque no hay nadie que te puede ayudar en los dolores que se tiene en el momento.

Q: ¿Por qué?

ME: Porque sólo Dios es poderoso... no llega alguien que te ayude, sola la mujer tiene que enfrentar el dolor.

Elcira construes this natural communion as a generalization of her own experience, through the link between the woman's lonely, intimate, unavoidable struggle with labour pain; a redundant exclusion of any other human agency in the process ("*no hay nadie que te pueda ayudar en los dolores que se tiene en el momento*", "*no llega alguien que te ayude*"), and a deeply felt communication with God as the only force who can determine the outcome.

There is yet another telling discursive articulation in Elcira's words. For this interpretation, we need to take into account the first question as part of the text. The interviewer asks Elcira if she knows whether everything will go well before childbirth. We posed this question to all our female participants, trying to generate a dialogue between the idea that childbirth is always a risky, uncertain event, and women's perceptions facing delivery. Elcira answers by thematically placing a universal assertion through categorical modality ("*Sí, se salva la mujer*"), and then elaborating on how this occurs, that is, through a combination of prayer (actively and consciously talking to God) and agency to overcome fear. In other words, these are the essential components of a safe delivery –or rather the safest possible delivery, because everything is, ultimately, in God's hands.

As we have seen from previous sections, some women feel their husbands urge them to go for prenatal care because they do not want to be blamed in case something wrong happens. Greater tensions arise facing delivery and eventual referral of the woman in labour. Our conversation with Plácida, an older mother of two from Xochis Cabecera, reveals how these dynamics and discursive traces operate in a critical juncture:

Q: ¿Y quién decide eso de que si va con la partera o con el doctor?
P: La familia, la familia... porque, por ejemplo, si yo estoy de nuera que todavía estoy con mi suegra y con mi suegro, entonces ellos dicen: "No la podemos dejar aquí en manos de la paretra... hay que llevarla con el médico, porque luego, ¿qué va a decir la familia, no? Que la dejamos morir en manos de la partera..."
Q: ¿Y en la familia quién tiene mayor peso en esa decisión, el hombre o la mujer?
P: Eh... siempre depende mucho de los suegros, también del esposo... A veces, el esposo no quiere tanto que vaya uno con el médico, porque sabe que le va a costar más, y con la partera, pues, más barato; pero, a veces, si se ve que el parto viene complicado, pues tiene que llevarla con el médico. Y la misma partera también a veces dice: "Mira, yo no puedo, no me arriesgo a atenderla porque su parto es difícil. Entonce, si el médico se presta a que yo vaya para ayudarla, yo voy, pero al médico no le gusta que vaya la partera...

Plácida's intertextual references vividly show how much is at stake here. From lines 2-5, we can tell her parents-in-law are aware that the partera is no longer the ultimate source of knowledge and expertise, and that the family of their daughter-in-law knows as much. Furthermore, they would expect them to take the pregnant woman to the hospital ("*porque luego, ¿qué va a decir la familia, no? Que la dejamos morir en manos de la partera*"). From lines 7-10, Plácida construes the husband as someone who will ponder the costs and benefits of a referral: the economic cost is a Given in her narration ("*no quiere tanto que vaya con el médico, porque sabe que le va a costar más, y con la partera, pues, más barato*"), while the notion of responsibility and accountability is implicit in the New (the obstetric complication) and may eventually tip the scale ("*pero, a veces, si se ve que el parto viene complicado, pues tiene que llevarla con el médico*"). Finally, from lines 10-13, Plácida brings the voice of the partera into her account, as she struggles with her limitations and her accountability before the family and the government health care system.

Everyone feels the weight of their responsibility and their accountability, in a context of intense pressure to avert maternal deaths. It is hard to tell from our data what would have

happened when the parteras were the sole providers, or what the situation was before the government started focusing on maternal deaths in rural Mexico. But the heat is on now and everybody feels it. Added to the community sanctions, the warning voices from TBA training have made inroads in parteras' decisions on how far they can or should go. We can trace these mounting pressures in Alicia's reflection about the parteras she trains:

Q: ¿Me estás diciendo que si el parto no es complicado, en calidad de atención, la partera supera al médico?
A: (Lowers her voice) Puede... (Back to normal volume) Por eso es que a veces nos echamos un raun (for the English word "round") con algunas, porque (she laughs).... No, no, ¡vea cómo atienden mis parteras! El mayor porcentaje se lo lleva... aunque últimamente quizás ya bajó un poquito, porque también la partera ya este quizás con el miedo que se me complique, más que saben que las muertes maternas... "¡No, que si alguna de ustedes se les muere!"... Porque son problemas, quizás hasta legales...
Q: ¿Quién dice eso?
A: La misma gente de la población, porque luego dicen "pues a fulana se le murió un niño", pues ya no van con ella... como que se les... acaba...
Q: ¿El prestigio?
A: Sí
Q: O sea que la gente de alguna manera castiga la muerte del niño no yendo a esa partera...
A: Ajá, así podríamos decirlo...ajá, sí
Q: Ése es el miedo...
A: La misma población ya no va. Incluso tuve un caso ahí de una partera de Sacualpan, ella incurrió en una muerte materna, tanto así que la misma población prácticamente la, pues la...
Q: ¿La hizo a un lado?
A: Sí
[...] **Q**: Y si el parto, si la mujer o el niño mueren en el hospital, ¿a quién culpa la población?
A: A la partera
J: ¿Ah, si?
A: Sí, porque luego dicen que no la refirió a tiempo.

The intertextual reference on lines 7-8 brings into this text the warning that parteras will likely have heard during one or more of their training sessions. It is a coercive interpellation, a fear appeal draped with legal overtones, as we see from line 8 and most tellingly from line 9, where Alicia uses the expression "*incurrió en una muerte materna*" ("she incurred in a maternal death"), which irrupts from the legal, law enforcement, administrative, and political orders of discourse with admonishing force. In everyday speech, one would likely use an expression like "*se le murió una paciente*", which is more often related to medical malpractice and which obscures both agency and responsibility from a discursive standpoint. On the other hand, "*ella incurrió en una muerte materna*" is a political and administrative way of framing agency in a material clause short of implying intentionality, as it would be the case with "*mató a una paciente*". At the same time, the substitution of "*una muerte materna*" for "*una paciente*" turns the dead person into an abstraction –a nominalization- and a public health issue. On lines 19-21, Alicia adds that the people of Sacualpan considered this to be such a grave fault (she uses the adverbial phrase of mode "*tanto así que*") that they ostracized the partera, framing this outcome as a cautionary tale.

Perceptions of responsibility, accountability, and blame are acute, intense, and unsparing in this context of political pressure, and they often crisscross with ethnic self-awareness and perceptions of knowledge and power. While Alicia contends that families and communities will tend to blame the parteras when someone dies in their care, some doctors and health officials are of a different view. This is what a hospital doctor who had worked in indigenous communities said during our dialogue in Spanish in Chilpancingo:

1 En una ocasión, en una experiencia que tengo, es que empiezo a trasladar a una
2 señora por preeclampsia. En el acto le dije al comisario, fui con el maestro y fuimos
3 a ver al marido que la tenemos que trasladar. Pero ahí no era el marido el que no
4 quería que se trasladara, sino la señora. Yo no me quise arriesgar a atenderla en esas
5 condiciones. Entonces, la llevaron con la partera; la partera la ayudó, salieron los
6 dos niños, la señora quedó debilitada, pero se salvó. Nada más yo metí un poco de

hipertensivo, no me acuerdo qué más, pero la alivió. Por supuesto que estuvo en boca de toda la comunidad... "Oiga, el médico está estudiado y, mira, no pudo atender a esa señora, y mira, fulana sí la atendió". Pero si yo la atiendo y se me muere, no me lo perdonan; si a la partera la atiende y se le muere, hizo todo lo posible... A las parteras se les pueden morir y hasta el momento yo no conozco a una partera que haya sido lastimada o que haya sido agredida u ofendida si se le murió una señora, porque la partera hace el favor... pero si a un médico se le muere una señora, tienen que sacarlo de ahí, porque es su obligación. No se te permite, porque tú estás estudiado, y eso lo van a notar. Podemos investigar cuántas gentes hemos cambiado por diferentes cosas... Hay gente que hemos cambiado porque ha hecho campañas de papanicolau y algunas mujeres fueron convencidas, pero no piden permiso al marido, entonces el marido se entera ... Nada más que ahora ya es un poquito más difícil sacarlos, porque tratamos de sensibilizar a la comunidad de que si al médico no se le garantiza su seguridad se le va a castigar... es una manera de decirles cuiden a sus médicos.

This account is particularly relevant, because it mirrors (in particular, on lines 13-15) the allusions to medical knowledge, obligation, responsibility, motivation –or lack thereof- and involvement –or uninvolvement- voiced by some of our participants from the communities. The clinical practitioner feels singled out in the communities precisely because he has studied (therefore, he is a learned expert, someone who has greater powers in the emergency) and because assisting patients is his obligation, whereas the partera "is doing them a favour". The doctor's account also provides a narrative of the biomedical and institutional conception of the emergency, compared to people's expectations in remote places with little access to medical services. From an ideational perspective, the doctor construes the emergency in terms of a complex process involving referral ("*empiezo a trasladar a una señora por preeeclampsia*", on lines 1-2), involvement of local authorities and community leaders ("*en el acto le dije al comisario, fui con el maestro*", on line 2), consultation with the husband ("*y fuimos a ver al marido que la tenemos que trasladar*", lines 2-3), clinical guidelines and criteria on when to treat and when to refer, and legal implications of adverse outcomes ("*yo no me quise arriesgar a atenderla en esas condiciones*", lines 4-5), as well as wariness of community blaming

("*si yo la atiendo y se me mueren, no me lo perdonan*", lines 9-10). These perceptions and these discourses were so strong that he was not prepared to heed the woman's own will to be treated in the community. In the doctor's mind –and in the public health conception- this is not her decision to make. She was choosing, but she did not have the right to choose –perhaps because the underlying biomedical view is that you cannot choose under these circumstances, or that rational choice is about the ability to comply with government guidelines. When the woman insists, health officials and health staff do all they need to cover their own responsibility –and washing their hands becomes their main concern. Thus happened in the critical case I recounted in chapter 1.1, and thus happened again in this case ("*Nada más yo metí un poco de hipertensivo, no me acuerdo qué más, pero la alivió*", on lines 6-7). Of course, the people in the village had no clinical guidelines in their minds. They expected the doctor to respond in the emergency; but the doctor responded to an emergency that was modeled in a different world –a conceptual device intended to draw people into that world and not to engage with them in their own circumstances. These worlds were not to merge, but one of them was to submit to the other. This becomes clear from lines 15-21, where our informant talks about pulling doctors out of the villages and eventually taking measures to make one world adapt to the other: "*porque tratamos de sensibilizar a la comunidad de que si al medico no se le garantiza su seguridad, se la va a castigar*".

Of course, I am not trying to justify violence against clinical practitioners. I am only exploring how questions of responsibility and blaming –in this case individual and collective responsibility- are perceived and dealt with, from the perspective of the participants, and in the uneasy interaction between different cultural views of knowledge, power, decision-making, choice, responsibility, and blame. From the doctor's point of view, his obligation was to refer the woman immediately to the nearest hospital; from the perspective of the community, the doctor's obligation was to assist the patient right then and right there. The doctor says that he would not be forgiven if the woman died in his care, and this may very well be the case. But we can safely hypothesize that government safe motherhood discourse may compound the situation by construing skilled care as the province of biomedical practitioners, above and beyond traditional knowledge and

abilities –thus raising the expectations in obstetrical emergencies. What happened in this case –the partera delivering the twins while the doctor stood by and the local authorities looked on- threw all these notions in disarray. If a skilled provider would not and could not solve the emergency, what did the community need this kind of skilled care for? To be sure, safe motherhood discourse promises skilled care *in institutional settings*, as we have seen from chapters 4 and 5. Clinical practitioners may look and sound authoritative in this context (as it happens in "Heed the messages"), but this is not always the case outside the multilayered structure of guidelines, referrals, technology, and intensive care. People, of course, will interpret and re-elaborate this discourse in the light of their own values, circumstances, and expectations.

Tension between doctors and parteras, government and parteras,[91] doctors and communities, and parteras and communities seem to have been exacerbated by increasing presence of government health services and the political pressure to lower maternal mortality rates. Something similar happens between different levels of government health care. Hospital staff contend that doctors in primary health units refer patients who are not necessarily at high risk of adverse outcomes –but it is not hard to see how medical practitioners can see they pose a risk to their own careers and even to their physical safety. A clinical practitioner interviewed in Spanish at the Ometepec Hospital explained the situation from his point of view:

> **Q**: [Para que el niño salga bien en el parto]¿Se puede trabajar mejor en el parto institucional, o es lo mismo con el médico presente o con la partera en la comunidad?
> **D**: Mire, sí lo pueden hacer... pero quizás, yo insisto en lo mismo, hay que estar valorando, escuchando el corazón del bebé, hay que ver el tiempo, a qué horas empezó, si ve que está, ya se está tardando... pues, ¿sabe qué? Yo estaría mejor, más tranquilo, si estuviera en una institución. Y actualmente, que las demandas están ya en su momento

[91] In March 2009, the Secretary of Health of Guerrero, Luis Barrera Ríos, said that most pregnant women who had died in La Montaña region, where maternal mortality rates had not followed the 50% average decline statewide since 2005, had been assisted by parteras. Rodriguez Montes J. Muertes maternas en La Montaña, por intervención de parteras, achaca Barrera. *La Jornada Guerrero*, March 6, 2009. Available at http://www.lajornadaguerrero.com.mx/2009/03/06/index.php?section=sociedad&article=010n1soc. Accessed April 27, 2010. This is in stark contrast with the absence of medical responsibility from public discourse, even though our sources in the state Health Secretariat said this was a mounting concern and doctors in Xochis and Ometepec felt the pressure of government inquiries into maternal deaths.

> aquí en México, ya los médicos pasantes dicen "mejor que se vaya al hospital, así me evito problemas"... Y, sí, a veces llegan y vienen entrando y ¡pum!, sacando al bebé, y dice uno: "Oye, este bebé hubiera nacido en tu centro de salud"... pero es que actualmente, como ya nadie quiere problemas, mejor dicen que se vaya a una institución...

While this happens among practitioners, government health services use anti-poverty programs to coerce women into prenatal control and government safe motherhood discourse tells pregnant women they are responsible for their own health and the health of their babies, as we have seen in chapters 4 and 5. Within the community, women are also signaled for responsibility in terms of self-care and blaming when something goes wrong. Let's see how these categories feature in Elcira's words:

Q: ¿Qué cosas no debes hacer durante el embarazo?
E: Ya no tener relaciones sexuales con la pareja.
Q: ¿Qué otra cosa?
E: No tejer telar de cintura, no levantar objetos pesados. Esas cosas se debe de hacer, se debe de tener cuidados.
Q: ¿Sólo son esas cosas?
E: Sí. Cuando la mujer recibe golpes es peligroso también. En el embarazo la mujer debe buscar medicina antes del parto. No debe inyectarse medicinas ni enfermarse. Si ya pensó en sacar el bebé, pues lo va a hacer, busca medicina, inyecciones, levanta objetos pesados, o va a emborracharse y se cae, pues saca su bebé. Se debe de pensar bien lo que se hace. Se debe de cuidar cuando se va por la leña, no levantarla cuando está pesada. No podemos decir que se está inconsciente cuando se hacen estas cosas. Cuando ya estoy embarazada, no hago cualquier cosa, pienso bien lo que hago y, como dije, los niños no tienen la culpa si se salen, no tienen ninguna culpa, cuando llega el día del parto ella dará a luz. Es como tu caso, naciste de esa manera y si tu madre hubiera abortado no habrías nacido. Hay mujeres que hacen eso y no está bien. Hay mujeres que abortan a los cuatro o cinco meses. Ella se siente grande porque no tiene hijos, pero no tiene conciencia que es porque mata a los hijos. Porque los hijos crecen y Dios sabe cómo hacerlos crecer. Y la mujer que aborta tiene mucha culpa [...] Hay niños que nacen enfermos, nacen crudos,

pero se debe porque la madre hizo algo. A veces aunque se acude al hospital, el médico puede darte pastillas porque no sabrá que estás embarazada mientras tú no le dices. No te da la medicina así nada más porque sí sabiendo que estás embarazada. Porque ellos saben qué medicina dar para no afectar al bebé, te indican qué medicina recetarte, puede ser medicina de la herbolaria, ellos saben. No se debe tomar cualquier pastilla cuando se siente dolor de estómago; no es bueno tomar pastillas contra la diarrea, es peligroso. Aunque no sabe uno leer, ya viene en la parte de afuera una equis, viene el dibujo de una persona donde se menciona que no se debe de tomar. En el hospital te dan pastillas que no tiene equis en la parte de afuera. Pastillas que no llevan esa marca porque así me pasó cuando tuve dolor de estómago... Me dieron una pastilla, yo le pregunté (a otra mujer) qué pensaba, como ve si tomo esta o aquella pastilla, porque ella ya sabía más, porque ya había dado a luz; eso es lo que preguntan las mujeres inteligentes, pero otras mujeres no lo hacen. Hay mujeres que viven bien, otras no. Porque tienen flojera de criar al niño, y hay otras que crían al hijo hasta crecer. Porque se sabe que es mejor criar al niño hasta la edad adulta.

There is a heavy normative tone in this text. In particular, Elcira brings up a host of interdictions that imply the woman's ability to choose and require her agency against a series of structural barriers and familial concerns. She must abstain from sexual relations (line 2), which likely implies contradicting her husband. She must put away the backstrap loom (line 4), which is bound to have an impact on the subsistence economy of her home, as we have seen from chapter 1. She must not get sick (lines 8-9), which is related to seeking proper medicine before childbirth (also on line 8). She must not lift heavy bundles of firewood (lines 11-12). And, above all, she must not self-medicate (lines 8-10) because this leads to miscarriage, a much-feared presence in most of our interviews. She elaborates on the woman's responsibility in averting this risk, and she dismisses illiteracy as a valid excuse: "*Aunque no sabe uno leer, ya viene en la parte de afuera una equis, viene el dibujo de una persona donde se menciona que no se debe de tomar*", on lines 27-29. And though she admits that medicine from the hospital may not have an X mark, she offers her own example to do away with this argument and to make a distinction between

those who ask and those who don't.[92] The first are intelligent and live life as they should; the others don't: "*Eso es lo que preguntan las mujeres inteligentes, pero otras mujeres no lo hacen. Hay mujeres que viven bien, otras no. Porque tienen flojera de criar al niño, y hay otras que crían al hijo hasta crecer. Porque se sabe que es mejor criar al niño hasta la edad adulta*" (lines 33-36).

But Elcira goes beyond miscarriage and blames women for intentional abortion, which is widely condemned in her religiously charged discourse and very negatively framed in the Amuzgo language, as I have discussed above. The woman's responsibility comes to life from lines (9-12): "*Si ya pensó en sacar el bebé, pues lo va a hacer; busca medicina, inyecciones, levanta objetos pesados, o se va a emborracharse y se cae, pues saca su bebé.*" The woman has great agency and sense of purpose in this clause complex, more than in most other construals of her role during pregnancy, either within Elcira's interview or across our dataset. The opening statement connects her intentions and her success; the follow-up complex elaborates on a series of material and behavioural clauses leading to this outcome. In Elcira's construal, nothing can stop a pregnant woman who wants to get rid of her child. Her intention is asserted through categorical modality and strong interpersonal meaning on lines 12-13: "*No podemos decir que se está inconsciente cuando se hacen estas cosas*". In other words, women who self-medicate, lift heavy objects, or get drunk are well aware of the consequences of their actions. Among other things, this shows that Elcira's attribution of awareness and responsibility is as strong or even stronger than the construal of these categories in safe motherhood discourse. After all, safe motherhood campaigns contemplate a target audience –or subgroup within the audience- of potentially unaware women. Elcira, as many other participants, leaves no room for doubt. Women *know* what is wrong. On line 13-14, she offers her own embodied experience as evidence in this regard: "*Cuando ya estoy embarazada, no hago cualquier cosa, pienso bien lo que hago.*"

[92] As I mentioned above, this is a typical discursive construal, whereby the speaker turns a specific reality (in this case, a specific moment in her own history) into an instance of a larger, preexisting case, namely, the categorization of women in two morally opposed groups. Vannini P 2007, p. 134-135.

This harsh social construal of the woman's agency in aborting goes hand in hand with legal penalization to put indigenous women who do not want to carry out their pregnancy in a very tough spot. Unmarried pregnant women are particularly singled out for blaming and often shunned by their families. Caught between a rock and a hard place, these women –most of them teenagers without economic support- try to conceal their pregnancies and stay away from government health services. Some of them will have their children without any assistance; some others will try to induce abortions in unsafe conditions.[93] Plácida talks about this unflattering subject position, with a mix of solidarity and blaming:

> **Q:** ¿Hay mucha gente que se pueda atender sola en el parto, sin partera?
> **P:** Mucha gente se alivia así, compañero... Es muy triste platicar de esta gente; por ejemplo, las mujeres que nada más recogen los niños, así nada más con cualquier hombre porque sí, porque ya se acostaron una vez, se embarazaron, y ya después al hombre le vale, se va... Entonces, esta gente, ¿quién la va a ver, quién la va ayudar? A veces los padres, en vez de ayudarlas mejor las corren, "pues ustedes verán adónde se van, porque aquí no queremos". Entonces ellas ven la manera de aiviarse como pueden...
> **Q**: Es muy pesado…
> **P**: Muy pesado y muy difícil, porque quedan totalmente abandonadas…
> **Q**: ¿Y en los hospitales no las atienden?
> **P**: Pues no, porque no tienen dinero…

Closely related to the above, the notion of the child as a person from before childbirth –a key construal in "Heed the messages"- is a poweful driver in Elcira's heavily normative words. Equally strong is the link between the mother and the child in terms of agency, responsibility, and blame. We see these discursive developments from lines 14-19, where she points to the woman's responsibility in several ways:

[93] In Mexico, poor indigenous women with less than five years of education are nine times more likely to have an unsafe abortion than rich, educated, non indigenous women. Sousa A, Lozano R, Gakidou E. Exploring the determinants of unsafe abortion: improving the evidence base in Mexico. *Health Policy and Planning* 25(4):300-310, 2010.

-She uses categorical modality and strong evaluation, including negation and redundancy, to oppose the child as a blameless victim of abortion ("*los niños no tienen la culpa si salen, no tienen ninguna culpa*") to the mother as a guilty perpetrator ("*Y la mujer que aborta tiene mucha culpa*").
-She highlights the natural order of things, materialized in the continuity of life, and the agentive role of the woman when this cycle gets interrupted. In order to make her point, she uses a powerful rhetorical device, and deictically addresses the interviewer to bring her into her text, trigger her empathy, and make her an example of what is alive but could have been dead because of a woman's decision ("*Cuando llega el día del parto, ella dará a luz. Es como tu caso, naciste de esa manera, y si tu madre hubiera abortado, no habrías nacido. Hay mujeres que hacen eso y no esta bien*").
-Then, she keeps elaborating on the natural, sacred cycle of life, and how the woman opposes God when she decides not to have her child. By using ellipsis, she covers from the fourth or fifth month of pregnancy to an indefinite period in the life of a grown child: ("*Hay mujeres que abortan a los cuatro o cinco meses. Ella se siente grande porque no tiene hijos, pero no tiene conciencia que es porque mata a los hijos. Porque los hijos crecen y Dios sabe cómo hacerlos crecer.*")

I have analyzed Elcira's text in larger detail because it features a complex set of discursive articulations and moral connotations, all of which construe the subject position of women as invested with great responsibility in giving life and caring for their children even before they are born –very much akin safe motherhood discourse, only from different orders of discourse, but with the same normative (assertive and directive) illocutionary force. Elcira tells her story in a way that fits a morality tale: women have the lives of their children –and God's children, if not Mexico's children, as in the Carnet Perinatal- in ther hands.

Religious discourse is hard on women's responsibility and agency concerning maternal health even before conception, as the following excerpt from an interview in Spanish with a traditionalist Catholic minister reveals:

Q: ¿Estas cosas se hablan aquí en la iglesia, padre?
A: Pues en la iglesia, antiguamente, cuando no había tantos problemas sexuales, nosotros nos manteníamos en predicar la palabra de Dios y punto; lo demás no nos interesa. Pero, al ver que esta comunidad ha ocupado hasta hoy día el primer lugar en prostitución, y que salió en noticias en Canal Dos, que me quedé anonadado, entonces la iglesia no tiene que estar callado ante esos problemas, la iglesia tiene que intervenir y hablar y aclarar, ¿verdad? Si queremos sana a la familia, tenemos que cuidar desde antes de que se procree la familia. Entonces horita estamos hablando bastante en la iglesia. ¿Por qué? Porque es importante que eduquemos... aunque te vuelvo a decir, el indígena es muy especial, no te va a atender... Vamos a ver, sobre los condones, por ejemplo, tú le dices al muchacho "usa condón", pero él dice "no, es que no siento igual", y no es su cultura usar condón, entonces qué pasa, ya vienen los contagios y ahí vienen los problemas de enfermedades, todo eso, o ahí vienen los embarazos sin desearlo, porque lo que ellos querían era el placer y no la responsabilidad como padre-hijo, porque las relaciones sexuales no se... no se están haciendo porque son casados sino porque quiero y punto, entonces el problema. Pero se está tocando este punto en la iglesia hoy día... bueno, por lo menos en mi iglesia yo lo toco. Aunque un sacerdote, para la cultura indígena, un sacerdote hablar de sexualidad para ellos es negativo, para el indígena, ¿eh?... pero nosotros tenemos que pedirles perdón antes y decirles quiero que me perdonen, pero yo tengo que hablar de esto aquí, y discúlpenme pero es necesario hacerlo.
Q: Entonces, para su iglesia, ¿no es malo el uso del condón?
A: Pues, para mí no. Yo, como pastor de mi iglesia, yo mil veces.... Claro, no te voy a decir que, como religioso, no te voy a decir el condón es bueno, ¿eh? No, es malo, es malo porque estamos procreando un ambiente placentero de la vida sexual sin responsabilidad, y si buscamos familia entonces tenemos que enseñarle al joven que el sexo es para procrear, y yo se los digo hasta descaradamente: "muchacha que abre las piernas está condenada a tener hijos" [he says this in a louder voice]

There are different topics emerging from this unit of analysis. Here, I will only focus on the construal of responsibility and blaming –I will discuss allusions to what is public and what is private below. On lines 7-8, the religious leader makes it clear that a healthy family starts before procreation. He then elaborates on how he addresses this issue with

his parishioners. From lines 9-16, he makes an attribution of ethnic responsibility in the spread of prostitution, HIV, unwanted pregnancies and abortion in his community.[94] The way he sees it, indigenous peoples are "very special" and won't "pay attention". He exemplifies with interpellations to use condoms going into deaf ears. It is interesting to see what goes on at the textual level, in the rhetorical organization of this text (originally in Spanish). In order to support his case, he first quotes from what he frames as a typical exchange with young indigenous males from his parish ("*Tú le dices al muchacho "usa condón", pero él dice "no, es que no siento igual*", on lines 11-12). He then turns this case into an instance of an inherent cultural trait ("*y no es su cultura usar condón*").[95] Next, he makes an attribution of causality, whereby this culture is to blame for sexually transmitted diseases, unwanted pregnancies and everything that comes with it ("*entonces qué pasa, ya vienen los contagios y ahí vienen los problemas de enfermedades, todo eso, o ahí vienen los embarazos sin desearlo*", on lines 12-14). Finally, he expands the attribution of responsibility and inhererent cultural blame from lines 14-16 ("*porque lo que ellos querían era el placer y no la responsabilidad como padre-hijo, porque las relaciones sexuales no se... no se están haciendo porque son casados, sino porque quiero y punto, entonces el problema*"), where the mental clause shows, with strong evaluation, the Senser's attitude and volition effectively rejecting the responsibility of getting married and being a father.

There is also a discursive construal of female responsibility in this text. Although the religious leader rejects the idea of premarital sex and makes a negative evaluation of using condoms, insofar as it leads to irresponsible sex (lines 23-27), he singles out women for blaming. On lines 10-11, he quotes himself interpellating a young man not to

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[94] The situation in this particular community was brought up in the media, as he says on line 5. It would also come up in conversations with local authorities, educational leaders, and other members of the community during our visits to the field.

[95] A study based on the 2000 National Health Survey in Mexico found that indigenous and rural adolescents, as well as those who engage in sexual activity earlier in this stage of their lives, are less likely to use condoms in their first sexual encounter that their urban counterparts. Gayet S, Juárez F, Pedrosa LA, Magis Rodríguez C. Uso del condón entre adolescentes mexicanos para la prevención de las infecciones de transmisión sexual. *Salud Pública de México* 45(5):632-640, 2003. Available at http://www.scielosp.org/scielo.php?pid=S0036-36342003001100008&script=sci_arttext. Accessed April 28, 2010. Of course, this does not mean that inherent cultural traits lead to reject condom use. Whatever the reasons, I am not arguing against the numbers, but rather discussing the discursive construal of inherent indigenous responsibility in a prominent community religious leader.

abstain from sex, but to use condoms ("*usa condón*"), whereas on lines 26-28, he quotes himself bluntly interpellating all women to remain virgins and blaming them for the consequences of straying from this strict mandate: "*Y si buscamos familia, entonces tenemos que enseñarle al joven que el sexo es para procrear, y yo se los digo hasta descaradamente: 'Muchacha que abre las piernas está condenada a tener hijos'.*" It is not only the interpersonal meaning, the tone of the intertextual reference ("*se los digo hasta descaradamente*", and the fact that he re-enacts his admonishment in a louder voice), but also the fact that he sets out to make a conditional statement for a positively evaluated social purpose ("*si buscamos familia*"), then lays out the means to do it –that is, telling young people in general ("*tenemos que enseñarle al joven que el sexo es para procrear, y yo se los digo hasta descaradamente*"), and finally singles out women as the actors in a material process with dire consequences for all involved: "*Muchacha que abre las piernas está condenada a tener hijos*" (lines 27-28). The crude metonymy (abrir las piernas) and its rhematic placement in the clause complex accentuate female agency and choice ("*muchacha que abre las piernas*"), in a world where macho expectations make it very hard for a woman to say no. The use of the expression "*condenada*" in the subordinate clause ("*está condenada a tener hijos*") makes meaning at different but interrelated levels. First, it indicates a negative outcome for the woman (a sentence or a conviction, in Spanish). At the same time, it is a negative evaluation of having children out of wedlock. And it is also, and most compellingly, a harsh interpellation not to induce abortion and to bear and care for those children, regardless of the woman's will. The deeply resonating absence of any alternative outcomes presupposes the implicit agreement that abortion is not an option. The woman's responsibility is cut out for her and hailed through the metonymycal, elliptical, and inescapable conclusion that opening her legs implies having children –and unwanted children to boot. As we have seen, this discursive construal is vividly present in women's accounts of pregnancy risks.

For all the focus on the life of the child, the life of the mother may be more valuable when both lives are hanging in the balance. Here is what Elcira said in this regard:

Q: ¿Crees que [las muertes maternas] son un problema muy grave aquí en la comunidad?
E: Sí, es grave, porque cuando se muere una mujer en el parto nosotras nos lamentamos, decimos "hubiera sido mejor que falleciera el bebé, no la madre, porque ella deja a sus hijos desamparados"... Cuando se salva agradecemos, porque así podrá continuar en su casa, cuidando a sus hijos. Hay mujeres que fallecen ellas y también el niño; ahí está lo más grave.

It is worth noting how Elcira frames the choice between two lives when tragedy strikes: it is a cost-benefit evaluation based on the greater loss to the community *in terms of responsibilities*. It is harder to lose the mother than it to losing the child, because she has valuable tasks to fulfill, like caring for the household and her other children. There is an undertone of blaming in Elcira's words. When whe woman dies, not only does she leave her duties unattended, but she also renders her children helpless. We can track the discursive (social) nature of this construal within the text. Elcira does not make her evaluation from a strictly personal point of view; she rather makes an intertextual reference that brings the voice of a collective of women into her text ("*nosotras nos lamentamos; decimos...*"; "*cuando se salva, agradecemos*"). Losing the child may be part of the natural order of things –or a breach in this order, for which the mother can be blamed-; but losing the mother alters the social and material balance in the community... and women have deeply internalized this communal discourse.

6.10. Blaming and purifying the culture

For all the talk about intercultural health –and some real action within the Mexico Health Secretariat-, blaming an entire ethnic group –indeed, blaming indigenous peoples as a whole- is still commonplace among government health officials, government health staff, and non-indigenous leaders in Xochis. Here is a telling excerpt from an interview in Spanish with a government health official in Ometepec:

1 Nosotros tenemos ya establecidos los problemas, aquí, en muertes maternas. No se
2 trata de descubrir el hilo negro, sino que ya está descubierto cuáles son los
3 problemas de muertes maternas. Que uno de ellas es la marginación en la

comunicación... en la carretera que no llega un vehículo hasta las localidades, o en ciertas épocas de lluvia no accede esa comunidad a ese transporte. Y la otra situación es la pobreza, que no tienen recursos para trasladarse a un hospital, para comprar medicamentos. La otra situación son sus costumbres y tradiciones, que un temascal, o hirviendo alguna hierba se van a tratar ellos sus complicaciones obstétricas... Son esas situaciones que tenemos, ¿eh? Pero como le comentaba, en el aspecto de maltrato o renuencia del personal de salud estamos actuando, no lo siento inalcanzable... ya, este, se está corrigiendo inclusive con sanciones, con cursos, con reconocimientos a lo bueno también. Para este mes vamos a mandar a Acapulco con todos los gastos pagados, dos días, a gente renuente para hablarles cómo ocurre una muerte materna, cuáles son los impactos, los costos sociales que se tienen con los familiares, los hijos, para sensibilizarlos de cierta forma. Lo que no podemos alcanzar, y el problema que tenemos es la promoción, la educación de la población, que exija la atención... es donde no... no llegamos todavía como institución... que nos exija, le decimos en pláticas que tenemos, que nos tire la puerta del centro de salud, que nos denuncie, que nos exija la atención y ahí es donde todavía no llegamos, no impactamos todavía en el autocuidado de la persona, porque en los indígenas hay la... la autoestima no está, este, alta, no está muy buena... ellos mismos, este, se maltratan, no se cuidan, no se protegen, y de ahí la situación que se nos hace más difícil a nosotros que nos dedicamos a cuidarlas, cuidar su salud, evitar muertes maternas... nos complican, nos hacen más difícil la labor, porque estamos prácticamente...trabajando doble.Una es por su lengua, por sus costumbres, dándole toda esa información que a veces no nos quieren entender, ¿eh? Ésa es la situación más fuerte que tenemos aquí de la autoestima de la población indígena, por sus costumbres, sus tradiciones... esa importancia que le queremos nosotros meter sobre el autocuidado que deben tener ellas, y no, no se ha logrado todavía.

From lines 1-3, our source establishes the Given with high evaluation and categorical modality: Public health authorities have already determined what the problems are, so there is no need to re-invent the wheel –whereby he affirms his authority and the validity of his knowledge, and perhaps insinuates his impatience with yet another researcher looking into the very same issues he has been working on for years. From lines 3-6, he refers to structural barriers like limited road access to health centres and poverty. From

lines 9-15, he acknowledges illtreatment and insensitivity from government health staff, a "soft" barrier (not in the eyes of our participants, who frequently raise these issues) that government is addressing through a mix of cultural training, sensitizing, and sanctions. But it is on lines 7-9, and particular from lines 15-29, that our source comes forth with his main concern (the government's main concern, as he uses the deictic "us" to refer to the Health Secretariat). "*Lo que no podemos alcanzar,*" he says on line 15, pointing to a contrast with his previous reference to health personnel (and taking for granted that something has been accomplished in this regard), "*y el problema que tenemos*", which indicates that this is the main concern, "*es la promoción, la educación de la población, que exija la atención*". This links back with his somehow scornful mention of people's culture and use of traditional medicine to treat obstetric complications on lines 7-9 ("*la otra situación son sus costumbres y tradiciones, que un temascal, o hirviendo alguna hierba se van a tratar ellos sus complicaciones obstétricas*") and forward with the rest of the text, where he lays the responsibility squarely on people's shoulders. "*Que nos exija*", "*que nos denuncie*", "*que nos tire las puertas del centro de salud*", he says, echoing the Carnet perinatal and the videofilm, where men and women from the communities are exhorted to take action and set the government maternal health machinery in motion by demanding, denouncing, and knocking down doors at health centres. As I mentioned in chapter 5, this is unlikely to happen. Instead of kicking doors, indigenous people pull away from health services. Pressed from higher levels of government to show results, our source expected people from the communities to put pressure on health services in turn. Both from an ideational and interpersonal perspective, his words ("*que nos exija la atención", "que nos denuncie", "que nos tire las puertas del centro de salud*") connote the existence of a new political, legal, and advocacy framework –the same expressions would have been highly unlikely until about that time- that could help in this effort. But much of this still went unnoticed to most of our participants at the time of fieldwok.

Then, on line 19, our source complains that they are not being successful at these things ("*y ahí es donde todavía no llegamos*"), where the deictic "*ahí*" points back towards the lack of agency of indigenous patients, but most tellingly forward to their lack of self-care and self-esteem: "*...y ahí es donde todavía no llegamos, no impactamos todavía en el*

autocuidado de la persona persona, porque en los indígenas hay la... la autoestima no está, este, alta, no está muy buena...", from lines 19-21). Again, one could interpret these words in cataphorical reference to his demand for indigenous agency facing government health centres, say, as acknowledging that low-esteem is what prevents them from standing up to claim for their rights. But the rest of the text strongly conveys our source's conviction that indigenous people simply do not take good care of themselves (lines 20-21). Moreover, these actions hamper government efforts to protect them and avert maternal deaths and make government people work twice as hard (lines 22-24). On lines 25-29, the speaker explains, with a series of assertive statements, what the reasons *are* for this state of affairs: indigenous language and mores stand in the way of government communication efforts to re-educate indigenous peoples. Moreover, on lines 26-27, our source makes an attribution of intentionality that reveals his frustration: "*dándoles toda esa información que a veces no nos quieren entender, ¿eh?*" Here, what passes for low modalization ("*a veces*") is not really an adverbial phrase to indicate low frequency, as opposed to a general state of affairs where indigenous people would want to understand, but an interpersonal device that must be read together with the negation and the interjection "*¿eh*?" at the end of the clause, as an attempt to level with the interviewer beyond the neutral language or political correctness that would be expected from a government official –like an implicit "off the record" that allows the source to speak his mind. On lines 26-28, he reiterates that indigenous self-esteem, mores, and traditions are the main obstacle he faces in his job ("*ésa es la situación más fuerte que tenemos aquí*"). He finally lays bare the purpose of their re-educational effort with a verb ("*meter*") that speaks of a hypodermical model of communication that would inoculate indigenous women with a biomedical view of self-control: "*Esa importancia que le queremos nosotros meter sobre el autocuidado que deben tener ellas, y no, no se ha logrado todavía*" (lines 28-29). His closing statement offers a glimpse of a major misunderstanding in government safe motherhood discourse and intercultural health communication as practiced in the region: self-care has a strong discursive presence in the community order of discourse, but not all women construe this imperative in the same way, and even when they do, they juggle it with other interpellations, with their embodied experience, and with the material circumstances of their own lives. As it is

widely documented by now, there is a long way between knowledge or awareness and expected behaviour in health communication. Many things happen in between.

As we have seen, some religious leaders share these thoughts. The same traditionalist Catholic source that I quoted as saying that indigenous people are "very special" and "do not pay attention", had more to say on this matter:

Q: Muy bien, ¿podría explicarme que creencia y prácticas ve usted que tiene la gente cuando muere una madre durante el embarazo, durante e parto o poco después de aliviarse?

A: Pues, mira, también hay un punto aquí... El indígena también es un poco supersticioso, y muchas veces cuando muere así una mujer que no pudo dar a luz, luego lo atribuyen a maldades, o si muere la mujer después de dar a luz, lo mismo, ¿verdad? Ellos piensan que porque se disgustaron con mengano o con mengana o por problemas de terrenos, problemas de infidelidades de la mujer porque andaba con su marido, y al rato ella me está haciendo maldad, ella me está haciendo daño, ella me está haciendo brujería, y suceden estas cosas, inmediatamente lo atribuyen... no es que fue maldad de fulana, es que me hicieron daño, es que ya ve está pagando lo que... o sea, esa es la influencia, pero es un poco supersticiosa.

Q: ¿Qué dice usted en estos casos, por ejemplo cuando dicen estas cosas?

A: Bueno, pues, yo siempre he tratado de limpiar un poco esa superstición, y por eso hace rato te hablaba de que ayer llevé a una señora al hospital... porque ellos, incluso eso, cuando la mujer tiene hemorragia, siempre dice: "es que me están haciendo maldad"... sin saber ellos que el problema es de la matriz o del ovario, un quiste o un... no sé como se llaman esas bolitas que se ponen en la matriz, no sé como se llaman, pero hay otros, son como caniquitas pero a veces se van haciendo grandototas y están adentro de la matriz...

Q: Miomas...

A: Miomas, exacto, qué bueno... hay eso, y entonces empiezan a sangrar; pero ellos dicen: "es maldad, es maldad"... Entonces yo evito eso, y gracias al doctor que me ayuda tratamos de evitar eso..."Mejor no, deja eso, no pienses que es maldad, es cosa física y normal... vamos con un doctor"... Entonces así aclaramos y varias personas hemos... yo, por lo menos, varias personas hemos llevado al hospital para

operarlos, pero porque ya está avanzado el cuello de la matriz con cáncer, y son esos problemas, ¿verdad? Pero que... pero eso es, la misma superstición de ellos... hacen cosas que no... por eso queremos limpiar nosotros todo eso. Nosotros no nos dedicamos a decirle: "No, si es maldad", y fomentar más lo que queremos sacar. Queremos quitar esto, pero ten en cuenta que como... como un documental que vi yo de América del Sur de unos indígenas... Decía que estuvieron más de veinticinco o treinta años los médicos, eh.... ¿cómo se llaman esos...?, antropólogos, psicólogos, haciendo estudios para cambiar esa cultura de allá, y que no tengan esas supersticiones. Se murieron todos y la comunidad sigue igual, y la conclusión de ellos es eso, y lo mismo sería mi conclusión... indio nacen, indio viven, indio mueren. Es tan difícil hacer un cambio rápido radical, te digo... yo ya llevo, ya llevo un cuarto de siglo aquí y todavía no podemos erradicar todas estas cosas.

This complex, polyphonic unit of analysis reveals not only the idea that indigenous peoples, and their misguided and superstitious attributions of causality, are a crucial factor in adverse maternal outcomes, but most significantly, that this is an inherent ethnic trait demanding re-education ("*he tratado de limpiar esa superstición*", on line 14; "*queremos quitar esto*", on line 31), a hopeless task according to our source (see his rethorical use of exemplum on lines 14-28 and 31-35; his despairing remarks on lines 36-38; and his crude, damning conclusion: "*indio nacen, indio viven, indio mueren*", on lines 36-37). It also shows how blaming operates at different levels: within the culture, as a means of explaining a breach in the social order of things (lines 6-12), and from outside the culture, in the construal of indigenous beliefs as a hindrance to maternal health. Of particular interest, from a discursive perspective, this excerpt features a hierarchical discursive interaction of knowledge and power, with authoritative and subordinate voices, where biomedical expertise dominates all other components. From lines 4-12, our source brings in indigenous voices and explanations, which he labels superstitious; on lines 14-20, he explains how he has tried to weed out this kind of thought ("*siempre he tratado de limpiar un poco esa superstición*"), by using a higher order of knowledge from medical science and siding with biomedical practitioners ("*y gracias al doctor que me ayuda, tratamos de evitar eso*", on lines 23-25). Most telling is the tone of the conversation and the subordination of the source to the interviewer –in this case, a medical practitioner

himself- from lines 17-22, where he tacitly asks for the right word to frame the woman's ailment in proper clinical terms. When the interviewer makes the clarification – "*miomas*", on line 21-, the religious leader says: "*Miomas, exacto, que bueno... hay eso*", where he interpersonally acknowledges the use of the correct expression and then asserts this is the frequently the case with indigenous women in the community.

The text not only displays the subordination of misguided beliefs to true knowledge (as it happened in the videofilm), but also shows how religion embraces biomedical views, by dismissing spiritual concerns in favour of physiological (material) explanations. This happens twice in the text, first on lines 23-25, where our source quotes from what he frames as standard dialogue with indigenous female parishioners: "*Entonces yo evito eso, y gracias al doctor que me ayuda tratamos de evitar eso..."Mejor no, deja eso, no pienses que es maldad, es cosa física y normal... vamos con un doctor*". This somehow links with the "*Ayúdate que Dios te ayudará*" mandate on the videofilm, insofar as it implies indigenous submission to biomedical care in order to obtain God's favour. Then, on lines 29-30, he makes the explicit admission that he chooses not to encourage spiritual, immaterial –and ultimately superstitious- explanations, though he implicitly observes that he could, or perhaps others in his same position do. In particular, the use of first person plural deictically points to his church, maybe as opposed to other religious affiliations operating in the communtiy: "*Nosotros no nos dedicamos a decirle: 'No, si es maldad', y fomentar más lo que queremos sacar. Queremos quitar esto.*" Equally telling in terms of his agreement with –and subordination to- expert scientific language is the way he rhetorically frames the conclusión of the experts on the TV documentary to support his own thoughts, on lines 35-37: "*y la conclusión de ellos es eso, y lo mismo sería mi conclusión... indio nacen, indio viven, indio mueren.*"

This discursive alliance between religion and science makes all the more sense when we see indigenous culture as a common obstacle, as our traditionalist Catholic source does:

Q: ¿Cómo ve el papel de la familia en todo esto?

A: Pues, el papel de la familia... hay mucha influencia, como te digo, en el area indígena, pues los niños van creciendo, van creciendo en el mismo ambiente; entonces la familia es... bastante, es la influencia, y tú le dices al niño "esto no es", la familia dice "sí, esto es"... "Esto es blanco" y no, dice el papá que es negro, y el niño va creciendo con esta mentalidad. Por eso es tan difícil hacer cambiar al indígena en ciertas... no sólo en esta vida sexual o matrimonial o familiar, sino en otras áreas, como por ejemplo la misma religión, como por ejemplo el noviazgo... No, no se puede, porque la cultura es mucha influencia y la familia está dentro de esta cultura y sigue influenciando a los que vienen.

A different view –with a significant point of convergence- emerged from the conversation that I had in English with a Catholic priest who had been working in Xochis for many years:

Q: You were saying people live by their customs, mostly... When those customs go against the teachings of the church, in those cases, would you raise the point?

P: Well, sure, that's part of evangelization, you know. They proclaim that the gospel is to... bring society, bring the world to Christ. So that which is good... is accepted. It purifies, and that which is bad, that which is bad, against the gospel, in the customs, should eventually be purified. So it's not a question of going to... doing away with customs, per se, but rather a process of purification. Purification of the culture. Evangelization of the culture. And I think, you know, in all cultures there are certain ideas that go against the gospel, against the teachings of Christ. And so, what's the church going to do? The church has to... present the truth, the church isn't gonna say "well, let's compromise on this point, you know... We could, you know, give and take a little bit, you know?" No, that's... that's compromising the truth in the gospel. So... of course, there's things here... that... are accepted as customs, but, you know, we have to present the truth... as we see it. As Christ says that... they view it. For the Church. And so, there is this confrontation, but not a... confrontation in the sense of... of... of...

Q: Open hostility...

P: Hostility, yeah. Or violence, you know...

Q: Is there anything in the realm of what we've been talking about, pregnancy and

childbirth, and the customs of the people here that would go against the teachings of the church, and that you would raise as an issue?

P: Not really. Not really. As far as the customs of pregnancy and childbirth, no. The only thing we raise issue with is when the government promotes artificial contraception. We raise issue with that. We provide courses of... family planning. But, family... natural family planning, the Billings method, which is approved by the Church, and also... actually safer for the health of the mother.

Q: I see...

P: And abortion, too, in that case they're beginning to raise in Mexico City. Approve abortion. The church would, you know, go against that.

Q: As far as... who to go to control, to monitor your pregnancy, take care of your pregnancy, weather to the health center or to the partera or... where to deliver, weather at home, or at the hospital, do you say something in that regard?

P: No, no... no. I've never said anything... about... I only mention the hospital when the hospital comes and they will ask for help in promoting vaccination campaigns, and we, you know, we tell people they should be vaccinated, you know... they are... So... as far as the actual... the... maternal care... we don't... we don't... say any... mentions about that.

Q: OK, I think I've covered most of what I needed to... I don't know if there is anything else that would be significant... that you would probably think: "You know, this could be a factor, if you guys are looking into issues of maternal health, or child survival"...

P: Well, I think that depends, you know... a mother that's... in good health is going to have babies in good health. I mean, there seems to be a... correlation. So, it's important that the mother gets a good diet... And I think a lot of these problems of birth are because women are not... they're not getting a good enough nutrition.

Q: Is that because of the customs, or because of poverty?

P: Poverty. You know, poverty.

This priest from the "iglesia grande" does not apparently engage in a dialogue on maternal health with his parishioners (lines 33-37) and does not seem to get personally involved with women's problems and people's decisions. However, he does speak up against artificial contraception –and therefore, against a government policy that has direct

impact on maternal health, on lines 22-26- and he anticipates that the Church would oppose any legal initiative in favour of abortion (lines 28-29). Moreover, he contradicts government-sponsored family planning policies and the knowledge behind them, by stating that the Billings method is "actually safer for the health of the mother" (line 26). Contrary to the traditionalist minister's stance, this priest does not seem to actively embrace biomedical discourse on maternal health, beyond his support for vaccination campaigns (lines 33-35). He also links malnutrition during pregnancy not with customs but with poverty as a social determinant of health.

The main difference between the two religious leaders, from a discursive perspective, seems to lie in how they perceive the articulations between religious, biomedical, and indigenous views (and their relative power). It is, ultimately, a question of knowledge as power. In effect, the priest says that he would speak against peoples' customs if they went against the teachings of the Church, but he doesn't see anything related to pregnancy and childbirth that would contradict the gospels (line 22).[96] He does see conflicting values in government-led family planning campaigns. However, this does not indicate a defense of the local culture as a whole. In fact, he sees the need for a "purification of the culture" (line 7-8), an "evangelization of the culture" (line 8), as part of what he describes as a universal phenomenon, a larger trend, namely that *"in all cultures there are certain ideas that go against the gospel, against the teachings of the Christ."* (lines 8-9). This is the religious version of the government intercultural health policy; in other words, *"it's not a question of going to... doing away with customs, per se, but rather a process of purification"* (lines 6-7). Put differently, the priest speaks up when he perceives that religious discourse is contradicted from other spheres. In this case, "the Church has to present the truth" (line 10), another unintended but major similarity with government safe motherhood discourse -as we have seen from the construal of the opposition between beliefs and true knowledge in the videofilm.

[96] One such example is the refusal of his parish to marry Amuzgo couples younger than the ecclesiastical age of 18 for men and 16 for women sanctioned by the Catholic Church in Mexico, which he mentions earlier in the interview. He even manifests himself against underage couples living together in the groom's house, which is still quite common among the Amuzgos, as discussed in chapter 1.

Our source makes this position explicit when he says: "The church isn't gonna say "well, let's compromise on this point, you know... We could, you know, give and take a little bit, you know?" No, that's... that's compromising the truth in the gospel" (lines 10-13). Here, the priest echoes the traditionalist minister's argument against sanctioning indigenous "superstitions" ("*Nosotros no nos dedicamos a decirle: 'No, si es maldad', y fomentar más lo que queremos sacar*"), though they both have different motivations and, most significantly from a discursive perspective, their approaches entail very different discursive articulations, with the traditionalist minister subordinating the voice of his church to the voice of medical science and the Catholic priest subordinating science and government to the voice of the Catholic Church.[97] Needless to say, indigenous voices are subordinate in any of these discursive scenarios.

On the other hand, as we have seen in this chapter, most of our indigenous participants are aware of the ethnically bounded nature of certain ailments and the knowledge required to avert these evils or to restore the lost balance. Some, like Carlos above, think this may be linked with material causes, such as lack of proper nutrition and structural poverty among the Amuzgos. Many others use low evaluation when referring to traditional beliefs, not only placing them within the boundaries of the in-group and their culture, but somehow hinting at the existence of competing –and perhaps more truthful- views.[98] Examples where interpersonal meaning qualifies ethnically bounded knowledge in terms of in-group and local beliefs with a relative degree of truthfulness, abound in our dataset. I have already mentioned that Zulema does not consult with traditional healers, because she doesn't know whether they will say truthful things. Talking about people's belief that pregnant women should cover themselves with a red or black cloth when walking outside under a lunar eclipse, Plácida said: "*Es la creencia, yo creo, de la gente, que porque es negro no traspasa la luz de la luna, dicen*". Describing traditional ways to

[97] From these examples, the orthodox minister seems to act as a religious interethnic mediator who is functional to the interests of the dominant Mestizo groups, as described by Coronado Suzán G 2003, p. 204.
[98] It should be noted that our sources take some distance with the truth and validity of what they are saying *in the context of these interviews*. Our participants may be aware that they are talking with someone or *for* someone who may not hold the same views, even when most interviewers were Amuzgo men and women, because they all introduced themselves as working for "doctors" and "the University of Guerrero". This indicates that interpersonal meaning also implied an explicit or implicit distinction between different types of knowledge, beliefs, and experiences.

help the pregnant woman through labour, Plácida mentioned the use of hot baths: *"...y ya se hace uno asiento de agua caliente, porque aquí mucho utilizamos la frialdá, que dicen..."* Here is another example from our interview with Francisco, in Llano del Carmen:

Q: Y de la enfermedad del coraje, ¿cómo se puede enfermar una embarazada?
F: Cuando tiene coraje, cuando discute con otras personas es cuando se enferma; es lo que dice la gente... quién sabe si sea cierto.
[...] Q: ¿Y el recién nacido se puede enfermar de esto también?
F: ¿Quiere decir al feto?
Q: Sí. ¿Cuáles son sus síntomas?
F: Pues, con el feto resulta imposible detectar la enfermedad, a menos que se tenga un aparato que lo detecte. El caso del recién nacido sí se puede ver. La gente comenta sobre eso y mucho más, pero sólo Dios sabe hasta dónde es verdad. Dicen que un recién nacido que comience a llorar sin parar es porque tiene coraje...

On lines 2-3, Francisco lowers the evaluation of what he is saying about coraje: "*Es lo que dice la gente... quién sabe si sea cierto.*" Then, on lines 7-8, he gives credit to biomedical ways of diagnosing a disease in the foetus –"*a menos que se tenga un aparato que lo detecte*". From an ideational perspective, Francisco seems to identify seeing with properly diagnosing a disease, even when he is referring to a cultural syndrome. In effect, his allusion to ultrasound as the only way to access foetal reality is followed, on line 8, by his mention of the newborn: "*El caso del recién nacido sí se puede ver*". Here again he talks about seeing the symptoms in order to diagnose. But even then he takes this knowledge with a grain of salt, on lines 8-9: "*La gente comenta sobre eso y mucho más, pero sólo Dios sabe hasta dónde es verdad*". Later in the interview, talking about the loss of the nahual, Francisco says his wife uses traditional medicine to good effect, but he then takes some distance from this conclusion:

> [...] A esta Cele le sucedió... En una ocasión yo estaba llegando del monte, vi en su pierna una mancha roja, era roja como de una quemazón; con solo tentarlo se sentía el calor intenso en la piel. Yo le dije que fuéramos al hospital y ella misma me dijo que llamara a

> una señora que sabe de medicina tradicional. Mandé a llamar a la señora y cuando ella vio la herida dijo que era por el nahual. Nos dijo que la cura eran las hojas mezcladas; fue por eso que decidimos hacerle la medicina. Con eso se curó. Por eso nosotros creemos en la efectividad de la medicina tradicional. No usamos ninguna crema, pastilla u otra cosa, nada de eso. A la vez, dudo que exista una enfermedad que aparezca de la nada y que solo con esa medicina se cure.

Low evaluation of indigenous beliefs and attribution of power to non-indigenous knowledge is also apparent in Jesús's reflection about what makes a child be born ill or with malformations:

> Cuando un niño nace mal, a veces la gente dice que le ocurre eso a las mujeres embarazadas cuando se muere la luna [**TN**, lunar eclipse]. Pero también decía un señor que era secretario, no sé si lo leyó en los libros o dónde, pero mencionaba que eso pasaba porque los maridos tomaban mucho y cuando lo hacían iban a tener relaciones con sus mujeres.

In this example, Jesús draws from different voices to explain why some children are born with problems, and explicitly states these intertextual references in a verbal clause, somehow keeping a distance with their validity claims ("*dicen*", "*decía*"). However, there is a hierarchy within this tight polyphony. Initially, Jesús refers to traditional, anonymous sources from the community order of discourse ("*dice la gente*"), but he takes additional distance with these sayings by using a circumstancial of time that undermines their universality ("*a veces*"), and then opposing them to an identified authoritative source with higher social status ("*pero decía un señor que era secretario*"), whose claims are in turn validated by what Jesús infers might have been the origin of this knowledge ("*no sé si lo leyó en los libros o dónde*"). At the sociocultural level, this discursive reference lies outside the traditional order of discourse: people with authority can read or get their knowledge from non-traditional sources, but this knowledge can nonetheless feed into commonsense views from a dominant position. The relative validity of in-group truths also suffers in comparison with religious truth, as we can see in the following excerpt from our interview with Elcira:

> [...] La mujer se da cuenta si tiene antojo o coraje tocándole la mano. Si tienen dolores en los pies, en la cabeza, no todas los mismos síntomas. Hay mujeres que dicen que ya tienen dolores del parto como si estuviera a punto de parir, pero no se debe por eso. Tocándole la mano se puede dar cuenta que es por antojo de chivo, de guajolote. Porque el guajolote es medicinal, lo mismo que el chivo. Por eso se sacrifica el chivo para la medicina. Hay quien siente recuperarse después de comer la carne, logra caminar, se detiene el dolor. Nos damos cuenta que la enfermedad se debía por el antojo de la carne de esos animales... es lo que decimos nosotras como indígenas. Puede se antojo de chivo o de guajolote y no otra cosa. Y si es por espanto, se recoge la sombra. Hay veces que sí ayuda. Hay veces que con el levantamiento de la sombra se recupera, porque sólo la mujer sabe lo que se siente. Es lo que nosotras pasamos, pero eso se debe porque la sangre se debilita, por eso se enferma de todas esas enfermedades, el antojo, nahual, coraje, por eso se enferman. Por eso, como dije, a muchas mujeres se les olvida la existencia de Dios. Muchas de nosotras pensamos que con el solo hecho de comer carne de chivo o de guajolote ya nos salvamos, creemos que es la carne lo que nos salva, y no es por eso, sino porque Dios bendice la carne de estos animales. Es lo que yo pienso.

In this text, Elcira undermines three types of beliefs and perceptions. First, she contradicts the embodied knowledge of women who think they are already in labour, when in fact –she asserts- they are in pain because they crave goat or guajolote meat. Then she admits the ethnic boundaries of this knowledge, which includes diagnosis and response efficacy (*"es lo que decimos nosotras como indígenas"*). Finally, and most tellingly in terms of knowledge and power, she attributes the response efficacy –the power of healing- to God's intervention: it is not the meat that cures, but the fact that the meat is blessed. In other words, she re-construes the traditional belief from her culture in terms of religious discourse, very much like some medical practioners re-construe the same beliefs in terms of biomedical knowledge.

6.11. Puerperal and newborn care

Many of the same topics, categories, and discursive implications that we saw in previous sections apply to puerperium and newborn care, and I have already offered some

examples in this regard. I will only focus here on a few issues of particular interest for safe motherhood discourse and related categories.

The Amuzgos have a well-ingrained tradition of care and self-care regarding puerperal women. Women are not expected to work, lift heavy objects, or engage in strenuous physical activity even beyond the *cuarentena*, which is the traditional period of close puerperal and perinatal care. Many of our participants, women and men alike, said recent mothers should be very careful and receive spousal and familial support with household chores for up to three months after childbirth. And though not all of our female participants complied, most were aware of this interdiction and the eventual fallout of doing otherwise ("*Cuando se tiene un problema así, es difícil*", said Narcisa. "*Por eso es importante prevenirlo, porque cuando ya se sufre no se encuentra la medicina fácilmente... La mujer debe cumplir con todo eso, porque si no lo hace no hay cura*"). Postpartum bleeding was by far the most serious and frequently mentioned threat to the health of the mother. Some participants said women should not have sexual relations while recovering from childbirth. All these elements coexist in Eulogia's account:

> **Q**: ¿Cómo debe cuidarse la madre después del parto?
> **E**: No hacer un trabajo pesado, no levantar objetos pesados, porque de lo contrario se puede enfermar, provocar una enfermedad. Las abuelas dicen que tres meses se debe de estar en reposo, pero de mi parte cualquier tipo de trabajo realizo y de todos los hijos que tuve así me acostumbré. Dos meses trabajé en telar de cintura, lavo ropa, hago cualquier tipo de trabajo...
> **Q:** ¿Qué problemas pueden ocurrir después de aliviarte?
> **E**: El sangrado, si sangra y no para, el sangrado es peligroso. También si tiene relaciones sexuales con el marido durante esos días puede causar enfermedad... es lo que dicen las abuelas. Se corre el riesgo de enfermarse de diarrea y ya no hay cura, aunque desaparece por momentos, pero regresa.

Here, too, we see the crucial mediation of personal experience in the woman's construal of her praxis. Eulogia knows the traditional expectation of self-care, but she doesn't heed these voices, because she got used to working after delivering her nine children ("*y de*

todos los hijos que tuve así me acostumbré"). Her deviation from the social norm is worth noting because public health officials and health staff often construe women's reluctance to comply with expected health behaviours as a reaction against biomedical views and practices, or as lack of agency to deviate from familial, community, and cultural expectations. A different picture emerges from our dataset: women try to exercise their autonomy against the background of *both* traditional and biomedical pressures. Their embodied experience plays an important role in this negotiation, both within the narrative of their own circumstances (as is the case with Eulogia) and in the construal of general patterns, normative statements, and ethnic identities (as mentioned in previous sections and as it happens below with Juliana's reference to binding and bathing after childbirth).

When asked what to do in case of bleeding, most participants said women should go to the hospital. For less serious symptoms, people usually opt for a combination of traditional and biomedical resources. Bathing in warm water and drinking cleansing teas are staples of postpartum hygiene. Wrapping or binding the woman's womb is a well-kept custom that people explain in different ways; for some, it is a way of keeping cold air out of the body in this delicate stage of life, a well-documented, widespread concern among indigenous peoples across the Americas, as mentioned in chapter 2. Drinking warm water and not bathing immediately after delivery have the same preventive purpose. In their accounts, some participants link these practices with ethnic awareness and identity, as we see from our interview with Juliana in Llano del Carmen:

Q: ¿Cuándo ya te aliviaste, cómo te cuidas?
J: Sólo tienes que poner atención de cómo estas, para que sanes, tienes que tomar agua tibia, te tienes que amarrar, te tienes que bañar con agua tibia.
Q: ¿Cuánto tiempo tomas agua tibia?
J: Dos meses.
Q: ¿Entonces ahora sólo tomas agua tibia?
J: Sólo agua tibia.
Q: ¿Y te bañas con lo mismo?
J: Sí, con lo mismo.
Q: ¿Dónde te tienes que amarrar la panza?

J: Sí, ahí, con una ropa, así como estuvieron los muertos [*she refers to her ancestors*], la gente que está más grande. Nuestras difuntas abuelas tenían una prenda especial, con eso se amarraban, y es diferente con la gente de ahora... ahora utilizan cualquier prenda, como un pedazo de una enagua que ya se rompió o un pedazo de huipil roto, con eso se amarra la panza.

Q: ¿Por qué se amarra la panza?

J: Pues, la misma persona que te atiende [*she refers to the partera*], ella te dice. Habla la gente que se puede meter un aire frío en la panza, por eso es que ves a algunas personas con la panza grande.

Q: ¿Y ésa es una enfermedad?

J: Sí, ésa es una enfermedad que se hace cuando una mujer no se amarra. Y es diferente a la gente mestiza o la gente que va al centro de salud... ella no se amarra para nada y ahí rápido se baña cuando ya se alivió.

Q: ¿No está bien que se bañe rápido la gente?

J: No, eso no está bien, no está bien, por lo que he escuchado que dice la gente.

Q: ¿Pero por qué no está bien?

J: No está bien porque ¿cómo crees que tú que apenas te aliviaste ya te vas a ir a bañar, si no tienes ninguna medicina en tu cuerpo? Es verdad que algunas personas hacen eso, pero esas personas tienen muchas medicinas en su cuerpo. Pero yo, una persona que se alivió en su casa, a mí no me pusieron medicinas, ninguna...

Experientially, Juliana makes a clear distinction between the sources of two different habits. From lines 11-15, she spontaneously refers to her ancestors and to elderly women to explain how –and implicitly why- she does what she does. Expressions like "*como estuvieron los muertos*", "*como la gente más grande*", and "*como lo hacían nuestros abuelos*" are the most consistent experiential markers of traditional mores across our dataset. In this case, she rhetorically uses a comparison to highlight the differences between now and then and the evolution of this custom (lines 13-15), which also reinforces the idea of its distant origin. From lines 21-23, she asserts the ethnically bounded nature of binding the recent mother, but she also implies that the health centre is the source of another way of doing things, the way of the Mestizos, and also the way of those who go to the health centre ("*Y es diferente a la gente mestiza o la gente que va al centro de salud... ella no se amarra para nada y ahí rápido se baña cuando ya se*

alivió"). In other words, she implicitly construes the health centre as a place where Amuzgos break away from traditional knowledge and practices –the re-educational undertaking discussed in chapter 4 and previously in this chapter.

From an interpersonal perspective, Juliana's text shows an ambivalent evaluation of the traditional knowledge behind these preventive practices. On line 16, the interviewer asks her why she binds her womb after childbirth, trying to get an explanation that would make sense from a clinical point of view (in this case, the interviewer is an Amuzgo medical practitioner). Brought into this logical framework of causes and consequences, Juliana first resorts to expert authority from within the culture: "*Pues, la misma persona que te atiende, ella te dice*" (line 17), then refers to commonsense knowledge (marked by a collective, anonymous Sayer in verbal clauses) to talk about the potential threat: "*Habla la gente que se puede meter un aire frío en la panza, por eso es que ves a algunas personas con la panza grande*" (lines 17-19). In Juliana's intertextual construal of this logical chain, she uses visual evidence (you can see recent mothers with a swollen belly) to validate the authority of the partera and the popular explanation. Interpersonally, it is worth noting how the exchange between Juliana and her interviewer (and between traditional and biomedical views at the experiential level), escalates between lines 24-30. On line 24, the interviewer wants to double check whether a common practice in hospital and health centres –bathing the woman after childbirth- is negatively viewed within the culture ("*¿No está bien que se bañe rápido la gente*?"). On line 25, Juliana uses categorical modality and double negation to stress her belief and its normative foundation ("*No, eso no está bien, no está bien*"), but immediately she seems to take some distance from the validity of those truths by pointing to the collective, anonymous Sayer: "*por lo que he escuchado que dice la gente*". Up to this point, she seems uncertain about the ultimate truth of this knowledge, which can be explained at the level of the register by her positioning vis-à-vis the interviewer (whom she knows is a doctor and therefore will likely think as other doctors). But then things change within the register. On line 26, the interviewer –here, too, asking from a biomedical standpoint- insists in knowing why bathing the woman after childbirth is not right. On lines 27-28, Juliana modifies the tenor of the exchange and directly engages her interlocutor: "*¿Cómo crees tú que apenas te*

aliviaste ya te vas a ir a bañar, si no tienes ninguna medicina en tu cuerpo"?[99] From a discursive perspective, what is remarkable here is not so much the reason she gives –you cannot expose yourself to water, let alone cold water, when you are weakened by delivery and without medicine to help you recover- but the way she expresses her views, confronting the doctor with the incredulity of someone who is talking about a self-evident truth. To a certain extent, her questioning of the interviewer from a traditional point of view mirrors the doctor's inability to find the logic in the traditional norm. Two different logics stare at each other in this conversation, with different evaluations of the validity of their claims. On the one hand, we see the implicit need to find clinical, physiological explanations for the traditional practice, which in turn points to the universal validity of this line of reasoning –or, at least, to the faulty, incomplete logic of a traditional view lacking a biomedical explanation. It is the same dichotomy of true knowledge versus traditional belief that we discussed in chapter 5, without the interpellative framework of a public health campaign. On the other hand, Juliana construes her knowledge as ethnically bounded yet grounded on physiological terms, which also reveals a connection between these two views. On lines 28-29, she admits that people can bathe right after childbirth when they have already been medicated, implicitly admitting the validity of Western medicine for this purpose –we can make this inference through the cohesive reading of lines 21-23 and 28-30. Once again, people's combinations of practices and discourses defy simplification.

Bathing -or not bathing- immediately after childbirth and how to do it properly are linked with a recurrent idea in government safe motherhood discourse, health officials' framing of institutional delivery vs. homebirth, TBA training, and people's own words about puerperal and newborn care: the notion of cleanliness (*limpieza*) and clean delivery (*parto limpio*). Many people, unlike Narcisa above, do not associate hospitals with a cleaner environment and partera-assisted homebirth with a less hygienic procedure. Arcadio, a father of seven from Guadalupe Victoria, said on this point in Spanish:

[99] Here, the use of *tuteo* reflects frequent social deixis between the Amuzgos, something that would unlikely be the case when a Mestizo woman addresses her doctor, as we have seen from the semiotic construal of the interaction in the videofilm. In this case, the interviewer was a young, familiar Amuzgo doctor from a nearby community, which favoured the informal tenor of the conversation.

> [...] Dicen que mucha gente no va al hospital porque en el hospital no... no piensan... Una mujer que van a llevar con su médico... ahí va a andar la mujer embarazada, va a andar paseando, no la van a sentar o acostar en la cama, no, sino que va a caminar... y cuando ella va a... ¿cómo se dice?... empujar, ¿no?... el médico la va a ayudar poquito, poquito se ayuda. Por eso, en su casa es más mejor, porque en su casa está más...como...más limpia, hay más cuidado. Pero en el hospital le dicen que se va a bañar con agua fría, no va a amarrar su...su barriga, nada... pero aquí, cuando una mujer se va aliviar en su casa, por ejemplo, si aquí se va a aliviar, lo mismo aquí van a acostarla, van a taparla con su cobija, le van a amarrar su barriga, le van a dar agua, agua tibia, por unos...dicen por unos dos meses, va a tomar agua tibia, y se va a bañar con agua tibia también.

Arcadio's account is based on a well-established discourse of homebirth and proper puerperal care, which he brings into his answer through rhematic placement of the same anonymous, collective Sayer that points to commonsense knowledge, prevailing views, traditional views, and different types of discourse (not necessarily hegemonic ones). He also construes this discourse by opposing his assertive (and implicitly normative) description of childbirth and puerperal care in the home to his reported characterization of institutional delivery. This type of construal is why government safe motherhood communication glosses over child delivery in hospitals and health centres, focusing on the ability to deal with eventual complications, while avoiding words or images that could arise other types of fears, and using instead semiotic connotations of cleanliness and intimacy.

The idea of continuum of care and self-care is present within the culture, together with its flip side, the notion of continuum of threat, mostly from culturally bounded syndromes, which I have discussed above. The most salient discursive connections on this topic involve the newborn and the relationship between the mother and her child. We can see how these categories interact in our exchange with Elena:

Q: ¿Qué cuidados hay que tener con el recién nacido?

E: Hay que cuidarlo, se debe de cubrirlo bien, de cuidarlo bien, porque puede enfermarse porque se expone al calor en el vientre y al momento de salir se expone al aire frío en los primeros dos o tres días, no se acostumbra, todavía no se acostumbra al aire. Hay que taparlo con ropa de mangas largas o taparlo con sábana.

Q: ¿Le das la primera leche del pecho?

E: Sí, le di y le seguiré dando [*She refers to her first child and the one in her womb*]

Q: ¿Por qué le das?

E: Porque de esta manera puede tener más fuerzas, porque la primera leche es nutritiva y se forma con todos mis alimentos. Tomando la leche estará con más energía, no como la leche en polvo.

Q: ¿Qué problemas puede tener el recién nacido?

E: Es difícil su crecimiento. Porque cuando es bebé su mamá puede tener mucha leche, le sale mucha leche y puede atragantarse. Si no se lo cuida, se puede enfermar de resfriado o de gripe, y es muy difícil cuando es así. Cuando el bebé es tierno y se enferma, no hay medicina para curarlo porque es demasiado tierno.

Q: ¿Qué haces si pasa alguna de estas cosas con tu hijo?

E: Si el bebé sigue amamantándose, se aprieta el pezón para que no salga demasiada leche, porque se puede atragantar, porque es tierno y no tiene una buena respiración y puede chupar mucho. También en el caso del bebé que le da resfriado o tiene gripe, puede bañarse con hojas de limón. Hay muchos remedios indígenas que se le puede hacer el bebé, pero que no sea muy fuerte, porque el bebé tierno se debe de cuidar porque no hay cura para él.

Q: ¿Alguien tiene la culpa si el recién nacido tiene problemas?

E: Sí, como el caso de la mamá... La mujer embarazada sabe que está embarazada y puede buscar medicina para que el bebé se enferme. Entonces no puede crecer bien. O en caso cuando su mamá toma mucha medicina y en eso puede provocar que el bebé nazca enfermo, porque en el embarazo no se debe de tomar muchas medicinas, no se debe de automedicarse, porque hay medicinas fuertes que pueden afectar el bebé. Como cuando le da a la mujer dolor de cabeza, no debe auto medicarse, porque ahí puede provocar la enfermedad del bebé y puede ser por culpa de la madre por no cuidarse con la medicina.

Elena's conception of the newborn as a tender, delicate, defenseless being in need of great care is a key construal across our dataset. She uses high experiential redundancy when referring to the newborn's inherent weakness and the inevitability and severity of the looming threats: "... *puede enfermarse porque se expone al calor en el vientre y al momento de salir se expone al aire frío en los primeros dos o tres días, no se acostumbra, todavía no se acostumbra al aire*" (about the sudden contrast in temperature after childbirth, on lines 2-4); "*es difícil su crecimiento*" (an overall appraisal on line 13, which she expands next); "*porque cuando es bebé su mamá puede tener mucha leche, le sale mucha leche y puede atragantarse,*" (lines 13-14); "*se puede enfermar de resfriado o de gripe, y es muy difícil cuando es así*" (lines 14-15); "*cuando el bebé es tierno y se enferma, no hay medicina para curarlo porque es demasiado tierno*" (lines 15-16); "*porque se puede atragantar, porque es tierno y no tiene una buena respiración y puede chupar mucho*" (lines 19-20); "*pero que no sea muy fuerte, porque el bebé tierno se debe de cuidar porque no hay cura para él*" (lines 22-23). From a health risk perspective, the construal of the newborn as essentially at risk fits nicely with government safe motherhood discourse; however, Elena's heightened perception of the severity of the threat and the lack of efficacy in the available responses are a direct consequence of this construal ("*no hay medicina para curarlo porque es demasiado tierno*") and may go against the expected outcome, that is, seeking biomedical care. This would be compounded by Elena's apparent preference for traditional medicine.

Elena refers to the mother's primary responsibility in caring for the baby in different moments and with different degrees of emphasis. There is a strong, redundant normative statement on line 2 ("*Hay que cuidarlo, se debe de cubrirlo bien, de cuidarlo bien*"), where she does not specifically talks about the mother. We find a similarly generic though more instrumental mandate on lines 4-5 ("*Hay que taparlo con ropa de mangas largas o taparlo con sábana*"). That changes on lines 10-12, where Elena construes breastfeeding in terms of maternal responsibility, by describing breastmilk as a carrier of energy for the child and opposing it to powder milk, a non-carrier of energy ("*tomando la*

leche estará con más energía, no como la leche en polvo").[100] This discursive construal of breastfeeding represents a widely shared view among Amuzgo women. In that regard, Elena's negative appraisal of powder milk also connotes a negative view of mothers who feed it to their newborns, which is more explicit and emphatic in Eulogia's response:

> **Q**: ¿Qué cuidados hay que tener con el recién nacido?
> **E**: Se debe de limpiarlo, cuidarlo, bañarlo, darle de beber, como decimos aquí pura leche, no como hacen otras personas con sus hijos, que le dan leche en polvo.

.

Then, on lines 13-14 and 18-19, Elena spontaneously highlights the risk of choking with the mother's milk and the need for the mother to take preventive measures. From lines 25-32, in response to a direct question about responsibility and blaming, she construes the mother's primary role in self-care, which is in turn framed within a continuum of perinatal threat. In this textual context, she makes a difference between intentionally (lines 25-26, where she refers to the mother's agency in inducing an abortion) and unintentionally (lines 27-32, on the unintended long-term consequences of self-medication) harming the baby. In general, both women and men frame responsibility for the newborn as falling primarily though not solely upon the mother and closely connected with the notions of self-control and self-care.

Reinaldo, a father of several children, who lives in El Santiago and whose wife was pregnant at the time of the interview, also highlighted the breastfeeding connection between the mother and the child, as well as the risks and responsibilities it implies:

> Dicen que al bebé le puede hacer mal cuando ella sale al sol o se expone al calor, ya que el bebé mama los pechos de su mamá y si su mamá va donde está caliente, llega y le da de mamar al bebé, entonces ese bebé se enferma, le duele la panza o le da diarrea, muchas cosas pueden pasar... si es que no tiene cuidado la mamá, también el bebé se

[100] The question about breastfeeding the child with colostrum ("*la primera leche del pecho*", on line 6) was included in the questionnaire following a specific concern of the MNH Project. Some 72% of Amuzgo women in Xochis feed their babies with their first milk. Government health units have an impact on this behaviour: according to the MNH Project 2008 baseline, women who delivered their children in health centres were twice as likely to feed them colostrum. Some of our participants also mentioned the hospital or the health centre as the source behind their explanation of colostrum advantages.

puede enfermar. También si su mamá no tiene cuidado y va donde hay muchas gentes o donde hay un problema [*he refers to tension, violence, or otherwise stressing circumstances*], se puede enfermar de coraje el bebé. Eso es lo peligroso con el bebé.

Reinaldo construes a watchful role for the breastfeeding mother, based on commonsense knowledge from the community -the thematic placement of "*dicen*" points to the source of his knowledge and the categorical modality in the rest of the text indicates that he does not distance himself from these claims. In the last part of his explanation, he also makes the mother responsible in case she exposes the baby to the risk of coraje from social tensions –hence a reluctance to take the baby out of the house until he is strong enough:

Q: ¿A qué edad sacan la boleta del bebé? [*It refers to registering the newborn*]
R: Yo veo que cuando ya pueda ir su mamá, como en 6 semanas; en un mes y medio ya puede ir su mamá adonde se saca su boleta
Q: ¿Por qué no puede ir más pronto?
R: Pues, como decíamos, ella se está cuidando con el bebé y ese bebé está muy chiquito, y eso es más delicado, por eso es que tiene que ir en un tiempo en que ya esté mejor.

From Reinaldo's standpoint, exposing the baby to environmental and social hazards is the greater risk; administrative concerns come far behind in his construal of parental responsibility. Would this all mean that Reinaldo would stand between government health services and immediate postnatal control? It would seem so, judging from his categorical modality in opposing traditional resources to the health centre in the following exchange:

Q: Cuando nace el bebé, ya hay enfermedades que puede tener, como tú mismo dijiste, que se enferman de los ojos o tienen calentura, ¿quién puede curarlo?
R: Pues la misma persona que atiende el parto hace medicina tradicional, con hojas, porque ese niño en un centro de salud no se le puede tratar porque está chiquito... solamente con hojas si es que tiene calentura o tos, o si está enfermo de los ojos. Sólo se usan hojas para que se vaya curando.

Here again, it is better to stay clear of simplifications and dichotomies. Reinaldo may sound like a man from a single world, but he is rather an example of how elements from different worlds transition and combine, as we can see from the following dialogue:

> **Q**: Acerca de las vacunas, ¿tienen que vacunar al bebé?
> **R**: Eso sí pienso que es necesario, porque cuando nace el bebé se le tiene que poner una medicina, una medicina que se pone en su brazo y que le deja una cicatriz; ésa es la medicina que le ponen primero.
> **Q**: Cuando ya pasó que se alivió tu mujer, junto con el bebé, ¿a quien buscas para que vea si todo está bien?
> **R**: Pues tienen que decirle a una persona que sabe curar a las personas, para que vean si no está enferma su mamá o el bebé. Hay personas grandes que hacen estos trabajos y a ellos les puedes decir que vean qué pasa.
> **Q**: Ahora con el centro de salud, ¿van a que vea el doctor si está enfermo el bebé o su mamá?
> **R**: Pues, puede que pueda ir para que vean si no hay algo delicado, pero en el centro de salud en la mayoría de las veces no hay medicinas para el bebé, que está un poco delicado... pero es menos peligroso darle medicina tradicional.

Clearly, the problem would not be vaccinating Reinaldo's child, but conflicts could arise from pressing him or his wife to bring the newborn out of the perceived safety of their home. At the same time, this last unit of analysis offers another glimpse of how people combine traditional and biomedical resources and why. Reinaldo accepts vaccines as preventive medicine (lines 2-4), but he is not so keen about taking his newborns to the health centre when they are sick. There is a cost-benefit evaluation on lines 12-14: yes, health staff can tell if the child has something serious, but most times they do not have medicine available (which he knows from hearsay of previous experience). Traditional medicine is less of a risk considering the low benefit (the low response-efficacy in behavioural terms) of going to the health centre and the high risk involved in prematurely exposing a newborn to the outside world. Biomedically minded cost-benefit assessments would likely leave out a core component of Reinaldo's equation -the need to isolate his delicate, vulnerable newborn- or else they would treat it as faulty reasoning. Maternal

health policies in Mexico would likely frame it as misguided beliefs and obstacles to proper maternal and newborn care.

Here is another take on the same issues –choice of providers and primary responsibility for the newborn- from our interview with Josefina in Xochis Cabecera, where there is easier acces to government health units, including the local hospital:

Q: ¿Qué problemas puede tener el recién nacido?
J: El problema puede ser por descuido de la madre. El lugar donde se descansa debe estar bajo para poder cuidarlo bien y también tener cuidado para que no llore mucho, porque si llora se le puede hinchar el ombligo.
Q: ¿Qué haces si pasa alguna de estas cosas con tu hijo?
J: Si a mí me llega a pasar, lo que haría sería ir con el médico, ir con la enfermera a platicarle, a preguntarle qué debo de hacer con mi hijo. Y también hablar con la partera por si ella sabe qué medicina puedo usar con mi hijo si le llega a pasar.
Q: ¿Alguien tiene la culpa si el recién nacido tiene problemas?
J: Sí, su mamá, porque ella no lo cuida. Si su mamá lo tiene con cuidados, no le pasa nada, porque se requiere de muchos cuidados.

Two things stand out from this unit of analysis: First, Josefina's spontaneous blaming of the mother in case of problems (line 2), in response to the opening question about types of problems with the newborn (not about responsibility and blame, though she later ratifies this view when answering a question which does aim in this direction, on lines 9-11). Then, from lines 6-8, Josefina anticipates her intention to consult with both government health staff (the doctor, the nurse) and the partera if something happened to her newborns. In general, both women and men seemed inclined to use a combination of biomedical and traditional resources with the newborn, though mostly as a response to adverse events than in terms of preventive measure. There also seems to be a more frequent association of newborn care with biomedical resources than it is the case for puerperal care. A few of our participants, both men and women, categorically expressed their preference for hospitals and doctors either for prevention or in case of problems with their newborns, even when some of them opted for a combination of resources or for

traditional providers as a first option to treat puerperal women after childbirth. Here is how Eulogia frames her choice of biomedical care for her newborns:

> **Q**: ¿Qué haces si se enferma tu hijo recién nacido?
> **E**: Busco medicina. Como dicen que amamos a nuestros hijos, voy con el médico para que me dé medicina. El médico revisa y se da cuenta de qué es lo que tiene.

Eulogia construes her choice as a natural extension of her love for their children, or rather, as a reflection of a social construal of motherly love. Notice the thematic placement of the intertextual reference to an anonymous, collective Sayer at the beginning of this assertive-normative statement: "*Como dicen que amamos a nuestros hijos, voy con el médico para que me dé medicina*". We do not know who is saying this, but we can tell this norm about motherly love already has enough logonomic power in the ideological complex of motherhood and maternal health for Eulogia to feel the interpellation. This power emanates precisely from the anonymous and –newly acquired- commonsense nature of this belief -which is also true knowledge from a safe motherhood perspective. This "true" and now commonsense knowledge is built on the inherent, undisputed presupposition that loving one's newborn children implies consulting with the doctor –not self-medicating, not seeing the partera or the traditional healer- whenever they are sick. Although the collective Sayer interpellating Eulogia remains anonymous (hence more powerful), we can hint at the forces that have facilitated this highly normative discursive process.

The social norms, practices, and expectations that I have discussed in this section play alongside an ever-tighter government surveillance policy, whose main guidelines were outlined, in Spanish, by a government health official in Ometepec:

> **Q**: ¿Ustedes hablan con las mujeres acerca del cuidado en la casa, les hablan de traer el niño a la consulta? ¿Qué es lo que le piden a la gente?
> **A**: Sí, es obligación de las mujeres, primero, durante el puerperio, que acudan a los siete días después del nacimiento, que acuda con su niño. Al mismo tiempo que se revisa toda la evolución uterina, todo el proceso de recuperación del embarazo, se le vacuna a su

niño, se le revisa que todo esté bien, principalmente los cuidados del muñón umbilical. Se le recomienda que no automedique, que no le dé cualquier medicamento al recién nacido, y especialmente, pues, que tenga todo el esquema completo de vacunación de ese niño, de acuerdo a su edad

Q: ¿Cuál es el resultado en la práctica? ¿Cómo responden las personas?

A: La respuesta es que el 50% acuden solas, voluntariamente, pero el otro 50% no está acudiendo. De ahí se le está pidiendo al personal de salud que realice visitas domiciliarias para vigilar al binomio madre-hijo, que no tenga ninguna infección, ningún problema, a través de estas visitas domiciliarias. O si no se les manda traer con familiares o con otra persona para que reciba la atención médica, y en vacunación se lleva una buena cobertura. Afortunadamente, responde nuestra población, porque vamos casa por casa vacunando a estos recién nacidos, e inclusive dándole también la oportunidad de detectar algún problema de defecto al nacimiento, como hipotiroidismo congénito [...]

Q: Entonces cuando van... ¿no hay un problema para, la gente no se resiste a vacunarlos?

A: En ocasiones sí, pero es muy bajo el porcentaje de personas renuentes a vacunar [...] y si no hablamos con el comisario, que ese niño no vacunado puede tener consecuencias ahí para toda la población, y las mismas autoridades nos apoyan también.

Q: De modo que ustedes, para vacunar, van al lugar...

A: Casa por casa.

Women feel this mounting pressure, which includes periodic home visits, and policing through community leaders, neighbours, and close relatives. All of this seems to create a new social norm –which articulates with traditional expectations of control and self-care-, a powerful logonomic mechanism at the level of discursive and sociocultural practices, bringing public health discourse and construals of responsibility into the private domain. We can trace the impact of this policy in Juliana's account of how she looks after her newborns:

Q: Me decías que a este bebé [*she has recently given birth and her newborn is in the same room*], una vez que te aliviaste, rápido lo llevaron al centro de salud. ¿Y tú fuiste también?

J: No, yo no fui.

Q: ¿Por qué no?

6 **J**: No, yo no voy, sólo él, y le pusieron dos inyecciones [*vaccines*], y apenas
7 llegaron allá, las enfermeras le pusieron otra inyección en su brazo para que se le
8 haga cicatriz. En esa ocasión lo llevó alguien... En mi caso, jamás faltan mis hijos al
9 centro de salud, tienen todas sus vacunas, y nadie me viene a seguir o me anuncian
10 para que yo lleve al niño. Eso no pasa conmigo, porque yo me apuro con ellos.

Juliana does not go herself to immediate postnatal consultation, but she makes sure to send her newborns. What 50 percent does she belong to (according to the subgroups and percentages used by the Ometepec health official above)? Is she voluntarily compliant? On one hand, Juliana's behaviour somehow supports my previous comment, in the sense that our participants seemed more inclined to link biomedical consultation with newborns than with puerperal women, except perhaps in cases of bleeding. Of course, the fact that Juliana remains at home may also be related to traditional self-care norms for the cuarentena, which would make her more compliant with these rules than with biomedical expectations. Material barriers could also play a role in this case.

But Juliana's words also show the impact of the new social norm concerning newborn care. We can see from lines 8-10 how she feels interpellated and tries to avert social blaming: "... *y nadie me viene a seguir o me anuncian para que yo lleve al niño.*" In a way, we can say that Juliana prevents health problems in her child as much as she prevents social fingerpointing in her direction. It is interesting to see how she construes her own case against a negative social situation (people following-up on you or telling you that you should take your child to the health centre), which has now become part of the ideological complex around motherhood and maternal care. In other words, taking proper care of your newborns now means taking them to the health centre in the first week after birth. It is women's responsibility to do so, and it is women's fault and shame if they do not –regardless of the health outcomes for the child. On line 10, we also see how she frames this compliance in terms of her own agency, here again, implicitly comparing with those who do not comply: "*Eso no pasa conmigo, porque yo me apuro con ellos*". We can see the impact of these policies from a man's perspective in our conversation with Jesús:

Q: Enseguida que nace el bebé, ¿acude al centro de salud o después lo llevan?

J: Antes no era necesario, pero ahora que reciben apoyo deben acudir rápidamente, incluso la partera lleva al bebé para que se enteren de que ya nació.

Q: Entonces, ¿ella va al centro de salud?

J: En ocasiones ella no va, sólo llevan al bebe; pero sí va después.

Jesús compares what used to happen "before" with the current situation. Before, people saw no need for taking the baby to immediate postnatal control. Now, things have changed: they receive "support" (meaning money from Oportunidades) and they must act quickly -to keep this support or to comply with increasingly close surveillance. The partera, a traditional resource, is also part of the enhanced surveillance mechanism. Altogether, social and economic pressure on the woman, government pressure on the parteras, and coopting of community networks, actors, and resources have contributed to create a new social norm and corresponding logonomic mechanisms. In this context, some women seem to make a distinction: the new norm is about their children, not so much about themselves. They can go to the health centre later, but their children cannot wait. This seems to be the negotiation of self-control, both for government health services and recent mothers, when it comes to puerperal care and newborn care.

6.12. Things that cannot be said, things that should not be said

I will now turn my attention to a couple of categories that bear particular interest in terms of maternal and perinatal health communication. From across our dataset, our participants point to a singular trait that makes newborns more vulnerable to all sorts of threats: they cannot express themselves through language. Here is the immediate textual context of this emerging PC from different interviews:

Q: ¿Hay algún peligro para el niño recién nacido?

Carlos: Sí, se puede enfermar porque el bebé no puede decir lo que tiene, sólo chilla.

Q: ¿Por qué crees que ocurren problemas en el parto y con el recién nacido?
Alfredo: Pueden ser varias cosas. El niño no puede decir lo que tiene, la madre debe estar pendiente y llevarlo al hospital

Q: ¿Qué problemas puede tener el recién nacido?
Narcisa: Le puede pasar algo si no lo cuidan bien. Si al momento de levantarlo se hace bruscamente, puede pasar que se le caiga la mollera, porque es delicado, porque es bebé. O si lo dejas donde es duro, o se le deja bruscamente sobre algo, puede pasarle algo, porque sigue estando blando, en el pie o en la cabeza. Si no se lo cuida, se puede enfermar, muchas enfermedades le pueden pasar porque es bebé y no puede decir lo que le pasa y no se le detecta fácilmente lo que tiene, si tiene un dolor, porque no puede hablar.

Francisco: Si se enferma [el recién nacido], se lo lleva al hospital
Q: ¿Es necesario llevarlo al hospital?
F:: Sí, es necesario, porque como es recién nacido es peligroso que se enferme. A diferencia de la persona adulta, que puede expresar lo que tiene al médico, como dolor de cabeza o de estómago, el recién nacido no puede expresarlo; sólo comienza a llorar y no sabemos qué es lo que pueda tener. Sólo si es visible su mal, como una fiebre o diarrea, en esos casos se puede saber lo que tiene.

Q: ¿Qué haces si pasa alguna de estas cosas con tu hijo?
Elcira: Lo llevo inmediatamente al hospital para que lo curen. En el hospital le dan medicinas, o si no con la nota vas a comprarlas.
Q: ¿Alguien tiene la culpa si el recién nacido tiene problemas?
E: Su mamá cuando no busca medicina, porque el bebé no puede decir lo que le pasa.

There is a common threads running through all these units of analysis: the perception and construal of the newborn as devoid of all agency in material and verbal processes. The baby is mostly the behaver in non-volitional, non transactive processes ("*se enferma*", "*se puede enfermar*", "*sólo chilla*", "*sólo comienza a llorar*"); the phenomenon and the goal in processes of maternal care ("*la madre debe estar pendiente y llevarlo al hospital*") and institutional care ("*en el hospital le dan medicinas*"); or the carrier of attributes in

relational processes, which indicate his inherent at-risk status ("*es delicado, es bebé*", "*sigue estando blando*"). Most significantly, from a communicational perspective, he is construed as essentially unable to take part in any kind of verbal processes that would allow him to tell what he is feeling or what his symptoms are ("*no puede hablar*", "*no puede decir lo que le pasa*", "*no puede decir lo que tiene*"). There could be a certain association between this inability of the newborn to communicate verbally and the apparent inclination among many Amuzgos to seek biomedical care for their babies. Some answers seem to give an indication in this regard: "*Sólo comienza a llorar y no sabemos qué es lo que pueda tener*", says Francisco. "*Sólo si es visible su mal, como una fiebre o diarrea, en esos casos se puede saber lo que tiene.*" This may imply that some parents would only consider opting for traditional medicine if they could "visibly" gauge what is going on with their newborn and, therefore, construe the symptoms in terms of traditional knowledge. Since this is not always the case, they become uncertain and seem to consider that seeking biomedical care, under the circumstances, is the safest way to go.

The perception that babies are at higher risk because they are unable to communicate through language matches what government health staff and indigenous patients think about their own communication barriers. As I mentioned in chapter 1, language barriers are a strong deterrent against the use of government health services in Xochis, and no less of a problem when people get there. Not speaking Spanish is considered a risk criterion within government health services. Amuzgo patients, in turn, often shy away from health centres and hospitals because not being able to communicate adds to their stress, as we can see from Carolina's account of her miscarriage:

> **Q**: Ahora que estás embarazada, ¿dónde piensas dar a luz?
> **C**: Yo creo que primero aquí en la casa, a ver si puedo. Luego, veo si será posible ir al hospital. Lo mismo hicimos la vez pasada.. La verdad es que yo tengo miedo de acudir al hospital. Me dicen que la gente del hospital es descuidada, de los médicos... Como te decía, yo no entiendo el español... la vez anterior me tocó acudir, me dieron unos papeles por el embarazo, me dieron una cartilla y en una ocasión me lo pidieron. Después, llegamos al hospital, pero el feto ya había fallecido y nos dijeron que nosotros no prevenimos esa muerte.

Carolina's narration sums up a good deal of what goes wrong when indigenous patients seek institutional care. A combination of hearsay and personal experience makes her afraid of going to the hospital, where she lost her child and was blamed for not preventing that death. It is also worth noting how she links her lack of knowledge of Spanish to her experience with institutional paperwork and the Carnet Perinatal analyzed in chapter 4. She only refers to these documents in terms of being handed over to her and then requested from her ("*me dieron unos papeles por el embarazo, me dieron una cartilla y en una ocasión me lo pidieron*"). She has no active role whatsoever in these processes, and she does not mention reading or comprehending these papers. Her entire narration –her entire interview, in fact- is characterized by this sense of disorientation and inability to understand what was going around her. Francisco, her husband, did not fare much better in terms of communication during the same episode at the Xochis hospital:

> La partera nos había dicho que sólo en el hospital podía curarse, por eso la llevé, y si era posible ahí no había necesidad de llevarla hasta Ometepec. Después nos dijo la señora [*he refers to a female doctor at the Xochis hospital*] que en el hospital no había herramientas para atenderla y que era necesario llevarla a Ometepec. Y en ese momento yo no tenía dinero, sólo llevaba ochocientos pesos. Lo pensé dos veces. Fue en ese momento que ella salió del cuarto, sólo le apretó el vientre a mi esposa y nos dijo que el feto estaba en una mala posición. Inmediatamente comenzó a llenar un papel y me dijo que lo firmara. Yo me rehusé a firmarlo; le exigí que me explicara antes de qué se trataba, porque aunque pocas pero entendía algunas palabras y lo que no podía entender sabía que la culpa no era de ella sino mía, porque no entiendo el español [...] Pensé que podría estar escrito que ella ya había cumplido con su trabajo, o ¿en qué nos ayudaría a nosotros con la firma? Eso fue lo que le pregunté, por eso ella se molestó conmigo. Sólo porque le pedí explicaciones. Porque yo tenía la impresión de que en la hoja decía que había cumplido con su obligación, lo que era falso porque no hizo absolutamente nada. Después ella me dijo "señor, entienda, esta hoja a mi no me ayudará en nada, sino a usted", y que ella me diría adónde dirigirme en Ometepec, porque yo le dije que no tenía dinero. Me respondió que no tenía por qué decirlo ahí en aquel momento, sino que estando allá le dijera a los médicos, y que si en realidad quería a mi esposa tenía que llevarla inmediatamente, de lo contrario ella podía fallecer, por eso yo accedí a firmar.

Francisco's narration of his interaction with hospital staff presents a situation far removed from the idealized picture on the video film. Illtreatment, anger, frustration, and mistrust dominate the exchange, which concludes with a coercive interpellation. Blaming and fear in highly stressing circumstances lead Francisco to sign a form whose content he does not understand. The language barrier plays a key role here –though it is not the only factor in the confrontation. Nevertheless, it is Francisco's construal of this barrier that stands out from a discursive perspective. He never points to the doctor's inability to speak Amuzgo as a problem: it is his lack of knowledge of Spanish that creates the barrier, and he blames himself for it ("*y lo que no podía entender sabía que la culpa no era de ella sino mia, porque no entiendo el español*"). The critical imbalance in the exchange between the doctor and Francisco is also connected to the imbalance between the two languages: Francisco and Carolina's fate, the doctor's responsibility, and the eventual repercussions of the entire situation were being decided within the domain of the Spanish language. The Amuzgo language -this "dialect", in the words of many health officials and clinical practitioners- did not count at all. Francisco knew it, he felt the disadvantage, and he perceived it was his fault. No wonder he would mention his newborn's inability to communicaty as a threat. He himself felt as a child in the context of the Spanish-dominated government health system. Many among government health officials and health staff treat and construe their illiterate Amuzgo patients as at-risk ("*casi todas son de alto riesgo; son indígenas, no saben leer escribir*", said a clinical practitioner at a government health unit in Xochis) rebellious children in need of paternalistic care, as we have seen in chapter 4, as it also emerges from the videofilm in chapter 5, and as Roque's mention of hospital staff telling their patients they have "*inyecciones para el coraje*" confirms on this chapter.

I will finally focus on the construal of what is –or should be- public or private in relation with maternal and perinatal care, from the perspective of our participants. I have already discussed in chapters 4 and 5 how government safe motherhood communication construes a relation of opposition-articulation between private and public spaces, coupled with related polarities (safety versus danger) and complementary dualities (control and

self-control). On the videofilm, the private space of the home is linked with danger when not subject to close surveillance efforts involving control and self-control. On one version of the Carnet Perinatal, the public space of the hospital is construed as allowing for the close, intimate connection between the mother and the baby that is typical of the private sphere. Both communication products convey the idea of clean hospital environments, implicitly opposed to lack of hygiene in home childbirth. On this chapter, women and men have different takes on these views and discourses: some feel safer and enabled at home, others have less fear when they know a c-section is at hand in case of complications. Some, like Narcisa, think that institutional care and delivery are healthier and cleaner than homebirth, and a sure way to avert risk. Others see the home as the site of proper puerperal and newborn care, including bathing the mother and the baby with warm water or, as Juliana puts it, not bathing immediately after childbirth.

But what about the idea that pregnancy, childbirth and perinatal care should be drawn out of the private sphere of the home and the married couple, where they dwelled until recently? Here, too, we find a complex, variegated set of discourses, which are typical of changing, transitional ideological landscapes. On the one hand, people seem to draw a line around sexuality and related issues that should not be crossed lightly; for some, at least, these things are not meant to be talked about in the open with someone who is not from the core family, and some types of social actors are not supposed to deal with these issues. I have already quoted a traditionalist Catholic priest from Xochis on this point:

> [...] Aunque un sacerdote, para la cultura indígena, un sacerdote hablar de sexualidad para ellos es negativo, para el indígena, ¿eh?... pero nosotros tenemos que pedirles perdón antes y decirles quiero que me perdonen, pero yo tengo que hablar de esto aquí, y discúlpenme pero es necesario hacerlo.

The minister construes his actions as the result of a moral imperative that justifies breaking what he perceives as a cultural taboo: a priest openly talking about sexuality. And he unveils his rhetorical strategy when addressing his parishioners, which includes an initial disclaimer: he apologizes for talking about something they do not expect him to

talk (implicitly alluding to the social norm), but he must do it because it is necessary. It is the weight of the issue itself –teenage prostitution and greater incidence of HIV/AIDS in the community- that makes him take this step and trespass this social norm. Equally or more revealing is the following exchange between a male Amuzgo interviewer and Horacio, at the beginning of their conversation:

> **Q**: Antes que nada, una disculpa por tratar estos temas que desean saber los médicos... Lo primero que deseo hablar contigo es sobre el embarazo. ¿Tú como hombre crees que es necesario que la mujer se cuide cuando está embarazada? ¿Cuál es tu opinión?
> **H:** Creo que este tema es necesario hablarlo. Antes que nada, Dios debe disculparnos al hablar de esto [...]

Here, there is no indirect reference to a perceived social norm and how an outsider should go about it; in this unit of analysis, the norm is played out and dealth with by the Amuzgos themselves, in a real-life exchange. The register of this brief interaction gives us plenty of insight. Both speakers use the same type of disclaimer that is part of the priest's rhetorical approach. From an interpersonal standpoint, the interviewer emphasizes the essential, indispensable nature of the disclaimer for this conversation to take place, by thematically anchoring his first question with the expression "*antes que nada*" and immediately apologizing for bringing up "these issues" with the participant. In doing this, the interviewer acknowledges the cultural taboo and brings it to life. The fact that he brings it up during a one-on-one chat with a 63-year old man tells us two things: first, that this is a well-established, traditional norm; but also that it is not only the priest who is not supposed to talk openly about these things (*estos temas*). These things belong in the private realm of the spouses and their immediate families, and the interviewer acknowledges that he is going to draw them out of there, into the "semi-public" sphere of the interview. How does he get away with it? He justifies going against this norm by using an external though authoritative source of curiosity: "*estos temas que desean saber los médicos*". In turn, this tells us, first, that breaking the norm and talking about these things *for authoritative outsiders* may be better than breaking it from within the culture. Conversely, we can infer that using the doctors to enable this dialogue *turns them into authoritative outsiders*. In other words, there is a fundamental presupposition operating

here: that the doctors have the right to ask and to know, because they can contribute solutions to the community. In a way, this implies that medical authority and medical knowledge are a given in this exchange and –by extension- in the community. Finally, it is also worth noting that the explicit, *generic framing* of the conversation *as an interview* -on behalf of an external, authoritative source- may have an impact in terms of the register, insofar as the participants, like Horacio, may not feel they are having a casual, everyday chat about private issues.

Horacio's opening statement contains elements that we have seen in both the priest's and the interviewer's words. He first acknowledges the relevance of the issue (in this case, improving maternal and perinatal health) as good enough reason to bring "these things" into the open. Then, he repeats the thematic anchoring of "*antes que nada*", and follows it with a request for God to grant forgiveness for talking about "*this*". Ideationally, both the interviewer and Horacio know what they are talking about when they deictically and elliptically refer to "these topics", "these things", and "this". On the surface, the interviewer has already said they will talk about pregnancy and maternal health; but what both speakers really apologize for is what reveals the underlying field of their conversation: the essentially intimate and ultimately private nature of the things they will have to say in order to talk about pregnancy and maternal health. Interpersonally, asking for God's forgiveness tells us how far against a "natural" norm the two speakers are going to go. In sum, it is a combination of external factors and higher powers (the weight of the issue as seen by an external, authoritative source of curiosity, the potential community benefit of opening up about these things, and the possibility of God's forgiveness) that warrants drawing into the "semi-public" something that belongs in the private domain.

This seemingly paradoxical ability of an external reference –by external I mean from outside the in-group and even from outside the community- to help pull essentially private matters into the semi-public domain can also be traced in Marcelina's words to explain why she does not consult with a partera during her pregnancy:

1 **Q**: ¿Vas a ver a la partera cuando estás embarazada?
2 **M**: Sí, antes iba, pero ahora ya no voy, porque ya no sé quién es buena para eso.
3 **Q**: ¿Aquí no hay parteras?
4 **M**: Sí, pero no le tengo confianza, porque ella le platica a toda la gente lo que ve en
5 el parto.
6 **Q**: ¿Por eso tú no acudes con la partera?
7 **M**: Por eso no voy con la partera. Prefiero ir al hospital y allá los médicos sabrán si
8 se lo dirán a otros médicos o no, pero ya dependería de ellos.

The person that Marcelina trusted was no longer available and she was not seeking assistance from another partera because she did not know who was "good for that" (line 2). On lines 4-5, we find out what she meant by "good for that"; she now makes it clear that she is not concerned about technical skills, but that she does not trust the partera from her own community to respect the essential confidentiality that Marcelina expects from their relationship[101] -which confirms that people's construal of professional trust and skilled care exceed technical considerations for *both* biomedical and traditional care. But the most telling part of the exchange comes towards the end. On line 6, the interviewer wants to confirm that this is the reason why she does not see the partera. On lines 6-8, Marcelina ratifies and then elaborates on her explanation: she prefers going to the hospital, where the doctors can decide whether they will tell what happened to other doctors, but "it would be up to them to do it" ("*pero ya dependería de ellos hacerlo*"). One possible interpretation is that Marcelina frames her expectations of what is and should be private in terms of two different worlds, with different codes and implications. The intimate, private nature of her pregnancy, labour, and delivery are not into question. But she frames them as opposed to the semi-public sphere of her community, not to the outside world of the hospital and the Mestizo doctors. We can also try to see Marcelina's choice in terms of a cost-benefit equation: if she had to surrender her privacy, she would rather do it somewhere else, where "somewhere else" implies physical, ethnic, and

[101] From the MNH Project 2008 baseline and subsequent work in the communities, it becomes clear that many women consult with parteras from outside their own communities. Some parteras visit the home of their patients; others would rather their clients come to see them. The MNH Project construction of *casas de parteras* (physical facilities initially conceived for traditional midwifery apprenticeship, but also used as parteras' consultation units) in three communities may accentuate this latter trend in some areas of Xochis.

sociocultural distance. These people, these doctors, they are not from her world and therefore she does not feel bounded by the same codes. Such interpretation would once again warn us against a single-note reading of women's concerns regarding their choice of providers. True, there is still enough evidence to contend that many women would rather not go to hospitals and not expose themselves in front of male Mestizo doctors. But women's construal of trust and skilled care defies simplification along the lines of purely traditional versus purely biomedical preferences.

Our participants, both women and men, were of different minds when we asked them whether it was good or bad when people from outside the family knew that a woman was pregnant. Some said it was a good thing, because they could be told how to look after themselves or they could be helped if needed. Others said it was nobody's business outside of the household. And yet others said people would know anyway. Some, like Elcira, hinted at the nature of social pressures and colliding discourses converging on their pregancies:

> **Q**: ¿Está bien o está mal que fuera de la familia sepan que estás embarazada?
> **E**: Eso una lo escucha... que te digan "oye, tú ya estás de nuevo embarazada, ya tienes tres o cuatro hijos"... Las personas pueden hablar mal de una, dirán "esa mujer ya está de nuevo embarazada". Hay a quien le molesta aunque no es familiar de una. Pero también hay quienes sí son familiares, te preguntan por qué se sigue embarazando si ya se tienen los hijos. Pero, ¿qué puede hacer la mujer si Dios ya lo dispuso así? Porque a la mujer ya la dispuso Dios para procrear... hasta se puede perder la vida, después de dos, hasta diez hijos, el tiempo detiene la fertilidad y no la medicina.
> **Q**: Pero, ¿cómo lo ves? ¿Está bien o está mal que fuera de la familia sepan que estás embarazada?
> **E**: No está bien. Ellos no saben cómo se vive en la casa, porque esa persona no te da dinero para el gasto... Los días pasan, tú sabes cómo irá viviendo, cómo irá creciendo... tú sabes cómo vives con él diariamente... así es como vivo yo.
> **Q**: ¿Por qué no está bien que otras personas sepan que estás embarazada?
> **E**: Porque es responsabilidad de cada quien... tú tienes la obligación de criarlo.

Elcira, a mother of seven, feels the interpellation of a non-traditional discourse on motherhood, both from within and outside her family (lines 2-6). It is not hard to see the imprint of family planning voices making their way into the community from different sources, such as NGOs, government programs, and religious institutions, as as we saw from our interview with a Catholic priest in Xochis. Elcira brings these voices from her own experience very vividly into her answer, and confronts them with a strongly normative discourse of a woman's inherent, God-sanctioned duty to bear children, despite all the risks and uncertainties, until time, not medicine, says it is enough (lines 6-8). By spontaneously answering the first question in this manner, Elcira draws a clear line between what ought to be public, semi-public, and private, precisely because she knows that the public and semi-public spheres can exert great pressure on her. On lines 9-10 and then 14, the interviewer insists twice with the same question (evidently, she feels it has not been answered), and Elcira once again draws a thick line to shelter her own private life, by stressing what outsiders do not know ("*no saben cómo se vive en la casa*") or do not do ("*esa persona no te da dinero para el gasto*") that would entitle them to have a say in her life, and also construing the daily experience of being a mother to her children as the only source of authoritative knowledge facing the hostile discourse that points both familial and non-familial fingers in her direction.

At the same time, a vast majority of women and men from the communities said they favoured setting up groups of pregnant women whose members would support one another and discuss common concerns, as well as home visits from health centres to follow up on the mother and the child after birth.[102] Both initiatives undermine the isolation of maternal and perinatal care within the private sphere. Participants in groups of pregnant women would bring their embodied knowledge -and eventually their familial and spousal issues- into a semi-public space within the community.[103] Home visits from

[102] Around 90% of men and elderly women surveyed for the MNH Project 2008 baseline said it was a good idea to have support groups of pregnant women and postnatal home visits from health staff. A similar percentage thought people in their communities would agree to these initiatives. Men and women in gender-stratified focus groups were almost unanimously for such proposals.

[103] As we have seen in this chapter, many people value women's embodied experience as a source of authoritative maternal knowledge. This holds in relation to pregnant women's groups. When we asked Alfredo why he thought these groups were a good idea, he said: *"Porque entre ellas pueden intercambiar experiencias, vivencias del embarazo; porque ellas saben más sobre eso."*

government health staff would bring the public sphere of government into the private domain, tightening the logonomic grip of control and self-control. All of which reveals that people favour an articulation of control and self-control that would bring issues traditionally kept within the private sphere further into the semi-public and public domain. Data on this chapter suggests that these trends are still counterbalanced by restrictive social norms from within the culture and the community –although these norms would mostly apply to certain roles and circumstances. It also suggests a fluid state of affairs, marked by a dislocation of what used to be strictly private and the rearrangement of the public, semi-public, and private domains around maternal and perinatal care.

6.13. Conclusions

In this chapter, I have explored how indigenous women and men use key dimensions of government safe motherhood discourse, as well as elements from different orders of discourse (e.g., family, community, religion, traditional health care) to make meaning in relation to pregnancy, childbirth, and puerperal and newborn care. I have also analyzed selected segments from interviews with other stakeholders, such as government health officials, government health staff, and religious leaders, to stress certain discursive influences and articulations, and to fill out the overall discursive picture that feeds into the ideological complex of maternal health and motherhood.

The notion of maternal risks, threats and dangers, is very much present among the Amuzgos, though few see maternal and perinatal health as major public health problems in their communities –I will discuss this apparent paradox in the concluding chapter. Construals of pregnancy risks include but also exceed biomedical views. Our participants were particularly concerned with the position of the baby inside the maternal womb, with cultural syndromes, miscarriage and abortion, and female lack of strength during labour and delivery. Our data shows that most women and men construe pregnancy as a debilitating, constraining state that exposes the mother and the child to physical and ritual

threats. For many of our participants, pregnancy *entails* danger, particularly in relation with childbirth.

All of this undermines the idea that indigenous peoples do not follow biomedical advice because of an inherent, cultural unawareness or disregard of maternal risks, which is often voiced by government officials and government health staff, as in the following example from a doctor at the Ometepec hospital, who said in Spanish:

> Cuando hablo de cultura me refiero a que la gente desconoce o ignora que por un embarazo se puede morir. Dicen: "no, pues, es un embarazo, a un embarazo no le pasa nada", y están acostumbradas a que su parto lo atiende una partera en su casa, con todos los riesgos que se puede llevar; desde un problema con la mamá hasta un problema con el bebé. No tienen el conocimiento o si lo tienen, el hábito de querer o tener la necesidad de buscar atención hospitalaria.

The last part of the doctor's statement is more in keeping with our data. People perceive the risks, but that does not necessarily mean they will seek biomedical care only, or that they will feel safer having their children in hospitals or health centres. It doesn't mean the opposite, either. Habits do play a role in this regard, but they cut both ways: some women do not want to deliver at home because they have gotten used to hospital settings. All of which shows that people make room for new practices within long-established cultural molds, and also confirms that living in a traditional ethnic environment does not entail adopting all the cultural mores. Furthermore, most of the men we interviewed did not think these new practices can endanger the Amuzgo culture.

However, awareness of pregnancy risks does not entail biomedical knowledge. Many biomedical alarm signs were frequently seen as common ailments. And while some participants spontaneously referred to risk factors and at-risk groups in ways that resemble the logical thinking of modern epidemiology -which may have an impact on people's views and health behaviours, e.g. older women feel they have higher maternal risk and therefore need closer medical control-, their definition of these problems and preventive measures often differed from biomedical concerns.

Most people use both traditional and biomedical resources, and they trust –or question- authoritative figures from both worlds, drawing from different discourses and explanatory models. However, they make coherent construals of these choices. One such case is the position of the baby in the womb, a severe and *ever-present* threat for the mother and the child, who are framed as members of at-risk groups requiring periodic prenatal control –often from doctors and parteras alike. This control should aim at assessing the position of the baby and, contrary to biomedical criteria, reposition as needed. Doctors and nurses can tell whether the baby is in the right position –sometimes aided by ultrasound imagery-, but *knowledge for repositioning is off limits for health staff*. This is something that only parteras can do. Doctors do not do it, and, equally important from a discursive perspective, *they do not know how to do it* –someone goes as far as saying that they don't know *because* they can perform c-sections. There is much logic in this exclusion, since clinical practitioners only consider breech position as an eventual obstetric complication and most of them discourage external version from parteras. On the other hand, Amuzgo women construe the repositioning of the baby in terms of restoring a natural balance in the relationship between the mother and the child in her womb. They also frame this practice in terms of childbirth prevention and readiness –something that holds for prenatal control as a whole-, as a means of preventing c-sections and vaginal cuts, and as a solution for pregnancy ailments such as swollen feet, lower abdominal pain and leg pain –in other words, *as an essential component of a preventive and restorative approach to maternal health.* They seek the parteras to do it not only because they have the technical expertise, but also because they share a common view and they can connect with the woman's anxieties and fears.

Many women perceive that being weak –or weakened- is a risk factor and a threat facing pregnancy and childbirth. Men seem to agree: weak women are at greater risk of taking ill or having complications during pregnancy and childbirth. Their children, too, are at greater risk. Women can be weakened by several factors, like weak blood, antojos, coraje, or untimely pushing in labour. There is also a certain connotation of blaming in this view, like an "original sin" that makes some women inherently weaker than others.

And there are discursive marks of a generational divide around this category: older women were stronger, tougher, more resilient and more agentive than younger women.

Our participants describe childbirth as a perilous event. The uncertainties surrounding delivery are frequently mentioned as the most serious threats to pregnancy. Not being able to push in labour is a common fear that women construe as weakness and lack of autonomy. On the other hand, being strong, knowing how to push, being able to do it, and successfully delivering a child are perceived as signs of female agency and success. This ability –this agency- will contribute to a safe delivery, no matter where it takes place. Delivering without assistance from doctors or parteras can also be linked with a woman´s sense of agency, something that goes against the grain of government safe motherhood discourse, where agency tends to be portrayed as the ability to comply with biomedical expectations, irrespective of social norms and traditional beliefs.

In women's accounts of their experiences, anxieties, and expectations, not being able to push is linked with a host of variables, such as big babies, unskilled parteras, disabling positions for labour and delivery, having had many children, and not knowing how to push. Fear is also related to these categories and discursive connections. To some participants, being afraid cripples the woman facing delivery; in other words, it implies a loss of agency. Many women fear hospitals and feel stronger in their homes, while others feel safer with doctors and technology at hand; some even take for granted the favourable outcome of institutional delivery both for the mother and her child, a key trait of safe motherhood discourse. All of them perceive that being able to choose the circumstances of delivery gives them more strength. As it has been widely reported by researchers all over the world, our data shows a direct association between homebirth, assisted or not, and structural barriers -lack of money being the most frequent concern. To some of our participants, when there is no money, there is no choice.

People draw from different discourses –sometimes the same types of discourses, such as fate, religion, and responsibility- to support their decisions. In this sense, we could say that these discourses contribute to shape people's choices, as much as people reshape

these discourses and align them with their own behaviours and intentions. Personal biographies and embodied knowledge (people's construal of their own embodied experiences) have a powerful impact on the way people make meaning about maternal and perinatal health. For many women, their embodied knowledge is equally or more important than expert knowledge from doctors or parteras. Some feel this knowledge is absent in biomedical doctors, and denied or contradicted in hospitals and health centres. Not knowing, not understanding, implies a fundamental lack of empathy that makes institutional delivery so difficult for them. Even comparisons with private practitioners hurt government health services; we have seen how Elena frames her choice of provider by defining quality care in terms of empathy and cultural awareness from her private doctor, which she rhetorically opposes to a negative image of government health care.

In particular, people use personal biographies and embodied knowledge to make generalizations based on what has happened to them. As mentioned in chapter 3, narrations of critical incidents are very insightful in this regard. Some participants turn their own personal experience –e.g., *me descuidé-* into an instance of a pre-existing discourse of self-care: *hay mujeres que no se cuidan.* Others draw from their personal biographies to reshape and reject construals of expert advice and skilled care, and attributions of responsibility and blame in government safe motherhood discourse; in some cases, they turn the very same notions of responsibility and blaming against the government or government health staff for not living up to their commitments and obligations. People also draw heavily from notions of fate and religion, and even from local political discourses of indigenous resistance.

Contrary to what may be concluded from a narrow biomedical perspective, these are coherent construals that blend people's experiences and multiple discourses in an intercultural context with competing authority claims. These meaning-making resources can either strengthen or undermine government safe motherhood discourse. For instance, the strong discursive connection between prenatal control and safe outcomes in government safe motherhood discourse –including the construal of medical technology as the ultimate source of truth and institutional services as the sole providers of expert,

skilled care- may suffer greatly from contradicting accounts in people's personal biographies. This may happen as people draw generalizations out of their own experiencies and share them socially, feeding into pre-existing discourses that impact negatively on biomedical care.

Of course, the opposite also happens, since many participants draw from personal biographies, embodied knowledge, and traditional orders of discourse to shore up biomedical views and practices. For instance, some draw a positive connection between biomedical care, God's intervention, and human agency from pregnant women and their spouses, very much like the video film does ("*ayúdate que Dios te ayudará*"). This only goes to show the fluid and transitional state of the ideological complex, where traditional and religious discourses can be harnessed for different purposes and combined to divergent effects. Safe motherhood discourse, a newcomer inching its way towards hegemony, can co-opt but not entirely dominate pre-established discourses –let alone the way people will use them to make meaning in their lives.

Our participants framed ethnically bounded syndromes as feared risk factors and frequent complications for maternal and perinatal health among the Amuzgos. Moreover, our Amuzgo sources construed this boundedness *as part of their own ethnic identity.* At the same time, these syndromes imply a close holistic connection between the pregnant woman and her child, and between the two of them and the familial and social environment and the material circumstances of their lives. Women who suffer from cultural syndromes are at higher risk of adverse outcomes and so are their children.

In the same way that both same motherhood discourse and traditional discourses lay out a continuum of care, people view cultural syndromes as a *continuum of threat* for the mother and the child, from before conception to the cuarentena. Moreover, the consequences of these cultural syndromes carry over from one stage of motherhood to the other. A mother who loses her nahual before being pregnant is at higher risk for pregnancy complicatons, and an unfulfilled antojo can affect the child at birth. This ever-looming threat entails a *continuum of responsibility* from the mother to the child, even

from before conception. The child in the womb may have a personality and a will, but he is also defenseless and dependent on his mother's choices and behaviours. Therefore, self-care implies not exposing the unborn child to stressing circumstances and environmental threats. Whether she is the actor or the goal in material processes, whether she is the senser or the phenomenon in mental processes, whether she is to blame or not for negative emotions affecting herself and her unborn, it doesn't make much of a difference in the end: she is always framed as being somehow responsible is a causal chain of events with a negative impact on the newborn health.

To be sure, it is not only the mother who must look after the newborn. Most participants draw from and contribute to a discourse of individual and social responsibility concerning maternal and perinatal health. In fact, the traditional order of discourse seems to be more emphatic than safe motherhood discourse when it comes to the holistic connection between the mother, the child, and the environment they live in.

Cultural and biomedical syndromes belong in the same field of maternal and perinatal health, but they do not mix well, because they come from different worldviews, with their own experts, diagnostic devices, explanatory systems, treatments, supportive discoursive devices, and logonomic rules. This poses a challenge for government safe motherhood policies and government health staff, insofar as many indigenous people seem to look for responses within the traditional order of discourse before they move into the biomedical realm, sometimes contributing to dangerous delays in seeking timely biomedical care. Government health personnel occasionally try to co-opt and reinterpret ethnically bounded syndromes from a biomedical perspective; but experiential meaning from the traditional order of discourse exceeds biomedical readings and proves elusive to "domesticate" and subsume within the biomedical order of discourse. These attempts also betray an underlying view of indigenous people as children who need to be reeducated into a different worldview.

There is abundant evidence that people move between two worlds –provided that we can talk about two worlds *at all*-, using resources from the different health systems and

making meaning though an articulation of semantic elements from different orders of discourse. This happens both with more traditionally grounded participants and with those who seem to be leaning towards a biomedical view of things. Examples abound in our dataset. Eulogia, for instance, goes to the health centre and follows their advice regarding prenatal care and newborn care; she consults with the doctor about the position of the baby and she values ultrasound imagery as a truthful source of knowledge on this point. But she also consults with traditional healers, uses traditional medicines,and seeks the partera to reposition the baby and give birth at home. "*En casa, le hago caso a ella*", she says, drawing a line between two different domains of knowledge and power. Catalina, too, seeks medical advice, complies with prenatal control, has a strong biomedical discourse in this respect, and says she would go to the hospital if she had problems with her newborns; but she acknowledges cultural syndromes, seeks traditionally sanctioned expert advice, consults with the partera about the position of the baby in her womb, and delivers her children at home.

One frequent set of combinations involves going for prenatal control in order to prevent complications during childbirth, delivering at home, and seeking institutional help in case of emergency. This goes against government safe motherhood discourse and global safe motherhood trends, as well as prevailing views among government health services, all of which frame institutional delivery as the only way to avert risk. However, this combination seems perfectly coherent from the perspective of our participants, because they tend to construe prenatal control as somehow *leading to* safe delivery, regardless of where childbirth takes place. This construal –a critical example of interethnic appropriation and refunctionalization of practices and meanings in the context of maternal health- may be having an impact on people's decision to deliver at home even when most of them see childbirth as a perilous event.

There seems to be great variation concerning people's specific combinations of practices and discourses, and further research would be needed to make valid generalizations beyond this point. What we can conclude from our data is that we should not attempt to make value judgments about the coherence of these choices from a biomedical

perspective only. If anything, our data confirms that coherence is a property of interpretation, as Fairclough contends. There is a good degree of coherence in people's discursive combinations when we take into account all three levels of any discursive event, and when consider what they say in the cross-sectional context of all interviews. By and large, women and men in the communities juggle competing views and influences, which often constrain their decisions but also create opportunities for change.

Though they are not the focus of this thesis, we can say that parteras, too, learn to move back and forth between these worldviews. Clinical practitioners, on the other hand, see these interactions as an obstacle to maternal health, though some tolerate them and even encourage them, in a negotiation of knowledge and power, as long as other actors submit to their control. There are no serious attempts –no epidemiological studies, no clinical trials- to understand key TBA practices, like re-positioning the baby in the womb, but there is an active, systematic policy to discourage them. Health authorities attempt to construe a subordinate subject position for parteras –that of students who must get rid of harmful habits-, undercutting their status as experienced practitioners. This also shows the mindset behind the definition of "skilled care" and the role of TBAs in global safe motherhood guidelines.

As is the case with government safe motherhood discourse, imperatives of control and self-control feature prominently in people's words, usually linked with notions of responsibility and blame. The idea of self-care is strongly present in people's words. Women must be very careful during their pregnancies and the cuarentena, and they must take care of themselves *and their babies*. Self-care is a far-reaching mandate, covering a wide range of norms and behaviours. Lack of self-care may lead to sickness, coraje, bleeding and miscarriage, postpartum hemorrhage, and newborn malformations, among other things. Self-medication, in particular, is widely viewed as a threat and a likely explanation when things go wrong.

From our data emerges a discursive *continuum of self-care* that places squarely on women's shoulders a great deal of responsibility –and blame- for maternal and perinatal

health, from the circumstances that lead to her pregnancy right through to the outcome of the cuarentena. Multiple voices speak in strongly normative terms through our participants, who draw from discourses of spousal rights and solidarity, natural and divine order, medical expertise, and elderly experience, to frame a subject position where *heeding, self-caring, responsible women* police their own bodies and submit to social controls, so they can carry out a safe pregnancy and deliver a healthy child.

Of course, pregnancy is not only a matter of self-care. Pregnant women are a focus of attention in the private sphere of the family, what I have called the semi-public domain in the community, and the public sphere of health care. People share an underlining mandate to give pregnant women and recent mothers an equivalent of what global safe motherhood discourse calls "the care they need". This care should come from various stakeholders, most notably parteras, doctors, husbands and close family. Husbands, in particular, are deemed responsible for providing material and moral support, and for showing leadership when needed, which was also the case in "Heed the messages". This imperative can feed on a range of discourses, from inherent manly identity, through spousal love and companionship, to blaming and penal responsibility. Caring for pregnant women is also linked with notions of material barriers and ethnic identity.

Many participants draw a direct link between ethnic identity and poverty, and between both variables and maternal health: indigenous people in Xochis are inherently poor and this puts them at higher risk of adverse maternal outcomes than their Mestizo counterparts. The link between ethnic identity and poverty also emerges as the symbolic and material cause of cultural syndromes like antojo and coraje. This construal of ethnic identity reflects clear differences in social status and unequal appropriation of resources that characterize interethnic relations in Xochis, as discussed in chapter 1.

Some participants frame spousal solidarity in this context. The husband must get involved in his wife's pregnancy because of the material constraints facing indigenous peoples. Rich people (Mestizo people) always have someone to help them and, because of this, their women fare well. In other words, spousal solidarity is a life strategy to cope

with the material disadvantages of being Amuzgo and being poor, which are one and the same thing. Indeed, for many women and men, spousal responsibility overrides structural barriers: men should give proper care to their women in spite of their poverty. What they seem to imply is there has to be agency in poverty (poor people can and must do something to overcome their circumstances), and they link this agency with positive maternal outcomes. Their construal of agency and poverty connects with government safe motherhood discourse, insofar as they assume poor people do have a choice and are responsible for overcoming material obstacles.

People construe institutional prenatal control in terms of choice and coercion. Many participants feel this is the right thing to do, in a continuum of care and self-care; others refer to prenatal control in clinical settings as something they got used to, already part of their mores (in other words, being pregnant *implies* going to the health centre for guidance and control, which seems the ideal outcome of the re-educational effort discussed in chapter 5); and there are those who link their own agency in seeking medical care with God's will. Most see biomedical prenatal checkups as an obligation stemming from government pressure and maternal health surveillance.

Coercion is a powerful category cutting across our data, often linked with fear and blame. It materializes as pressure from government programs and health staff on women to go for prenatal control and deliver their children in hospitals and health centres; as intensified surveillance from the Ometepec health district and local health centres to identify pregnant women for prenatal control; as follow-up visits after childbirth so recent mothers will take their newborns for medical checkups; and as warnings to parteras to comply with biomedical practices and refer patients for prenatal checkups and in case of obstetric complications. Many participants point to the coercive use of Oportunidades as a key variable that has drawn women towards institutionalized prenatal control.

In many cases, the husband is depicted as the drive-belt between control and self-control, and the bridge between two orders of discourse. Many factors have an impact in this regard. Husbands should be agentive in making sure their wives go for prenatal checkups,

not only because it befits their spousal role, but also to avoid blaming and penal responsibility. And some husbands, like Francisco, indeed see themselves in that role, drawing from a combination of traditional discourses and safe motherhood discourse to construe their own experience and articulate their thoughts. Across our dataset there is abundant evidence of how safe motherhood interpellations reach the woman through her husband, which confirms findings from the SM household survey regarding the important role of Amuzgo men as trusted advisors. Most significantly for the objectives of this thesis, it reveals how people use and reshape different types of discourses in this process.

However, for all the reverberation of government safe motherhood discourse across our data set, for most women, prenatal control entails a combination of traditional and biomedical resources, based on their own embodied knowledge, previous experiences, assessments of response efficacy and, in many cases, a normative framework where indigenous medicine is the first choice and biomedical care a second option. By and large, women recognize the different health systems and their explanatory models, and they use them in a variety of ways, as I have mentioned in different sections of this chapter. They also draw from different discourses and from their own personal experiences to make meaning of these uses and to explain their decisions.

Throughout this chapter, there is a strong presence of discourses about individual, group, and collective responsibility and blaming. I have tried to show how much pressure these oft-colluding, oft-colliding discourses impact on different participants and how they take them up, negotiate them, and reshape them. Tension between doctors and parteras, government and parteras, doctors and communities, and parteras and communities seem to have been exacerbated by intense political pressure to lower maternal mortality rates. Government health staff, parteras, women, spouses, and their families both feel and transmit this pressure to other members of the community. Something similar happens between different levels of government health care.

Attributions of responsibility are also linked with people's expectations regarding expert care from health providers. A particularly telling narration involves conflictive

expectations from a medical practitioner and a remote community facing an obstetric emergency. From the doctor's point of view, his obligation was to refer the woman immediately to the nearest hospital, while members of the community said the doctor's obligation was to assist the patient right then and right there. From this and other interviews it seems that government health staff would rather not treat certain emergencies outside of institutional environment for fear of community reprisal and disciplinary measures within the government health system. Government safe motherhood discourse may compound the situation by construing skilled care as the province of biomedical practitioners, above and beyond traditional knowledge and abilities –thus raising the expectations in obstetrical emergencies.

Within the communities, women's responsibility is closely connected with self-care from before pregnancy to the cuarentena, prenatal control, agency in labour and delivery, and newborn care. Several participants framed these responsibilities as imperatives of inherent female identity.[104] Men's responsibilities in maternal care were similarly construed as part of manly identity.

Closely related to the above is the subject position of the child as a person from before childbirth –also a key construal in "Heed the messages". Equally strong is the link between the mother and the child in terms of agency, responsibility, and blame. Women are invested with great responsibility in giving life and caring for their children even before they are born. Religious discourse has a strong bearing in this regard -to the point where it singles out women for "irresponsible sex" and its consequences. For many participants, there is always some kind of female agency in adverse maternal events such as miscarriage and abortion. This harsh social stance goes hand in hand with legal penalization to put indigenous women who do not want to have their children in a very tough spot. Unmarried pregnant women are particularly singled out for blaming and often shunned by their families. Caught between a rock and a hard place, these women –most

[104] Módena captured the same social construal around female identity and health care in her study of the interactions between women, clinical practitioners and traditional healers in southern Veracruz state. "El cuidado de la salud y la atención de la enfermedad se concibe *naturalmente* como parte del ser femenino de la madre de familia." Módena ME 1990, p. 215-216.

of them teenagers without economic support- try to conceal their pregnancies and stay away from government health services. Some of them will have their children without any assistance; some others will try to induce abortions in unsafe conditions.

For all the focus on the life of the child, the life of the mother may be more valuable when both lives are hanging in the balance. One of our participants framed this choice as a collective cost-benefit evaluation based on the greater loss to the community *in terms of responsibilities*. It is harder to lose the mother than it to losing the child, because she has valuable tasks to fulfill, like caring for the household and her other children. There is an undertone of blaming in this construal. When whe woman dies, not only does she leave her duties unattended, but she also renders her children helpless. Losing the child may be part of the natural order of things –or a breach in this order, for which the mother can be blamed-; but losing the mother alters the social and material balance in the community.

Our data also reveals ethnic attributions of responsibility and blame. Despite all the talk about intercultural health –and some real action within the Mexico Health Secretariat-, blaming an entire ethnic group is still commonplace among government health officials, government health staff, and some non-indigenous leaders in Xochis. Indigenous peoples are blamed for their inherent, "cultural" lack of self-esteem and self-care, their reluctance to use condoms, and their rejection of biomedical care, among other things. At the same time, they are expected to be agentive and forceful in their demands from government health services. Because of their ethnic traits and their lack of initiative, indigenous people hamper government efforts to protect them and avert maternal deaths. This is why they need to be re-educated into a different worldview.

The idea that indigenous people are lacking in self-care because they do not submit to self-control and prenatal control on governmental terms reveals a major misunderstanding in government safe motherhood discourse and intercultural health communication as practiced in the region: self-care has a strong discursive presence in the community order of discourse, but not all women construe this imperative in the same

way, and even when they do, they juggle it with other interpellations, with their embodied experience, and with the material circumstances of their own lives.

Our data shows a complex relation between religion and biomedical views. Sometimes, religious leaders embrace biomedical knowledge, but this is not always the case. Their approaches entail very different discursive articulations, with the orthodox minister subordinating the voice of his church to the voice of medical science and the Catholic priest subordinating science and government to the voice of the Church. Indigenous voices are subordinate in any of these discursive scenarios. While religion and science have oft-competing universal "truths", indigenous people have "beliefs". To a certain extent, many Amuzgo women and men also seemed to construe a lower status for traditional indigenous knowledge. By taking some distance from the validity of traditional claims, they not only placed them within the boundaries of the in-group, but they also hinted at the existence of competing –and perhaps more truthful- views. This finding also reveals the complex interaction of indigenous and non-indigenous discourses in the construal of indigenous identities in Xochis.[105]

The construal of the newborn as a tender, delicate, defenseless being in need of great care is a key presence across our dataset. In general, both women and men see the breastfeeding mother as the primary though not sole responsible for the newborn. Although our participants seem inclined to use a combination of biomedical and traditional resources with the newborn, there seems to be a more frequent association of newborn care with biomedical resources than it is the case for puerperal care. Of particular interest from an ideological perspective, one of our participants frames her choice of biomedical care for her newborn as a natural extension of her love for their children, or rather, as a reflection of a social construal of motherly love. In this case, the normative, given link between the two types of discourse reveals the commonsense

[105] Coronado says in this regard: "*Es común encontrar ejemplos que dan por hecho que la visión occidental es la legítima, y así se acepta como 'natural' la descalificación de su cultura.*" At the same time, as the author observes, some groups and individuals reject the imposition of new values and reaffirm their own views. Coronado Suzán G 2003, p. 77. My own data reveals these tensions both in cross-sectional analysis and within single interviews.

nature of this belief –which also happens to be "true" knowledge in terms of safe motherhood discourse.

Men and women also depict the newborn as essentially unable to take part in any kind of verbal processes that would allow him to tell what he feels. There could be a certain association between this inability of the newborn to communicate verbally and the apparent inclination among many Amuzgos to seek biomedical care for their babies. Some parents would only consider opting for traditional medicine if they could "visibly" gauge what is going on with their newborn and, therefore, construe the symptoms in terms of traditional knowledge. Since this is not always the case, they become uncertain and seem to consider that seeking biomedical care is the safest way to go. The perception that babies are at higher risk because they are unable to communicate through language matches what government health staff and indigenous patients think about their own communication barriers. Not speaking Spanish is considered a risk criterion within government health services. Amuzgo patients, in turn, often shy away from health centres and hospitals because not being able to communicate adds to their stress.

Peoples' views and practices regarding puerperal and newborn care play alongside an ever-tighter government surveillance policy, which includes periodic home visits, and policing through community leaders, parteras, neighbours, and close relatives. All of this contributes to create a new social norm –which articulates with traditional expectations of control and self-care-, a powerful logonomic mechanism at the level of discursive and sociocultural practices, bringing public health discourse into the private domain. In this context, some women seem to make a distinction: the new norm is about their children, not so much about themselves. They can go to the health centre later, but their children cannot wait. This seems to be the negotiation of self-control, both for government health services and recent mothers, when it comes to puerperal and newborn care.

Our participants use a complex, often contradictory set of discourses when referring to the idea that pregnancy, childbirth and perinatal care should be drawn out of the private sphere. This complexity is typical of changing, transitional ideological landscapes. On the

one hand, people seem to draw a line around sexuality and related issues that should not be crossed lightly by certain social actors and in certain circumstances. People (both outsiders and Amuzgos) resort to different rhetorical strategies –usually involving a combination of external factors, community benefits, and higher powers- to break through these taboos and talk openly about maternal care. At the same time, both men and women were almost unanimously in favour of creating groups of pregnant women to discuss maternal care and implementing postnatal household visits by government health staff. In other words, the Amuzgos do not oppose an articulation of control and self-control that would bring issues traditionally kept within the private sphere further into the semi-public and public domain. All of this suggests a fluid state of affairs, marked by a dislocation of what used to be strictly private and the rearrangement of the public, semi-public, and private domains around maternal and perinatal care.

In this context, women try to negotiate their autonomy between government pressures and traditional social norms and expectations. The resulting collisions reveal a conflict of knowledge and power around women's bodies, behaviours, and subject positions. This happens within and between both orders of discourse. Within the traditional order of discourse, women are recognized as experts in their own bodies; nevertheless, they are put in a subject position of heeding, self-caring mothers in need of control from spouses, close family, parteras, and traditional healers.

Women's deviation from traditional social norms is of particular importance, because public health experts, government officials, and health staff usually construe women's reluctance to comply with expected health behaviours as a reaction against biomedical views and practices, or as lack of agency to stray from familial, community, and cultural expectations. A different picture emerges from our dataset: women try to exercise their autonomy against the background of *both* traditional and biomedical pressures. Personal biographies and embodied knowledge play an important role in this negotiation, both within the narrative of their own circumstances and in the construal of universal categories, general patterns, and social norms.

Chapter 7: Discussion and conclusions

In the preceding chapters, I tried to answer the questions that guided my research by connecting theory and methodology with the lives and actions of real people. In particular, I tried to show how institutions and individuals draw from existing discourses, adopt them, reject them, and reshape them according to their own needs and aspirations in a context of unequal power relations. I will follow the same procedure to discuss and summarize my key findings.

As I discussed in chapter 2.2, health risk discourse has been at the heart of safe motherhood discourse, which was the institutional label for an overarching set of policies and guidelines that shaped the prevention of maternal mortality and morbidity on a global scale for two decades. International commitments, like the Millennium Development Goals, together with the international political stigma attached to high maternal death rates, led international agencies and national governments to impose safe motherhood policies and guidelines, based on Western biomedical views and practices, overriding indigenous traditions, which are mostly seen as part of the problem.

In Latin America, safe motherhood was translated and adopted as *maternidad sin riesgo* (literally, maternity *without* risk). In Mexico, as I have shown here, risk-informed safe motherhood discourse is embedded in public health campaigns to promote *embarazo saludable* (healthy pregnancy) from Mexico City to remote indigenous villages across the country. Although the government has tried to implement intercultural maternal health policies within the National Health System, these efforts are still far from having deep and far-reaching impact on health services. This study shows that the relation between biomedical and traditional views and practices is extremely one-sided, and that many among health officials and health staff view indigenous cultures as an obstacle to overcome rather than as a pool of valuable resources. Government safe motherhood discourse reproduces and reinforces these underlying ideas with a paternalistic approach, blending solidarity and power through interdiscursive devices that co-opt and subordinate

different voices from the community, including the orders of discourse of familial relations, religion, and traditional health care.

Mainstream models of health risk communication revolve, one way or another, around the ideas of individual choice, responsibility, and blame, all of which are part of government safe motherhood discourse in Mexico. These models address individuals as rational decision-makers, in full command of their lifestyle choices, who are ultimately responsible for their own wellbeing. Such is the prevailing public health ideology in most Western countries. My research in Xochis reveals that many of these ideas are also present among indigenous peoples –and some may have been there from even before the arrival of biomedical practitioners and contemporary public health.[1] This contributes to generate "discursive synergies" between safe motherhood discourse and traditional orders of discourse –I elaborate on this topic below.

Over the last decade, the Mexican government has defined maternal health as a political priority, bearing down on key stakeholders to institutionalize pregnancy and childbirth in rural communities with a majority of indigenous population such as Xochis. This pressure materializes through surveillance policies involving health staff, community leaders, neighbours and families in close maternal control from pregnancy to puerperium and newborn care. The government has also turned up the heat on health staff to avert and account for maternal deaths, and made coercive use of poverty relief programs to engage women in prenatal education and pregnancy control. Public health communication interpellates pregnant women and recent mothers through safe motherhood campaigns and makes them responsible for their own health and the health

[1] Módena observed the same emphasis on individual responsibility in rural Veracruz state. "Los curadores tradicionales y las 'nuevas religiones' también invocan al individuo y su responsabilidad en la enfermedad", says the author. "Aunque los espacios terapéuticos sean colectivos y las causas se busquen en la naturaleza, en el accidente o en el castigo divino, finalmente se vuelve al individuo". Módena ME 1990, p. 210. As we saw in chapter 1, Hochstein contends that belief in nahualism implies that individual responsibility is limited by "the hidden and therefore unknown behavior" of one's *nahual* or *tono.* Hockstein G 2000, p. 34. In that sense, says the author, "a man's tonal is a fate." Ibid, p. 39. From our data, it is clear that fate does not preclude individual responsibility. For some of our participants, if you are agentive (usually in a normative way, that is, if you do what you are supposed to do, as a man or as a woman), God will be with you (the "ayúdate que Dios te ayudará" reference in the video film). If something goes wrong in spite of this, then it is His will –and perhaps your fault.

of their unborns and newborns –which fits nicely with similar imperatives from other orders of discourse in Xochis-, for giving their children an even start in life, and, ultimately, for taking action to revert health and social inequities in Mexico. Husbands, too, are held responsible for providing material and moral support, and for showing manly leadership when needed, in a complex articulation of social identities that tries to reflect and reshape gender roles in a shifting social landscape.

So much pressure to institutionalize pregnancy and childbirth has made a difference. According to the MNH Project 2008 baseline, most pregnant women in Xochis go for prenatal chats and checkups. My own data confirms that many women feel coerced into these practices, though many are also convinced that pregnancy merits close control from both biomedical and traditional providers. As mentioned in chapters 1 and 6, the government has made inroads on the childbirth front, though less so than with prenatal control. There seems to be a trend away from homebirth, but many women still construe institutional birth as a second option in case of complications during pregnancy or labour, and many still feel safer delivering in their homes. What most of them value greatly is being able to face childbirth *on their own terms*. In some cases, this implies the safety of an institutional environment where c-sections are at hand. In many others, it is a matter of personal agency; of knowing how to push and being able to do it come labour time; and of a woman's effort and ability to overcome fear and deliver a child. Whatever hinders this ability will undermine a woman's autonomy –and her identity and role *as a woman* ("*una como mujer*"). Using epidemiological language, we could say that such a risk is linked with negative maternal outcomes in Amuzgo women's perception and construal of maternal risks. Which confirms that people do not understand –and do not *experience*- certain ideas the way maternal health communication would expect them to. In this case, the idea of female agency –a close relative of self-efficacy as a behavioural construct- may be construed and experienced as a woman's autonomy from government health services at the time of delivery.

As we have seen in chapter 6, people use both traditional and biomedical resources, and they trust –or question- authoritative figures from both worlds. They also harness

different discourses –including safe motherhood discourse- to support their views and decisions.[2] For instance, a pregnant woman may go for prenatal control and exams at government health centres, seek the *partera* to re-position the baby in her womb, and choose to deliver her children at home, construing these choices as a safe combination. If anything, the analysis of safe motherhood discourse in the intercultural context of Xochis reveals a process of social change where different actors and forces –like the creators and sponsors of safe motherhood discourse, and men and women in the communities, who are the targets of government communication efforts- use meaning making resources to reposition themselves under pressing circumstances. From an ideological perspective, these uses and interactions both reproduce and undermine existing power relations, thus creating new tensions within the ideological complex of motherhood.

As both an indication and a result of these tensions, complex processes of intertextuality emerge from the texts in chapters 4-6. One such example is the link between safe motherhood discourse and the religious order of discourse. Government co-opts religious discourse for its own purposes, making divine intervention depend on timely agency from pregnant women and their husbands to submit to medical control (e.g. the *"ayúdate que Dios te ayudará"* construal in chapter 5). In turn, people use religious discourse to anchor their views and choices concerning maternal health, sometimes underlining and sometimes undermining government expectations and safe motherhood discourse. Some draw a positive connection between biomedical care, God's intervention, and human agency from pregnant women and their spouses, very much like the video film does. For some others, doing by God entails going for prenatal checkups, but not necessarily giving birth in institutional settings. In fact, putting oneself in God's hands may be positively associated with the ability to deliver at home through one's own effort. This construal of religious discourse and personal agency contradicts government safe motherhood communication. At the same time, there is a connection between this interpretation and the idea that prenatal control may lead to a safe delivery, no matter where it takes place, as we have seen in chapter 6.

[2] We could say that these discourses contribute to shape people's choices, as much as people reshape these discourses and align them with their own behaviours and intentions.

The link between poverty, maternal outcomes, and Amuzgo ethnic identity is another example of these complex discursive construals in a context of social change and unequal ethnic relations. Government health officials acknowledge structural barriers for maternal health such as poverty, low quality of care, fear of discrimination, language barriers, and cultural misunderstanding. At the same time, government health services label indigenous people at higher-than-normal risk for maternal outcomes, because of their physical traits, their traditional views, and their lack of knowledge of the Spanish language. As we have seen from chapters 4-6, government safe motherhood discourse also captures some of these concerns. So do our Amuzgo sources, though they do it in a different way. Our participants see material barriers such as lack of food and lack of money not only as risk factors for adverse maternal outcomes, but they also construe them as inherent traits or disadvantages of their ethnic identity vis-à-vis the Mestizo population. Being Amuzgo *means* being poor. It also *means* getting poor quality health care and having worse maternal outcomes than the Mestizos. This construal seems to reflect the clear differences in social status and unequal appropriation of resources that characterize ethnic relations between the dominant Amuzgo minority and the Amuzgo majority in Xochis, which I discussed in chapter 1. However, many of our participants felt they had to be agentive in their poverty and find a way to overcome these barriers, positively echoing responsibility and blaming appeals from government safe motherhood discourse, as we have seen from chapters 4-6. In other words, there are substantial synergies between governmental and indigenous discursive construals in this regard. These synergies tend to reinforce the unequal position of Mestizos and Amuzgos, since they encourage the labelling of individuals (each pregnant Amuzgo woman), groups (Amuzgo women in general) and communities (the Amuzgos as an ethnic group) as being at risk, and therefore expected, persuaded and coerced to keep these risks under control –a central characteristic of risk-driven contemporary public health communication, as we have seen in chapter 2.

My own findings in this regard fully confirm what Módena says in her study about the interactions between women, clinical practitioners and traditional healers in Mexico, which I mentioned in chapter 2.1.4:

> En la dimensión ideológico-cultural de estos hechos predomina la reproducción de una subalternidad vivida como responsabilidad individual y culpa, en especial frente al discurso médico, por no resolver satisfactoriamente aquello que se considera una obligación.[3]

Indigenous construals of poverty, ethnic identity, and individual responsibility in Xochis create a synergic articulation with key dimensions of choice, responsibility and blame in safe motherhood discourse. Amuzgo women and men know they are poor –in fact, they know they are poor *because* they are Amuzgo- and that is why they are faring worse than the Mestizo population; and yet they feel they have to overcome these circumstances through self-care, familial organization, and submission to biomedical control.

Of course, in this fluid, rapidly shifting semantic landscape, people can also make meaning to undermine –and resist- government safe motherhood discourse. For instance, the strong discursive connection between prenatal control and safe outcomes in government safe motherhood discourse –including the construal of medical technology as the ultimate source of truth and institutional services as the sole providers of expert, skilled care- may suffer greatly from contradicting accounts in people's personal biographies. This may happen as people draw generalizations from their own experiences and share them socially, feeding into pre-existing discourses that impact negatively on biomedical care.

It may also happen that safe motherhood discourse backfires. Many women and men in the communities seem to construe prenatal control -submitting to close monitoring, getting the recommended treatments, and taking the prescribed medicines- as somehow *leading to* safe childbirth, regardless of where it takes place. Government safe motherhood discourse may contribute to influence people's views on this matter.

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[3] Módena ME 1990, p. 121.

Another example of indigenous construal that reshapes and resists government-sponsored maternal risk discourse is related to the position of the baby in the womb, a severe and *ever-present* threat for the mother and the child, who are framed as members of at-risk groups requiring periodic prenatal control –often from doctors and parteras alike. This control should aim at assessing the position of the baby and, contrary to biomedical criteria, reposition as needed. Doctors and nurses can tell whether the baby is in the right position –sometimes aided by ultrasound imagery-, but *knowledge for repositioning is off limits for health staff.* This is something that only parteras can do. Doctors do not do it, and, equally important from a discursive perspective, *they do not know how to do it* – someone goes as far as saying that they don't know *because* they can perform c-sections. There is much logic in this exclusion, since clinical practitioners only consider breech position as an eventual obstetric complication and most of them discourage external versions from parteras. On the other hand, Amuzgo women construe the repositioning of the baby a safe way of restoring a natural balance in the relationship between the mother and the child in her womb. They also frame this practice in terms of childbirth prevention and readiness –something that holds for prenatal control as a whole-, as a means of preventing c-sections and vaginal cuts, and as a solution for pregnancy ailments such as swollen feet, lower abdominal pain and leg pain –in other words, as an essential component of a preventive and restorative approach to maternal health. They seek the parteras to do it not only because they have the technical expertise, but also because they share a common view and they can connect with the woman's anxieties and fears.

Personal biographies and embodied knowledge have a powerful impact on how people make meaning about maternal and perinatal health. For many women, their embodied knowledge is equally or more important than expert knowledge from doctors or parteras. Some feel this knowledge is absent in biomedical doctors, and denied or contradicted in hospitals and health centres. Not knowing, not understanding –the reverse of indigenous lack of awareness from biomedical risk standpoint- implies a fundamental lack of empathy that makes institutional delivery so difficult for many indigenous women.

People also use personal biographies and embodied knowledge to make generalizations based on what has happened to them. As mentioned in chapter 3, narrations of critical incidents are very insightful in this regard. Some participants turn their own personal experience –e.g., *me descuidé-* into an instance of a pre-existing discourse of self-care: *hay mujeres que no se cuidan.* Others draw from their personal biographies to reshape and reject construals of expert advice and skilled care, and attributions of responsibility and blame in government safe motherhood discourse; in some cases, they turn the very same notions of responsibility and blaming against the government or government health staff for not living up to their commitments and obligations. People also draw heavily from notions of fate and religion, and even from local political discourses of indigenous autonomy and resistance to make sense of maternal experiences.

Indeed, there is a wide range of synergetic and contradictory interactions between the different views of risk in Xochis. On the one hand, people draw from government safe motherhood discourse and existing community discourses to shore up the idea that life and social events such as pregnancy, childbirth, puerperal and newborn care face a continuum of threat and, therefore, require close material and ritual control in a mirroring continuum of self-care and prenatal control. But this does not necessarily entail evaluating the same risks in the same manner, choosing the same preventive and curative resources, trusting a single set of experts, and most importantly from a semantic perspective, using the same explanatory models and making meaning about motherhood and maternal health the way government officials and biomedical experts do. Contrary to what may be concluded from a narrow biomedical perspective, these are coherent –and rational- construals that blend people's experiences and multiple discourses in an unequal multiethnic context with competing authority claims.[4]

All of this only goes to show the fluid and transitional state of the ideological complex, where multiple –even contradictory- discourses can be harnessed for different purposes

[4] There is a close connection between the notions of coherence (or incoherence) and rationality (or irrationality). Those who see irrationality in people's decisions may tend to construe some of the texts in chapter 6 as incoherent. Both rationality and coherence need a wider definition, based on how people draw from multiple experiences and use available semantic resources to make decisions within a given sociocultural context and under specific circumstances.

and combined to divergent effects. Government safe motherhood discourse, a newcomer inching its way towards hegemony, can co-opt but not entirely dominate pre-established discourses –let alone the way people will use them to make meaning in their lives.

As it happens with religious syncretism, the prevailing combinations and reinterpretations of views, practices, and resources from the biomedical and traditional worlds may be part of adaptive strategies that allow people to maintain their Amuzgo identity and sense of community in a shifting ideological complex where government and other stakeholders seek to "purify" and dominate the Amuzgo culture for their own purposes.[5] [6] As Ginsburg and Rapp observe, local reproductive relations seem to be both "constituted by and resistant to more global forms of power."[7]

Módena, whose findings ripple and resonate across this study, gives an overarching assessment of interethnic and intercultural developments within the ideological complex:

> Autonomía, individualismo, proceso mercantil, secularización, culpa y responsabilidad personal y familiar. La medicina tradicional continúa, las nuevas formas religiosas aparecen y se extienden, pero la lógica que articula el conjunto es la de la ideología hegemónica que involucra en sus operaciones lo que se encuentra. No lo hace en la forma óptima del capitalismo puro, sino en esa forma contradictoria y desigual con la que opera cuando se topa con los hechos provenientes de una historia distinta de la suya.[8]

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[5] Gutiérrez Ávila also sees cooperative back-strap weaving as an identity-affirming practice in a context of social, political, and economic threats to Amuzgo culture and traditional community ways. As a corollary, the training of new weavers to preserve this knowledge is linked to the survival of the Amuzgo culture. Following a similar line of thought and going against the grain of mainstream safe motherhood discourse and policies, the MNH Project sponsors the training of new TBAs by established parteras.

[6] As we have seen in chapter 2.3.3, Bonfil contends that conservatism is a means of cultural resistance for the oppressed. Based on my own study and other data from the MNH Project, I would say that both practices and semantic construals that blend the biomedical and the traditional are means of *adaptive resistance*. That may help explain why women who go for prenatal control and choose to deliver in hospitals still seek a partera to reposition the baby in the womb, or why many men do not think that institutional childbirth is a threat to Amuzgo mores.

[7] Ginsburg F, Rapp R. The Politics of Reproduction. *Annual Review of Anthropology* 20:311-343, 1991, p. 313.

[8] Módena ME 1990, p. 210.

When we consider that three decades went by between Módena's study in rural Veracruz and my own research in Xochis, we can marvel at the resilience of traditional actors, views, and practices; but we can also see little change in the overall trend, the discursive configurations, and the unequal power relations between the different social and ethnic groups. Safe motherhood policies –which did not exist at the time of Módena's research- have had an impact on these developments, as the government fights a muted discursive battle within the ideological complex to place safe motherhood as a commonsense, "natural", and hence hegemonic view of things in Xochis and elsewhere in rural indigenous Mexico.[9]

The strength and recurrence of these hegemonic patterns is all the more evident when we look farther back in the history of Mesoamerica. In his study of the links between ideology and social conceptions of the body among the ancient Nahuas, López Austin describes how the conquering Mexicas –and other indigenous groups before them- co-opted traditional views and ideologies as part of their strategy of domination:

> Los explotadores 'respetaron' las formas ideológicas tradicionales, modificándolas y adicionándolas en beneficio de los intereses propios. Así fueron montándose unas en otras las distintas concepciones del cosmos [...] Lo anterior sirve de pauta para el estudio del sistema ideológico de las concepciones del cuerpo humano. En este sistema, como en el resto del complejo ideológico, se proyecta la forma de dominación del aparato gubernamental sobre las comunidades propietarias de la tierra. El 'respeto' de las tradiciones fue una de las bases de la coexistencia de la antigua organización comunal y el aparato gubernamental.[10]

We need only substitute maternal health for conceptions of the body –and public health for traditional health care- and we can apply the author's words to the current situation in Xochis and in rural indigenous Mexico in general, despite still marginal efforts sponsored by the direction of Traditional Medicine and Intercultural Development at Mexico's

[9] Chapter 6 offers a simple but powerful example of what would be the ideal outcome of this strategy –a woman who says she does not get sick with cultural syndromes because she does not go to the healer or the partera.
[10] López Austin A 1980, p. 98.

Health Secretariat, including intercultural health policy guidelines and training of government health staff.

To be sure, hegemonic changes within the ideological complex do not come about only as a result of discursive struggles. We have seen how aggressive government policies have increased women's attendance to prenatal chats and checkups, as well as the proportion of institutional deliveries over the last decade. These policies combine intense community surveillance, conditional payments from antipoverty programs, and great pressure on all stakeholders –from health staff to pregnant women and their husbands- in the communities. As López Austin contends and our data confirms, this coercion is implicitly and explicitly justified by the need to align indigenous views and practices with the explanatory models and political priorities of the dominant Mestizo majority – which are in turn conditioned by global policies, guidelines, and comparisons of maternal and perinatal mortality rates. All of which suggests that current safe motherhood policies, practices, and goals hinge, at least partially, on what Bonfil calls *desindianización* (de-indianizing),[11] that is, the forceful eradication of indigenous views, practices, and traditions –to the extent that they threaten public health definitions and goals.

A more dialogical view of these developments is also possible, in line with Coronado's analysis of interethnic relations in Cuetzalan. As I discussed in chapter 2.3.1, the author does not see hegemonic relations as a one-way imposition of cultural views and practices from dominant groups over subordinate groups, but rather as instances of interethnic dialogue and negotiations that shape and reshape both indigenous and mestizo cultures. There is conflict, creativity, contradictions, adaptation, appropriation (of meanings and practices from another culture) and refunctionalization (of meanings and practices from the in-group) in these exchanges. [12] In chapters 5 and 6, I have offered several examples of these processes.

[11] Bonfil Batalla G. 1987, p. 42.
[12] Coronado Suzán G 2003, p. 33-34, 45-60, and 73-74.

In chapter 6, I have also shown how coercive appeals merge in people's words with government and indigenous discourses about individual, spousal, and community responsibility and blame. Strong logonomic rules and mechanisms operate at the level of discursive practices, as government, health staff, and other stakeholders embark in a re-educational effort to change people's explanatory frameworks and expert references. By logonomic rules and mechanisms I mean specific material and symbolic devices to steer people's views and behaviours. It is not only the coercive means of ensuring that pregnant women will attend prenatal chats, but also what happens when they get there: the one-sided manner in which pregnant women receive information from biomedical practitioners who are portrayed –and often act- as socially superior sources of true knowledge regarding pregnancy care and childbirth. It is not only governmental pressure to enroll parteras in training sessions, but also the one sided biomedical training, which dismisses their knowledge and seeks to alter some of their practices, like assisting deliveries in upright position. All of this does not mean that logonomic rules determine people's actions, but they somehow *constrain their choices* and loom large on the ideological complex, particularly in terms of responsibility, blaming, control, self-control, and subject positions.

What happens at the level of the ideological complex is best summarized in terms of power and solidarity. Government imposes prenatal checkups through coercive means, like conditioning social benefits (power function), while it does not always discourage the relationship between *parteras* and pregnant women (solidarity function). At the same time, it tries to steer *parteras*' practices in a biomedical direction (power function). Some stakeholders are at the forefront of these interethnic articulations of knowledge and power. Women and parteras seem to be the most flexible "navigators" between the different orders of discourse and sociocultural practices. I have already given examples of women's combinations of views, practices, and providers. I have also discussed how *parteras* go for prenatal training and advice their patients to go for prenatal checkups, thus attaining some legitimacy in the eyes of the government and cementing their status in the communities, where biomedical discourses are gaining ground. At the same time, they validate their role as sole providers of key traditional maternal care services, like the

re-positioning of the baby in the womb -which is now the single most required service from *parteras*, both from those who deliver at home and from those who have their children in institutional settings. One of the best examples of mutually adaptive strategies involving knowledge, solidarity, and power between a medical practitioner, a *partera*, and a pregnant woman comes from chapter 6.8. There, we see how all three actors negotiate different worldviews in a delicate balance that reinforces their own interests without altering the core values and subject positions at the heart of prenatal control. Neither the doctor nor the partera tamper with essential logonomic rules from the other's world. In fact, they reinforce these rules through a strategy of solidarity and power that foregrounds the need to trust and heed biomedical and traditional experts and to articulate control and self-control. Both the doctor and the partera –and their respective orders of discourse- have a dialogue full of agreements that resonates in the woman's words.

However, this example should not obscure the fact that, for the most part, there is no agreed-upon articulation between biomedical and traditional practitioners, and much of this happens under the surface, as indigenous populations straddle both worlds and negotiate their own practices.[13] Data from this study and the MNH Project show the Mexican government tries to assimilate the parteras –and traditional health care in general- within a hegemonic model of public health, despite much talk about intercultural health care. WHO's exclusion of TBAs from the definition of "skilled" assistance and TBA training programs in rural Mexico confirm the instrumental role of safe motherhood discourse and practice in this regard.

From our data emerges a discursive *continuum of self-control and self-care* that feeds from different sources –traditional, religious, governmental- to saddle women with a

[13] Some authors, like Cosminsky and Davis-Floyd, have a positive view of these processes and of the role that "postmodern", adaptive parteras have in it, both accepting and contesting medical knowledge and authority as they see fit in their own practice. Cosminsky S. Midwifery Across the Generations: A Modernizing Midwife in Guatemala. *Medical Anthropology* 20:345-378, 2001. Davis-Floyd R. Daughter of Time: The Postmodern Midwife (Part 1). *Revista da Escola de Enfermagem da USP* 41(4):705-710, 2007. Available online at http://www.scielo.br/pdf/reeusp/v41n4/22.pdf. Accessed June 11, 2010. Módena says in this regard that private doctors working with traditional practitioners manipulate this relation from a dominant position and within a hegemonic model of unequal accumulation of wealth and power. Both in economic and ideological terms, this implies that patients and healers alike accept, from a subordinate position, the reproduction of these unequal relations of power. Módena ME 1990, p. 209.

great deal of responsibility –and blame- for maternal and perinatal outcomes, from the circumstances that lead to her pregnancy right through to the outcome of the cuarentena. Multiple voices speak in strongly normative terms through our participants, who draw from discourses of spousal rights and solidarity, natural and divine order, medical expertise, and elderly experience, to frame a subject position for *heeding, self-caring, responsible women* who must police their own bodies and submit to social controls, so they can carry out a safe pregnancy and deliver a healthy child.

Indeed, pregnant women are at least partially defined in terms of the perils they face and the things they should do to avert these threats. These fears and expectations become part of their social identities. In government safe motherhood discourse, a pregnant indigenous woman is an at-risk woman, a woman who needs to be cared for, a woman who needs to heed biomedical experts, and a woman who must look after herself and her child, in a recursive pattern of control and self-control. In the order of discourse of traditional health care, a pregnant woman is a woman in a delicate state ("*está delicada*"), a woman who must take good care of herself ("*debe cuidarse*") and her child ("*porque lleva a su hijo y eso no es cualquier cosa*"), someone exposed to a *continuum of threat* from cultural syndromes and from her own latent or inherent carelessness. In the fluid discursive landscape of Xochis, these views do not cancel each other out, but they increasingly feed off from one another. As we saw in chapter 2, some authors contend that human groups and individuals were not defined in terms of their risk identities before the emergence of public health risk discourse. Data from this study indicates that these risk identities were already in place in Xochis -and likely in any other pre-risk society, as Mary Douglas suggests- before contemporary public health discourse made its way into the societal order of discourse. What safe motherhood discourse and health risk discourse in general may have done is reinforce and reshape social tendencies to avert risk by singling out and casting blame on those who embody and bring about these threats.[14]

[14] The interaction and complementarity of self-care and self-control is an excellent example of how tradition and modernity coexist and influence each other in Xochis. Both self-care and self-control are forms of self-monitoring. Self-care is based on knowledge that comes from the elders, from the "dead", and becomes common sense. A pregnant woman is inescapably aware of these things -she "knows" these things, as some of our sources put it ("*está embarazada... ella sabe lo que significa*")- and must do everything in her power to avert danger. Self-control, as a key category of contemporary risk discourse,

There are further synergies between safe motherhood discourse and other discourses about maternal risk in Xochis. When a woman says "*me descuidé*" and "*hay mujeres descuidadas*", she is in fact drawing from a pre-existing, readily-available category ("*hay mujeres descuidadas*") to label her own behaviour. This type of construal somehow mirrors health risk discourse, by following a reverse route. In contemporary public health communication, based on statistical analysis of risk factors in large population samples, certain population groups –e.g., people who are overweight and have high blood pressure- are deemed at risk of developing certain diseases –e.g., diabetes and heart disease. These people are interpellated as at-risk individuals in the public sphere. They are responsible for their own health and they are singled out when they fail to do so. When an Amuzgo woman has a negative maternal outcome, in a social context where pregnancy is seen as fraught with risks and self-care as an imperative, people may think she had problems because she already belonged to a "higher-risk" group of careless women. In the case mentioned in chapter 6, our participant tries to construe her experience as an exceptional instance of carelessness –though she acknowledges the existence of careless pregnant women and her own responsibility in what went wrong.

As mentioned above, pregnancy is not only a matter of self-care. The government and the people in the communities share an underlining mandate to give pregnant women and recent mothers an equivalent of what global safe motherhood discourse calls "the care they need". As a major point of convergence between safe motherhood discourse and indigenous views, maternal care should come from various stakeholders. But the similarities end at this point. Government safe motherhood discourse acknowledges doctors, nurses, husbands, close family, and social kinship, though it grants them different degrees of authority, always subordinated to the ultimate power and expertise of biomedical experts. Traditional birth attendants are either ignored or co-opted for biomedical purposes –following the safe motherhood definition of skilled care, and

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requires a different kind of knowledge, based on biomedical understandings of risk and submission to different -often impersonal- expert systems and risk interpellations in the public sphere. As we have seen throughout this text, women inhabit a world of complex interactions between these different discourses and practices of self-monitoring.

traditional healers are never mentioned, likely because they are presupposed to be key Opponents (in the sense I have used this word in chapter 5) of timely biomedical care – particularly facing potential obstetric complications. From within the communities, the emphasis on health provider may shift according to people's personal biographies, embodied knowledge, trusted providers, material circumstances, and their own interpretation of social norms and explanatory frameworks.

There are further differences and synergies between governmental and indigenous views and practices regarding social control of maternal health in Xochis. Traditionally, social control had been absent from what is nowadays the public sphere –including institutionalized care and the open circulation of discourses of sexuality and maternal care. This is still a point of friction between government expectations and indigenous views and practices, particularly regarding institutionalized childbirth. But rather than universal rejection of government health control, this friction entails a re-accommodation within existing views. In particular, people seem willing to accommodate prenatal and newborn control within the domain of traditional health care. As I mentioned in chapter 6, most people surveyed for the MNH Project 2008 baseline favoured setting up mutual support groups of pregnant women and postnatal home visits from community health promoters. Both initiatives undermine the isolation of maternal and perinatal care within the private sphere. Participants in groups of pregnant women would bring their embodied knowledge -and maybe their familial and spousal issues- into a semi-public space within the community. Home visits from government health staff would bring the public sphere of government into the private domain, tightening the logonomic grip of control and self-control. Other data from the same chapter suggest that these trends are still counterbalanced by restrictive social norms from within the culture and the community – for instance, what can be openly talked about and with whom. They also suggest a fluid state of affairs, marked by a dislocation of what used to be strictly private and the rearrangement of the public, semi-public, and private domains within the ideological complex of motherhood.

In this changing social context, women try to reaffirm and reconfigure their roles and identities from a subject position shaped by government pressures and traditional social norms and expectations. As I discussed in chapter 1.2.1, women are increasingly gaining autonomy and participation in community life through both traditional means, such as groups of back-strap loom weavers, and non-traditional organizations of bilingual elementary and high school teachers who support indigenous autonomy. However important, this trend happens in the context of a still heavily male-dominated society. Machismo patterns are clearly present in gender relations across different social spaces, and men are seen as the "natural" leaders of the households. In this context, our female participants regard their spouses as their closest partners and advisors concerning maternal care. "*El padre de mis hijos*" (the father of my children) is a powerful presence in women's words, as much as it is in government discourse, as we have seen from chapters 5 and 6.

This study also shows a conflict of knowledge and power around women's bodies, behaviours, and subject positions. This happens within and between both orders of discourse. Telling women to heed the messages of their bodies always implies heeding *an interpretation* of those messages. In safe motherhood discourse, this means heeding biomedical experts, who are the bearers of "true" knowledge, and turning away from misguided cultural beliefs and misconceptions. Within the traditional order of discourse, women are recognized as experts in their own bodies; nevertheless, they are put in a subject position of heeding, self-caring mothers in need of control from spouses, close family, parteras, and traditional healers. Women draw from these and other discourses, and from their own embodied knowledge and personal biographies, and combine them in complex ways to negotiate their role and autonomy not only among the Amuzgos, but also in an interethnic society.

Women's deviation from traditional social norms is of particular importance in this regard, because public health experts, government officials, and health staff usually construe women's reluctance to comply with expected health behaviours as a reaction against biomedical views and practices, or as lack of agency to stray from familial,

community, and cultural expectations. A different picture emerges from our dataset: women try to exercise their autonomy against the background of *both* traditional and biomedical pressures. Personal biographies and embodied knowledge play an important role in this negotiation, both within the narrative of their own circumstances and in the construal of universal categories, general patterns, and social norms.

7.1. Implications for health risk discourse

As I mentioned in the opening chapters, research on health risk communication has long established that people's views and behaviours of risk often do not match expert and government definitions, which are mostly based on numerical evidence, political priorities and policy needs. A host of emotional, cultural, economic, and social factors, as well as a string of competing risks, also play a role in people's decisions. My own research confirms that safe motherhood is no exception, particularly where cultures and languages collide, and people live in dire conditions, as it happens in indigenous Mexico.

The idea that indigenous people are lacking in self-care because they do not submit to self-control and prenatal control on governmental terms reveals a major misunderstanding in government safe motherhood discourse and intercultural health communication as practiced in the region: self-care has a strong discursive presence in the community order of discourse, but not all women construe this imperative in the same way, and even when they do, they juggle it with other interpellations, with their embodied experience, and with the material circumstances of their own lives.

From chapter 6 we know that the Amuzgos construe pregnancy and childbirth as fraught with risks. They derive these risks from embodied experience, personal biographies, hearsay, and also from biomedical sources and safe motherhood communication. Construals of pregnancy risks include but also exceed biomedical views. Our participants were particularly concerned with the position of the baby inside the maternal womb, with cultural syndromes, miscarriage and abortion, and female lack of strength during labour and delivery. Our data shows that most women and men construe pregnancy as a

debilitating, constraining state that exposes the mother and the child to physical and ritual threats. For many of our participants, pregnancy *entails* danger, particularly in relation with childbirth.

All of this undermines the idea that indigenous peoples do not follow biomedical advice because of an inherent, cultural unawareness or disregard of maternal risks, which is often voiced by government officials and government health staff. People perceive the risks, but that does not necessarily mean they will seek biomedical care only, or that they will feel safer having their children in hospitals or health centres. In fact, some people associate biomedical solutions –institutional childbirth in particular- with dreaded outcomes, like c-sections and vaginal cuts, or with lack of skilled care, as is the case of doctors who do not assist women immediately or misjudge the immediacy of childbirth, contradicting women's embodied knowledge and contributing to overdue deliveries, among other threats.[15] On the other hand, some women do not want to deliver at home because they have gotten used to hospital settings. All of which somehow shows that people make room for new practices within long-established cultural molds and, conversely, that living in a traditional ethnic environment does not entail adopting all the cultural mores.

Few people construe maternal risk as a public health issue of grave concern in their communities, the way government discourse does. This is an important mismatch, and a typical one in contemporary public health. Safe motherhood discourse and policies are driven by a governmental reaction to maternal health rates –which capture the scope of the problem in terms of population aggregates. The government then tries to raise public awareness about maternal health as an issue, which many do not see that way. When we ask people a direct question about maternal and newborn deaths, some see it as a problem because it has happened in their own families or in their communities. Yet some others may think negative maternal outcomes are a fact of life, *precisely because they are all too frequent*, as we see from the following exchange with Belisaria:

[15] Roth Allen documented similar perceptions of biomedical solutions as risks in rural Tanzania. Roth Allen D 2002, p. 9.

Q: ¿En este pueblo se mueren muchos niños en el vientre de su madre, o cuando se alivian o una ves que nacen los bebés?

B: Sí, muchas personas... he escuchado que a muchas mujeres se le muere el bebé en su vientre o cuando el bebé nace antes de tiempo

Q: ¿Es un problema eso para la gente del pueblo?

B: Yo veo que para ellos no es algo importante

Q: ¿Por qué dices eso?

B: Porque a mucha de nosotras como madres nos sucede

But indigenous people are not the only ones who make multiple risk construals. The notion of risk is far from being one and the same for government health officials and staff. Mexican guidelines and health services still resort to levels of risk for the prevention of illness and death during pregnancy and childbirth, in spite of a global shift in focus and the fact that most women who die in Mexico have been labeled as having "low risk". At the time of data gathering for this research, conflicting risk approaches coexisted within government health services, which created additional hurdles and uncertainties for all involved. On the one hand, government health services have tried to identify higher risk pregnancies for closer monitoring and institutionalized delivery. Applying risk criteria was standard policy within the Ometepec health district, at least until the first half of 2008. Frontline health workers used similar criteria for handling their patients –however, there was no consensus on who should be referred, when, and where. At the same time, government safe motherhood discourse construes all pregnant women –particularly indigenous women- as being "at risk" and institutional delivery as the only safe option. Most health services kept encouraging all women to give birth in hospitals and health centres.

Of course, values are always at stake in any evaluation of risk. When the government puts pressure on "high-risk" women to deliver in hospitals, as is the real-life example I chose for the Introduction, it is imposing politically defined value priorities to pregnant women and their families. As Mary Douglas points out, "private decisions about risk are taken by comparing many risks, and their probable good and bad outcomes".[16] The

[16] Douglas M 1985, p. 31.

woman in our example said she would rather die at home –a frequent expression among some Amuzgo women, according to one of our participants. Other women say they feel strong enough and they have faith in God to deliver by themselves or with the partera. Does the government have the right to press them and their families to bring them out of their homes?

7.2. Success and shortcomings: A reflexive look on this project

Going back on my footsteps, I see some success and quite a few shortcomings in my tackling of the research problem and the overall handling of the project. As I mentioned in chapter 3, I found Fairclough's three dimensional conception of discursive events as texts, discursive practices, and sociocultural practices very useful to account for the dynamic interaction between language and other aspects of social life in multicultural environment where the dominant Mestizo minority tries to impose its own views and practices of maternal health, and the power relations that come with them, on the indigenous majorities. Applying Hodge and Kress' conception of ideological complexes, hegemony, logonomic regulations also allowed for a nuanced articulation and re-articulation of power relations. Most importantly, the theoretical framework worked well to accommodate the tensions between stability and change.

I had also envisioned a type of analysis that would allow me to show that discourses are not mere abstractions; that they have a *material* presence in our lives, and that people *use* them in many different ways. I am quite happy in this regard. –even more so than I expected when I began this work with too many abstractions and few if any tangible applications. I also think that I have had some success in showing how discourse analysis of risk can "reveal the shifting meanings around risk phenomena and the struggles over these meanings," [17] through concrete examples from individual and institutional semantic production. Of course, my findings are valid for a certain time and a specific place. If we take government safe motherhood discourse in Mexico, we can see, for instance, that it bears many traces of health risk discourse as has been described and documented

[17] Lupton D 1999a, p. 15.

elsewhere; but it also has a collective dimension that is not typical of lifestyle-oriented health discourse.[18] This collective dimension –and its particular articulation of solidarity and power- may have not been there before the decade of the 2000s and may not hold in the future. Moreover, the interaction of these construals with people's views in Xochis may not be the same in other indigenous groups in Mexico, and will likely be different in urban centres with majority of Mestizo population. Hence, the positioning and repositioning within the ideological complex of motherhood would also have to be studied for each place and each period. This may sound obvious, but it is of the essence to my understanding of discourses, ideologies, and what I mean by the sociocultural level of discursive events.

I would also like to address the practical implications of using certain theoretical constructs. It is not always easy to determine what constitutes a given discourse, an order of discourse, or an ideological complex in the sense I have used these words here. I admit that limits and the differences are not always clear. This is partly connected with the socio-culturally bounded nature of my theoretical approach. It is also part of a larger issue: the interpretive nature of qualitative research. For instance, why have I used the overarching notion of "ideological complex of motherhood"? I could have instead talked of "motherhood" as another type of discourse from the community. However, I thought, based on the data, that "motherhood", as a set of descriptive and normative ideas about being a mother and mothers as a subgroup within any given society, would work well as an overarching semantic framework to accommodate social views and practices like maternal and newborn care, and particular discourses such as safe motherhood discourse and other discourses bearing upon these topics. I could have also talked about a broader ideological complex –like López Austin does in his study of the human body and ideologies among the ancient Nahuas.[19] But, in keeping with my opening statement in this final chapter, I think that we have to make theories more manageable and abstractions as concrete as possible in terms of real life and social interactions. Hence, I

[18] In chapter 5, we have seen how the video film construes a collective proposition, but it makes it contingent on individuals taking action in the private sphere of their homes to set in motion a wider set of collective events.

[19] López Austin A 1980, p. 14. Ideological complex, for the author, means "the interconnected aggregate of the world views of different groups who, in a given era, composed a society".

found it useful and descriptive to work with a narrower version of ideological complexes that would apply to a specific domain of social life –in this case, the social domain of motherhood. To be sure, I have double guessed myself quite a few times with regard to these definitions, and I have often found as many good reasons to keep them as I have to get rid of them and use different terms. Still, I think these conceptual choices are a good fit for my data and for the objectives of my research –which include showing discursive articulations at work both within particular texts and at the sociocultural level of discursive events.

I am also satisfied with the integrative methodological approach, which gave me great flexibility to tackle the different texts. Of course, I could have chosen to focus on a few semantic features and track them across the data sample, but this was not the best option for different reasons. On the one hand, I was searching for different dimensions of health risk discourse and safe motherhood discourse in a variety of textual modes (written, audiovisual, transcription of interviews), and I soon found it useful to look from different angles and with multiple tools. On the other hand, I was exploring the way designers of government communication products, people from the communities, and other participants used different semantic resources –discourses among them- to make meaning about maternal health, which required a flexible approach to the way *they built* their texts. In particular, I have made intensive use of the notions of intertextuality and interdiscursivity to explore discursive articulations and the dynamics of discursive hegemony at work.

In chapters 3 and 4, I have discussed other methodological choices and limitations. Working with inexperienced interviewers and structured questionnaires with open-ended questions yielded mixed results. For instance, I could not solve the lack of timely follow-up questions that would encourage participants to elaborate on key topics. This happened all-too-often during the interviews. On the other hand, unscripted follow-ups made for telling, insightful moments that enriched the analysis, as I mention with specific examples in chapter 4.

Working with translations from the Amuzgo language was particularly tricky, and I am not sure that I have been able to avoid the many pitfalls that the use of discourse analysis implied in this case. As I mentioned in chapter 4, I have a fair degree of confidence when it comes to the main idea within a unit of analysis, most experiential meaning, some logical meaning, and intertextual and interdiscursive references. I have made a more restricted use of interpersonal meaning and I have analyzed some aspects of the rhetorical organization of certain texts; but I have not attempted to discuss the linguistic construal of the responses beyond this point. Despite some coordination and frequent consultation with the translators, there will still remain differences and inconsistencies that will further limit the validity of my analysis.

I also perceive a tension between depth and scope at different levels of this study. When I consider what I set out to do and what I found along the way, I think that I may have spread myself too thin, in detriment of a more elaborate discussion on each different topic. Indeed, each dimension of safe motherhood discourse, including those from health risk discourse, would merit a specific piece of research, all the more so when we take into account interactions with related discourses in any given social setting. And yet I feel there is something exciting and insightful when casting a wide net over social and cultural issues -like putting together a map of uncharted territory and seeing who is there, what they do, and how these people and doings connect with one another. To be sure, I have focused on some of these social actors and left others in the background. This happened for two reasons: first, I was mainly concerned with safe motherhood discourse, its main proponents, and their target audiences; then, I found it hard to manage a huge amount of data from the MNH Project. Charting the ideological complex of motherhood in Xochis with greater detail would require additional analysis of interviews, particularly with parteras and traditional healers. Follow-up studies would also be consistent with my theoretical approach, since they would allow us a longitudinal view of textual chains and social changes as they unfold in time. Among other things, we would be able to see how the different discourses gain or lose ground, and how people use them to make meaning and decisions regarding maternal health. This would have the same logic and value of other longitudinal studies in the medical and social sciences, and could be integrated to

future epidemiological and anthropological research in Xochis, together with the findings from the MNH Project 2008. It is in this sense that I reaffirm the exploratory value of my own study as a work in progress.

If I spread too thin on the research subject and the research problem, then I may have erred on the other side of the depth-versus-scope dilemma when it comes to the corpus. Here, I deliberately chose to work in depth on two representative samples of safe motherhood discourse targeting key stakeholders, and to provide additional elements from interviews with public health officials. I mentioned in chapter 3 how and why I did this. I selected two of the richest and most representative health promotion texts targeting primarily pregnant women and, to a lesser extent, their husbands and the general population in Xochis at the time of fieldwork. These texts condensed in a complex way key dimensions of safe motherhood discourse from both the global scene and the Mexican context. They were also important either because of their universal availability (every pregnant woman must carry her perinatal carnet) or the elaborated audiovisual narrative development of key safe motherhood topics (the video film), particularly in a rural indigenous context with high rates of female illiteracy. If I looked at these two texts in great detail it is because I believe –as do many discourse analysts- that the devil is in the semantic details –between the lines, in the framing of an image, and in the subtleties of a not-so-subtle musical score-, all the more so in heavily engineered texts for public health communication. Sometimes, it is in a frame rather than in a sequence that we will find a key intertextual reference with ideological implications.

There is also the fact that some semantic resources were representative of larger government campaigns and other communication products –like the expression "*Hazle caso a los mensajes de tu cuerpo*", and the construal of heeding as going by biomedical advice, which is also the key message in a flipchart-like booklet- and therefore deserved a closer look, precisely because of their wider presence in the discursive landscape of government safe motherhood communication. Truth be told, I also got carried away as I worked in the analysis, which I attribute as much to my own enthusiasm and obsession with detail as to the detail-oriented toolkit I drew from for textual analysis. Of course,

this type of analysis is not well suited for large corpora, and that is why sample selection becomes a crucial issue. I have confidence in my sample, but this is not quantitative research and other researchers might have selected other pieces or a larger sample.

Finally, I hope to have made some contribution to the field of contemporary public health communication and to have called the attention to some issues that may warrant further research –for instance, does safe motherhood communication steers people into thinking that prenatal control leads to safe childbirth, regardless of where it takes place? In this regard, my findings add to the vast body of literature, part of it discussed from chapters 1-3- that warns against expecting too much from health risk communication –particularly, when experts think it is all about getting people to "get it". People make meaning in very different ways, which are related to their own personal and social circumstances. Therefore, it may be productive to encourage more lines of research to try to determine how people make meaning out of specific health messages and apparently contradictory views and behaviours, taking into account their own active use of semantic resources and without looking for "the" meaning in particular, as Fairclough suggests.[20] [21]

My findings also add to the smaller though important amount of studies that point to ideological and value issues in public health communication. I also think that my work may have some added value in terms of encouraging the use of linguistics and discourse analysis in the domains of intercultural studies and public health.

Public health experts and government officials often believe –despite more than enough evidence to the contrary- that the social world can be captured through the same kind of

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[20] Fairclough N 1992, p. 105, 134.

[21] In this regard, it may be useful to differentiate between "making meaning" and "making sense". Both expressions are used, often interchangeably, in the literature. To me, "making sense" refers to *expectations of coherence* in our interpretation of utterances, texts, or situations. This might lead us to look for a particular, singular, univocal, and thus coherent and rational interpretation, based on the expectations of the Speaker –i.e. the designer of a government safe motherhood message. I even find the term connotes a passive stance from the person who makes or should make sense. On the other hand, "making meaning" implies using semantic resources to actively construe the world and our position in it, in the process drawing from, accepting or challenges other views; the result will often be ambivalent, equivocal, even contradictory, and thus incoherent or irrational when judged from a certain expectation of coherence or a narrow definition of rationality. This is why I mostly use the expression "making meaning" on this text.

scientific precision, usually translated into numbers, that we have come to expect from the natural sciences. This is not what happens in the domain of meaning making, and perhaps no research field gives us better evidence of this than the domain of public health communication, where the biomedical and epidemiological rationality behind public health campaigns meets –and often collides with- the multiple semantic worlds of our social life. If anything, I expect to have confirmed through my work that this is all the more evident in a multiethnic, multicultural environment like the one in Xochis.

Annex I: Letters

Red de Promotores de Salud Indígenas Amuzgos, A. C.

Guadalupe Victoria, Xochistlahuaca

Agosto 2 de 2006

Dr Ascencio Villegas Arrizón
Director de CIETmexico

Dr Villegas, primeramente a nombre de mis compañeros quiero agradecer a usted y a todos los compañeros del CIET por la capacitación que nos han dado para servir mejor a nuestras comunidades. ya que como sabe en muchos lugares no hay médicos ni enfermeras y muchas veces la gente no quiere ir por problemas de la lengua.

También queremos manifestarle nuestro agradecimiento por tomar en cuenta nuestra solicitud de ayudar a mejorar la salud de las mujeres. sobre todo de las embarazadas y de sus niños. Nosotros los promotores estamos dispuestos a colaborar en el Programa que el CIET ha elaborado sobre salud materna indígena en Guerrero, porque además de ayudar a nuestra gente vamos a seguir aprendiendo.

Atentamente
Celestino Gómez Vázquez

Guerrero
GOBIERNO DEL ESTADO

SECRETARÍA DE SALUD

DEPENDENCIA SECRETARIA DE SALUD DEL ESTADO DE GUERRERO
SUBSECRETARIA DE PREVENCION Y CONTROL DE ENFERMEDADES
DIRECCION DE SERVICIOS DE SALUD
SUBDIRECCION DE EDUCACIÓN MEDICA E INVESTIGACIÓN EN SALUD
SECCION AV. RUFFO FIGUEROA No 6
VIA COL. BUROCRATAS C.P. 39090
NUMERO DE OFICIO CHILPANCINGO, GRO
EXPEDIENTE 1581

ASUNTO: Carta de Colaboración

Chilpancingo, Gro; a - 8 SEP 2006

DR. ASCENCIO VILLEGAS ARRIZON
DIRECTOR DEL CENTRO DE INVESTIGACION DE ENFERMEDADES TROPICALES (U.A.G.)
ACAPULCO, GRO.
PRESENTE

Por medio de este conducto, informo a usted, que una de las prioridades de la Secretaría de Salud a mi cargo, es disminuir la mortalidad materna e infantil, preferentemente en los pueblos indígenas del Estado de Guerrero; por tal motivo me es grato manifestarle nuestra disposición a colaborar en la ejecución del Programa "Reducción de la Mortalidad Materna e Infantil en Comunidades Indígenas Remotas: Estudio Aleatorizado en México", que se pretende implementar en los municipios de Tlacoachistlahuaca y Xochistlahuaca con posibilidad de extenderlo a San Luis Acatlan, en la Costa Chica del Estado de Guerrero.
Sin duda los resultados que se generen con el programa serán de gran utilidad para nuestra institución, para la toma de decisiones, el diseño y desarrollo de estrategias que permitan fortalecer la organización y operación de los servicios, algunos de ellos son los siguientes:

1. Se pondrán obtener productos en beneficio de las mujeres y sus hijos, de los municipios incluidos; con la participación activa de diferentes actores sociales.
2. Mejorar la capacitación del personal de salud y adecuar los Programas de Salud materna y perinatal, descuerdo a las necesidades culturales de la Población indígena.
3. Se podrá mejorar la infraestructura y equipamiento de los Hospitales; básico comunitario de Xochistlahuaca y Hospital General de Ometepec, que son los Hospitales de Concentración, que atienden a la población de los municipios, donde se efectuará el programa.

Sin otro particular y esperando nos comente los apoyos necesarios para la ejecución de este programa hago propicia la ocasión para enviarle un cordial saludo.

ATENTAMENTE

SUFRAGIO EFECTIVO NO REELESCIÓN
EL SECRETARIO DE SALUD EN EL ESTADO

DR. LUIS R. BARRERA RIOS

DESPACHADO
08 SET. 2006
CONTROL DE GESTION
CHILPANCINGO, GRO

Guerrero
SECRETARÍA DE
ASUNTOS INDÍGENAS

Oficio No. : SAI/SSDPI/CI/ 00140 / 2006

Chilpancingo; Guerrero a 18 de agosto de 2006.

"2006. Año del Bicentenario del natalicio del Benemérito de las Américas,
Don Benito Juárez García"

DR. ASCENCIO VILLEGAS ARRIZÓN
INVESTIGADOR DEL CENTRO DE INVESTIGACIÓN DE ENFERMEDADES TROPICALES DE LA UNIVERSIDAD AUTÓNOMA DEL ESTADO DE GUERRERO.
ACAPULCO; GUERRERO.

En atención a la presentación de la propuesta del proyecto **"Salud Materna"** a realizarse en los municipios de Xochistlahuaca, Tlacoachistlahuaca y San Luis Acatlan. Me permito informarle que después de un análisis colegiado, esta Secretaría ha determinado que dicho proyecto es pertinente y certero para su aplicación en los municipios enumerados anteriormente, debido a que en ellos se concentra el mayor índice de mortalidad materno-infantil de nuestro estado de Guerrero.

No omito mencionar la importancia que este proyecto manifiesta hacia la participación social en el rescate de su cultura médica tradicional de los Pueblos Indígenas de la región; lo que enlaza de manera sustancial un posible trabajo conjunto sobre el tema, así como la activación de los procesos sociales para el fortalecimiento del tejido social de las comunidades que esta Secretaría realiza a través del instrumento metodológico denominado Modelo Intercultural para el Desarrollo de los Pueblos Indígenas (MIDEPI),eje rector de nuestro actuar institucional.

Sin otro particular y deseándole los mejores éxitos profesionales por el bien de los Pueblos Indígenas del estado de Guerrero, le envio un cordial saludo

ATENTAMENTE
EL SECRETARIO
"SUFRAGIO EFECTIVO, NO REELECCION"

GOBIERNO DEL ESTADO
SECRETARÍA DE ASUNTOS INDÍGENAS

C. CRISPIN DE LA CRUZ MORALES.

Guerrero
SECRETARÍA DE LA MUJER

DEPENDENCIA : SECRETARIA DE LA MUJER

NUM. DE OFICIO : SM/SP/671/06

ASUNTO : El que se indica

" 2006, Año del Bicentenario del Natalicio del Benemérito de las Americas, Don Benito Juárez García"

Chilpancingo, Gro., a 22 de agosto del 2006

DR. ASCENCIO VILLEGAS ARRIZON
DIRECTOR DEL CIET
UNIVERSIDAD AUTONOMA DE GUERRERO
P R E S E N T E.

En respuesta a su oficio de fecha 25 de Julio del año en curso, donde nos informa sobre su participación en obtener un financiamiento de una Institución Canadiense para un proyecto sobre salud materna en los Municipios de Tlacochistlahuaca y Xochistlahuaca con posibilidad de extenderlo a San Luis Acatlán.

Le manifiesto que es interés de esta Secretaria el colaborar con esta propuesta informándole que nuestra dependencia a través de la Subsecretaría de Equidad de Genero y Desarrollo Humano y la Dirección de Equidad de Genero implementan el Programa de la Institucionalización del Enfoque de Genero y Participación Social con el Subprograma Bienestar y Calidad de Vida de las Mujeres, el cual tiene el objetivo de fomentar entre las mujeres el conocimiento y cuidado de su cuerpo, así como el ejercicio de sus derechos sexuales y reproductivos. Cabe mencionar que este Subprograma lo realizamos en coordinación con la Secretaría de Salud. Una de las acciones del fortalecimiento de la salud de las mujeres, es la capacitación a parteras tradicionales buscando con ello contribuir a disminuir la mortalidad materna.

Por lo antes expuesto le expreso mi más amplio reconocimiento y colaboración con el proyecto que la unidad académica que usted dirige presentado para lograr financiamiento por una institución extranjera, esperando realizar una agenda de trabajo con algunas dependencias del gobierno del estado comprometidos con la problemática antes mencionada.

Sin otro particular, me despido de usted enviándole un cordial saludo.

ATENTAMENTE
"SUFRAGIO EFECTIVO. NO REELECCION"
LA SECRETARIA

Gobierno del Estado Libre y
Soberano de Guerrero
Poder Ejecutivo
Secretaría de la Mujer

C. ROSA MARIA GOMEZ SAAVEDRA

C.C.P.- C.P. CARLOS ZEFERINO TORREBLANCA GALINDO.-Gobernador Constitucional del Estado. Para su superior conocimiento. Presente.
C c.p.- LIC. VIOLETA PINO GIRON .-Sub`secretaria de Equidad de Genero y Desarrollo Humano.-Para su conocimiento.- Edificio.
C.c.p.- MINUTARIO.

Guerrero
GOBIERNO DEL ESTADO
SECRETARIA GENERAL DE GOBIERNO

COESPO

"2006 AÑO DEL BICENTENARIO DEL NATALICIO DE DON BENITO JUÁREZ GARCÍA"

SECCIÓN: Secretaría General de Gobierno
ASUNTO: El que se indica.

Chilpancingo, Gro; a 17 de Agosto de 2006.

DR. ASCENCIO VILLEGAS ARRIZON
INVESTIGADOR PRINCIPAL DEL PROYECTO
SOBRE SALUD MATERNA Y PERINATAL.
P R E S E N T E

Como es de su conocimiento, el estado de Guerrero es una de las entidades federativas con mayores rezagos en desarrollo humano y con índices de mortalidad materna e infantil más elevados. A pesar de los grandes avances logrados en materia de derechos sexuales y reproductivos logrados en nuestro Estado, continua habiendo diferencias importantes entre la población indígena y el resto de la población.

Por lo anterior, el Consejo Estatal de Población, por mi conducto, le expresa todo el apoyo en la realización del proyecto:"reducción de la mortalidad materna e infantil en comunidades indígenas remotas; estudio aleatorizado en México", el cual generara información que nos sera de utilidad en el diseño de políticas adecuadas culturalmente para la población indígena y encaminadas a mejorar la salud materna e infantil entre esa población.

Sin otro particular, aprovecho la ocasión para enviarle un cordial saludo.

T E N T A M E N T E.
SUFRAGIO EFECTIVO. NO REELECCIÓN
EL SECRETARIO TÉCNICO DEL COESPO

M.C. [illegible] CAMPAÑA LÓPEZ

COESPO
GUERRERO

RECTORÍA

Universidad Autónoma de Guerrero

AV. JAVIER MÉNDEZ APONTE NÚM. 1 COL. SERVIDOR AGRARIO C.P. 39070 TEL. 47 19310 . FAX 47 22910
CHILPANCINGO, GUERRERO, MÉXICO

"2006 Año del Bicentenario del Natalicio de Don Benito Juárez García"

Dr Ascencio Villegas Arrizón
Presente

La Universidad Autónoma de Guerrero se congratula por el esfuerzo que ha realizado el Centro de Investigación de Enfermedades Tropicales, elaborando el proyecto: ***"Reducción de la mortalidad materna e infantil en comunidades indígenas remotas: Estudio aleatorizado en México"***, con el cual la UAG cumplirá su vocación de servicio y compromiso con la población más necesitada del estado de Guerrero.

Por la calidad de la investigación científica que caracteriza a su institución, estoy seguro que el mencionado proyecto generará conocimiento de utilidad en la capacitación de los estudiantes de medicina y de enfermería, quienes realizan su servicio social en las comunidades indígenas.

Me despido de usted, reiterándole el apoyo de la Universidad para que el CIET cumpla con los compromisos planteados en el proyecto.

A t e n t a m e n t e

UNIVERSIDAD AUTÓNOMA DE GUERRERO

Dr. Dolores Arturo Contreras Gomez
Rector

RECTORÍA

Dependencia: H. Ayuntamiento Municipal
Sección: Presidencia Municipal
Oficio Número: PM/393/2006
Asunto: Solicitando apoyo al programa de mortalidad materna.

"2006" Año del Bicentenario del Natalicio del Benemérito de las Américas Don Benito Juárez García

Xochistlahuaca, Gro., a 07 de Septiembre del 2006.

DR. ASCENCIO VILLEGAS ARRIZÓN
DIRECTOR DEL CIET
ACAPULCO, GRO.

Sirva la presente para enviarle un cordial saludo, aprovecho la ocasión para solicitarle su invaluable apoyo para que el Municipio de Xochistlahuaca, Gro., que muy dignamente represento pueda entrar y ser beneficiado con el programa **"Reducción de la Mortalidad Materna e Infantil en Comunidades indígenas Remotas: Estudio Aleatorizado en México"**, con objetivo de mejorar la salud de mis hermanas amuzgas y reducir la mortalidad materna, reiterándole mi compromiso y disposición de contribuir en lo que sea necesario para la difusión y aplicación del programa.

Sin otro particular, en espera de vernos beneficiados con dicho beneficio, le reitero mi más distinguida consideración.

Atentamente
Sufragio Efectivo No Reelección
La Presidenta Municipal Constitucional

PRESIDENCIA
H. AYUNTAMIENTO
CONSTITUCIONAL

Profra. Aceadeth Rocha Ramírez

c.c.p. Expediente.

H. AYUNTAMIEN[illegible]

Guerrero

DEPENDENCIA: H AYUNTAMIENTO CONST
SECCION: PRESIDENCIA
OFICIO NUM.: 1313/2006
ASUNTO: El que se indica.

Tlacoachistlahuaca, Gro., a 9 de Septiembre de 2006.

C. Dr. Ascencio Villegas Arrizon
Director del CIET.
Acapulco, Gro.
P r e s e n t e :

Como es de su amable conocimiento que el Municipio de Tlacoachistlahuaca, Guerrero, se encuentra dentro de los nueve Municipios mas pobres del Estado de Guerrero, por lo tanto la población tiene un sin fin de necesidades, así como también padece de muchas enfermedades; razón por la cual solicito su comprensión y apoyo para que este Municipio entre y sea beneficiado con el programa: **"Reducción de la Mortalidad materna e infantil en Comunidades indígenas remotas: Estudios aleatorizado en México"** con la finalidad de mejorar la salud de nuestros hermanos indígenas; reiterándole mi compromiso y disposición de contribuir en lo que sea necesario para la difusión y aplicación de este tan importante y necesario programa.

Sin más por el momento reciba un cordial saludo.

Atentamente
"Lucha y Reelección"
El Presidente Municipal Constitucional

LIC. ELOY SALMERON DIAZ

C.c.p. El archivo.

Kinal Antzetik, A. C.

Mèxico, D. F., a 18 de agosto - 2006

Dr. ASCENCIO VILLEGAS ARRIZON.
Centro de Investigación de Enfermedades Tropicales.
Universidad Autónoma de Guerrero
Presente.

Por este medio, me permito avalar los objetivos planteados en el proyecto *Reducción de la mortalidad materna e infantil en comunidades indígenas remotas: Estudio aleatorizado en México*, considerando que se enfoca en las zonas marginadas del estado de Guerrero, que se caracteriza por la marginación se la población indígena y por los escasos servicios de salud.
Para nuestra organización, el desempeño de dicho proyecto representaría un avance en la valorización de los medios tradicionales de sanación, tales como la parteria, y reforzaría el trabajo de las promotoras comunitarias en salud materna.
Asimismo, reconocemos la importancia de enfoque intercultural que se plantea en su proyecto, por lo que estamos seguras del logro de las metas que se proponen, así como del cumplimiento de los programas de desarrollo comunitario y de capacitación a los cuales se comprometan, teniendo la certeza que es una institución que cumple cabalmente los compromisos adquiridos.

Sin otro asunto a tratar, quedo de usted.

Atentamente

Nellys Palomo Sánchez
Representante legal

San Simon No. 82 – 306 Col San Simón, C P. 03660. México, D. F. Tel/fax 55394377
Correo electrónico: kinaldf@yahoo.com mx

7 de septiembre del 2006

Dr. Ascencio Villegas Arrizón

Estimado Dr. Villegas,

Al enterarme de su proyecto de investigación sobre salud materna indígena en Guerrero por parte del Centro de Investigación de Enfermedades Tropicales de la Universidad Autónoma de Guerrero y del cual usted es el investigador principal del proyecto, quiero a través de este conducto manifestarle mis mas sinceras felicitaciones por este trabajo que se llevará a cabo dada la importancia que tiene en estas zonas tan aisladas como las comunidades amuzgas del municipio de Xochistlahuaca que tanto requieren de la atención de todos.

Le deseo el mayor de los éxitos en esta investigación en la reducción de la mortalidad materna e infantil al integrar las prácticas tradicionales de atención del embarazo y el parto con los métodos de la medicina moderna, y así, con el tiempo veamos un cambio favorable en una realidad como la que se vive en este siglo XXI en estas comunidades indígenas.

Le informo que Fundación Justicia y Amor impulsa la Red Nacional de Salud Comunitaria "Casa de Vida" al cual pertenecen estas comunidades amuzgas del Municipio de Xochistlahuaca. Esta Red es un espacio de encuentro de promotores, grupos organizados e instituciones que trabajan para recuperar la salud comunitaria de manera integral. En esta Red al compartir conocimientos, experiencias de fe y vida, estrategias de trabajo, así como , formación y capacitación, las personas reciben la motivación y el fortalecimiento humano y espiritual necesarios para continuar su tarea de transformar la realidad de marginación, pobreza y desesperanza favoreciendo la organización, la creatividad comunitaria y el mejoramiento de la calidad de vida de las comunidades donde están insertos.

Creo firmemente que el trabajo que ambos realizamos están fuertemente ligados y por esta misma razón le invito a mantener un fuerte lazo en la comunicación. Reitero mis mejores deseos en su investigación, y que sus logros se traduzcan en bienestar para todas estas familias, mujeres y niños que son el futuro de nuestro México.

Atentamente

Ma. del Pilar Martínez Maqueo
Directora General

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Iniciativa por una Maternidad sin Riesgos en México

Mexico D.F. 12 de agosto, 2006

Dr. Ascencio Villegas Arrizón
Centro de Investigaciones de Enfermedades Tropicales
Universidad Autónoma de Guerrero

Estimado Dr. Villegas Arrizón:

Como usted conoce, el Comité Promotor por una Maternidad sin Riesgos en México (CPMSR) es una instancia plurisectorial, creada en 1993, para contribuir al abatimiento de la mortalidad materna. En los últimos años se ha visto un ligero avance en este sentido. Sin embargo, en nuestro país, al igual que en muchos otros, los promedios nacionales ocultan las enormes e injustas desigualdades a su interior. Las muertes maternas coinciden, en la geografía nacional, con la existencia de grupos de población que sufren mayores índices de marginación social y económica, particularmente, los indígenas.

Su vulnerabilidad se incrementa por el inadecuado diseño de los programas de salud, que no reconocen sus valores, formas de organización, enfoques hacia las enfermedades, prácticas médicas tradicionales, etc., generándose "desencuentros culturales y operativos" entre las instituciones y las comunidades, afectando la solución a sus problemas de salud.

De ahí que el CPMSR considere de gran utilidad el proyecto **"Reducción de la mortalidad materna e infantil en comunidades indígenas remotas: Estudio aleatorizado en México".** Sus resultados -cuya calidad estará garantizada por su amplia experiencia y capacidad profesional-, brindarán al Comité insumos pertinentes para elaborar propuestas de políticas públicas concertadas con la sociedad civil, no sólo dirigidas al Estado de Guerrero sino a los demás del país donde habita población indígena. Por ello le expresamos nuestro total apoyo al Proyecto.

Aprovechamos la oportunidad para enviarle un saludo y suscribimos de usted.

Atentamente

Dra. María del Carmen Elu
Secretaria Técnica,CPMSR

Comite Promotor por una Maternidad sin Riesgos en Mexico Secretaria Tecnica Maria del Carmen Elu 518
Calle 9 No 88, Col San Pedro de los Pinos, 03800 México, D F Tel y Fax. 5273-4319 imesinsr@prodigy.net.mx

CIET

UNIVERSIDAD AUTÓNOMA DE GUERRERO
UNIDAD ACADÉMICA
CENTRO DE INVESTIGACIÓN DE ENFERMEDADES TROPICALES

Agosto 30 de 2007

To the
Research Ethics Board
University of Ottawa

Dear Sirs/Madams,

This is to confirm that Jorge O. Laucirica, PhD candidate at the University of Ottawa, will be working with the Centro de Investigación de Enfermedades Tropicales (CIET) at the Universidad Autónoma de Guerrero, in his doctoral thesis project on: "Key dimensions and ideological implications of safe motherhood discourse in a remote indigenous community in Mexico."

Mr. Laucirica's project is part of an overarching research initiative on maternal and newborn health in Aboriginal communities bringing together researchers from CIETmexico, CIETcanada -an academic NGO that carries out public health research in several countries-, Guerrero State's Health Secretariat, and other key partners/users from government and civil society in Mexico. This initiative was born at the request of the Association of Indigenous Amuzgo Health Promoters of Xochistlahuaca, a rural municipality with majority of Amuzgo population in Guerrero state, where CIET has been partnering with communities for health research and planning since 1986. These voluntary community workers experienced first-hand community resistance to government policies that seek to institutionalize pregnancies and childbirth, based on western biomedical views and practices, in order to revert excessive rates of maternal mortality among indigenous populations –a common trend in Mexico and across the Americas.

Our response to this community concern is an attempt to find ways of reducing maternal mortality and morbidity in cultural safety. Mr Laucirica's work on risk discourse would fit very well into this, adding a valuable new angle to CIET's usual epidemiological approach. He will analyze government, expert and lay discourses on pregnancy and childbirth, in order to identify underlying conflicts and connections, cultural values and ideological implications –in particular, concerning women's rights.

To facilitate his work in Mexico, CIET will assist Mr. Laucirica in accessing key informants and recruiting participants. He will also have full institutional and logistical support from CIET

Please, note that both the overarching research initiative and Mr. Laucirica's thesis project have received ethical approval from the University of Guerrero.

Sincerely

Dr Ascencio Villegas Arrizón
Director UA CIET

Unidad Academica
CIET

Annex II: Questionnaires

Guía para entrevistas con funcionarios de salud en el ámbito estatal y de la jurisdicción de Ometepec

Introducción

Los entrevistadores entregarán la carta de información sobre el proyecto, o bien leerán la información en voz alta, incluyendo los derechos de los entrevistados, el anonimato y la confidencialidad de los datos, y el uso que se hará de la información, tal como fue aprobado por el Comité de Ética. Los informantes clave firmarán los formularios de consentimiento o bien darán su aprobación en forma oral en la grabación de la entrevista, según prefieran, siguiendo el formato aprobado por el Comité de Ética. Aun cuando se obtenga consentimiento escrito, los entrevistadores pedirán la confirmación verbal al inicio de la grabación, como sigue:
"La siguiente entrevista se realiza en XXX, el XXX, con PRIMER NOMBRE o SEUDÓNIMO.
"¿Puede identificarse con su primer nombre, de manera que quede registrada su voz como la de la misma persona que vamos a entrevistar?
"¿Acepta que lo entrevistemos para este proyecto, en las condiciones que mencionamos anteriormente?"

Entrevista

[*No todas las preguntas se emplearán con todos los entrevistados, ni se harán siempre en el mismo orden*]

-¿Cuáles son las principales causas de complicaciones del embarazo y el parto en el Estado/el distrito?
-¿Estos problemas siempre se pueden prevenir?
-¿Qué tipo de consejos les dan a las embarazadas indígenas en poblaciones rurales?
-¿Qué política siguen ustedes para trabajar con las embarazadas indígenas y con qué dificultades se encuentran?
-¿Qué uso se hace del programa Oportunidades?
-¿Cuál es la relación que existe entre Oportunidades y el Seguro Popular?
-¿Para tener Oportunidades y el Seguro Popular, las mujeres tienen la obligación de asistir a los controles y charlas mensuales?
-¿Hacen ustedes una estrategia de detección y seguimiento de la embarazada, o les dan instrucciones y esperan que las cumplan?
-¿Cuándo piden ustedes que se deriven las embarazadas al segundo o tercer nivel del sistema?
-¿Consideran ustedes que todos los embarazos son de riesgo?
-¿Clasifican a las embarazadas según niveles de riesgo?
-¿Sobre qué base clasifican embarazos de riesgo alto, mediano o normal?
-¿Es política estatal/distrital explicarle a las embarazadas si son de riesgo alto, mediano o normal?
-¿Ser indígena es un factor de riesgo en el embarazo?
-¿Ser de talla pequeña es un factor de riesgo?
-¿No hablar español es un factor de riesgo?

Si los entrevistados responden afirmativamente a cualquiera de las últimas tres preguntas: ¿Esta evaluación queda registrada en la historia clínica? ¿Se lo informan a la embarazada?
-¿Cuál es la política cuando las embarazadas de alto riesgo no vienen a los controles prenatales?
-Cuando las embarazadas van a los controles, ¿dónde les sugieren que tengan a sus hijos?
-¿Los partos en centros de salud y hospitales son menos riesgosos que los partos en el hogar?
-¿Cómo es un caso típico que llega hasta el sistema de salud a raíz de una complicación en el parto? ¿Puede recrear el proceso, desde su inicio en la comunidad?
-En la política de atención del parto ¿ustedes tienen alguna norma que pida en los centros de salud a los médicos que le den a la mujer la opción de parir en la posición que quiera y en el lugar que quiera?
-¿En qué posición se atiende en la mayoría de los casos? ¿Por qué?
-¿Ustedes están dispuestos a aceptar el parto domiciliario como alternativa al parto institucional?
-¿Qué están haciendo ustedes desde el Estado/la jurisdicción para mejorar la interacción con las embarazadas indígenas?
-¿La estrategia consiste en llegar a las mujeres o también a los maridos y a otros miembros de la familia?
-¿Cuáles son los principales problemas que encuentran en este sentido? ¿Cuáles son los problemas con las pacientes y sus familiares? ¿Cuáles son los problemas dentro del sistema de salud?
-¿Se encuentran con los mismos problemas cuando interactúan con personas mestizas en las mismas comunidades?
-¿Cómo manejan la interacción entre el personal de salud y la gente que concurre a los centros de salud cuando no se habla el idioma de las comunidades?
-¿Cuál es la actitud de las mujeres durante las consultas? ¿Hablan, preguntan, expresan sus ideas, o simplemente escuchan lo que se les dice?
-¿Están haciendo algún seguimiento de cómo se trata a las mujeres y sus familiares desde una perspectiva cultural en los centros de salud y hospitales?
-¿Cuál es el impacto en la comunidad cuando una embarazada muere en un centro de salud o en un hospital?
-¿Qué pasa cuando las mujeres han tenido malas experiencias y no quieren regresar a los hospitales?
-¿Qué cuidados les piden a las madres después del parto?
-¿Qué cuidados les piden con sus niños recién nacidos?
-¿Cuál es la respuesta de las personas en las comunidades?
-¿Hay conflictos entre lo que ustedes piden y lo que se hace tradicionalmente en las casas?
-¿Cómo actúan ustedes cuando las madres no llevan los niños a la consulta posparto?
-¿Cómo hacen para saber si todos los niños que nacen están registrados?
-¿Puedo acceder a una copia de los distintos materiales de difusión sobre embarazo saludable y parto seguro que tienen para trabajar con el público?
En algunos casos,
-¿Podemos discutir cuándo y cómo se usan estos materiales?

Guía para entrevistas con el personal de centros de salud y hospitales públicos de Xochistlahuaca y Ometepec

Introducción

Los entrevistadores entregarán la carta de información sobre el proyecto, o bien leerán la información en voz alta, incluyendo los derechos de los entrevistados, el anonimato y la confidencialidad de los datos, y el uso que se hará de la información, tal como fue aprobado por el Comité de Ética. Los informantes clave firmarán los formularios de consentimiento o bien darán su aprobación en forma oral en la grabación de la entrevista, según prefieran, siguiendo el formato aprobado por el Comité de Ética. Aun cuando se obtenga consentimiento escrito, los entrevistadores pedirán la confirmación verbal al inicio de la grabación, como sigue:
"La siguiente entrevista se realiza en XXX, el XXX, con PRIMER NOMBRE o SEUDÓNIMO.
"¿Puede identificarse con su primer nombre, de manera que quede registrada su voz como la de la misma persona que vamos a entrevistar?
"¿Acepta que lo entrevistemos para este proyecto, en las condiciones que mencionamos anteriormente?"

Entrevista

[*No todas las preguntas se emplearán con todos los entrevistados, ni se harán siempre en el mismo orden*]

-¿Cuáles son los principales problemas que encuentran al tratar con las embarazadas amuzgas y sus familias?
-¿Encuentran los mismos problemas cuando tratan con embarazadas mestizas y sus familias?
-¿Puede usted explicarme cómo es una charla habitual con una embarazada indígenas, cuando llega por primera vez a su consultorio? ¿Quién tiene el primer contacto con la mujer y qué le dicen o le preguntan?
-¿Durante la primera consulta, en términos generales, qué cosas suelen decir las mujeres y qué cosas les dice usted?
-¿Hay normas que indiquen lo que ustedes tienen que decirles y pedirles a las embarazadas?
-¿Cuál es la actitud de las mujeres durante las consultas? ¿Hablan, preguntan, expresan sus ideas, o simplemente escuchan lo que se les dice?
-¿La conversación se desarrolla en español o en amusgo?
-¿Quién traduce?
-¿Hay problemas de comunicación incluso con traducciones?
-¿Los términos que ustedes usan, existen en amusgo, o los traductores usan los términos en español?
Para el personal que habla amusgo o conoce el idioma:
-¿Existe la palabra "riesgo" en amusgo?
Si no existe,
-¿Cómo la traduce y qué significa en amusgo?

-¿Qué otros problemas presenta la traducción de los conceptos occidentales? Pedir ejemplos

Para todos los entrevistados:

-¿Les explican a las mujeres para qué sirven las vacunas que se deben aplicar durante el embarazo? ¿Cómo les explican?
-¿Cada cuánto se les pide a las embarazadas que regresen a la consulta?
-¿Estas consultas se plantean como una obligación o como una elección?
-¿Las embarazadas siguen estas indicaciones?
-¿Las mujeres van a las visitas solas o acompañadas?
-¿Los médicos tocan a las embarazadas para explorarlas? ¿Cómo les explican la necesidad de tocarlas?
-¿Cuál es la reacción de las mujeres?
-¿Es diferente la reacción si se trata de una médica?
-¿Qué tipo de estudios se ordenan?
-¿Cómo reaccionan las mujeres indígenas frente a estos estudios?
-En este centro de salud/hospital, ¿tienen ustedes una estrategia de detección y seguimiento de la embarazada, o les dan instrucciones y esperan que las cumplan?
-¿Consideran ustedes que todos los embarazos son de riesgo?
-¿Clasifican a las embarazadas según niveles de riesgo?
-¿Sobre qué base clasifican embarazos de riesgo alto, mediano o normal?
-¿Ustedes le explican a las embarazadas si son de riesgo alto, mediano o normal?
-¿Ser indígena es un factor de riesgo en el embarazo?
-¿Ser de talla pequeña es un factor de riesgo?
-¿No hablar español es un factor de riesgo?
Si los entrevistados responden afirmativamente a cualquiera de las últimas tres preguntas: ¿Esta evaluación queda registrada en la historia clínica? ¿Se lo informan a la embarazada?
-¿Qué clase de consejos les dan, en general, a las embarazadas indígenas?
-¿Cómo le explican a una embarazada indígena que tiene o puede llegar a tener pre-eclampsia? ¿Qué le dicen de los riesgos?
-¿Qué hacen cuando las embarazadas de alto riesgo no vienen a los controles prenatales?
-¿Cuándo derivan a las embarazadas al segundo y tercer nivel?
-¿Cómo reaccionan las mujeres y los familiares ante las derivaciones al hospital?
-Cuando la mujer es reacia, ¿hablan ustedes con el marido para persuadirlo?
-¿Las mujeres derivadas deben pagar algo en los hospitales? ¿Ustedes les informan acerca de esto? ¿Qué pasa cuando no pueden viajar al hospital por los costos?
-¿Qué les dice usted respecto del parto? ¿Dónde les recomienda que se alivien y por qué?
-¿Qué piensa usted de que las mujeres se alivien en su casa y con parteras?
Posible repregunta:
-¿Ustedes consideran que el parto en el centro de salud o en el hospital es menos riesgoso que el paso en los hogares con asistencia de la familia y la partera?
-¿Qué les dice usted a las pacientes respecto de aliviarse en su casa y con partera?
-¿Qué dicen las mujeres cuando ustedes les comentan que pueden tener un parto riesgoso?
-¿Y qué hacen las mujeres para el parto, vienen al centro/hospital o se alivian en su casa?

-¿Cómo atiende usted los partos que llegan al centro de salud/hospital? ¿Puede describir el proceso?

Si no lo menciona, preguntar por:

-¿Quién recibe a la embarazada y qué le dice?
-¿Qué preguntas se le hacen a la embarazada?
-¿Dónde se atiende el parto?
-¿En qué posición se atiende el parto? ¿Por qué?
-¿Le ofrecen a las mujeres que elijan en qué posición se quieren aliviar?
-¿Se permite que la familia esté presente mientras la mujer se alivia?
-¿La partera puede estar presente durante el parto?
-¿Usted permite que la partera atienda el parto?
-¿Usted permite que la mujer conserve sus amuletos en la sala de parto?
-¿Ustedes le entregan la placenta a la madre o a la familia, o sólo lo hacen si la familia la reclama?

-¿En este centro de salud/hospital pueden resolver un parto complicado o tienen que derivar a la paciente?
-¿En este centro de salud/hospital pueden atender a un niño que no respira al nacer?
-¿Cómo interactúan con las familias de las embarazadas? ¿Qué problemas encuentran en este sentido?
-¿Cuál es el impacto en la comunidad cuando una embarazada muere en un centro de salud o en un hospital?
-¿Qué cuidados les piden a las madres después del parto?
-¿Qué cuidados les piden con sus niños recién nacidos?
-¿Cuál es la respuesta de las madres?
-¿Hay conflictos entre lo que ustedes piden y lo que se hace tradicionalmente en las casas?
-¿Cómo actúan ustedes cuando las madres no llevan los niños a la consulta posparto?
-¿Cómo hacen para registrar nacimientos y muertes perinatales?
-De su experiencia, ¿en las comunidades se presta más atención a la salud de la madre o a la del bebé?
-¿Puedo acceder a una copia de los distintos materiales de difusión sobre embarazo saludable y parto seguro que tienen para trabajar con el público?

En algunos casos,

-¿Podemos discutir cuándo y cómo se usan estos materiales?

Guía para entrevistas con informantes clave en instituciones religiosas

Introducción

Los entrevistadores entregarán la carta de información sobre el proyecto, o bien leerán la información en voz alta, incluyendo los derechos de los entrevistados, el anonimato y la confidencialidad de los datos, y el uso que se hará de la información, tal como fue aprobado por el Comité de Ética. Los informantes clave firmarán los formularios de consentimiento o bien darán su aprobación en forma oral en la grabación de la entrevista, según prefieran. Aun cuando se obtenga consentimiento escrito, los entrevistadores pedirán la confirmación verbal al inicio de la grabación, como sigue:
"La siguiente entrevista se realiza en XXX, el XXX de XXXX, con XXX.
"¿Puede identificarse con su primer nombre o seudónimo, de manera que quede registrada su voz como la de la misma persona que vamos a entrevistar?
"¿Acepta que lo entrevistemos, en las condiciones que mencionamos anteriormente?"

Entrevista

-¿Cómo ven ustedes, en la Iglesia, que las parejas tengan relaciones y se casen jóvenes aquí en Xochistlahuaca?
-¿Hay diferencias de prácticas entre amuzgos y mestizos?
-¿Cómo ven el papel de las familias en todo esto?
-¿Se habla de estas cosas en la iglesia?
-¿Cómo lo hacen, desde el púlpito, o hablando personalmente con la gente?
-¿Qué es lo que recomiendan ustedes en la iglesia?
-¿Cuál es la política y la práctica de su iglesia, aquí en Xochistlahuaca, respecto de los casamientos entre menores?
-¿Consideran que alguna de estas prácticas es un pecado? ¿Así lo hablan con la gente?
-¿Se habla en la iglesia del cuidado de la embarazada?
-¿Se habla de la atención del parto?
-¿Qué les recomiendan ustedes a las mujeres embarazadas?
-¿Ustedes desalientan algún tipo de prácticas tradicionales o recomendadas por los médicos durante el embarazo?
-¿Consideran que alguna de estas prácticas tradicionales o médicas es un pecado?
-¿Ha habido cambios en ese sentido, o se siguen las mismas políticas y enseñanzas que hace veinte o treinta años?
-¿Qué creencias tiene la gente en torno del embarazo y el parto aquí en Xochistlahuaca?
-¿Quién consideran ustedes que es la principal influencia en materia de cuidados del embarazo y el parto entre las mujeres indígenas aquí en Xochistlahuaca?
-¿A quiénes consultan las personas acerca del embarazo y el parto?
-¿Ustedes recomiendan que consulten a alguien en particular?
-¿Quién toma las decisiones en la familia sobre los cuidados que hay que dar, a quién ver y todo eso?
-¿Sus feligreses prefieren tener los hijos en su casa, en el centro de salud o en el hospital? ¿Por qué?
-¿Qué prefiere la gente, tener hijos o hijas?

-¿Podría explicarme qué creencias y prácticas tiene la gente cuando muere una madre en el embarazo, durante el parto o poco después de aliviarse? (por ejemplo, cómo reaccionan, por qué creen que pasó, qué creen respecto del alma de la persona que murió)
-¿Qué dicen ustedes en la iglesia en estos casos?
-¿Qué creencias y prácticas tiene la gente cuando muere un niño en el vientre de la madre o recién nacido? (cómo reaccionan, por qué creen que pasó, qué creen acerca del alma del niño, cómo los velan o los entierran)

-*Si el entrevistado no lo dice, comentar lo siguiente*: Algunas personas nos dicen que la creencia es que el niño que así muere es un angelito y va directamente al cielo; otros dicen que hay diferencias entre niños bautizados y no bautizados. ¿Qué piensa la gente aquí en Xochistlahuaca?
-¿Qué dicen ustedes en la iglesia en estos casos?

Guía para entrevistas con maestros y directores de escuelas

Introducción

Los entrevistadores entregarán la carta de información sobre el proyecto, o bien leerán la información en voz alta, incluyendo los derechos de los entrevistados, el anonimato y la confidencialidad de los datos, y el uso que se hará de la información, tal como fue aprobado por el Comité de Ética. Los informantes clave firmarán los formularios de consentimiento o bien darán su aprobación en forma oral en la grabación de la entrevista, según prefieran, siguiendo el formato aprobado por el Comité de Ética. Aun cuando se obtenga consentimiento escrito, los entrevistadores pedirán la confirmación verbal al inicio de la grabación, como sigue:
"La siguiente entrevista se realiza en XXX, el XXX, con PRIMER NOMBRE o SEUDÓNIMO.
"¿Puede identificarse con su primer nombre, de manera que quede registrada su voz como la de la misma persona que vamos a entrevistar?
"¿Acepta que lo entrevistemos, en las condiciones que mencionamos anteriormente?"

Entrevista

-¿Qué actitudes y costumbres ve usted entre los jóvenes que puedan estar relacionados con la salud durante el embarazo y el parto?
-¿Ve usted alguna diferencia entre los jóvenes que acuden a la escuela y los que no?
-¿Ve alguna diferencia entre los/las jóvenes amuzgos/as y los mestizos?
-¿A qué edad se comprometen y se casan los jóvenes en Xochistlahuaca? ¿Por qué cree que es así?
-¿Cómo ve usted que las parejas se casen cuando aún no tienen la edad legal para hacerlo?
-¿Cómo ve el papel de las familias en todo esto? ¿Cómo son los arreglos entre familias?
-¿Los alumnos le piden consejo a usted o a otros maestros?
-¿Qué hace usted en esos casos?
-¿Se habla en la escuela de la prevención y el cuidado del embarazo?
-¿Cuándo se habla de estos temas, en las distintas clases, mediante invitados, o hay momentos especiales dentro de la actividad escolar?
-¿Son charlas para grupos de varones y mujeres?
-¿Cuáles son los contenidos?¿Qué es lo que recomiendan ustedes en la escuela?
-¿Siguen alguna política o lineamiento para estas charlas? ¿Son contenidos generales que vienen del gobierno federal o provincial? ¿O hay contenidos locales? ¿Se contemplan las culturas de la región?
-¿Utilizan materiales que vienen en los libros, materiales de otras instituciones?
-¿En qué idioma vienen estos materiales?
-¿Ha habido cambios en ese sentido, o se siguen las mismas políticas y el mismo discurso que hace veinte años?
-¿Estas charlas tienen algún tipo de impacto entre los jóvenes? ¿Cómo lo sabe?
-¿Cuál es la reacción de los padres ante lo que se hace en la escuela sobre estos temas?

-¿Hay alumnos que se le hayan acercado a usted o a otros maestros para conversar estos temas en forma personal, para consultar lo que hacer ante un embarazo?
-¿Quién considera usted que es la principal influencia en materia de cuidados del embarazo y el parto entre las mujeres indígenas aquí en Xochistlahuaca?
-¿A quiénes consultan las personas acerca del embarazo y el parto?
-¿Qué diferencias ven ustedes entre brujos, médicos tradicionales y parteras?
-¿Quién toma las decisiones sobre los cuidados que hay que dar, a quién ver y todo eso?
-¿Las jóvenes que están embarazadas prefieren tener los hijos en su casa, en el centro de salud o en el hospital? ¿Por qué?
-¿Ustedes ven que los amuzgos integren conocimientos tradicionales con conocimientos médicos?
-¿Hay diferencias de creencias y prácticas entre mestizos, amuzgos y mixtecos?

Guía de entrevistas para parteras

Introducción

Los entrevistadores entregarán la carta de información sobre el proyecto, o bien leerán la información en voz alta, incluyendo los derechos de los entrevistados, el anonimato y la confidencialidad de los datos, y el uso que se hará de la información, tal como fue aprobado por el Comité de Ética. Los informantes clave firmarán los formularios de consentimiento o bien darán su aprobación en forma oral en la grabación de la entrevista, según prefieran, siguiendo el formato aprobado por el Comité de Ética. Aun cuando se obtenga consentimiento escrito, los entrevistadores pedirán la confirmación verbal al inicio de la grabación, como sigue:
"La siguiente entrevista se realiza en XXX, el XXX, con PRIMER NOMBRE o SEUDÓNIMO.
"¿Puede identificarse con su primer nombre, de manera que quede registrada su voz como la de la misma persona que vamos a entrevistar?
"¿Acepta que la entrevistemos, en las condiciones que mencionamos anteriormente?"

Entrevista

-¿Cuántos años hace que trabaja como partera?
-¿Cómo aprendió este oficio?
-¿En qué momento del embarazo la vienen a ver las mujeres?
-¿Qué hace usted durante la consulta?
-¿Cuántas veces les sugiere a las mujeres que la visiten durante su embarazo?
-¿Las embarazadas le hacen caso?
-¿Qué le recomienda a las mujeres indígenas para cuidar su embarazo, para que ellas estén bien y sus niños también?
-¿Por qué recomienda esto?
Si no los menciona, preguntar por:
    -¿Les recomienda que coman más, menos o igual que de costumbre?
    -¿Les recomienda que trabajen más, menos o igual que de costumbre?
    -¿Les recomienda que vayan al centro de salud para controlarse?
-¿Las mujeres siguen estas recomendaciones suyas?
-¿Qué problemas o señales de alarma indican peligro para una mujer o para el niño durante el embarazo?
-Si la embarazada tiene alguno de estos problemas o signos de alarma, ¿qué hace usted?
-¿Piensa usted que todos los embarazos tienen algún riesgo? ¿Por qué? ¿Por qué no?
-¿Usted distingue entre embarazos con más o menos riesgo?
-Si dice que sí: ¿Usted les dice a sus clientes si el embarazo viene con más o menos riesgo?
-¿Usted siempre atiende a sus clientas en el parto, o algunas veces las envía con el doctor? ¿Cuándo las envía al doctor?
-¿Cree usted que siempre es seguro que la mujer se alivie en su casa, asistida por la partera? ¿Por qué sí? ¿Por qué no?
Si responde que no a la pregunta anterior:

-¿Usted les dice a las clientas cuando piensa que no deberían aliviarse en su casa? En ese caso, ¿cómo reaccionan las mujeres y sus familias?
-Cuando usted atiende los partos, ¿usted deja que la mujer elija la posición que desea para aliviarse? Si no, ¿en qué posición las atiende? ¿Por qué prefiere usted esa posición?
-Cuando llega el momento de pujar, ¿qué les dice usted a las mujeres?
-¿Puede haber problemas para la madre y el bebé durante el parto? ¿Qué problemas?
En este punto, la entrevistadora puede mencionar algunos problemas que la mujer puede tener durante el embarazo o el parto y discutir cuál de ellos implica riesgo al parir:
a) el niño no sale del vientre; b) el niño está atravesado; c) la cabeza del niño es muy grande; d) la mujer tarda mucho en aliviarse; e) la mujer no sabe cómo pujar; f) la mujer sangra en exceso; g) los pies de la mujer están hinchados; h) pre-eclampsia; i) placenta voladora; j) espanto; k) pérdida del nahual o tono; l) frío; m) coraje
-¿Puede usted solucionar estos problemas o recomienda que las pacientes llamen a otra persona o vayan al centro de salud?
-¿Qué problemas puede tener el recién nacido?
Posibles temas de repregunta:
a) El bebé no respire; b) el bebé respira muy rápido o está agitado; c) el bebé no se alimenta bien; d) el corazón del bebé late poco o demasiado; e) el cuerpo del bebé se pone morado; f) el bebé no llora o llora demasiado; g) el bebé llora demasiado fuerte, etc.
-¿Qué otras cosas pueden ser malas para la madre o el bebé?
-¿Por qué se dan estos problemas? ¿Cuál es la causa?
-¿Por qué cree usted que a veces mueren las madres o los niños en el embarazo o el parto?
-¿Habla usted con sus clientes de los problemas que pueden ocurrir durante el parto?
-¿En esta comunidad hay algún programa para transportar a las embarazadas o a las mujeres que se están aliviando al hospital en caso de problemas?
-¿Usted ha participado de cursos de entrenamiento para parteras?
-¿Esos conocimientos le son útiles en su trabajo? ¿Los usa usted? ¿Puede darme algún ejemplo?
-¿Con qué cosas que enseñan en los cursos está de acuerdo y con cuáles no?
-¿Usted tiene confianza en el centro de salud de este pueblo? ¿Por qué sí? ¿Por qué no?
-¿Usted tiene confianza en el hospital de Xoshitlahuaca? ¿Por qué sí? ¿Por qué no?
-¿Tiene confianza en el hospital de Ometepec? ¿Por qué sí? ¿Por qué no?
-¿Usted cobra lo mismo cuando el recién nacido es niño o niña? Si responde que no, porqué no?
-¿Cómo se debe cuidar una mujer después de aliviarse? ¿Qué debe hacer y qué no? ¿Por qué?
-¿Cómo se debe cuidar al recién nacido? ¿Qué se debe hacer y qué no? ¿Por qué?

ENTREVISTAS CON MUJERES EN EDAD REPRODUCTIVA

Entrevistadora

La Universidad de Guerrero y los promotores de salud de Xochistlahuaca estamos trabajando para mejorar la atención de las embarazadas y los recién nacidos aquí en Xochis. Por eso es importante hablar con las mujeres embarazadas o que se han aliviado hace poco.

Con tu permiso, te voy a hacer algunas preguntas sobre el embarazo, el parto y el cuidado del bebé. Si alguna pregunta no te parece bien, no tienes que contestarla. Si tú lo permites, grabaremos la plática para no olvidarnos de nada de lo que se dijo. Lo que tú digas es confidencial: sólo lo sabré yo, la persona que traduzca la entrevista al español y una persona de la Universidad. Sólo vamos a emplear tu primer nombre o un nombre que tú inventes. No vamos a usar tu apellido, así que nadie te podrá identificar.

¿Puedes decirnos tu primer nombre y si aceptas que platiquemos?

[CONTESTA LA ENTREVISTADA]

ENTREVISTADORA: Esta entrevista se hace en [NOMBRE DEL LUGAR], el [FECHA COMPLETA], con [PRIMER NOMBRE o NOMBRE INVENTADO DE LA ENTREVISTADA]

PREGUNTAS GENERALES

-¿Qué edad tienes?
-¿Hasta qué año estudiaste?
-¿Sabes leer?
-¿Entiendes español?
-¿Estás casada?
-¿Cuál es tu religión?
-¿Haces algún trabajo donde ganas dinero?
-¿Cuántos hijos has tenido?
-¿Recibes ayuda de Oportunidades, Seguro Popular u otro programa del gobierno? [MENCIONAR CUÁLES]

PREGUNTAS SOBRE EL EMBARAZO

1. ¿Piensas que hay peligros cuando una mujer está embarazada?
2. ¿Qué puede pasar? ¿Son cosas graves?
3. ¿Estas problemas les pasan a muchas mujeres aquí en el pueblo?
4. ¿Piensas que estas cosas te pueden pasar a ti? ¿Por qué sí, por qué no?
5. ¿Por qué hay mujeres que tienen problemas cuando están embarazadas? ¿A quién le pasan estas cosas?
6. ¿Quién debe cuidar que el niño esté bien en el vientre de la madre?
7. En el embarazo, ¿comes igual, más o menos que de costumbre? ¿Por qué?
8. ¿Trabajas igual, más o menos que de costumbre? ¿Por qué?
9. ¿Qué cosas NO debes hacer durante el embarazo? ¿Por qué?
10. ¿Cómo te das cuenta cuando tienes problemas en el embarazo? ¿Hay alguna molestia o señal que te indique si hay problemas?
11. ¿Qué haces cuando sientes esas molestias? ¿Por qué haces eso?
12. ¿Puede haber problemas de antojo, coraje o espanto, o problemas con el nahual durante el embarazo?
13. ¿Cómo sabes si tienes uno de estos problemas?
14. ¿Qué haces en esos casos?
15. En tu familia, ¿con quién platicas de tu embarazo? ¿Qué consejos te dan?
16. ¿Te dicen que vayas al centro de salud o que no vayas? ¿Por qué?
17. ¿Tú siempre haces lo que te dicen en la familia? ¿Por qué sí, por qué no?
18. ¿Hablas con tu esposo de estas cosas? ¿Qué te dice él?
19. ¿Tú siempre haces lo que dice tu esposo?
20. ¿Está bien o está mal que fuera de la familia sepan que estás embarazada? ¿Por qué?

La partera

21. ¿Vas a ver a la partera cuando estás embarazada? ¿Por qué sí/no?

SI DICE QUE VA A LA PARTERA, PREGUNTARLE:

22. ¿Qué te dice la partera? ¿Dice lo mismo que el centro de salud?
23. ¿Tú siempre haces lo que te dice la partera? ¿Por qué sí, por qué no?
24. ¿Es importante que la partera acomode al bebé? ¿Por qué sí, por qué no?

SI DICE QUE SÍ, PREGUNTARLE:

25. ¿Platicas de acomodar el bebé con el doctor? ¿Qué dice el doctor?

El centro de salud

26. ¿Vas al centro de salud para que cuiden tu embarazo? ¿Por qué sí, por qué no?

SI DICE QUE VA, PREGUNTARLE:

27. ¿Vas al centro de salud porque tienes ganas o porque te obligan?

Si dice que la obligan: ¿quién te obliga?

28. ¿Qué te aconsejan en el centro de salud?
29. ¿Tú siempre haces lo que te dicen en el centro? ¿Por qué sí, por qué no?

Médico privado

30. ¿Consultas a un médico que no es del centro de salud o del hospital durante el embarazo? ¿Por qué sí, por qué no?

Si dice que sí, preguntarle:

31. ¿Qué te dice el médico privado? ¿Dice lo mismo que el centro de salud?
32. ¿Siempre le haces caso al médico privado? ¿Por qué sí, por qué no?

El brujo

33. ¿Consultas a algún brujo durante el embarazo? ¿Por qué sí, por qué no?

Si dice que sí, preguntarle:

34. ¿Qué te dice el brujo sobre el embarazo y el parto?
35. ¿Tú siempre le haces caso al brujo? ¿Por qué sí, por qué no?

36. ¿A quién le haces más caso en estas cosas del embarazo y el parto? (Ejemplos: ¿A tu madre, a tu esposo, a tu suegra, a los médicos, a la partera, o al brujo?) ¿Por qué?

PREGUNTAS SOBRE EL PARTO

37. Antes del parto, ¿ya sabes si todo va a salir bien? ¿Por qué sí/no?
38. ¿Tú crees que puede haber problemas en los partos? ¿Qué problemas?
39. ¿Pueden ser peligrosos estos problemas para la mamá o el niño?
40. Aquí en el pueblo, ¿hay muchas mujeres que tienen problemas en el embarazo y en el parto?
41. ¿Crees que estos problemas te pueden ocurrir a ti? ¿Por qué sí, por qué no? SI DICE QUE ALGO LE PASA/PASÓ, DEJARLA QUE EXPLIQUE
42. ¿Por qué pasan estos problemas en el parto? ¿A quién le pasan?
43. ¿Tú puedes hacer algo para que todo salga bien en el parto? ¿Qué puedes hacer?
44. ¿Tú haces planes con tu marido por si hay problemas en el parto? ¿Qué planes hacen?
45. ¿Tus padres y tu marido, dónde quieren que te alivies? ¿Por qué?
46. ¿Dónde te aliviaste la última vez y con quién? ¿Por qué?
47. ¿Dónde vas a aliviarte la próxima vez y con quién? ¿Por qué?
48. SI SE ALIVIÓ LAS DOS VECES EN SU CASA, PREGUNTARLE:
-¿Por qué NO te alivias en el centro de salud o el hospital?
SI SE ALIVIÓ LAS DOS VECES EN CASA DE SALUD, PREGUNTAR:
-¿Por qué NO te alivias en tu casa y con partera?

49. ¿Dónde es más fácil aliviarse, en tu casa o en casa de salud? ¿Por qué?
50. ¿En qué posición prefieres aliviarte? ¿Por qué?
51. ¿Prefieres parto natural o por cesárea? ¿Por qué?

PREGUNTAS SOBRE CUIDADOS DESPUÉS DEL PARTO

52. ¿Cómo debe cuidarse la madre después del parto? ¿Por qué?
53. ¿Qué problemas pueden ocurrir después de aliviarte?
54. ¿Qué haces si tienes un problema así?
55. ¿Qué cuidados hay que tener con el recién nacido?
56. ¿Le das/vas a darle el pecho enseguida? ¿Por qué sí/por qué no?
57. ¿Qué problemas puede tener el recién nacido?
58. ¿Qué haces si pasa alguna de estas cosas con tu hijo?
59. ¿Alguien tiene la culpa si el recién nacido tiene problemas?
60. Aquí en el pueblo, ¿mueren muchos niños en el vientre, el embarazo o recién nacidos? ¿Éste es un problema importante en el pueblo?
61. ¿Piensas que las mujeres indias tienen más problemas que las mestizas durante el embarazo y el parto?

Guía para entrevistas con maridos

Entrevistadora

La Universidad de Guerrero y los promotores de salud de Xochistlahuaca estamos trabajando para mejorar la atención de las embarazadas y los recién nacidos aquí en Xochis. Por eso es importante hablar con los esposos.

Con tu permiso, te voy a hacer algunas preguntas sobre el embarazo, el parto y el cuidado del bebé. Si alguna pregunta no te parece bien, no tienes que contestarla. Si tú lo permites, grabaremos la plática para no olvidarnos de nada de lo que se dijo. Lo que tú digas es confidencial: sólo lo sabré yo, la persona que traduzca la entrevista al español y una persona de la Universidad. Sólo vamos a emplear tu primer nombre o un nombre que tú inventes. No vamos a usar tu apellido, así que nadie te podrá identificar.

¿Puedes decirnos tu primer nombre y si aceptas que platiquemos?

[CONTESTA EL ENTREVISTADO]

ENTREVISTADORA: Esta entrevista se hace en [NOMBRE DEL LUGAR], el [FECHA COMPLETA], con [PRIMER NOMBRE o NOMBRE INVENTADO DE LA ENTREVISTADA]

1. PREGUNTAS GENERALES

-¿Qué edad tienes?
-¿Hasta qué año estudiaste?
-¿Sabes leer?
-¿Hablas español?
-¿Cuál es tu estado civil?
-¿Cuál es tu religión?
-¿Cuántos hijos tienes?
-¿En tu casa reciben ayuda de Oportunidades, Seguro Popular u otro programa del gobierno? [MENCIONAR CUÁLES]

2. PREGUNTAS SOBRE EL EMBARAZO

1. ¿Tú piensas que hay peligros en los embarazos o no hay de qué preocuparse? ¿Por qué?
2. ¿Cómo sabes estas cosas? ***SI DICE QUE ALGO LE PASA/PASÓ, DEJARLO QUE EXPLIQUE***
3. ¿Sabes si las mujeres necesitan cuidados especiales cuando están embarazada? ¿Cuáles? ¿Por qué?
4. ¿Qué cosas NO deben hacer las mujeres durante el embarazo? ¿Por qué?

5. ¿Es necesario que alguien atienda a tu mujer durante el embarazo, o crees que puede arreglarse sola? ¿Por qué?
6. ¿Tu mujer va a controlarse al centro de salud durante el embarazo? ¿Por qué sí, por qué no?
7. ¿Tú hablas con tu esposa de las cosas del embarazo? ¿Tú qué le dices?
8. ¿Puede haber problemas graves durante el embarazo? ¿Qué problemas?
9. ¿Conoces alguna señal o molestia que pueda indicar problemas graves?
10. ¿Qué hay que hacer en esos casos?
11. ¿Por qué ocurren estos problemas? ¿A quién le pasan?
12. ¿Alguien tiene la culpa de que pasen estas cosas?
13. ¿A quién hay que hacerle más caso en estas cosas del embarazo? (Por ejemplo, al marido, al doctor, al curandero, a la partera, a tu madre, a tu suegra, a tu mujer) ¿Por qué?
14. ¿Está bien o está mal que fuera de la familia se sepa que las mujeres están embarazadas? ¿Por qué?

3. PREGUNTAS SOBRE EL PARTO

15. ¿Antes del parto ya se sabe si todo va a salir bien? ¿Por qué?
16. ¿Dónde se alivia tu esposa y con quién? ¿Por qué?
17. ¿Siempre es mejor que se alivie en ese lugar? ¿Por qué?
18. ¿Dónde NO se alivia y con quién NO se alivia? ¿Por qué?
19. ¿Quién decide dónde se alivia tu mujer? ¿Por qué?
20. ¿Piensas que puede haber problemas para la madre en el parto? ¿Qué problemas?
21. ¿Pueden ser peligrosos estos problemas para la mamá o el niño?
22. ¿Por qué pasan estos problemas? ¿A quién le pasan?
23. ¿Alguien tiene la culpa de que pasen estas cosas?
24. ¿Qué hacen/qué hay que hacer si tu esposa tiene problemas durante el parto?
25. Si tu mujer tiene problemas en el parto, ¿piensas que puede enfrentarlos sola en tu casa, o necesita ayuda?
26. ¿Quién y dónde la puede ayudar mejor?
27. ¿Puede haber problemas con el niño al nacer? ¿Qué problemas?
28. ¿Por qué crees que ocurren problemas en el parto y con el recién nacido?
¿A quién le pueden pasar?
29. ¿Alguien tiene la culpa de que pasen estas cosas?
30. ¿Has platicado con tu esposa qué hacer si hay problemas en el parto? ¿Se ponen de acuerdo o no?
31. ¿Hacen planes en tu casa para el parto? ¿Por qué sí/no?
32. ¿Quién puede resolver mejor los problemas del parto? (por ejemplo, la mujer que se alivia, la familia, la partera, el médico) ¿Por qué?
33. ¿A quién le hacen más caso acerca del parto? (Por ejemplo, al doctor, al curandero, a la partera, a tu madre, a tu suegra, a tu mujer) ¿Por qué?
34. Según la encuesta que hicimos aquí en Xochis, la mitad de las mujeres se alivian en el hogar con partera y la mitad en casa de salud con médico. Esta pérdida del hábito de aliviarse en la casa con partera, ¿es un problema para los esposos y para los amuzgos en general? ¿Por qué sí, por qué no?

4. CUIDADO DE LA MADRE Y EL NIÑO DESPUÉS DEL PARTO

35. ¿Las mujeres necesitan cuidados después de aliviarse? ¿Cuáles? ¿Por qué?
36. ¿Puede tener problemas la madre después de aliviarse? ¿Qué problemas?
37. ¿Qué hay que hacer en esos casos? ¿Por qué?
38. ¿Cómo hay que cuidar al bebé? ¿Alguien debe revisarlo? ¿Dónde y cuándo deben revisarlo?
39. ¿Hay algún peligro para el niño recién nacido? ¿Cuál?
40. ¿Qué hay que hacer si el recién nacido tiene problemas? ¿Por qué?
41. ¿A ti te parece bien que la gente del centro de salud o del comité de salud de la comunidad visite los hogares para ofrecer ayuda durante el embarazo y el parto, y para cuidar al recién nacido? ¿Por qué sí, por qué no?
42. Si se organizaran grupos de embarazadas para ayudarse entre ellas, ¿tú crees que tu esposa debería participar? ¿Por qué sí, por qué no?

Annex III: Ethical approval

Comité de ética del Centro de Investigación de Enfermedades Tropicales (CIET) de la Universidad Autónoma de Guerrero

Con el fin de evaluar los aspectos éticos del estudio de "Principales dimensiones e implicancias ideológicas del discurso de la maternidad sin riesgo en una comunidad indígena remota en México", se reunió el comité para llevar a cabo esta tarea, quedando conformado por:

Master en ciencias José Legorreta como presidente, miembro permanente del Comité de ética del CIET
Dra. Elizabeth Nava Aguilera, como secretaria.
Master en ciencias Arcadio Morales Pérez, como primer vocal, y
Celestino Gómez Vázquez, representante de los Promotores de Salud Indígenas Amuzgos de Xochistlahuaca, como segundo vocal.

Después de recibir los siguientes documentos:
a) Guía para los entrevistadores de informantes clave
b) Carta de consentimiento informado de las mujeres entrevistadas
c) Carta de consentimiento informado de los informantes clave
d) Carta de compromiso de las mujeres entrevistadoras
e) Solicitud al comité de ética del CIET
f) Síntesis del proyecto de tesis doctoral
g) "Research Ethics Board Project Submission Form" de la Universidad de Ottawa, completado por el investigador y su supervisor académico.

El Comité ha deliberado y hace las siguientes consideraciones:
1) Que el estudio es complemento del proyecto "**Mexican-Canadian cooperation to build capacity for multi-centred implementation research on newborn survival among Indigenous populations**", del cual este Comité ha emitido un dictamen favorable.
2) Que el estudio ha incorporado las sugerencias hechas por este Comité, y que no se aparta de las normas éticas internacionales y las que nos rigen.
3) Que el investigador ha tenido en cuenta los requerimientos éticos de la Universidad de Ottawa, en un todo compatibles con los requerimientos de este Comité.

Por lo anterior, los miembros del Comité aprueban la realización del proyecto solicitando al responsable nos haga llegar los avances del mismo así como cualquier contingencia que pudiera presentarse.

Se levanta la presente acta a los 30 días del mes de agosto de dos mil siete.

M. en C. José Legorreta Soberanis
Presidente

Dra. Elizabeth Nava Aguilera
Secretaria

M. en C. Arcadio Morales Pérez
Primer Vocal

Celestino Gómez Vázquez
Segundo Vocal

Université d'Ottawa University of Ottawa
Service de subventions de recherche et déontologie Research Grants and Ethics Services

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for ethical approval for the research project **Key Dimensions and Ideological Dimensions of Safe Motherhood Discourse in a Remote Indigenous Community in Mexico (File # 09-07-07)** submitted by Jorge Oscar Laucirica and supervised by Walter Moser of the Department of Modern Languages & Literatures. The members of the REB found that the research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave the research project a Category Ia (Approval).

This certification is valid for one year from the date indicated below.

October 12, 2007
Date

Catherine Paquet
Assistant-Director Interim (Ethics)
For the Chair of the Social Sciences and Humanities REB
Peter Beyer

550, rue Cumberland 550 Cumberland Street
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5841 • Télec Fax (613) 562-5338
http://www.uottawa.ca/services/research/rge/index.html

Université d'Ottawa University of Ottawa
Service de subventions de recherche et déontologie Research Grants and Ethics Services

October 12, 2007

Walter Moser
Canada Research Chair in Literary and
Cultural Transfers
University of Ottawa

Jorge Oscar Laucirica
Department of Modern Languages
University of Ottawa

Re: Key Dimensions and Ideological Dimensions of Safe Motherhood Discourse in a Remote Indigenous Community in Mexico (File # 09-07-07)

Dear Professor Moser and Mr. Laucirica,

Thank you for your response to the REB's questions re your project. Please find enclosed the Social Sciences and Humanities Research Ethics Board (SSH REB).

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until October 11, 2008. Please submit an annual status report to the Protocol Officer in October 2008 to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact me at extension 1787.

Sincerely yours,

Catherine Paquet
Assistant-Director Interim (Ethics)
For Peter Beyer, Chair of the SSH REB

550, rue Cumberland 550 Cumberland Street
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada
(613) 562-5841 • Telefax / Fax (613) 562-5338
http://www.uottawa.ca/services/research/rge/index.html

Université d'Ottawa | University of Ottawa
Service de subventions de recherche et déontologie | Research Grants and Ethics Services

October 31, 2008

Walter Moser
Modern Languages and Literature
University of Ottawa

Jorge Oscar Laucirica
Department of Modern Languages
University of Ottawa

RE: Key Dimensions and Ideological Dimensions of Safe Motherhood Discourse in a Remote Indigenous Community in Mexico (File #09-07-07)

Dear Professor Moser and Mr. Laucirica,

The Social Sciences and Humanities Research Ethics Committee has accepted your request for extension of ethics approval of the above-mentioned project. You will therefore find enclosed the Social Sciences and Humanities Research Ethics Board Certification extension for your research project.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This extension is **valid from October 12, 2008 until October 11, 2009**. Please submit an Annual Status Report to the Protocol Officer in October 2008 to either close the file or request a renewal of ethics approval. This document can be found at: http://web9.uottawa.ca/services/rgessrd/ethics/application_dwn.asp.

If you have any questions, please do not hesitate to contact me at extension

Sincerely yours,

Leslie-Anne Barber
Protocol Officer for Ethics in Research
For Dr. Peter Beyer, Chair of the Social
Sciences and Humanities REB

Université d'Ottawa | University of Ottawa
Service de subventions de recherche et déontologie | Research Grants and Ethics Services

SOCIAL SCIENCES AND HUMANITIES RESEARCH ETHICS BOARD

CERTIFICATION OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Social Sciences and Humanities Research Ethics Board (REB) has examined the application for extension of ethics approval for the research project **Key Dimensions and Ideological Dimensions of Safe Motherhood Discourse in a Remote Indigenous Community in Mexico (File # 09-07-07)** submitted by Jorge Oscar Laucirica and supervised by Walter Moser of the Department of Modern Languages and Literature of the University of Ottawa. The Social Sciences and Humanities REB found that the project met appropriate ethical standards set out in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and granted initial ethics approval to the project on October 12, 2007.

This ethics renewal certification is valid for one year from the date indicated below.

Leslie-Anne Barber
Protocol Officer for Ethics in Research
For Peter Beyer, Chair of the Social
Sciences and Humanities REB

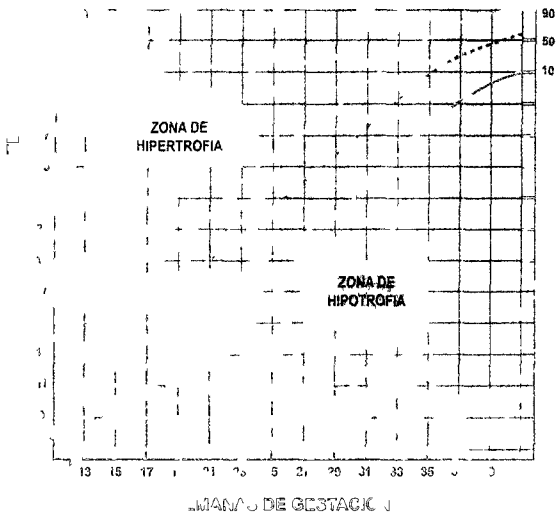
October 12, 2008
Date

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Appendix A: Perinatal carnet

Este carnet contiene información indispensable para tu salud y la de tu hijo. Llévalo contigo y entregalo al equipo de salud toda vez que requieras una atención, ya sea para el embarazo, parto, puerperio o control de crecimiento y desarrollo de tu hijo.

URA DEL FONDO UTERINO
N LA EDAD GESTACIONAL



CENTE FESCINA RH Y COLO CLAP 1060

Para lograr un embarazo saludable es importante que sigas las siguientes recomendaciones:

Acudir a tus consultas
Alimentarte adecuadamente y evitar el consumo de refrescos, tabaco, alcohol y drogas
Checar que te apliquen la vacuna contra el tetanos y difteria.
Tomar acido folico hierro, vitaminas o suplemento alimenticio

Acude de inmediato a cualquier unidad de salud:

Si tienes dolores de parto en cualquier mes del embarazo
Si te duele la cabeza, te zumban los oidos tienes vista borrosa o ves luces
Si tienes sangrados o dolor en el vientre
Si no sientes el movimiento de tu bebe
Si tienes hinchazon en pies, manos y cara
Si tienes dolor en el abdomen.
Si se te rompe la fuente o sufres algun accidente

Recuerda:

Alimenta exclusivamente a tu bebé con leche materna cada vez que lo pida
Verifica que le hayan aplicado al nacer las vacunas BCG, Sabin y realizado la prueba del tamiz neonatal
Llévalo a consulta médica a los 7 y 28 días

Acude de inmediato a cualquier unidad de salud si tu bebe:

Tiene fiebre, vomita, está pálido o no quiere comer
Llora demasiado tiene diarrea, presenta dificultad para respirar o se pone morado (boca, unas y pies)

¡CUIDA TU SALUD Y LA DE TU BEBÉ!
PARA ARRANCAR PAREJO EN LA VIDA

Salud



Carnet Perinatal

Nombre: _____

Domicilio: _____

Localidad: _____

1.- DATOS GENERALES

Edad en Años
Menor de 20
Mayor de 35

Escolaridad:
Ninguna
Menos de 3 Años
Secundaria o Equivalente
3 a 5 años de Primaria
Preparatoria o Equivalente
Primaria Completa
Profesional
Se ignora

Estado Civil
Casada
U. Libre
Soltera
Otro

Fuma
Si
No

2.- ANTECEDENTES

FAMILIARES	Si
Hipertención	
Cardiopatías	
Diabetes	
TB Pulmonar	
Cáncer	
Tiroides	
Epilepsia	
Otros	

PERSONALES	Si
Hipertención	
Cardiopatías	
Diabetes	
TB Pulmonar	
Cáncer	
Tiroides	
Epilepsia	
Otros	

OBSTÉTRICOS
Gestas
Paras
Gemelares
Abortos

Fecha Ultimo Parto
Mes Año
Partos
Vaginales Cesáreas
Fecha Ultima Cesárea
Mes Año

Nacidos Vivos
Nacidos Muertos
R. N. Mueren:
1a Semana
2a Semana

3.- EMBARAZO ACTUAL

Peso Previo (kg)
Peso Inicial (kg)
(mes de gestación) Talla (cm)

Hb.
Mes gestación

Examen general de Orina
Normal
Anormal

Elisa
+
-

VIH/SIDA
+
-

Ultrasonido
Normal
Anormal
Observaciones

	Día	Mes	Año
FUM.			
FPP.			

Grupo:
Rh + -

VDRL:
+
- Día Mes

Papanicolaou
+
-

Examen de Mamas
+
-

Toxoide tetánico/difterico
Si
No

Consulta No.	1	2	3	4	5	6	7	8	9
Fecha									
Sem. de Gestación									
Peso (kg)									
Tensión Arterial									
Altura Fondo Uterino									
Presentación/Situación									
Frecuencia Cardiaca Fetal									
Movimientos Fetales									
Edema									
Vitaminas (Fe, Ac, Fólico)									
Exámenes (Bh, GO)									
Hemorragia									
Vasopresión									

4.- RESOLUCIÓN

Semanas de Gestación
Menor 37
42 y más

Inicio
Espontaneo
Inducido

Membranas
Integras
Rotas

Ruptura
Hora

Patología del embarazo
- Hipertensión crónica
- Preeclampsia
- Eclampsia
- Cardiopatía
- Diabetes
- TORCH
- Otras infecciones
- Parasitosis
- Amenaza de parto prematuro
- Otra

Parto Puerperio
- Hemorragia 1er trimestre
- Hemorragia 2do trimestre
- Hemorragia 3er trimestre
- Anemia crónica
- Ruptura prematura memb.
- Infección puerperal
- Hemorragia puerperal
- Isoinmunización
- Otra
- Ninguna

Vía de resolución
Vaginal
Cesarea
Distósia

Hora Min. Día Mes Año

Episiotomía
Media
Lateral
Desgarros
1° y 2°
3° y 4°

Alumbramiento espontáneo
Si
No
Placenta comp Si No
Rev Cavidad Si No

Muerte fetal
No Si
Embarazo Si
Parto Si
Ignora Momento

Nivel de atención
Atendido
Parto
Neonato

3°	2°	1°	Domicilio	Otro
Médico	Enf. Part	Aux	Partera Trad	Otro

5.- RECIÉN NACIDO

Sexo
F
M
Gpo. Sanguineo:
Rh + -

Vivo
Si
No

Apgar (minuto)
1° 5°

Reanimación
Pers Cap
Si
No

Peso al Nacer
gr.
Edad Gestacional Capurro
Sem.

Peso/EG
Adecuado
Pequeño
Grande

Talla cm
Per Cef cm

Defectos al Nacimiento
Cardiovascular
Gastrointestinal
Pulmonar
Hematológica
Renal
Neorológica

Egreso RN
Sano
Con Pat.
Traslado
Fallece

Alimento
Lact. Materna
Mixta
Artificial

Egreso Materno
Sana
Traslado
Con Pat

Muerte Materno
Embarazo
Parto
Puerperio

Planificación Familiar
Ninguno
Oral
OTB
Condón
DIU
Otro

Salud



Embarazo Saludable

Carnet Perinatal

Nombre: _____

Domicilio: _____

Localidad: _____

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Si tienes dolor en el abdomen.
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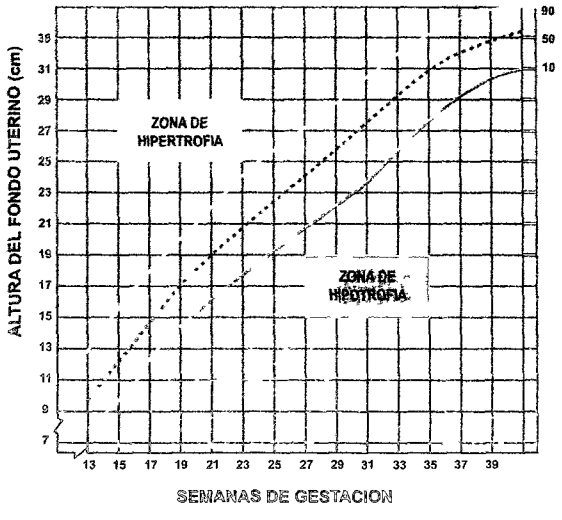
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Llora demasiado, tiene diarrea, presenta dificultad para respirar o se pone morado (boca, uñas y pies)

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PARA ARRANCAR PAREJO EN LA VIDA

Este carnet contiene
información indispensable
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vez que requieras una atención,
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puerperio o control
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de tu hijo.

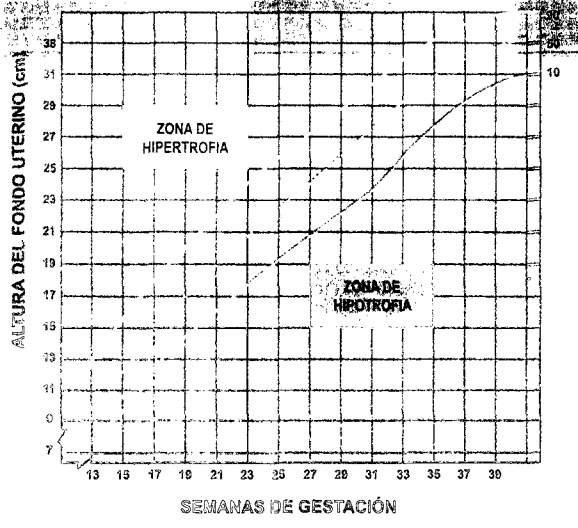
ALTURA DEL FONDO UTERINO
SEGÚN LA EDAD GESTACIONAL



FUENTE FESCINA R.N. Y COLS. CLAP 1990

Este carnet contiene información indispensable para tu salud y la de tu hijo. Llévalo contigo y entregalo al equipo de salud toda vez que requieras una atención, ya sea para el embarazo, parto, puerperio o control de crecimiento y desarrollo de tu hijo.

ALTURA DEL FONDO UTERINO SEGÚN LA EDAD GESTACIONAL



FUENTE: FESCINA, R.N. Y COLS; CLAP; 1990

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Checar que te apliquen la vacuna contra el tétanos y difteria.
Tomar ácido fólico, hierro, vitaminas o suplemento alimenticio.

Acude de inmediato a cualquier unidad de salud:

Si tienes dolores de parto en cualquier mes del embarazo.
Si te duele la cabeza, te zumban los oídos, tienes vista borrosa o ves luces.
Si tienes [illegible] dolor en el vientre.
Si no [illegible] al movimiento de tu bebé.
Si tie[illegible] hinchazón en pies, manos y cara.
Si tie[illegible] en el abdomen.
Si se [illegible] la fuente o sufres algún accid[illegible]

Recuerda:

Alimenta exclusivamente a tu bebé con leche materna cada vez que lo pida.
Verifica que le hayan aplicado al nacer las vacunas BCG, Sabin y realizado la prueba del tamiz neonatal.
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Acude de inmediato a cualquier unidad de salud si tu bebé:

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Llora demasiado, tiene diarrea, presenta dificultad para respirar o se pone morado (boca, uñas y pies)

¡CUIDA TU SALUD Y LA DE TU BEBÉ!
PARA ARRANCAR PAREJO EN LA VIDA

Salud

Embarazo Saludable

HOSPITAL DE LA MADRE Y EL NIÑO GUERRERENSES
HMNG

Carnet Perinatal

Nombre: _____

_____

Domicilio: _____

_____

Localidad: _____

Salud

Embarazo Saludable

HOSPITAL DE LA MADRE Y EL NIÑO GUERRERENSES

HMNG

Carnet Perinatal

Nombre: _____

Domicilio: _____

_____

Localidad: _____

Appendix B: Structural dramatic components

Appendix B: Structural dramatic components, behavioural constructs, health risk discourse, and safe motherhood discourse

Episode 1			
Category: functions, roles, actants	**Key reference in video drama**	**Behavioural construct-assumption (what the text says or connotes)**	**Health risk discourse dimension Safe motherhood discourse Other key dimensions**
State of harmony	Family life, pregnancy in private sphere		
Signs of villainy, evil presence, trickery Opponent	Pre-eclampsia. Villain attempts to trick victim. Gabriela is not feeling well, but thinks it is normal and it will go away soon. We see warnings of evil presence, but we do not know its name yet; Jorge and Gaby ignore these signs.	Danger/threat: vulnerab ility Lack of knowledge and awareness	Danger/threat: private Risk=danger behind apparent normalcy Subject position: at risk mother Lack of self-control
Rules	Interdiction: Do not heed commonsense advice, own judgment on these matters: wrong reading of body messages.	Beliefs (obstacle) Weak attitudes toward going to health centre and weak intention to go. Social norm hinders timely assistance.	Danger: private realm Trust: negative; wrong source/expert
	Suggestion: Heed medical advice; go to health centre; act promptly	Have-to-do: deviate from traditional social norm.	Individual, familial responsibility to respond promptly
Violation of rules, wrong turn	Heeding commonsense advice, own judgment.	Weak intention to perform expected behaviour. Subjective norm (no deviation from tradition). Maladaptive response	Trust: negative, wrong source/expert Individual choice (Gabriela) Individual responsibility, blame (Gabriela, Jorge)
Complicity	Commonsense, traditions, beliefs,	Belief, misconception	Trust: negative, wrong source/expert

Opponent Anti-sender	ignorance, lack of awareness, own judgment Some of these actants are also explicit or implicit anti-senders, as they manipulate Jorge and Gaby into not-wanting-to-do and not-having-to-do	Social norm: negative Own judgment: unreliable	
Complication, disruption Sender	Symptoms get worse. Gabriela takes ill at home. Evil force begins to manifest its true nature. Emergency transportation to hospital (ellipsis)	Danger/threat: vulnerability, severity Behaviour (negative, untimely)	Danger: private realm Subject position: at risk woman Untimely access to skilled health providers
Villainy/quest/ordeal	Seizure, eclampsia (evil force unfolds its full power); health staff unable to control situation.	Danger/threat: severity	Lack of control (health centre, public, too late) Individual responsibility (Gabriela, Jorge)
Lack	Jorge is both helpless and hopeless. He realizes that he may lose both Gaby and their child. He longs for the heroes (doctors, health staff) to restore harmony in his life. He has low competence (knowing-what-to-do, being-able-to-do)	Subjective norm (implied): Jorge regrets having heed Gaby and having gone by his mother's advice.	Lack of control (health centre, public) Individual responsibility, blame (Jorge)
Outcome/resolution No restoration Disjunction Sanction	Eclampsia, death Disjunction: Jorge cannot save Gaby and the baby Sanction: punishment	Danger/threat: severity Cost-benefit in decision making	Risk=danger Lack of self-control/control Individual responsibility, blame
Epilogue (moral of the story) Explanation (generic	Most pregnancies end well, but not all Maternal health stats	Danger/threat: severity Knowledge, awareness Positive attitude towards	Representative, fact-based story Knowledge, awareness Pregnancy=risk

component of health promotion videos) Revelation Exposure	Pre-eclampsia and eclampsia, 1/3 of all maternal deaths What is pre-eclampsia Most deaths can be prevented with timely action Heed the messages of your body Heed and consult the right experts	timely action Negative attitude towards delays	Subject position: at risk mother Risk=danger Self-control/control Individual, familial responsibility Individual, familial agency Blame (Jorge, Gabriela)
Subject Potential helper Passive opponent Possible hero and fallen hero	Jorge wants Gaby and their baby to have a healthy pregnancy and a safe delivery (implied) Jorge should have been a timely helper to both Gaby and the baby He is not a real helper. Lacks competence (being-able)	Lack of agency and knowledge, weak attitudes and intentions toward expected behaviour lead to negative, maladaptive response Low self-efficacy	Individual choice, agency, responsibility Subject position: (un)helping husband and father; (fails to act as) head of household
Subject Potential helper Loved one	Gaby wants to have a healthy pregnancy and a safe delivery for herself and her baby (implied) Gaby is not helper of baby and self Same as Jorge, she was (and still is) a possible helper, but in version 1 she was not a real helper. Lacks competence (wanting-to-do, having-to-do).	Same as Jorge	Individual choice, agency, responsibility Subject position: at-risk mother
Object	Jorge wants Gaby and the baby to be healthy Gaby wants self and baby to be healthy	Attitude: positive value of healthy pregnancy, safe childbirth	Healthy pregnancy and safe childbirth need skilled continuum of care; awareness of alarm signs and meaning; timely access to skilled experts/providers; strong positive attitudes and intentions towards expected behaviours.
Villain/evil presence	Pre-eclampsia/eclampsia	Danger/threat:	Risk=danger

Opponent		vulnerability, severity Knowledge, awareness	Knowledge, awareness
Opponents	Lack of knowledge of alarm signs, Unawareness of risk/danger of pre-eclampsia	Knowledge, beliefs Attitudes, intentions Behaviour; agency, self-efficacy; subjective norm	Knowledge, awareness Individual, familial responsibility Blame Private/public
Sender (non-diegetic, explicit)	Speaker (Government) wants Jorge and Gaby –and the real-life men and women they stand in for- to seek skilled care when something seems wrong. Sender manipulates having-to-do. Non-diegetic sender represented by voice-over, explanation and images about maternal death.	Subjective norm: seek to establish new social norm and encourage subjects to deviate from traditional norm	Healthy pregnancy, safe childbirth require skilled continuum of care, timely response to signs of alarm
Receiver, victim of eclampsia and own behaviour Victim-hero (fallen hero)	Gabriela: As a receiver, she should have benefited from the actions of the subject and the helpers. Instead, she suffers from them and stands out as a victim. This is also the result of her actions.	Lacks knowledge, is unaware, holds onto beliefs, misconceptions, own judgment Has no agency Subjective norm (does not deviate from social norm) Intention: weak intention to adopt expected behaviour Behaviour: negative, maladaptive	Subject position: at-risk woman Responsible for own health/health baby Self-control Wrong choice, blame Does not heed the messages of her body (does not heed/consult right experts), goes by her own judgment Remains in private realm Breaks continuum of care by skilled providers
Receiver, victim of eclampsia Loved one	Baby. Same as above, except it is not the result of his/her actions. He is alluded to, but his image is not shown on screen.	Child health does not reinforce expected actitudes, intentions, behaviours	Child health not discussed together with mother's health Responsibility/blame: Jorge, Gabriela, accomplices
Receiver, victim of	Jorge. Same as Gabriela.	Lacks knowledge, is	Does not heed the messages of her

eclampsia and own behaviour Victim-hero (fallen hero)		unaware Has no agency Subjective norm (does not deviate from social norm regarding pregnancy) Subjective norm (deviates from social norm, does not impose his will as a man) Intention: weak intention to adopt expected behaviour Behaviour: negative, maladaptive	body (does not heed/consult right experts) Control (Jorge is expected to make sure Gaby's pregnancy is monitored at health centre) Responsibility for Gaby's health and the health of the baby Blame Remains in private realm Breaks continuum of care by skilled health providers
Helpers	Health staff They were (and still are) possible helpers. In version 1, they are real but rendered incompetent (not-being-able-to-do)	Consequence of negative attitudes, weak intentions, own judgment, maladaptive behaviour from Jorge and Gaby	Skilled health personnel (public) Trust (positive) Untimely treatment of complications renders skilled staff helpless
Accomplice Opponent False helper Anti-sender	Mother-in-law has power over Jorge and Gabriela. Unwittingly helps the evil force. Jorge and Gabriela think she is a true helper. Reference observer (ultimate truth bearer) says she is false helper, anti-sender, and unintentional opponent, who manipulates Gaby's not-having-to-do and not-wanting-to-do	Bearer of commonsense belief and social norm. Gaby abides by both; partly because of this, she has low positive attitude and weak intention towards expected behaviour.	Trust (negative) Social/cultural responsibility Risk of remaining within private realm Blame Prevents access to skilled care
Accomplice Opponent False helper	Elderly women, bearers of common sense They may seem true helpers in the community. Reference observer	Same as above	Same as above

	(ultimate truth bearer) says they are false helpers Active though unintentional opponents		
Accomplice Opponent Anti-sender	Gabriela-Victim is deceived by commonsense advice, own judgment. Unwittingly deceives Jorge, damages baby and self. Anti-sender, manipulates Jorge's not-wanting-to-do Active, unintentional opponent	Subjective norm (no deviation, active reproduction of negative social norm)	Trust (negative) Individual responsibility Social responsibility (norm) Blame Keeps problem within private realm
Accomplice Opponent	Jorge-Victim is deceived by commonsense advice, Gabriela's judgment. He unwittingly damages Gabriela and baby Passive, unintentional Opponent	Subjective norm (no deviation regarding pregnancy) Subjective norm (deviates, does not impose his will)	Trust (negative) Individual responsibility Social responsibility (norm) Blame Keeps problem within private realm
Reference observer (non-diegetic)	Speaker (government): ultimate truth bearers. Indicates who are Helpers and Opponents. Evaluates characters and events. Decides on sanction (punishment) Manipulates competence (wanting-to-do, having-to-do)	All constructs/assumptions it tries to impact or modify, as detailed above. It seeks to establish norms and induce behaviour	Interpellates subjects through all dimensions, as detailed above

Episode 2			
Category: narratemes, functions, roles, actants	**Key reference in video drama**	**Behavioural construct-assumption (what the text says or connotes)**	**Health risk discourse dimension** **Safe motherhood discourse** **Other key dimensions**
State of harmony	Family life, pregnancy		There is risk in apparent normalcy
Signs of Villainy, evil presence, trickery Opponent Complication, disruption	Pre-eclampsia. Villain attempts to trick victim. Gabriela is not feeling well, but thinks it is normal and it will go away soon. We see warnings of evil presence, but we do not know its name yet. Gabriela does no heed these signs.	Danger/threat: vulnerability Lack of knowledge and awareness	Danger/threat: private Risk=danger behind apparent normalcy Subject position: at risk woman Lack of self-control
Complicity Opponent Anti-sender	Commonsense, traditions, beliefs, ignorance, lack of awareness, own judgment Some of these actants are also explicit or implicit anti-senders, as they manipulate Jorge and Gaby into not-wanting-to-do and not-having-to-do	Belief, misconception Social norm: negative Own judgment: unreliable	Trust: negative, wrong source/expert
Rules	Interdiction: Do not heed commonsense advice, own judgment on these matters: wrong reading of body messages.	Belief, misconception Negative attitude towards belief, social norm Subjective norm (deviate from trad)	Danger: private realm Trust: negative, wrong source/expert

	Heed the messages of your body (heed medical advice) Health is more important than physical barriers (distance) and domestic needs (tending to poultry) *Con la salud no se juega* Go to health centre Act promptly *Ayúdate que Dios te ayudará*	Attitude, response efficacy weighed down by Gaby's cost-benefit assessment Self-efficacy weakened by environmental barrier (distance) Subjective norm: Gabriela does not deviate from mother (commonsense); Jorge's attitude creates balance in subjective norm. Jorge deviates from mother, not from health centre/health staff	Individual choice, responsibility Timely response to complications Trust health experts Private, unsafe Health centre/hospital are safe Risk could be danger (probability)
Counteraction Manipulation Competence (wanting-to-do, having-to-do) Performance	Jorge does not accept Gabriela's appeal to commonsense and own judgment, chooses positive action. Jorge manipulates having-to-do, wanting-to-do Jorge clearly verbalizes object: the safety of Gaby and their child	Jorge has positive attitude towards health centre, strong intention to go Positive cost-benefit evaluation Perception of response efficacy Self-efficacy (Jorge)	Individual awareness of risk (not knowledge of alarm signs) Individual choice, responsibility Self-control/control Trust health experts Private, unsafe Health centre/hospital are safe Risk could be danger (probability)
Departure (timely) Competence (knowing-to-do, being-able-to-do) Performance	Jorge takes Gabriela to the health centre (ellipsis)	Positive behaviour Overcomes environmental constraints Self-efficacy: Jorge is able to get health-care centre in time (implied)	Timely response to signs of alarm (although Jorge does not have knowledge) Health centre/hospital are safe
Quest/ordeal/struggle Guidance Manipulation	Gabriela and Jorge travel to health centre (ellipsis). Gabriela is in pain in waiting room (evil	Environmental constraints (long waits) and cultural and gender barriers (*pena*,	Individual knowledge/awareness of risk Risk could be danger (probability)

	force/opponent continues to insinuate itself, but victim remains unaware); Jorge looks for help. Victoria helps Gaby: refers personal experience (daughter took very ill during pregnancy) Victoria manipulates have-to-do, able-to-do)	embarrassement) weaken Gaby's self-efficacy Prior experience/behaviour Victoria has positive attitude, intention to help/seek help Victoria refers to response efficacy, reinforces rule Motherly figure encourages deviating from "misguided" commonsense	Trust, motherly figure, connects with trust in health staff Health centre/hospital are safe Solidarity/social responsibility
Signs of evil presence Struggle, rescue Competence (knowing-to-do, able-to-do) Performance	Helpers/heroes/subjects identify signs of evil presence (headache, buzzing, high blood pressure). Gabriela is taken care of (nurse weighs and measures her, asks questions, takes blood pressure and urine sample).	Response efficacy	Health/centre hospital are safe Trust, health staff, technology Subject position: at-risk-mother Timely response to complications Skilled care, control "Women receive the care they need"
Explanation/revelation Lack revealed Exposure (villain exposed) Competence Performance Manipulation (have-to-do)	Male doctor scolds Jorge for not bringing Gaby sooner Doctor asks questions, draws family history, risk factors Doctor confirms, names evil presence (likely pre-eclampsia). Doctor makes Gaby aware of high risk due to family history.	Environmental constraints (dismissed) Knowledge, awareness Threat: vulnerability, severity	Risk as probability Risk factors, risk=danger Timely response to alarm signs Safe motherhood=mother + child Skilled care Trust: health staff Individual, familial responsibility, blame
Guidance Manipulation (knowing-how-to-do, being-able-to-do)	Male doctor offers help to take Gabriela to hospital in municipal vehicle.	Self-efficacy (removes constraints) Response efficacy	Solidarity Control Hospital=safety, skilled care "Women receive the care they need"
Quest, guidance, rescue	Health staff make arrangements	Removes structural	Solidarity

Competence (knowing-to-do, wanting-to-do, being-able-to-do) Performance	with municipal government to take Gaby to hospital (announced, implicit) Health staff and municipal staff take Gabriela to hospital, where she is treated (ellipsis)	constraints Response efficacy	Control Hospital=safety, skilled care "Women receive the care they need"
Partial outcome/resolution Receipt of magical agent Liquidation	Eclampsia prevented Gabriela stabilized in hospital	Response efficacy Cost/benefit valuation	Control Hospital=safety, skilled care "Women receive the care they need"
Return, partial restoration Sanction, reward	Gabriela and Jorge go back to their home (ellipsis)	Response efficacy Cost/benefit evaluation Attitudes (towards expected behaviour, responding to alarm signs through health centre or hospital)	Private=safe if controlled from public
Rules Sender (personified in doctors, health staff)	Go for checkups at health centre Look after yourself and baby Do not work as usual Alleviate workload for pregnant woman	Knowledge, awareness Normative beliefs and motivation to comply with new rule	Knowledge, awareness of risk, danger Self-control/control Private=safe if controlled from public Subject position: responsible individuals, family
Quest, counteraction Guidance Competence (wanting-to-do, knowing-how-to-do, being-able-to-do) Performance Receipt of magical agent Sanction, reward	Checkup, control Ultrasound Female doctor asks questions, evaluates Gabriela's symptoms have largely subsided Doctor says Gaby must keep taking her medicine, because "risk	Response efficacy Attitude (towards health staff, health centres, technogloy) Normative beliefs and motivation to comply Positive behaviour Threat: vulnerability	Trust in health staff, health care centre/hospitals, technology Risk (probability) Risk=danger Self-control/control Continuum of care Timely consultation Risk can be averted with skilled care

Rules Object	has not yet ended" Doctor tells Gaby she must be attentive and "closes person" must take her to health centre if there are similar alarm signs Doctor shows Gaby ultrasound of her baby	Outcome: cost-benefit, reinforce intention though ultrasound image of baby Attitude towards target behaviour	in health centre/hospital Gaby responsible for self and baby Subject position: at-risk-mother
Competence (wanting-to-do, having-to-do, knowing-how-to-do, being-able-to-do) Performance Object	Heroes/victims follow guidance/rules Self-control at home Support from Jorge (family) and comadre (extended family) Watchful pregnancy Gaby watches ultrasound of baby, relates with her own body	Knowledge, awareness Positive behaviour Reinforce attitude towards traditional and new roles, and expected behaviours Traditional social norm=New social norm	Private, self-control/control Private is safe when controlled from public Individual, familial, social responsibility Solidarity
Recognition Subject/sender/helper	Comadre recognizes Jorge as a hero Comadre says: "Help yourself and God will help you"	Reinforce attitude towards traditional and new roles, and expected behaviours Traditional social norm + New social norm Belief + knowledge Agency/self-efficacy Response efficacy Reinforce intention	Private is safe when controlled from public Timely consultation Individual, familial, social responsibility Solidarity
Final outcome/resolution/restoration Subjects + Object + Helpers	Healthy pregnancy and safe childbirth Heroes rewarded: Jorge and Gabriela are given a gift (healthy mother and healthy baby).	Response efficacy Reinforce attitude towards self-contro + control Traditional social norm + New social norm Belief + knowledge Reinforce intention	Safe pregnancy=monitored pregnancy Safe childbirth=institutional delivery (implicit) Continuum of care Maternal health + child health Trust in skilled providers, health

			centre, hospital, technology
Epilogue (moral of the story) Explanation (generic component of health promotion videos) Manipulation (wanting-to-do, having-to-do, knowing-how-to-do) Moral of story	Your health and the health of your baby are in your hands Certain ailments are not normal and will not go away. They are alarm signs: you may have high blood pressure and probably pre-eclampsia. Heed your body; heed life. For everything to go well, take good care of yourself	Attitude Subjective norm Threat, awareness Normative beliefs and motivation to comply Response efficacy	Self-control/control Individual responsibility Risk=probability Risk=danger Continuum of care
Villain/evil presence Opponent	Pre-eclampsia/eclampsia	Danger/threat: vulnerability, severity Knowledge, awareness	Risk=danger Knowledge, awareness
Accomplice Opponent False helper Anti-sender	Mother-in-law unwittingly helps evil force. Has power over Jorge and Gaby Gaby thinks she is a true helper. Reference observer (ultimate truth bearer) says she is false helper Anti-sender, manipulates Gaby's not-having-to-do and not-wanting-to-do Active though unintentional opponent (the forces she represents are active opponents)	Lay belief and social norm. Gaby abides by both, perhaps for fear of consequences (mixed response efficacy). Partly because of this, Gaby has low positive attitude and weak intention towards expected behaviour Influences Gaby's weak perception of self-efficacy	Trust (negative) Social/cultural responsibility Risk of remaining within private realm Blame Prevents access to skilled care
Accomplice Opponent False helper	Elderly women (implied), bearers of common sense They may seem true helpers in the community. Reference observer (ultimate truth bearer) says they	Same as above	Same as above

	are false helpers Active though unintentional opponents		
Accomplice Opponent Anti-sender	Gabriela-Victim is deceived by commonsense advice, own judgment She is anti-sender because she manipulates Jorge's not-wanting-to-do and not-having-to-do Active, unintentional opponent She weighs cost-benefits of leaving the house She goes to health centre in spite of her will Gaby has weak intention of seeking help when feeling sick She tries to dissuade Victoria from seeking help for her, because she is embarrassed to jump the line at the waiting centre She insists that her ailments will pass without immediate assistance	Subjective norm (active reproduction of negative social norm; she deviates because Jorge creates dissonance) Environmental constraints (distance from health centre, tending to poultry) Cost-benefit evaluation (wrong assessment, wrong values prevail) Unawareness	Trust (negative + positive, tension between mother in law and Jorge) Individual responsibility Social responsibility (norm) Blame Wants to keep problem within private realm Not aware that complications affect child
Opponents	Lack of knowledge of alarm signs, Unawareness of risk/danger of pre-eclampsia Commonsense facing pregnancy ailments Gaby is active though unintentional opponent (so are the forces that act upon her)	Knowledge, beliefs Attitudes, intentions Behaviour; agency, self-efficacy; subjective norm	Knowledge, awareness Individual, familial responsibility Blame Private/public
Subject, sender, helper,	Jorge wants Gaby and their baby	He does not have	Individual and familial choice,

and hero (Also unintentional opponent)	to have a healthy pregnancy and a safe delivery (explicit) He is not deceived by commonsense advice and Gabriela's judgment. He abides by rules ("Con la salud no se juega", trust health centre on health matters) and timely takes Gaby to health centre. By doing this, he saves both Gaby and their baby. He goes from passive, unintentional opponent, to active, intentional sender/helper. (As opposed to Version 1, he is a real helper.) He has competence (wanting-to-do, having-to-do, knowing-how-to-do, being-able-to-do). Through his actions + actions of other helpers/heroes, he is no longer a victim. He takes initiative in private but is submissive in public sphere. He does not accept macho role at home ("mandilón"), helps with house chores. Because of his actions in the private sphere and because he submits to public control, he leads to a successful outcome and he becomes a hero (in the eyes of his	knowledge, but he has good self-efficacy and he abides by the right rules. Subjective norm (deviation from traditional + positive response to external norm, which implies doctors are part of their value reference, significant others) Subjective norm (also deviates from macho role) Strong positive attitude towards health centre Strong intention to go Positive response	agency, responsibility Subject position: helping husband and father; head of household Trusts health centre on matters of health (No knowledge of pre-eclampsia, but applies main rule) Individual agency, responsibility Public=safe Maternal health=mother + child

	comadre, a young woman bearer of new commonsense). Jorge is also cast as unintentional opponent when the doctor chides him for not bringing Gaby sooner to health centre The shifting construal of his role is key component of this video.		
Subject Helper	Gaby wants to have a healthy pregnancy and a safe delivery for herself and her baby (explicit, after Jorge says so) At first, she is passive helper; later, she actively seeks care (implied) First, she lacks competence (wanting-to-do, having-to-do, also being-able-to-do). After the emergency, she has competence (wanting-to-do, having-to-do, knowing-to-do, and being-able-to-do), but her agency remains unclear	First, she lacks knowledge and awareness, and she has low perception of self-efficacy. She is passive throughout, except that she attends checkups after emergency. She resolves subjective norm by doing as her husband says. She seems to change attitude towards health centre and has positive response after emergency and revelations.	Individual and familial choice, agency, responsibility Subject position: at-risk mother Trusts health centre after personal ordeal + awareness Public=safe Maternal health=mother + child
Subject (both diegetic and non-diegetic) Sender (explicit at both levels)	Government, health staff, makers of video want Gaby and her baby to have healthy pregnancy, safe delivery and postpartum. They also want Jorge and Gaby to seek skilled care when something seems wrong. Sender manipulates all	Create awareness about alarm signs, risk and threat of pree-clampsia Create, reinforce intention to seek timely assistance in health centres Create, reinforce positive attitude towards	Same as column 3 Maternal health=mother + child Healthy pregnancy, safe childbirth require skilled continuum of care, timely response to signs of alarm.

	components of competence. Non-diegetic sender represented by voiceover, explanation and images of skilled care, technology.	institutionalized continuum of skilled care Subjective norm: seek to establish new social norm and encourage subjects to deviate from traditional norm	
Object	Jorge wants Gaby and the baby to be healthy Gaby wants self and baby to be healthy	Attitude: positive value of healthy pregnancy, safe childbirth	Healthy pregnancy and safe childbirth need skilled continuum of care; awareness of alarm signs and meaning; timely access to skilled experts/providers; strong positive attitudes and intentions towards expected behaviours.
Receiver, victim of pre-eclampsia	Gabriela. In this case, she benefits from actions from sender, heroes, helpers, and her own.	Lacks knowledge, is unaware, holds onto beliefs, misconceptions, own judgment Has no agency Subjective norm (she does not deviate, but goes by Jorge's opinion) Intention: at first, weak intention to adopt expected behaviour; with new knowledge, awareness, interpretation of personal experience, she later adopts positive behaviour.	Subject position: at-risk woman Subject position: mostly passive, in need of care Responsible for own health/health baby Self-control Wrong cost-benefit evaluation Blame Does not heed the messages of her body (does not heed/consult right experts), goes by her own judgment Would have remained in private realm; benefits from going public Accepts continuum of care by skilled providers
Receiver, victim of pre-eclampsia	Baby. In this case, he benefits from actions taken by sender,	Jorge's stress on child health + strong emphasis	Child health discussed together with mother's health

(benefits from actions from senders, helper, hero, and Gaby)	heroes, and helpers. This time the baby is not only alluded to, but we see his ultrasound image, and we finally see him in person, when he is delivered to Jorge in the waiting room at the hospital. We can see it is a boy (Jorgito). This last image proves that the outcome was successful.	from skilled providers reinforce expected attitudes, intentions, behaviours. Response efficacy as motivation to comply.	Responsibility: Jorge (also first choice), Gaby (to a lesser extent), helpers, social. Safe birth=institutional birth Maternal health=mother + child Trust in skilled care
Victim (of pre-eclampsia)	Victoria's daughter (alluded to)	Threat: reality, vulnerability, severity	Risk=danger
Victim (of eclampsia)	Gaby's sister and her baby (alluded to)	Threat: reality, vulnerability, severity Awareness	Risk criteria (Gaby is at higher risk because of family history) Risk=danger
Helper, wise man, hero, sender	Male doctor takes care of the situation, scolds Jorge, evaluates symptoms, asks questions in search for knowledge, reveals and names evil presence, explains what it is, offers and manages help to get Gaby to the hospital. He is an active, intentional helper Shows competence, performs	Threat: vulnerability, severity Both dismisses (distance) and acknowledges (cost) environmental constraints Reinforces self-efficacy (offers, manages help) Normative beliefs and motivation to comply	Trust in health centre Superiority of skilled care, doctors Risk as probability Risk=danger Knowledge, awareness Timely consultation Individual and family responsibility, blame Hospital=safety
Helper/donor	Victoria (lady in waiting room) is spontaneous and intentional helper. She dismisses Gaby's concern about jumping the line and requests immediate help. She is sensitive because her daughter took seriously ill in the past. Shows competence (wanting-to-	Awareness of threat Positive attitude towards helping out Strong intention to help, positive behaviour She brings in "enlightened common sense" Encourages deviation from	Subject position: aware elderly woman ("enlightened common sense") Agency, individual and social responsibility Private, safe when controlled in public

	do, having-to-do, knowing-what-to-do, being-able-to-do)	"wrong common sense" (same as Jorge) Vulnerability, severity of threat	
Helper/donor	She is a true, active, and intentional helper. Comadre helps Jorge and Gaby, hails Jorge as a hero, and brings in another dose of "enlightened common sense" ("Help yourself and God will help you", "Imaging what might have happened if you didn't take her to the hospital"). She also jokingly calls Jorge "mandilón", but in reality affirms the positive values of male spousal support in household chores. She manipulates knowing-what-to-do, being-able-to-do	Awareness, positive attitude and behaviour. Danger/threat Agency Subjective norm (she brings a different social norm from a generational perspective=trust in health centre, go in case of doubt) As such, she compensates for deviation from traditional norm	Subject position=aware young woman ("enlightened common sense") Agency, individual choice Individual and social responsibility Solidarity Threat: severity Private=safe when controlled from public
Helper/donor	Female nurse in charge of checkup. She takes care of Gaby, asks questions in search of knowledge, shows competence and performance, uses biomedical technology, and refers to doctor.	Helps interpret body signs, gain true knowledge Reinforce positive attitude towards skilled care in health centre.	Skilled care in institutional setting. Trust in skilled providers Public=safe
Helper, magical force/agent	Clinical checkup: weighing, measuring, taking blood pressure, urine analysis.	Necessary to interpret body signs, gain true knowledge. Reinforce positive attitude towards skilled care + technology in institutional settings	Skilled care in institutional setting Trust in medical procedures Public=safe

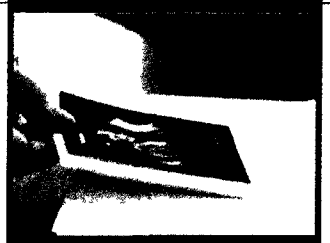
Helper, magical force/agent	Ultrasound, health staff Ultrasound image of baby links images in both public and private settings.	Necessary (sufficient?) to tell whether baby is well (true knowledge). Reinforce positive attitudes towards skilled care + technology in institutional settings	Skilled care in institutional setting Trust in medical procedures Control Knowledge is fact-based
Helper/donor	Female doctor asks questions in search for knowledge, interprets results of tests, tells Gaby baby is well, shows empathy, tells her that she cannot stop taking her medicine because "risk is not over". Finally, she gives Gaby an ultrasound image of her baby.	Knowledge, awareness Reinforce positive attitude toward health staff in institutional settings. New normative beliefs and motivation to comply. Reinforces behavioural beliefs (response efficacy). Threat: vulnerability	Skilled care in institutional setting Trust in medical staff, procedures Knowledge is fact-based Risk=danger Self-control/control Maternal health=mother + child
Helper/donor	Nurse who handles baby to Jorge	Reinforces positive attitudes towards skilled care in hospital	Safe birth=institutional birth
Reference observer Reference observing subject	Narrator, creators of the video (government) Ultimate truth bearers Sanction: they decide on fate of subjects (reward) They manipulate competence (wanting-to-do, having-to-do, knowing-how-to-do, being-able-to-do)	All construct/assumptions it tries to impact or modify, as detailed above In particular, indicates who are the helpers, opponents, and heroes, through evaluation (attitude) It seeks to establish norms, create or reinforce attitudes, induce behaviour	Interpellates subjects through all dimensions, as detailed above

Appendix C: Multimodal analysis

T	Visual frame	Visual image	Kinesic action	Soundtrack	Analysis
0:45		Cut from Jorge working in yard HP: direct to world, oblique to Gaby VP: median D:MCS VC: sink, dishes, window S: Gaby's smile, hands on womb CO: nat. DoF: deep, details G: far, off-screen, towards Jorge L: from outside, bright, highlights Gaby's face and hands.	Gaby (A) smiles, sighs (behavioural process), and gently holds her womb with both hands (transitive material, process, baby is Goal) Jorge and baby are Agents, Gaby is Reactor.	Harmony motif (figure)	Grown belly signals pregnancy; hands highlight. Resource systems (gaze, hands on womb) textually index the presence of Jorge and baby and connect all three of them. Ideationally, gaze+smile+hands on womb signal love and satisfaction. Gaby is happy with her role, with her family, and with her future. There is a bright future together (looking out, bright light in). We are involved onlookers; we can see the world through her eyes.
0:48		Dissolve from previous shot. HP: direct to world outside, oblique to Gaby VP: median to Gaby, high to Jorge. D: CS of Gaby, LS of Jorge, crib. VC: curtain, crib, painting stuff S: painted side of crib CO: nat, blue stands out. DoF: shallow, background G: far, towards Jorge	Gaby (A) enters frame towards window pane, leans forward, towards Jorge, turns back to viewer (P, behavioural) Jorge and crib are Agents, Gaby is Reactor	Harmony motif (figure)	Mise-en-scène connects Gaby with Jorge, who is painting the crib. Crib highlights pregnancy, presence of (future?) baby. Symbolic reference to future, hopes. Gaby leans forward to embrace future; distance remains between her and Jorge+crib Viewer is engaged through Gaby's gaze, open frame. We remain involved onlookers.
0:50		Cut from previous shot. Subjective point of view (Gaby) HP: dir. VP: High. D: MLS. VC: paint, brush, crib DoF: deep Gaze: towards Gaby (demand)	Jorge (A) is painting crib (G) for baby (Client). He looks (behavioural process) tenderly (circumstance) at Gaby (G). Next in the same shot, he leaves blue paint on platform, stands up and points with the brush to the pink paint. Gabriela smiles and nods. Gaby is Agent, Jorge is Reactor	Harmony motif (figure)	Medium close shot of Jorge and the crib bring us closer to their world, from Gaby's perspective. We remain involved onlookers. Jorge's tender looks matches Gabriela's smile. The textual presence of blue and pink, together with Jorge's gesture, indicate that he wants a baby boy, while Gaby expects a baby girl. This stereotypical contrast -which underscores their mutual attachment to the child-is reinforced later in the film. The baby is the Goal and the Client of visual material and behavioural clauses throughout the scene
3:01		HP: direct VP: median D: MLS DoF: deep VC: Gaby's body, stretcher closed door, blinders, white uniforms S: G shaking on stretcher, helpers G: towards Gaby L: half-light, somber, brighter light enters from next room CO: nat. Given in shot: Gaby's seizure New: help from health staff	Gabriela has a seizure. Something (A) makes her (G) shake violently. Health staffers (A) try to control (P) Gaby (G) without success, as Jorge looks on (Circumstance)	"Threat" motif, percussive stinger (ground). Metallic structure of stretcher rattles as Gaby shakes (field) Voice-over (figure): "La inmensa mayoría de los embarazos termina bien, con la mamá y el bebé en buen estado de salud [...]"	The content of the voice-over offers a stark contrast with the visuals. We know this pregnancy will **not** end up well for the mother and the baby. The "threat" motif underscores the gravity of the situation. All participants (actors and goals) are impotent.
3:11		Cut from previous shot HP: slightly oblique VP: median D: close-up DoF: shallow, foreground S: Gaby's gaze, expression L: balanced, no hard-contrast CO: nat. G: slightly off camera, unfocused, into the distance, does not engage viewer	Gabriela (A) is still, looking into the distance (behavioural process), the corner of her mouth slightly curved downwards.	Voice-over (figure) "[En nuestro país] en sólo un año [..] "Threat" motif (ground)	Gabriela is engaged in a behavioural, non-transactive activity (looking off screen) with no apparent purpose. She seems aloof, detached from her surroundings. She has a grave but distant expression, as if she had been let down (typical shot from telenovelas). She does not engage the audience, but the voice-over does: "En nuestro país" is the point of departure (the Theme) of a clause complex about maternal death stats in Mexico. The shallow focus de-contextualizes her presence. Gabriela is construed as a non-agentive archetype.

T	Visual frame	Visual image	Kinesic action	Soundtrack	Analysis
3:15		Frame progressively splits into multiple images of Gabriela (same shot as above) S: frame splitting, image multiplication	Frame splitting	Voice-over (figure): "[..] más de 1,200 mujeres mueren durante el embarazo, el parto, o poco tiempo después, en la cuarentena"... "Threat" motif (ground)	Ideationally, Gabriela's case embodies 1,200 maternal deaths in Mexico. This gives a human face to the numbers, and it recreates Gabriela's case in each one of the 1,200 deaths through semantic reduction. Interpersonally, the epilogue makes the viewer aware of the risks from a biomedical point of view.
3:20		Same shot as before. White lettering against intense red sheath and mosaic with myriad small images of Gabriela. S: white lettering, red sheath Text: "Más de 1,200 mujeres mueren al año"	Red sheath progressively covering the screen.	"Threat" motif pounding, percussive stinger (figure)	Text+red+music highlight threat, scope of problem. The matching of the individual case and the statistics reaches maximum salience and redundancy. This may give the idea that more than 1,200 women die in similar circumstances. There is an explanation in successive images. Ideationally, there is enough cohesion for the viewer to infer the likely death of many babies; but the text does not highlight this fact from an intepersonal perspective. There are no mentions to perinatal deaths in this scene.
4:33		HP: direct. VP: median. D: MS VC: house, yard, shovel S: Jorge leaning forward towards Gaby. Jorge's movement to place his left hand on Gaby's womb. CO: nat. Gaby's dress stands out DoF: deep, comprehensive L: nat + softlight fill G: close, Jorge to Gaby, then briefly at baby, the Gaby again	Jorge and Gabriela hold each other's hands. Jorge (A) caresses her (G), leans forward, then extends his left arm to stroke her abdomen (G). Gaby lowers her head, snickers. Jorge is Agent, Gaby is Reactor.	Jorge: "Yo prefiero cuidarte a tí... y al Jorgito" (figure) Gaby snickers (figure) Field: birds chirping.	Mise-en-scène emphasizes strong bond between the three participants. The position of the bodies and the linking of arms have been carefully staged to this effect (they even seem to form a heart). The system of gaze and the vector running along Jorge's arm, together with his utterance give equal importance to the lives of Gabriela and their baby. Unborn child is named with diminutive, after his father. Multimodal device stresses the existence of another human being. Mental process ("Yo prefiero") implies expected attitude.
4:35		Same as above. S: Gaby leaning closer to Jorge's face, smiling and talking at very intimate distance. G: close, Gaby at Jorge, then down towards her womb.	Same as above. Gaby (A) leans markedly towards Jorge (G), smiles and talks (P) from very intimate distance. Jorge is Agent, Gaby Reactor	Gaby: ".. Y a la Gabrielita" (figure) Field: birds chirping.	Same as above. Now the child is named after her mother. The "relief"" exchange further signals the presence of another human being. It also connotes that baby girls are as welcome and valued as baby boys.
7:54		HP: direct to the world, slightly oblique to participants. VP: median. D: MS DoF: deep VC: stretcher, framed poster, window, doctor's uniform S: doctor places his right hand almost touching Gaby's womb; Gaby strokes her abdomen. G: close, doctor to Jorge, baby. Gaby to doctor. Jorge downwards	Doctor (A) looks from Jorge to Gabriela's womb (deictical, scope). Doctor moves right arm and hand to barely touch Gaby's womb. Jorge lowers head, shows expression of distress. Gabriela (A) strokes her womb (G) after the doctor mentions her baby. Doctor is Agent, Jorge and Gaby are Reactors.	Doctor (to Jorge): "[...] Pones en peligro la vida de Gaby y del futuro bebé" (figure)	Mise-en-scène frames the doctor as authoritative presence, supportive from a higher status. He qualifies the existencial status of the baby ("futuro bebé") in the fifth month of pregnancy. Movement and collocation of arms and hands + doctor's gaze point to the unborn, emphasize medical and maternal concern in a different way (professional vs instinctive).

T	Visual frame	Visual image	Kinesic action	Soundtrack	Analysis
8:47		Shot: reverse angle (classic editing for dialogues) HP: direct to world, oblique to participant VP: median D: CS S: participant CO: nat. L: nat+fill. DoF: shallow, foreground, discernible background G: close, off-screen, to Jorge L: key light, natural, from window	Doctor (A) slightly nods as he talks to Jorge (G). Doctor underscores the word "graves" with slight change facial expression a movement of shoulders. Doctor is Agent.	Doctor: "[. .] que puede ocasionar daños graves en la salud de Gaby..." (figure)	Speaker raises awareness of the danger for both the mother and the baby. The rhetorical tone is didactic, explanatory. The tone of the doctor's voice, his grave expression and the way he looks at Jorge (from the opening image in this shot) also connote paternalism and reproach. The formal register of the exposition incorporates a more familiar register, as the doctor uses the informal "tú" and the diminutive "Gaby".
8:48		Cut from shot above to show Gaby's face when we hear the doctor mention the baby's health HP: direct. VP: high. D: CS. S: participant's gaze, anxiety, hand clasping Jorge's hand VC: stretcher, white pillow, sheets G: off-screen, upwards, turns towards Jorge. L: key light, natural, from window	Gaby (A) turns her gaze from the doctor to Jorge (G), with wrinkled brow, tense mouth and distressed look.	Doctor: "[...] o del bebé" (figure)	The cut to an anxious, helpless Gabriela looking for Jorge's gaze when the doctor mentions potential danger to herself to her baby is both a deictic reminder and an interpersonal evaluation of maternal health. The co-patterned kinesics indicate both a behavioural process (looking) and a mental one (fear, anxiety). The use of main light from the window creates a certain contrast between the two sides of Gaby's face. There are shadows on her right side (facing Jorge). This connotes the tension of the yet unresolved situation.
9:09		Same as above. S: Gabriela's anguish when she recalls the death of her sister and her baby. G: off-screen, upwards, towards doctor; then unfocused, as she collects her thoughts and tries to put herself together, then to the doctor again.	Gaby (A) turns her gaze to the doctor. Her expression of distress is accentuated.	Gaby: "Sí, doctor. . Mi hermana se murió cuando ya se iba a aliviar, y... (holds back tears)... y el bebé también se murió" (figure)	From an interpersonal perspective, the text proposes a worst-case scenario regarding Gaby's family history, including the baby's death. The text seeks to extend the perception of vulnerability and severity, so as to cover the baby's life. Rhetorically, this creates a single-case balance to the maternal mortality numbers, which only referred to women's deaths.
10:16		D: CS of hand, tool, womb, MS of monitor, image VC: arm, uniform, transducer, monitor, image DoF: shallow focus; shot starts with sharper focus of procedure in foreground, then shifts to sharp focus on monitor image in background S: image on monitor	Hand of doctor or technician slowly moves transducer with soft pressure on abdomen. We see some movement in the image on the screen.	Soft, low-tempo descending piano chords (figure)	Ideational representation of the baby and the connection between the procedure on the foreground and the image on the background. Ultrasound image as photography, iconographic representation of baby. The image connotes the power of biomedical technology to confirm the existence of the baby and to certify his health status in terms of hard facts (as opposed to soft traditional knowledge). By showing the relax, non-invasive nature of the procedure, it seeks to allay fear of mistreatment and bad quality of care.
10:25		HP: direct. VP: median. D: Medium to close shot DoF: from mid- to back-ground VC: walls, window, scale, stretcher, sheets, medical tools CL: salmon pink matching Gaby's shirt and walls; white matching Gaby's dress and sheets. DoF: mid- to back-ground.	Gaby (A) looks at doctor (G) as she receives information from doctor. Doctor is Agent, Gaby is Reactor. Gaby closes her eyes, makes sigh of relief as she gets the good news. Gaby looks sheepish throughout the scene, her head slightly bent downwards. She has difficulty keeping eye contact with doctor.	Female doctor: "[...] Tu bebé tiene el tamaño correcto para sus ocho meses..." (figure) Soft, low-tempo synthesized chord (ground)	The doctor delivers the news from ultrasound as true knowledge (categorical modality). Register, interpersonal meaning capture and reinforce power differentials, stereotypical roles of doctor and women in rural and indigenous communities. The use of the possessive "*sus* ocho meses" in the circumstantial gives the idea of an eight-month old human being, enhancing the existential status of the unborn and the imminence of birth. Reference to the right size refers to diagnostic power of technology.

T	Visual frame	Visual image	Kinesic action	Soundtrack	Analysis
10:34		Shot: reverse angle in conversation with Gabriela. HP: direct. VP: median D: pocket shot (expert) VC: white uniform, pen, clip on name tag, diploma on the wall S: participant G: indexical, off-screen, towards Gaby CL: pink matches shirt, walls	Doctor demeanor is restrained, professional, didactic, reassuring, as she informs Gaby about the results of the ultrasound. Her facial expression (smile, eyebrows) engages Gabriela and her hands leave no doubt regarding the diagnose. Doctor is Agent, Gaby Reactor	Doctor: "[...] y su corazón late perfecto" (figure) Ground: same as previous shot	Same as above. The doctor delivers expert reassurances based on hard facts. Intertextually, text frames biomedical knowledge as capable of delivering reliable news about the health of the foetus facing childbirth (a key service rendered by parteras). The overall tenor of the interaction during this scene accentuates the differences at the level of sociocultural practices. The doctor is like a gentle but firm adult dealing with a child.
11:25		Open frame, camera stationary. HP: direct. VP: slightly high. D: CS. VC: white paper, table S: ultrasound image, then hand enters from left (New), ultrasound (Given)	Doctor's hand (interpersonal operator) enters open frame from left, picks up ultrasound image Doctor, Agent.	Doctor: "Éste es el ultrasonido de tu bebé..." (figure) Ground: same as previous shot	Ideational representation of the baby: ultrasound image as photography. Interpersonally, the image ratifies the true knowledge in the doctors' statements. It connotes the power of biomedical technology to confirm the existence of the baby and to certify his health status. The doctor is confirmed as the expert who has access to knowledge and resources, and who can produce tangible evidence.
11:29		Same shot as above. Camera pans from left to right. HP: direct. VP: slightly high. D: CS. VC: computer keyboard. S: ultrasound image (G), passing of image from hand to hand (N)	The doctor (A) gives (P) the ultrasound image (G) to Gaby (Recipient). The panning of the camera co-patterns this vector and highlights the transitive action. Doctor, Agent. Gaby, Reactor.	Doctor: "[...] Llévatelo" (figure) Mid-tempo pop theme ("Watchful Care" motif) in the ground, gaining volume.	Ideationally, the ultrasound image changes hands. Symbolically, the doctor passes responsibility for the baby onto Gabriela, together with an exhortation to self-control. This is cohesively confirmed by the assertion in the epilogue: "Tu salud y la de tu bebé están en tus manos". This is quite literally the case in the ideational construal of the film. The doctor is confirmed as having the power to share true knowledge and visible evidence with the patient.
11:30		Same shot as above. S: Gaby's hand + ultrasound image	Gaby's hand exits open frame from right, with ultrasound image. Gaby (A) takes (P) ultrasound image of her baby. Doctor, Agent (tacit). Gaby, Reactor	"Watchful Care" motif slowly builds up (figure)	Ideationally, Gaby now has the ultrasound image in her hand. Symbolically, she also takes responsibility for the well-being of her child.
11:35		Cut from previous shot HP: direct. VP: high DoF: deep focus VC: back of monitor computer, table, white sheets, pink walls D: MCS S: Gaby's leaning closer to image, staring G: close, from Gaby to image	Gaby holds the image with both hands, leans towards it, stares, and begins to insinuate a smile. (Behavioural and mental process) Gaby is Reactor	"Watchful care" motif (ground)	Ideationally, there is direct, visual connection between mother and child (even though she has been carrying him in her womb for eight months). Visual connection is construed as hard fact. Technological knowledge confirms embodied (uncertain) experience of motherhood. Gabriela gets closer to her child. Int. they are both subjects of maternal care. She has his/her life in her hands.

T	Visual frame	Visual image	Kinesic action	Soundtrack	Analysis
11:38		Cut from previous shot Subjective perspective from Gaby's viewpoint (from above) HP: direct VP: median D: CS VC: words, numbers, white frame around central image S: fuzzy, grayish images with vague human-like contour against black background		"Watchful Care" theme (figure)	Ideationally, the ultrasound image is presented as an iconographic representation of the "baby". Intensive (identifying) clause: "This is the image of Gaby's baby". Interpersonally, the viewer sees the image through Gaby's eyes, "discovers" the shape of the baby and confirms his existence. Behavioural, mental (cognitive and emotive) process are involved in the visual construction of the "clause".
11:44		Dissolve from previous shot. HP: oblique. VP: median. D: MCS VC: bed, cover, chair, wall, window CO and L: nat DoF: deep focus S: Gaby's right arm on her womb, Gaby's gaze and smile G: close, alternatively from Gaby to image and from Gaby to her womb.	Gabriela looks at ultrasound picture, then turns to look at her womb. She intensifies her caresses, then looks again at image, giggles and quivers with anticipation. (Behavioural and mental processes) Gaby is Reactor (to object and to Phenomenon in mental process)	"Watchful Care" them (figure)	The viewer is placed as involved onlooker. Ideationally, we are situated in the privacy of the home. Interpersonally, this is a "safer" privacy. Four strong vectors lead the narrative pattern: a) from her eyes to the image; b) from her eyes to the womb; c) from her right arm to the womb; d) from her folded arm to the ultrasound image. They form a rhomboidal pattern framing the womb and connecting with the image. Now Gaby has a better perception of her child, who is safer in her womb.
12:08 to 12:13		Open frame (Comadre enters through door). HP: direct. VP: median. D: MS VC: broom, pot, Comadre's dress table, bags, TV set, kitchen DoF: deep focus CO+L: nat. S: participants, broom, pot G: close, connects the two participants in mutual exchange.	Jorge uses an emphatic tone, highlights his words with facial expressions. He stresses the word "retebién" and closes grip on broom. Comadre smiles, holds pot during conversation. Jorge is Reactor (to Comadre's previous comments)	Jorge: "[...] porque la Gaby y el bebé ya están retebién... [sighs with relief]... y el chamaco ya nace en esta semana" Figure: dialogue. Ground: "Watchful Care" theme.	Jorge's utterance give Gaby and the unborn child the same existential status. His second utterance presupposes the (medicalized) safe birth of the child. Ideationally, the visual collocation and salience of broom and pot indicate that Jorge and Comadre have been engaged in material processes. Interpersonally, they connote role modeling (maybe deviation from stereotypical role in Jorge's case) and solidarity.
12:38		HP: direct. VP: median. D: MCS S: Gaby's arm and hand lying on womb (G), image changing hands, Comadre's expression of surprise (N) G: close, from Comadre and Gaby to image	Comadre (A) grabs (P) ultrasound image (G) from Gaby's hand (C). She looks at it with heightened surprise and delight. She opens her mouth and her eyes wide, as she leans back and smiles. Comadre is Agent	Comadre: "¡A poco si es el Jorgito!" Music: "Harmony" theme. Voice and music share figure and ground	Here, again, the baby is identified as being the person in the ultrasound picture. The Comadre uses an identifying relational clause where the identified is deictically indexed through gaze (from Comadre to image). The exchange intertextually alludes to a stereotype from the order of discourse of everyday life around pregnancy and childbirth. Comadre names the child as Jorgito, which may imply that greater value is assigned to the coming of a baby boy.
12:40		Same shot as above. S: Gabriela's arm (G), movement to take image from Comadre, Gabriela leaning closer to Comadre (N). G: close, from Gabriela to Comadre and image; from Comadre to image.	Gaby (A) grabs (P) image (G) from Comadre's hand (C). She leans forward towards Comadre, who in turn leans toward her, but keeps looking at picture (G). Gaby smiles and speaks to Comadre (G) at very intimate distance. Gaby is Reactor (to Comadre's comment)	Gabriela: "¡La Gabrielita!" Both women giggle. Music: "Harmony" figure. Voice and music share figure and ground.	The exchange anaphorically refers to a similar interaction between Jorge and Gabriela. The mother names the baby after her own name. In this case, the interaction (grabbing the image from each other's hand, giggling) is construed as childish. The equal balance between the "Harmony" motif and the volume of the voices may indicate that "harmony" and safety are now real. The childish participants, and the child in the womb are safe in a private space subject to control and self-control.

T	Visual frame	Visual image	Kinesic action	Soundtrack	Analysis
12:45		Same shot as above. S: Gaby's hand pointing to image. G: close, from Gaby to image; from Comadre to image and to Gaby	Gaby leans forward, smiles, and points at image. Comadre smiles, looks at image and then at Gaby. (Behavioural and mental processes)	"Harmony" theme (figure) Gabriela: "Y éste es el ojito, así..." (ground) Gaby (Sayer) explains image to Comadre (Addressee) Gaby is Agent in verbal process	"Harmony" motif takes over the figure, completes re-semantization of domestic environment. Gabriela passes visible (true) knowledge of the baby to Comadre. A new type of shared knowledge is generated. Identifying relational clause (identified is deictically indexed through demonstrative pronoun, gaze and gesture) confirms the equation ultrasound image=reality and the presence of the baby as human being.
12:47		Same shot as above. S: women smiling, looking at picture, Gaby's hand on womb, then points to picture. G: close, Gaby to picture; Comadre to picture, then to Gaby's womb.	Described in "visual image" (behavioural and mental processes)	Voice-over (figure): "Tu salud y la de tu bebé están en tus manos" Music: ground, "Harmony" motif Voices: field (verbal processes)	The Speaker (Government) takes over the figure to interpellate the viewer as at-risk mother and to pass on responsibility for her own health and the child's health. The multimodal device has maximum redundancy: gaze, smiles, hands, voice-over, even the field (inaudible) deictically index the baby (a visible, tangible baby) as subject of care. Baby is increasingly salient throughout sequence. Voice-over is assertive, declarative (performative), and directive.
13:24		Dissolves from previous shot. Closed, tight frame, fully occupied by participants in foreground. HP: direct VP: high D: CS VC: white blanket, white uniform DoF: shallow (baby, blanket) CL: white L: key light from right on face, uniform, blanket G: baby, closed eyes S: participant's face	Nurse's (A) arm gently cradles baby (G).	Voice-over: "Hazle caso a tu cuerpo, hazle caso a la vida" Music: "Harmony" motif. Voice-over is figure, music is ground when shot begins. Music volume increases, becomes figure when voice-over ends.	Dissolve indicates ellipsis, connects shots, suggests topical theme relationship (ultrasound>baby, control+self-control>healthy baby). Ellipsis glosses over hospital delivery. Close-up of baby boy (Jorgito) in nurse's arm highlights key protagonist in good hands (skilled care). High shot signals protection. Emphasis on whiteness highlights safety, cleanliness in hosp. environment. Sharp focus on baby, nurse, whiteness, indefinite background, render archetype. Voice-over connects self-care, heeding doctors with life (baby)
13:28		Dissolves from previous shot. Open frame. HP: direct VP: median. D: MCS VC: white uniform, cap, white blankets. DoF: deep, hospital hallway CL: white S: nurse delivering baby, Jorge in awe G: close, from nurse and Jorge to baby. V: along nurses arm, baby, Jorge's arms.	Jorge is looking off-screen, with blanket on shoulder, turns around, shows suprise. Nurse (A) enters from left, hands baby (G) to Jorge (R), smiles, turns around, exits frame, briefly looks at camera (suggests demand). Jorge shows he is in awe. Nurse is Agent, Jorge is Reactor.	"Harmony" theme is figure.	Whereas closed, tight frame in previous shot construed safe delivery and safe baby in skilled hands, open frame in this shot highlights passing of healthy baby from skilled care to parents in public space (hospital). This delivery signals ideal (idealized) outcome of control + self-control under medical supervision and points to a continuum of care after childbirth. Jorge (hero) is rewarded. We remain involved on-lookers (direct + median perspectives, medium close shot of intimate interaction in clearly visible hospital environment.
13:41		Same shot as above, camera slightly zooms-in on Jorge and baby. VC: white blankets, hospital hallway. S: Jorge's facial expressions. G: close, from Jorge to baby; far, from Jorge to a higher point off-screen.	Jorge cradles and kisses baby, looks alternatively at baby and to higher, off-screen point. His face shows emphatic, childish expressions of tenderness, delight (when looking at child), and gratitude (when he looks off-screen). As he looks up, he briefly and gently shakes his head, purses his lips, smiles, and seems to utter the word "gracias".	"Harmony" theme is figure.	Behavioural and mental process predominate. Jorge is Agent (of care) and Reactor (thanks God). Though Jorge thanks God (cohesive reference), we know the outcome is also result of his own timely actions (cataphorical cohesive reference + he holds reward in his hands), combined with skilled care (open frame, delivery from nurse). Interpersonally, deep connection with baby also implies role modelling (fatherhood). We remain involved on-lookers, though a bit closer to the participants (zoom in).

Appendix D: Risk table

Appendix D- Pregnancy risks perceived by pregnant Amuzgo women, recent mothers, and Amuzgo men

Introduction

Input for column one on this Annex came from two different sets of categories, "Pregnancy risks" and "Danger, perils, threats", and the units of analysis therein. Originally, these were two separate sets of categories: "Pregnancy risks" included responses to specific questions about risks, while "Danger, perils, threats" focused more on perceptions of threat magnitude, severity and vulnerability. However, it made sense to bring both sets of categories together, since they had closely related and often overlapping contents. Also, as I mentioned before, we could only translate risk as "peril" or "danger" in the Amuzgo language. And government safe motherhood discourse in Mexico presents risk in terms of threats and dangers, as we have seen from chapters 4 and 5, which confirms a well-established trend discussed on chapter 2.

The table also shows how axial coding was greatly dictated by the implicit dialogue between people's answers and different notions of risk in safe motherhood discourse. For instance, under the overarching notion of risk we find "Risks factors" (malnourishment, self-medication, etc.), "Alarm signs and symptoms" (headaches, dizziness, abdominal pain, weakness, sadness, not seeing well) and "Pregnancy complications" (miscarriage, complications during childbirth), which clinical and epidemiological literature treat as different things, as we have seen on chapter 2. This happens because these categories are all intertwined in participants' views of pregnancy risks. In other words, people construe these categories as pregnancy risks, dangers or threats.

Participants also mention these same categories as potential outcomes of a threat (miscarriage as the outcome of self-medication, bleeding, antojo or loss of the nahual) or as the reason for this outcome –i.e. women who are not careful and self-medicate may miscarriage, which makes them part of an at-risk group and, in turn, discursively links with notions of responsibility and blame. All of this shows the need and added value of interpreting these references in the immediate context of people's answers (both intra-interview and across our dataset) and the discursive landscape they reflect. Such an approach goes beyond counting how many times people say this or that and allows exploring the semiotic richness of many categories and how they relate to one another – i.e. how "*cuidarse*" (take care, look after oneself) feeds into self-control and how it connects with responsibility and blaming. From this perspective, having had many pregnancies can be a risk factor ("*hasta se puede perder la vida después de dos y hasta diez hijos*"), but also a good thing because women who have many children are more experienced, do not "exaggerate" their ailments, know how to push, and are not afraid of giving birth. It all depends on how these views make sense in people's narrations and what discourses are brought into play.

In the other four columns, I have collated additional data from and about the same units of analysis. Column 2 ("What can happen") links with threat severity (a core component of behavioural models, as discussed on chapter 2), and other pre-established categories,

such as "Child", "Mother-child", "Childbirth as risk", and "Malnutrition", or to an all-important emerging category such as "Miscarriage".

Column 3 ("How to prevent it") aims to see whether people feel they can prevent danger and how; it also links with pre-established categories such as "Prenatal control", "*Cuidarse*" (self-care), "Trust", "Health centre, hospital", "Partera", "Prevention", "At-risk women, risk factors", "Agency", and "Responsibility, blame". On chapter 6, I have delved into some of these discursive connections.

Column 4 ("What to do when it happens") seeks to determine whether people think something can be done when bad things happen and what is the preferred course of action. Most data for this column comes from specific questions, such as what to do or whom to see in case of problems. The content also connects with other pre-established categories, such as "Health centre", "hospital" and "partera", and to emerging categories, such as *La persona que sabe* (Healer), *destino* (Fate) and *Dios* (God), among others.

Column 5 ("To whom/why does it happen") links with key pre-established categories, like *Responsabilidad, culpa* (Responsibility, blame), *Factores de riesgo* (Risk factors), and *Mujeres en riesgo* (At-risk women), and emerging categories such as "*Nosotros, nosotras*" (Us, We).

As for the horizontal reading of the Annex, each row includes data from within single interviews (intra-interview) and also from different participants (cross-sectional); therefore, it only occasionally reflect the views of a single respondent. I refer to both kinds of textual connections when I discuss selected units of analysis.

Appendix D- Pregnancy risks perceived by pregnant Amuzgo women, recent mothers, and Amuzgo men

Related to government texts and biomedical concerns				
1. Risk, threat, danger	**2. What can happen**	**3. How to prevent it**	**4. What to do when it happens**	**5. To whom/why does it happen**
Woman can get sick	-Miscarriage -Woman can die	-Be careful, look after herself -Go to health centre, see doctor for prenatal control *"La mujer que lleva un buen control no corre riesgos. La mujer que acude al centro de salud"* (husband) -Heed doctor -Not sure hospital can help prevent problems: *"Yo dudo mucho que revisen el estado de salud; puede ser que ni ellos lo sepan"*	-Go to hospital -Sometimes, nothing can be done: *"Pero ni ellos la pueden salvar; no tienen asegurado el destino... sólo Dios sabe"*	-Women who do not go to hospital and heed doctors -Women who are not careful, do not look after themselves *"Si ella no se cuida, se puede enfermar"* -Women who do not eat well -Women who are of weak health -Husband does not take woman to hospital: *"Si él me quiere no me deja, pero si no me quiere me deja y se va a trabajar; me puede dejar a mi sola sin saber si mi hijo nació bien o mal."* -Fate: *"Cuando el destino ya está definido, no hay nada*

				que hacer"
Baby is in wrong position inside the womb	-Leg pain -"Many things can happen" -Woman pushes without success, gets exhausted -Woman may not be able to deliver -Woman may die, leave husband a widower, children destitute -Baby can die -Transverse position is particularly dangerous	-See partera periodically to position baby in womb -Baby must be well positioned before labour -See doctor, go to hospital for prenatal control, ultrasound	-See partera -Go to hospital -Have c-section	It can happen to anyone
Baby is not moving in womb	-Difficult delivery -Baby can die	-See partera -See doctor	-See doctor	-Baby may be tightly stuck inside womb -Baby may be dead
Body aches, back pain, headaches, dizziness, abdominal pain, tiredness, weakness, sadness, loss of appetite, not seeing well, turning pale	-Sickness -Miscarriage -Complications during childbirth -Woman can die	-Avoid doing laundry heavy work -Woman must heed doctors -Woman must be careful, look after herself -Husband must not allow woman to work hard -Others must help pregnant women with house chores	-See doctor, health centre -See partera -Use traditional medicine, eat local food (*cosas que tenemos aqui*) -Nothing can be done if it is God's will	-Pregnancy itself can make women sick -Woman makes physical effort -Women who do heavy work, do not look after themselves -Women do not go to hospital, heed doctors -Exposure to the sun -Baby grows big and heavy in the womb

Flu, diarrhoea	-Baby can get sick	-Be careful, look after herself	N/A	-Woman is not careful, does not look after herself
Blood grows weaker	-Woman gets sick -Newborn stunted -Woman can die	-Eating well -Women must be careful, look after themselves	-Go to hospital -Vitamins, medicine, injections make blood stronger	-Some women are weaker than others -Some women do not eat enough, sometimes for lack of money
Loss of appetite	-Woman gets weak, is unhappy -Unborn, newborn may have problems	-Eating well	-Go to hospital, take medicines to restore appetite	-It happens to some women during their pregnancy
Swollen feet, varicose veins	-Veins ache, woman cannot walk -Veins can break, women can die *"Y dicen los médicos que es peligroso a la hora del parto. Se me puede romper una vena que tengo en mi parte íntima y corro riesgos de morir, los médicos me dijeron que tengo que operarme."*	-Not jumping from high places, not sitting on high chairs -Women must be careful, look after themselves	-Go to hospital, see doctor -See partera	-Sitting in high chairs -Jumping from high places -Women who are not careful, do not look after themselves *"... porque muchas de nosotras no nos cuidamos, no nos cuidamos a diario. Paseamos descuidadamente."* -Women with espanto or coraje
Leukorrhea (vaginal discharge), itching	N/A	N/A	-Go to health centre	-No one in particular -"*La gente dice que puede haber una*

				enfermedad"
Self-medication	-Woman can get sick -Baby can be born with problems, sickness -Miscarriage -Woman may kill baby	Avoid self-medication	-Go to health centre, hospital	-Women who are not careful and self-medicate -Women who want to kill their babies -"*La mujer es consciente cuando dañó al bebé por la inyección o la pastilla*"
Having had many pregnancies	-Woman can die: "*Hasta se puede perder la vida, después de dos hasta diez hijos.*"	-Nothing can be done, because it is God's will: "*Pero, ¿ qué puede hacer la mujer si Dios ya lo dispuso así?, Porque la mujer ya la dispuso Dios para procrear [...] El tiempo detiene la fertilidad y no la medicina.*"	N/A	-Women who have more than two children
Being of a certain age (*estar grande, ser vieja*)	-Baby can have problems inside womb -Complications during childbirth -Woman can die	-Partera must position baby inside womb -Go for prenatal control to health centre, hospital "*Voy porque quiero ir porque necesito que me revisen, como dicen cuando alguien*	-Go to health centre, hospital	-Women of a certain age (usually in their 30s and 40s)

		envejece necesita más atenciones. Es dificil si algo me pasa a esta edad [...] Debo ir por si se presentan complicaciones en el parto; debo de recibir tratamientos porque ya estoy grande, corro riesgos de tener complicaciones en el parto".		
Bleeding during pregnancy	-Miscarriage	-Husband should be aware of pregnancy, look after woman	-See doctor, go to health centre	-Poor women -Malnourished women -Jobless husband -Woman must work -Husband is not aware of pregnancy, does not care, does not help his wife -Woman suffers from espanto -It can happen to any woman (all women are at risk)
Miscarriage	-Baby comes off and falls -Baby dies -Micarriage is the much feared outcome of the	-Avoid self-medication -Do not drink -Avoid hard work, backstrap loom, lifting heavy objects	-Go to health centre, hospital	-Accident, no one to blame -Woman self-prescribes drugs: *"Cuando se toma*

	many things that can happen during pregnancy	-Avoid running, reduce risk of tripping -Do not use petticoat only -Woman must be careful, aware, look after herself *"Se debe de cuidar, porque es consciente la mujer de su embarazo, de que está cargando el bebé."* -See doctor, partera for prenatal control -*"Porque la mujer se puede enfermar hasta tener consecuencias graves como abortar; pero la mujer que lleva un buen control no corre riesgos, la mujer que acude al centro de salud."*		*alguna pastilla sin consultar al médico se corre riesgos; por eso se suceden los abortos. Por eso yo iba al hospital. Hay mujeres que sí lo hacen y provocan un aborto*" -Woman drinks -Man drinks, gets violent, hits wife -Women who do not love their babies -Women who do heavy work, do not look after themselves (women who run, use petticoat only, etc.) -Women who do not go to health centre -Husband is not aware of pregnancy, does not care, does not look after his wife or help with house chores -Husband does not take wife to hospital -Poor women -Malnourished

				women -Jobless husband -Woman must work to make ends meet
Heavy work, lifting heavy objects, brisk movements, impacts	-Abdominal pain -Pain, swelling in feet -Bleeding -Placenta comes off -Miscarriage	-Avoid heavy work, lifting heavy objects, riding a bike -Avoid backstrap loom in mid-to-late pregnancy -Help women with work, house chores	Go to health centre, hospital	-Women who do not look after themselves -Men who are not aware of pregnancy, do not care, or do not help their wives -Poor women who need to work to make ends meet -Indigenous women cannot stop working: "*No hay de otra, porque somos pobres*"
Not eating well during pregnancy	-Woman takes ill -Woman is not strong enough for delivery -Child is born sick, too small, with low weight -Newborn can die	-Eat well during pregnancy -Eat all sorts of things	See doctor, go to health centre	-Women who do not eat well or only eat certain things during pregnancy -Husband is not aware of pregnancy, does not care, does not help his wife -Poor women do not have enough to eat
Premature birth	-Newborn is weak, sick	-Woman must eat well, so she will not be sick -Husband must be	N/A	-Malnourished women -Women who do not

		aware of pregnancy, help his wife		have any help from their husbands
Pregnancy *as* risk (pregnancy is fraught with risks)	-Many things can happen to pregnant women: *"Pienso que aunque la persona embarazada se encuentre bien, cuando menos se lo espera, repentinamente, puede pasarle algo malo"* -The outcome is always uncertain: "*Una persona no sabe cómo va a terminar el embarazo, ya que una mujer se embaraza por nueve meses y en esos nueve meses no sabe cómo terminará todo*"	-See doctor for prenatal control *"... pero la mujer que lleva un buen control no corre riesgos, la mujer que acude al centro de salud."* -Women must be careful, look after themselves ("*Ella debe de cuidar su embarazo para tener un buen parto*") -Woman must not be afraid facing delivery	-See doctor, go to health centre, hospital -See partera -See healer	-All pregnant women are at risk -Women who do not look after themselves, go for prenatal control: "*Porque hay mujeres que no van a ver al médico, no llevan control de su embarazo, creo que por eso*" -Multiparous women and older women (in their 30s and 40s) are at higher risk
Delivering at home, with partera	-Partera can press in wrong place, hurt baby -Partera cannot handle certain complications -Parteras ask women to push when they have no strength left -Women suffer -Mother, baby can die -Woman may not get to	-Deliver with doctors, in health centre or hospital	-Go to hospital	-Women who deliver with parteras -Women who do not have money to deliver in hospital

	the hospital in case of complications			
Complications during labour and delivery, childbirth *as* risk (childbirth as fraught with risks)	-Many things can happen when the time comes to deliver (baby gets stuck, placenta blocks delivery, retained placenta, delayed delivery, low blood pressure, bleeding, etc.) -Woman, child can die -"*Nunca estoy completamente segura en el parto, porque corro riesgos. No puedo saber si me salvaré; no lo sabré hasta en el parto*" -"*El parto es delicado y peligroso [...] Peligroso porque cuando algo sale mal corre el riesgo de fallecer*" (husband)	-Prenatal control + hospital delivery: -Prenatal control + deliver at home -Make plans with husband in case something goes wrong	-Go to hospital -Partera knows how to extract placenta -Stay at home, use traditional medicine: "*Si algo me pasa, que sea en mi casa. Porque las enfermeras ya no te reciben, y si hay alguna complicación y me muero, mejor que sea en mi casa, porque ahí hay medicina también*" -Some people may try either of the above, and then have an explanation for a negative outcome: "*[Hay que] Llevarla al hospital o buscarle la medicina indígena aunque a veces es inevitable la muerte*".	-All pregnant women are at risk: -"*Porque veo que es difícil cuando llega el día del parto, por eso pienso que todas corremos riesgos*" -"*A las personas que viven en este mundo. Las mujeres en edad reproductiva*" -Women at risk when baby is not well-positioned for birth -Older women tend to have more difficult deliveries -Fate: "*Puede ser porque es su destino; cada mujer tiene su destino*" (husband)
Delayed, overdue delivery; not being able to deliver	-Women suffer -C-sections, cuts -Woman and baby can die	-See partera to position baby in womb -See doctor for prenatal control -See doctor for	-See healear -Go to hospital -Have c-section -Nothing can be done if God has called one's	-Baby is not well positioned for birth -Baby is too big -Placenta previa "*Cuando el bebé*

		ultrasound -Deliver in hospital: *"La gente dice, los médicos dicen: 'Si no vas al hospital, puedes fallecer.' Significa que tienen medicina para ayudarte y que si no logras dar a luz pueden hacerte la cesárea, sólo eso"* -Deliver at home *"Como en mi caso, si voy al hospital y ellos no se apuran quiere decir que yo misma estoy matando a mi bebé. Y en mi casa el parto es normal".* -Have faith in God "*Eso es principalmente cuando no acudo al hospital, pero yo veo que es mejor en casa, me ayuda más; cuando es en casa, Dios no me deja sola*" -Overcome fear -Personal effort -Doctors should provide timely	number *"Como te dije cuando le llega la hora a la persona no hay nada que hacer, porque le llegó la hora, aunque vayan al hospital o en la casa. Cuando dios decide el día y la hora, no hay nada que hacer. Él ya decidió recibir tu alma."*	*tiene problemas con la placenta no puede la mujer parir, es por la placenta no puede parir porque aunque puje la mujer no sale".* -Umbilical cord wrapped around baby -Antojo, espanto, coraje, loss of nahual -Women are afraid of pushing, delivering -Some women do not know how to push -Mostly, first-time mothers (lack of experience) -Woman is ill (i.e. ovary problems) -Many women have these problems: *"He escuchado que a muchas mujeres les pasa [aquí en el pueblo]... por eso digo que es peligroso"* -Women who do not deliver in hospitals -Women who do not

		assistance to women who go to health centres and hospitals for childbirth		think about God, do not ask for God's help when they are healthy, and do not go to the hospital for prenatal control -Some doctors do not assist women immediately and misjudge the immediacy of childbirth, and contribute to an overdue delivery
Not knowing how to push, not being able to push, not having enough strength to push	-Not being able to deliver -Woman, baby can die	-See partera to position baby in birth canal -Deliver in position of choice (mostly, traditional, vertical positions) -Husband must help, grab woman from behind -Woman must grab pole, handle, etc. -Overcome fear -Personal effort "*Cuando llega el tiempo me esfuerzo para pujar porque solo depende de mí y de*	-Go to health centre, hospital	-As women get older and have many children, they lose their strength: "*Mientras más hijos se tenga, se va acabando la fuerza. Llegará un día en que ya no podrá parir*" -Women are afraid of pushing, delivering -Some women do not know how to push -Mostly, first-time mothers (lack of experience) -Baby is not well

		nadie más. Solo depende de mí para que no pase por momentos difíciles". -Have faith in God -Deliver in hospital: doctor helps, IV gives energy		positioned for birth -When women deliver at home, all they can do is push, and that wears them out and complicates delivery
Not being able to get to the hospital on time, not getting timely care in case of complications	Woman, baby can die	-Make plans with husband, putting away money in case something goes wrong -Make ambulances available for transportation in obstetric emergencies -Municipal government should make vehicles available for emergencies	N/A	-Poor women are particularly at risk in case of complications: "*Porque soy pobre, por eso prevengo posibles complicaciones. Si no puedo parir en casa, voy al hospital.*" -Hospitals do not take care of poor indigenous women who cannot pay: "*Hay indígenas que se mueren por complicaciones porque no tienen dinero para ir al hospital y los médicos no las atienden. En el hospital de gobierno*

				no atienden bien y con el médico privado es diferente, pero el problema es que nos falta dinero, los mestizos si encuentran dinero y acuden a los mejores hospitales". -Ambulances are not readily available
Sickness, bleeding after delivery	-Diarrhoea -Postpartum haemorrhage -Some women pass out after childbirth -Women can die	-Woman must lie down immediately after delivery -Woman should not bathe immediately after delivery; then, bathe with warm water -Woman must rest, look after herself, during *cuarentena* -Woman must heed elderly women -Woman must avoid doing house chores, heavy work, lifting heavy objects, walking too much, and making brisk movements -Woman must eat "good foods", avoid	-Get medicine (Western and/or traditional) -Go to hospital	-Women do not look after themselves -Husband, family do not help

		spicy food, fat, lard, greasy foods. -Husband, mother-in-law, family must look after woman, feed her, help with house chores -Spouses should not have sexual relations		
Baby in the womb and newborn are very delicate, tender, fragile (at-risk baby)	-Baby is not well positioned inside womb -Baby can get sick, die -Mother can pass sickness onto child in womb and to newborn when she breastfeeds -Miscarriage *"... porque el bebé es delicado y se puede salir"* -Problems during childbirth, like placenta previa, maternal waters dripping into baby's mouth, doctor sticking his fingers inside the vagina to extract baby, partera pressing in the wrong place -Death during childbirth -Defects,	-Go for prenatal control with doctors, partera -Mother must be very careful, look after herself and her child -*"La mujer debe de cuidarse para que no se enferme su hijo"* -Avoid smoking, drinking, doing hard work, lifting heavy objects -Mother must consult with partera, doctors about child's position inside the womb -Partera must reposition baby in womb -Mother must not self-medicate -Deliver in hospital -Deliver at home	-See partera, use traditional medicine -See doctor, go to hospital, particularly with newborn	-Unborn and newborn children are essentially tender, weak -Mother is not careful, does not look after herself and her child -Father drinks, is violent with woman -When man has sexual relations with woman, it can affect baby -Mother lives in a stressing environment or exposes herself to stressing situations, negative vibes -Baby inside womb and newborn can get sick, have problems if mother suffers from

	malformations -Pinkeye -Babies can have accidents -Newborn can suffer from coraje -Malnourishment -Crown of the head falls off -Navel falls off -Bleeding from mouth, eyes	-Mothers must be very careful, attentive with their babies -Feed first milk -Keep baby dry, clean, well fed -Vaccinate -Not vaccinate -Not letting baby cry too much -Baby should not go out of the house too soon after birth		antojo, susto, coraje or loss of nahual, or she exposes herself to lunar eclipse -Newborn cannot communicate through language -Mother and father are always responsible for their children's health: "*La persona que no lo atiende bien, puede ser su mamá o su papá, ellos tienen la culpa; porque él no puede cuidarse solo, depende de ellos*". -Woman is not healthy ("*Cuando la mujer se enferma es muy delicado, porque puede enfermar al hijo también*") -Sometimes, bad things happen and nothing can be done -Government plan to exterminate indigenous peoples:

				"El gobierno busca la forma de exterminar con los indígenas y las inyecciones son parte de esa estrategia. Mi bebé estaba bien cuando nació, pero después de las inyecciones comenzó a sentirse mal".

Unrelated to government texts and biomedical concerns				
Risk, threat, danger	**What can happen**	**How to prevent it**	**What to do when it happens**	**To whom/why does it happen**
Lunar eclipse	Moon "eats" baby; baby can be born with malformations	-Not go out during eclipse -Cover womb with blanket, piece of cloth	N/A	-Woman is not careful
Cold air	-Dizziness, headache -Swollen feet, pain during pregnancy -Bloated womb (after delivery)	-N/A during pregnancy -Wrapping the womb tightly with a piece of fabric (belly wrap) after delivery -Cover head with a piece of cloth after delivery	-Massage foot with alcohol during pregnancy -Not easy to get medicine once recent mother gets sick	Can happen to any woman during pregnancy and after delivery
Susto, espanto (scare)	-Intense pain hinders delivery -Miscarriage -Delayed, overdue delivery; complications during childbirth -Woman, baby can die	Avoid frightening, stressing situations	-See healer for diagnosis and treatment, use traditional medicine -See elderly people with knowledge, experience -There is no cure for espanto is hospitals	-Woman exposes herself to stressing situations -Other people cause stress to woman -Indigenous people, Amuzgos: "*Entre nosotros los amuzgos uno corre el riesgo de enfermarse de esa enfermedad del susto*" -Poverty, malnutrition

				"La gente se pregunta por qué no le pasa a los mestizos. Porque ellos viven diferente a nosotros, tienen buena alimentación; en cambio, los indígenas no la tienen porque no les alcanza el dinero"

Coraje (a series of symptoms related to negative emotions such as anger, frustration, and grudges, or unpleasant situations, such as violence, arguments, etc.)	-The mother and the child can both be affected in different ways, depending on how the coraje air impacts the body -Miscarriage -Delayed childbirth, complications during childbirth	-Avoid exposure to unpleasant, stressing situations –Women must "think a bit" and "not see unpleasant things" -Coraje is a contagious, community-wide threat. Sometimes, there is coraje in the air and women get it. People should avoid exposing women to stressing circumstances	-See healer for diagnosis and treatment, use traditional medicine -See elderly people with knowledge, experience	-Woman is not careful -Woman gets involved in arguments -Husband does not provide for wife, children -Husband is violent, argues with wife -There is coraje in the air, vicinity, community -Coraje also stems from the uncertain outcome of childbirth *("Este coraje viene de la incertidumbre que ella siente, de no estar segura que dará a luz sin complicaciones")*
Loss of the *Nahual* or *tono* –Something bad happens to the person's nahual (an animal she is deeply connected with).	-Delayed childbirth, complications during childbirth	N/A	-See healer for diagnosis and treatment, use traditional medicine -See elderly people with knowledge, experience	-Something bad happens to the woman's nahual
Antojo (craving, particularly for food).	-Mother shows different symptoms	Satisfy cravings	-See healer for diagnosis and	-Women who do not satisfy their cravings

It is often seen as a desire of the unborn child expressed through her mother.	during pregnancy, from itching and headaches, to swollen feet and bleeding -Complications during childbirth -Child can be affected in the womb -Child can be born with birthmarks, defects		treatment, use traditional medicine -See elderly people with knowledge, experience	-Not helping women satisfy their cravings
Other diseases during pregnancy	-Woman can pass sickness to child -Woman can die	-Go for prenatal control with doctor, partera -Women must be careful, look after themselves -Women must pray to God, seek His help when they healthy	-Go to health centre, hospital	-Some women are neglectful, do not look after themselves -Women do not go for prenatal control -God abandons some women when they stop adoring Him
Lack of food	-Child is born sick -Malnutrition -Mother, baby get sick	N/A	-Women must go to health centre, hospital, to get vitamins	-Poor women -Indigenous women -Husband does not bring enough money to support household
Lack of money	-Coraje -Malnutrition -Mother, baby get sick -Mother cannot make it to the hospital in case of emergency -Hospitals do not receive patients who do	-Make provisions for emergencies: "*Porque soy pobre, por eso prevengo posibles complicaciones. Si no puedo parir en casa, voy al hospital.*" -Free hospital services	N/A	-Poor women -Indigenous women are poor -Husband does not bring enough money to support household

	not have money -Mother cannot see private doctor -Mother cannot get good medical attention	for poor people -Make ambulances available for transportation in obstetric emergencies		
Domestic violence	-Coraje -Bleeding -Miscarriage -Complications during childbirth	-Men and women should avoid arguments -Men should not drink, hit their wives	N/A	-Men who drink and/or hit their wives -Household stress, tension between husband and wife
Accidents, scorpion sting	-Miscarriage -Mother and baby can die	N/A	-Seek attention in hospital -Do not stay at home -Do not self-medicate	-Some accidents happen, even when women are careful -Women who do not seek help from hospital and self-medicate
Baby is too big	-Complications during childbirth -Woman, baby can die during childbirth	-Work hard -Eat less	-Quickly transporting woman to hospital -See private doctor	-Woman who are not careful, eat too much -Aboriginal women live in poverty -Parents did not seek a way for woman to have c-section -Government doctors do not assist poor women -Poverty + poor quality of care + parental responsibility

				"Todas estamos en la pobreza, no tenemos dinero para vivir; pero donde no queremos pasar por algo trágico buscamos la manera de llegar con el médico privado. Como hay médicos que paga el gobierno no atienden a la mujer y hay bebés que son demasiados gordos y complican el parto. Puede nacer pero nacerá muerto y no podrá nacer porque no se apuraron sus familiares para buscar la forma de operarse."
Parto seco (dry labour)	-Woman suffers from intense pain, goes through longer labour	N/A	-Traditional medicine: herbal teas, etc.	-Woman does not break waters or have hemorrhage at the beginning of labour (it may be another description of delayed delivery; description differs

				from biomedical definition, which implies early breaking of waters)
C-sections, vaginal cuts, incisions	-Sickness: "*Prefiero parto natural, porque por cesárea se enferma la mujer*" -Long-term consequences: "*La mujer queda mal*"	-Prenatal control + delivery at home -Have faith, pray, commend oneself to God	N/A	-Women who deliver in hospital -Doctors do not know: "*Es dificil porque los médicos no saben qué es un parto en cambio nosotras que ya hemos tenido hijos entendemos. También si ellos entienden se ve porque muchas mujeres se mueren en el hospital porque ellos no saben.*"
Giving birth in hospital	-Some doctors do not assist women immediately and misjudge the immediacy of childbirth, and contribute to an overdue delivery -Women suffer -Women must expose their intimate parts; doctors penetrate with	-Give birth at home -See private practitioner	-Give birth at home -See partera	-Some doctors, nurses do not provide good quality care to poor, indigenous women -Health staff make mistakes

	hands -Woman, baby can die -C-sections, cuts -Ill treatment -Women can get sick in health centre, hospital: *"Cuando llega una mujer embarazada ellos las operan y allí le ocasionan otra enfermedad. En ocasiones le pasa algo a la persona que no tiene problemas"* (husband)			
Child is born with defects, malformations	N/A	-Do not self-medicate -Go to hospital for medication	N/A	-Women who self-medicate

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