Prenatal Healthcare in Two Rural Communities: El Gusano, Mexico and Indiana, Pennsylvania

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PRENATAL HEALTHCARE IN TWO RURAL COMMUNITIES:
EL GUSANO, MEXICO AND INDIANA, PENNSYLVANIA

A Thesis
Submitted to the Department of Anthropology
In Partial Fulfillment of the
Requirements for the Honors Degree
Bachelor of Arts

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May 2007
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We hereby approve the thesis of

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05/09/07

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Professor of Anthropology, Reader
Women in rural areas are often faced with several options regarding their prenatal healthcare. Three weeks were spent living in El Gusano, a peasant village in Guanajuato, Mexico, examining this problem, as a part of an Indiana University of Pennsylvania ethnographic field school. A parallel study was conducted over a six month period in a Mennonite population in rural Pennsylvania to complete an undergraduate honors thesis in Anthropology. Direct observation, participant observation, genealogies, and unstructured interviews were utilized to research the topic in both locations. The research question of what access women have to prenatal care and how they choose to utilize their options was investigated. It was found that both traditional healthcare practices and biomedicine have a presence in these communities, each with perceived strengths and weaknesses. Women have a high level of comfort with traditional midwives, but value the uses of technology by biomedicine in the case of a birth outside of the norm. Women see each system as having authoritative knowledge in certain situations and use embodied knowledge to combine these systems as they see fit. Possible models for improving healthcare options in these communities are also explored.
ACKNOWLEDGEMENTS

First and foremost, I would like to thank my informants both in Mexico and in Pennsylvania. They patiently and thoughtfully responded to my questions and welcomed me into their homes. It was these women's interest in and dedication to my project that allowed me to construct this narrative.

My thesis advisor, Dr. Victor Garcia, was involved in every conceivable step of this project: creating research opportunities for me, teaching me field methods, assisting me with research designs, guiding me through unfamiliar paperwork, and reading countless drafts. He was instrumental not only in this project, but also in ensuring my professional and academic development; for this, I will always be grateful.

Dr. Laurence Kruckman and Carolyn White were valuable in choosing a community in Indiana. Carolyn also took time out of her busy schedule to introduce me to informants in my research community and advised me in approaching informants. Additionally, Dr. Kruckman never failed to provide me with helpful literature for my study and helped me to develop drafts of my thesis.

I appreciate that Dr. Miriam Chaiken has always held me to high standards and pushed me to work hard. She also helped me to navigate the oh-so-intimidating IRB and was key in the development of my thesis drafts.

The Anthropology Department also allowed me use of their resources for the first part of my work in Indiana. Meghan Armes and Ann Marie Zatorsky came to my rescue (on a regular basis) as transportation became an issue in my research in Indiana. Furthermore, Dawn Fels and Beth Campbell lent me their expertise in composition, generously helping me to edit the first draft of my thesis.
My interest in the topic of maternal/child health began in the summer of 2004. I was one of two students from the Robert E. Cook Honors College selected for the Pennsylvania State System of Higher Education (PASSHE) Summer Honors Program and was awarded a full scholarship to study the topics of maternal/child health and ecotourism. I participated in two weeks of honors classes at a PASSHE university, including field trips to Pittsburgh to speak to professionals about maternal/child health. I then traveled in Costa Rica for two weeks to explore these topics through visits to hospitals and meetings with experts, such as healthcare workers and shamans. My participation in this honors program sparked my interest in both Latin America and maternal/child health and launched my career aspirations to conduct research in this area.

This project began in the summer of 2005, when I attended an ethnographic field school in Guanajuato, Mexico. The main part of the course was to design and create an original research project. I wanted to find out how women in the community of El Gusano, a peasant community in rural Mexico, utilize healthcare resources during their pregnancies. Specifically, I set out to learn: if women receive check-ups during pregnancy and, if so, how often and from whom; whose advice women follow; if migration of the woman or family members affects these decisions; and if accessibility to healthcare facilities affects women’s use of them. However, my research problem shifted as I conducted my research. Since I encountered a scarcity of families with few to no members who migrate to work in the United States, I changed the emphasis of the project, and I focused on prenatal healthcare choices that the women made and how they had changed over time in the community.
In the spring of 2006, I decided to expand this work into a comparative project for my honors thesis in Anthropology by doing fieldwork in a community in rural Pennsylvania. A Stauffer Mennonite community in rural Indiana County was identified, and I investigated the same research problem that I addressed in Mexico in this community beginning in the fall of 2006.

Research Problem

The goal of this project is to construct a comparative narrative that examines prenatal healthcare, decisions on prenatal healthcare service use, and the manner in which prenatal healthcare services are integrated into the daily lives of women. The research question that I addressed in both communities is: what access do women have to prenatal healthcare in a rural setting, and how and why do they choose to utilize these services and integrate them into their lives? The focus of the project is on collecting detailed qualitative data in order to better understand the choices that pregnant women make about healthcare. I hypothesized that the rural location of the communities would both influence and limit the healthcare options available to pregnant women, as women are often physically separated from healthcare centers and are influenced by traditional beliefs that have broken down in urban environments. I also hypothesized that women in these communities would be navigating competing healthcare systems because the biomedical model of healthcare has been exported from the West to most communities, placing itself in conflict with traditional healthcare systems.

Justification of Comparison

Initially, it may not seem probable that a peasant community in rural Mexico and a Stauffer Mennonite community in rural Pennsylvania have a lot in common. However,
they were chosen as comparable sites because of their rural settings, small community sizes, and partial removal from the biomedical model of birth that is most commonly used in the United States (Davis-Floyd, 2003). Robbie Davis-Floyd (2001, 2003) also emphasizes the influence of the biomedical model of birth in developing countries (such as Mexico) and the struggle for midwives to retain representation in communities. These issues are present in both communities. Therefore, both research populations are dealing with the intersection of traditional birthing practices and the perceived authority of biomedical birthing practices. Furthermore, both communities are partially removed from modern life. In Mexico, this was due largely to geographical separation, while in Pennsylvania, this was a conscious cultural separation from the dominant culture.

Literature Review

Completing a search of the literature on maternal health, Traditional Birth Attendants, life in rural Mexico, and scholarship regarding Mennonite and Amish groups was a large part of this project. This was completed at various times throughout my research. I began my search for information on birth in Mexico before I began research in Mexico and continued it throughout the process of writing my thesis. Similarly, I began my literature search on Mennonites and related groups before beginning fieldwork in Indiana, and continued to build upon this information as the project continued. In this way, a context was created in which I could place my research design and field work experiences.

Conflicting Medical Systems

Each culture characterizes birth differently and identifies its own “who, where, and how of birth” (Jordan, 1993, p. 48). However, it is also important to remember that
"the conduct of birth displays and reinforces larger societal values" (Jordan, 1993, p. 54). This can make it difficult to separate the physiological necessities and social products of birth.

The model of birth generally accepted in the United States is what Davis-Floyd (2003) terms the "technocratic model of pregnancy and birth." This model assumes that "the baby develops mechanically and involuntarily inside the woman's body, that the doctor is in charge of the baby's proper development and growth, and that the doctor will deliver (produce) the baby at the time of birth" (p. 28). This reflects Western society's tendency to see birth as mechanistic, rather than as an organic natural process. It is also a profoundly patriarchal view of birth that perceives the pregnant woman as abnormal and problematic, and allows men (doctors) to create the product (the baby) instead of viewing women as the protagonists in birth.

This model is based on the biomedical model of medicine that dictates the way most Americans view health and sickness. This comes from the germ theory of disease, and all new knowledge is produced through clinical tests. Within this model, reasons for illness cannot stray to the realms of religion or magic, as these are not seen as legitimate factors in illness. The biomedical model is what I refer to throughout the study, rather than the more politically charged, specific model implied by the technocratic view of birth. However, the technocratic model of birth is still an influential premise in this study.

American medical practices surrounding birth are seen as highly desirable to the governments of other cultures (Davis-Floyd, 2003; Jordan, 1993). Van Hollen (2003) argues that Jordan's model of the exportation of biomedicine:
depicts a scenario in which modernity, and biomedicine in particular, does not emerge locally throughout the globe, but is transplanted around the globe. But biomedicine is not a monolithic entity. And the biomedicalization of reproduction is not a uniform process either within or across national boundaries. (14)

This highlights the idea that biomedicine evolves variably in different locations.

However, because this view of birth often does not coincide with the beliefs and values of countries' citizens, conflict between systems occurs.

*Identifying Authoritative Knowledge*

Bridgette Jordan (1993) identifies socially accepted medical models as authoritative knowledge, “the knowledge that participants agree counts in a particular situation, that they see as consequential on the basis of which they make decisions and provide justifications for courses of action” (p.154). In other words, communities identify the characteristics that are important to them in regards to prenatal care and birth.

These systems are deeply ingrained and respected in their cultures. Bridgette Jordan (1993) argues that “as long as systems are stable, they are generally experienced as appropriate from within” (p.45). This causes systems to perpetuate themselves and to retain a high degree of internal validity. For this reason, Linda Hunt, Namino Glantz, and David Halperin (2002) remind us that we should “question the assumption that improving access to and knowledge about medical birthing services will necessarily increase their use” (p.99). However, this does not mean that medical systems are static.

Carole Browner and Nancy Press (1997) argue that, for American women, knowledge regarding prenatal care is not accepted blindly; they choose among competing forms of knowledge. Browner and Press term “embodied knowledge” the subjective
knowledge that women obtain through their bodies. Embodied knowledge is often used to interpret biomedicine, the model that is authoritative in mainstream America. If biomedical recommendations run contrary to women’s lived experiences, they will frequently be rejected. Furthermore, Hunt, Glantz, and Halperin (2002) argue that pregnant women in Chiapas are also reasoning their way through healthcare options in their community, rather than blindly following a proscribed set of actions.

For example, Paola M. Sesia’s (1996) work in Oaxaca suggests that traditional maternal practices, rather than the biomedical model of birth, are seen as authoritative. Sesia names courage, strength, and expertise based on experientially based obstetrical knowledge as important factors in parteras’ authority. Field work in the Yucatan by Barbara Anderson, E. N. Anderson, Tracy Franklin, and Aurora Dzib-Xihum de Cen (2004) identifies parteras’ (midwives’) spiritual role as central to parteras’ ability to retain authoritative knowledge. Furthermore, Carolyn Sargent and Grace Bascope’s (1996) work in the Yucatan also identify the partera’s family’s position in the community and shared experience with mothers as central to her authoritative position. However, during birth, authority is shared among the partera, the birthing woman, and others in the room, based upon who has first-hand experience with birth.

Methods

Both parts of my project were approved by the human subjects Institutional Review Boards (IRB). The work in Mexico was done under IRB approval for the Mexican Non-Governmental Organization, Fundación Comunitaria del Bajío, that I was associated with. My work with the Mennonite population in Pennsylvania was approved by the IRB at my home institution, Indiana University of Pennsylvania.
Time at Research Sites

**Mexico.** I resided in a rural community in Mexico called El Gusano from June 13, 2005 to July 1, 2005, a duration of approximately three weeks, as part of an ethnographic field school. This course was taught by Dr. Victor Garcia from Indiana University of Pennsylvania. During this time, I lived with a family and participated in their daily lives to the greatest extent possible. This time in the field was coupled with two weeks of workshops. We studied ethnographic research methods such as direct observation, organizing field notes, drafting genealogies, and compiling field reports through lectures and hands-on practice.

**Indiana.** I visited a Stauffer Mennonite community in rural Indiana County, Pennsylvania with frequency from November 6, 2006 through May 2007, around six months. This community was identified through discussions with Dr. Laurence Kruckman, professor of Anthropology at Indiana University of Pennsylvania, and his wife, Carolyn White BSN, RN, LCCE, CD(DONA); they had contacts in this community and were able to introduce me to potential informants there. I was unable to live in this community, as my resources were limited and I had other obligations, such as classes, during the time that I conducted field work. I visited the community on average once a week, though these visits were not necessarily evenly distributed. However, I believe that these visits were sufficient for me to build rapport, as informants seemed happy to welcome me into their homes, sharing refreshments with me and inviting me to attend church and visit for dinner.
**Sampling Methods**

The same sampling methods were used in both research sites. I used a combination of snowball and judgment sampling methods to recruit the women. The combination of snowball and judgment sampling is ideal for exploratory studies, such as the one that I completed, and when dealing with a small research population. The snowball sample gave me access to prospective research subjects, and following judgment sampling procedures, I drew on the information gathered on these prospective subjects and their communities to select my sample. While this combined sampling technique does not give me a random sample, it still provides me with important insights into the subject of my study.

Sampling methods for healthcare practitioners occurred in much the same way. After speaking with several women in the communities, I was able to identify the healthcare practitioners that were commonly used by my women informants. I then was able to contact these healthcare practitioners and invite them to participate in my study.

**Direct Observation**

*Mexico.* I relied heavily on direct observation to learn about the daily life of the family and community members. I used direct observation primarily to help me understand ceremonies and processes. For example, I used direct observation at church services and graduation ceremonies. I also used direct observation to understand processes before I used participant observation to learn more about them. Some instances in which I used direct observation as a prelude to participant observation were making tortillas and washing clothes. Due to my limited Spanish-speaking skills at the time, I often relied on watching people completing activities in order to learn about them.
Indiana. Direct observation was used to a lesser extent in my time in Indiana, as I had less unstructured time available to use this research method. However, I still made use of it during visits, for example, to learn the steps used in making bread or to learn what kind of diapers women use for their babies.

Participant Observation

Mexico. I typically used participant observation so that I could gain a deeper appreciation for the nuances of certain tasks. As mentioned above, I used participant observation in tortilla making. This allowed me to understand the difficulty in learning and perfecting this skill. For example, it helped me to understand why it was important not to flip one's hand over while putting the tortilla on the *comal*, or metal over the fire (because the tortilla tears). This is something I would not have learned simply watching the process. I used participant observation whenever a new skill to learn presented itself. On average, this happened two or three times a week.

Indiana. Participant observation was also used to a lesser extent in Indiana. Occasionally, I was able to use this technique by participating in household chores or joining an informant's family for a meal.

Genealogies

Mexico. I drew genealogies for all of the people that I interviewed who were either currently pregnant or had past pregnancies, except for one. One of my genealogies was created by Dr. Laura Gonzalez, a professor at University of Texas in Dallas who also works with this population. In all, I have five genealogies and drew four of them myself. While creating the genealogies, I collected information about any infant deaths and the locations of family members, especially those who had participated in migrant labor.
Indiana. I also created genealogies for all of my women informants in Indiana. I included information about places of birth, current residence, and infant deaths. Three genealogies were completed in all, as some informants were located on the same family tree.

Group Interview

This method was only used in Mexico. In that community, it was a reasonable activity due to convenience. A group of women in the community gathered each Tuesday to embroider goods, which they later would sell as a group in San Miguel de Allende. One Tuesday I used this opportunity to conduct a group interview. Women at the interview ranged in age from 16 to 41 (with a mean of 30.8), and the number of children that they each had ranged from 0 to 10 (with a mean of 2.6). I explored trends that I had been seeing in the interviews and asked questions about prenatal health in El Gusano to 13 women. Topics explored were:

1) The majority of women giving birth with a partera
2) The benefits/disadvantages of giving birth with a partera versus with a doctor
3) Diet during pregnancy
4) Sources of information/advice during pregnancy
5) Difficulties of access to prenatal healthcare

Unstructured Interviews

Mexico. I used unstructured interviews as a direct method of obtaining information about my research problem. All interviews were conducted in Spanish with the use of a translator. Spanish was the primary language used among informants and the first language of my translator. I interviewed four groups of people: parteras, biomedical
healthcare professionals, previously pregnant women, and currently pregnant women. In all, I completed 16 interviews. Each group of people was asked different questions. (See Appendix for list of questions.) Additionally, parteras and healthcare professionals were only interviewed once, while the women were interviewed up to three times each.

The information that I sought to obtain from the parteras was mostly about their views of prenatal healthcare and what happened at check-ups and births with them. My goal in speaking with the healthcare professionals was similar in many ways. I wanted to learn what they thought pregnant women should be doing about their prenatal healthcare. I also wanted to find out about government efforts to improve prenatal healthcare in this and similar communities. When speaking to the previously pregnant women, I encountered women of an older generation who were able to help me understand the past of prenatal healthcare in the community. Lastly, I was able to find out about current prenatal healthcare trends in the community from currently pregnant women.

Indiana. Unstructured interviews were also my primary source of information in Indiana. All interviews were conducted in English. Pennsylvania Dutch was my informants’ first spoken language, which they defined as a form of German that includes words from several other languages in it. However, my informants all learned both written and spoken English during the eight years of school that is standard in the community. As a result, all informants were comfortable expressing themselves in English. Therefore, it made sense to conduct interviews in English. Interviews also followed the same categories and purposes as in the research in Mexico, and 12 interviews were completed with women informants. (See Appendix for list of questions.)
Discrepancies in Samples. There were some inconsistencies in the number of informants in each sampling category. For my Indiana sample, there was only one older woman informant who was available to speak with me, as opposed to the two that I spoke with in Mexico. The community in Indiana is young, only having been around for ten years, which made the number of women in this category few. However, the birth history of several of my other woman informants spans many years, which makes this discrepancy in number of informants in the studies less problematic. Numbers of younger woman informants were also comparable between the two sites: four in Mexico and three in Indiana. I was unable to find a last informant during my allotted time in Indiana because of unforeseen transportation difficulties.

Another discrepancy between my informant composition in Mexico and in Indiana is in midwives. I was able to interview two midwives in Mexico. However, the midwife in Indiana County that most of my informants reported using for prenatal care and birth declined to speak to me. She did not live in the community that I spent time in, and so did not know me. Furthermore, the political climate was one where Diane Goslin, a lay midwife who served Amish and Mennonite communities in Eastern Pennsylvania, was facing up to $40,000 in fines for practicing midwifery without a license, as the certification that she had from the North American Registry of Midwives is accepted in 28 states but not in Pennsylvania (Lindt, 2007). So the local midwife’s reluctance to talk to outsiders is certainly understandable. Appointments were made to visit midwives who work with similar populations, but were subsequently cancelled by potential informants.

Numbers of biomedical healthcare practitioners also vary between the two sites. In Mexico, I spoke with one doctor and one healthcare educator who traveled to the
community regularly. However, in Indiana I was able to contact the doctor who works with the Mennonite population, and scheduled phone interviews, but also received several last-minute cancellations that did not result in an interview.

Description of Key Informants

Mexico. One of the older woman informants is Adriana, who has had 17 pregnancies. She is a short, sturdy-looking woman of 70 years old. She has deep wrinkles on her face, arms, and hands and always wears pink chandelier earrings. She has bright eyes and a mouth that disappears into wrinkles. She has black wavy hair that comes to the middle of her back, is thinning at the ends, and always seems to be pulled back into a low ponytail. She is missing her bottom middle tooth. She was born in La Mesa de los Garcias on August 23, 1935 and lived there until she was married, at which point she moved to El Gusano. She was married in 1950 (when she was about 15) in Dolores Hidalgo. She has never been to school, but she knows how to read (her husband helped to teach her) and only knows how to write her name.

The other older woman informant is Rosa. She is 51 and has had 11 pregnancies, including one miscarriage. Rosa has a small frame, long black hair, large teeth, and deep laugh lines around her eyes. She was born in El Gusano April 1, 1954 with a partera. She was married in Dolores Hidalgo in 1969. She has a third grade education and has lived in El Gusano for her whole life.

A younger woman informant was Maria, who lived in the compound that I stayed in. Maria is 29 years old and is 6 months into her third pregnancy. Her other two pregnancies were at ages 22 and 23. She has light skin and light brown hair that is straight and falls at the middle of her back. She has straight eyebrows and light brown

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1 Pseudonyms are used for all informants.
eyes. She speaks softly without moving her mouth much and has a calm demeanor.

Maria was born in La Cañada del Muerto. At 17 she moved to Charco Azul with her family, at 22 she was married in San Anton de las Minas, and at 26, she moved to El Gusano. She went to elementary school until she was 11 years old.

Guadalupe is another woman that I interviewed. This is Guadalupe’s first pregnancy, at 23 years old. She is seven months pregnant. Guadalupe has a small frame from which her belly protrudes dramatically. She has a round face with dark spots on her cheeks and nose. She has sparse eyebrows, a flat nose, a small mouth, and narrow eyes. She is very soft-spoken. She was born in 1981 in El Capulín. She moved to el Gusano at age 23 because she got married and has been there for 5 months. She has an elementary school education.

Ana was another pregnant woman. Ana is 29 years old and in the third month of her fourth pregnancy. Ana was born and raised in El Gusano. She has an education up to the fourth grade. She was married in El Capulín 11 years ago at age 18. Ana has a flat face with deep laugh lines around her eyes, white teeth that are fairly uneven, numerous small scars on her face, and deep dimples when she smiles.

Finally, there was Cecilia, Rosa’s daughter. Cecilia is 27 and in her sixth month of her fifth pregnancy. Cecilia has spent all of her life in El Gusano. She was married there 9 years ago at age 18. She has a second grade education. Cecilia has a big smile, and a turned up nose. Her left cheek has light brown spots on it, and she has black hair that always seems to be pulled back.
Table 1: Key Women Informants in El Gusano

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th>Husband’s Migration Status</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adriana</td>
<td>70</td>
<td>Married</td>
<td>Migrated to US twice when he was younger.</td>
<td>16</td>
</tr>
<tr>
<td>Rosa</td>
<td>51</td>
<td>Widow</td>
<td>Migrated to US when he was alive.</td>
<td>10</td>
</tr>
<tr>
<td>Maria</td>
<td>29</td>
<td>Married</td>
<td>Used to migrate to the US, but now holds a job locally.</td>
<td>2 (pregnant with 3rd)</td>
</tr>
<tr>
<td>Guadalupe</td>
<td>23</td>
<td>Married</td>
<td>Migrates to US.</td>
<td>0 (first pregnancy)</td>
</tr>
<tr>
<td>Ana</td>
<td>29</td>
<td>Married</td>
<td>Used to migrate to US, but now migrates to León.</td>
<td>3 (pregnant with 4th)</td>
</tr>
<tr>
<td>Cecilia</td>
<td>27</td>
<td>Married</td>
<td>Migrates to US.</td>
<td>4 (pregnant with 5th)</td>
</tr>
</tbody>
</table>

I also spoke with two *parteras*. One *partera*, Alejandra, was in Las Cabañas. Alejandra is a small, older woman with very white hair and a hunched back. She is missing one of her front teeth and has a dark spot under her left eye. She said that she started to work as a *partera* about 12 years ago. The other *partera* that women in El Gusano went to was Elsa in Ojo del Agua. Elsa has a serious face framed by thin black and gray hair. She is now 74 years old. She has a large nose and dark brown, slightly sunken eyes with bags underneath them. She also has long hands. She breathes deeply when she talks due to her asthma. Elsa’s first training as a *partera* was 27 years ago.

I also spoke to two biomedical healthcare practitioners. The doctor that I spoke to is Irma. She is a woman with a serious demeanor, short, styled hair, glasses, dark, sculpted eyebrows, and copious amounts of black liquid eyeliner. She has been in the healthcare profession for 15 years. She is a *medico general*, a general doctor. She has been traveling to rural communities in this area for five years and provided much of the information about pregnant women’s health in Mexico. Miguel is the man that does
informational seminars for people in the community with this program. He has a round
face, a slight double chin, sparse eyebrows, and brown eyes. He provided much of the
information about the program they work for in Mexico.

Indiana. My older woman informant in this community was Rebecca. Rebecca
was born in Southern Maryland and moved to Lancaster County with her family when
she was 14 months old. She married and had 5 children there, though 1 died. Then she
moved back to the same area in Maryland that she was born in for 12 years. Finally, she
moved to Brush Valley with her family, and has been there for 8.5 years. They moved to
Brush Valley because it was hot and humid in Maryland and was becoming very
congested. She heard about this place and was interested in greenhouses, something that
they couldn't do in Maryland because they didn't have room. Rebecca met her husband
in youth group, and they married she was 19 and he was 22. Rebecca and her husband
each have 14 siblings. Rebecca went to school in a one room schoolhouse with about 30
children that was run by horse and buggy Mennonites and included grades 1-8.

Ruth is Rebecca's daughter and one of my informants. She has a small face with
a light brown birthmark on her left cheek. She has thin lips, dark brown hair, and brow
eyes. She was born in March 1977 in Lancaster County. She married her husband when
she was 19 in Lancaster. Later, she moved to Snyder County, then Minnesota, and
finally to Indiana because her husband's family left from Minnesota. They wanted to live
near family, so they moved near Ruth's family. She is now 29 with 6 children, the
youngest of which is 6 months old. Ruth spends her time working in the home and her
husband works as a stonemason and also builds barns and similar structures. Ruth went
through the 8 years of schooling typical of their group, and also earned her G.E.D. in
2004 so that she could home school her children under Pennsylvania law. Additionally, Ruth used to write stories for publication in Plain People publications.

Sarah, another informant, lived in South Maryland until she was 20. She has 4 brothers and 4 sisters and is 35 years old. She taught school in Snyder and spent summers in MD for three years beginning at 20, then taught in Maryland for 5 years. When she was around 28, she moved to Indiana because she wanted a change of scene and to live in a smaller community, where she taught for four years. She also didn’t like the congestion and expense of living in Maryland. She met her husband through boarding with his mother and working for her during one of her pregnancies. Sarah became pregnant with her only child two years after she married her husband. Her husband works with hydraulics, making and fixing hoses. After teaching, Sarah has mostly worked at home. She used to do sewing for others in the community and write stories for Plain People magazines. Since she has had her child, she has not had time to do these things any more. Now she runs the house and takes care of her child. Sarah went to a Mennonite school through the seventh grade. She says that she studied most of the things taught in the eighth grade, and probably past that, because she loves to read and used to read quite a bit.

Bethany has round glasses, a lazy eye, and graying hair. Her face is fairly round, she is heavier, and is almost always smiling. Bethany is 39 and has completed the eight grades of education that is standard in the community. Bethany has eight children. The oldest is almost 17 and the youngest is almost 1. Bethany was born in Lancaster, then moved to Ohio, then to Indiana. They chose to move to Indiana to be closer to family and to be in a more central location; her husband’s sister and her cousin both live in
Indiana. She met her husband through their youth group. Her husband has a woodworking shop. He specializes in kitchens and does custom jobs: mostly bigger pieces such as cabinets and vanities. Bethany makes pinafores and sunbonnets to sell. She also makes other odds and ends as they are requested. Additionally, she bakes breads and pies to sell from the house, but sometimes during the summer she will send them down to a flea market to be sold.

I was only able to get one interview with my last informant, Elizabeth. She is 39 and has completed eight years of school. Her husband is 40, and they have 9 children. She grew up in Maryland and moved to Indiana eight years ago because they wanted land to farm, and it was too crowded in Maryland. She met her husband when his youth group would come to visit her youth group in Maryland. Elizabeth and her husband sell produce from their house. Elizabeth’s family is in the process of moving, as they are joining a different Mennonite group in their new community – the Weaverland conference.

Table 2: Key Informants in Indiana

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital Status</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebecca</td>
<td>49</td>
<td>Married</td>
<td>6</td>
</tr>
<tr>
<td>Ruth</td>
<td>29</td>
<td>Married</td>
<td>6</td>
</tr>
<tr>
<td>Sarah</td>
<td>35</td>
<td>Married</td>
<td>1</td>
</tr>
<tr>
<td>Bethany</td>
<td>39</td>
<td>Married</td>
<td>8</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>39</td>
<td>Married</td>
<td>9</td>
</tr>
</tbody>
</table>
Description of Communities

Mexico

The community that I studied was El Gusano, a small community in the municipality of Dolores Hidalgo, in the state of Guanajuato. The Promotora de Salud was in charge of the census in the community. She said that there were 440 people there at the last count and that at least ten more had been born since then. So the population of El Gusano was approximately 450 people in 70 families as of summer 2005.

Physical. The name of the community, El Gusano, translates to “The Worm” in English. This is because a large river, which the residents refer to as Rio Grande, winds its way through the community looking much like a worm. Normally this river is full of water and makes the community difficult to access. Even though my visit to El Gusano was during the rainy season, there was a drought; it did not rain once during my three weeks there. The river was diminished to a trickle.

Another major geographic feature is the single road in El Gusano, a winding dirt road that connects all of the small communities in this area to the paved freeway nearby. This dirt road makes a rough semicircle, meeting the paved road at two points. It is supremely uneven, with ruts and rocks along its length, which makes it difficult to navigate by foot or by vehicle. The road is referred to as Camino Real in the community. Most of El Gusano is on one side of this road, with many of the residences some distance from the road.

The residences are also difficult to distinguish from one another. A residence typically consists of many buildings; most of the buildings in a residence only consist of one room, but some have of two or three rooms. This means that potentially, a residence
could have a building for each room needed for sleeping or cooking. Additionally, there are usually smaller structures used to house animals or as stand alone ovens.

El Gusano also has several convenience stores; I counted five during my stay there. These stores are typically plain looking buildings except for some advertisements for products such as Coca-Cola hanging outside of them. That seems to be the only way to identify many of these structures as stores. They all have one window facing the street from which customers can order what they want to buy. These stores mainly sell small convenience items such as soda and potato chips.

The kindergarten is one of two schools in the community. It is a single room with a mural on the outside of it. Kindergarten (kinder) lasts two years, and there is only one teacher, who seems to do almost everything alone. The inside of the kindergarten is sea green with a blackboard in the front of the room and educational signs. Outside of the building is a chain link fence enclosed area covered in cement, and everything else is dirt. There is a separate bathroom, also painted sea green, on the opposite side of the property. There is a water faucet outside. There are also toys: one swing with a wooden frame, painted tires lodged in the ground, and a large sandbox with a red barrier.

The community also has a primary school. The outside of the primary school is very similar to that of the kindergarten. It has cement tops for sections and dirt tops for others. There is more playground equipment in the primary school playground. It has several swings, a teeter-totter, and a slide. The primary school also consists of three buildings instead of one.

Another prominent building in the community is the clinic. The clinic is made of brick and has a white front. The inside has an entranceway in the center and a room on
either side. It is painted a peach color and was fairly plain. The entranceway contains a bench for patients to sit on while waiting, a scale, and several posters about health. One of the rooms has chairs and tables; the other room has a large table in the center and an examination table.

There is a building that serves as a meeting hall for many of the women in the community. It is large enough to house several rooms. One room, for example, stores sewing supplies and another houses the molina, the machine used to grind corn. It has a large concrete porch in front of it, which is protected from the sun by a large overhang of the roof.

*Familial Organization.* An analysis of genealogies of my informants demonstrated that while some families only have a few children, it is common for families to have seven or eight children, and not uncommon to have ten or more. Furthermore, this trend seemed to be consistent throughout several generations. Women typically marry around age eighteen, while women in past generations tended to marry a few years earlier, around age 16. Women usually have their first children in their early twenties. Furthermore, patrilocal residence seems to be the norm.

*Religious.* The community’s members are overwhelmingly Catholic. There is a church in El Gusano, the community’s only two-story building, but no priest. The building’s main function is to serve as a place to pray the rosary every night. However, attendance at this event is overwhelmingly comprised of women and children. Men pass their time playing cards and socializing at meeting places instead.

On Sunday mornings, the residents of El Gusano go to El Capulín, a neighboring community, for mass. Most people walk there, which takes about 20 minutes, and do so
in dress clothes. They use the only road, which is made of dirt and rocks, has a very uneven surface, and is difficult to walk on. From the outside, the building seems much bigger than the church in El Gusano, but the area for service is approximately the same size.

Furthermore, many important events in the community are preceded by mass. For example, both the kindergarten and elementary school graduations begin with a religious service at the community church, presided over by the priest from El Capulín.

Economic. Many, if not most, of the men in the community migrate to the United States to earn money. They send a portion of the money they earn home to support their families. Oftentimes, the men feel that they can earn more money in the United States than they can at home. A common migration pattern in the area is to migrate for nine months, then return home for three months. Then, the pattern starts over again. Another common pattern is for men to leave for years at a time (often three), and then to return home for a block of years.

Still other men migrate to large cities in Mexico in order to find jobs. For example, one woman I talked to had a husband working in León, who would come home to visit about twice a month. Men migrate to larger cities because jobs in the rural areas are scarce. Some men, however, do manage to find wage work in or near the community.

The other main economic activity for males is agriculture and taking care of large livestock, such as cows. This allows the family an extra food supply, as well as a way to bring in money.

The most common economic activity for women in the community is working in the home. More often than not, the women are solely responsible for running the
household. The women cook, clean, look after children, and take care of small animals such as chickens, among countless other activities. Even if the males in the household have not migrated, the women are often still solely responsible for running the house because that is the traditional gender role in the community.

Some women in the community do have ways of earning money. Some women, for example, go into cities such as Guanajuato to sell prepared foods such as tortillas. A group of women in the community have also formed a cooperative and are able to bring in some money through that. One way that women earn money through the cooperative is by working in the *molina*. The women in the community use the ground corn from the *molina* to make tortillas at least several times a week. Three women in the cooperative run the machine in the mornings and collect money from women who come to get corn ground. The money is collected all year, and at the end of the year the women decide what to do with the money. Oftentimes, the women who work at the *molina* receive at least some of the money from this collection. Another activity that the women participate in through the cooperative is embroidering. The women embroider girls' dresses and cloth napkins and adorn *rebozos* (shawls) to sell in San Miguel de Allende.

*History of Medicine and Birth in Mexico.* Pilar Alicia Parra (1993) describes the history of the medical system in Mexico. The government began to be involved in organizing the medical care system and medical education in the 1920s. In the 1950s, it began to extend coverage of the medical system and to apply public resources. Curative instead of preventative medicine was emphasized in these efforts. The 1970s brought lowered investment in medical care and continued expansion of the medical education system. This left large areas without medical coverage, especially rural areas. As a result,
the Mexican government began programs to incorporate traditional midwives into the medical system; before this point, traditional medicine in Mexico was ignored (Sesia, 1996). The general tone of these training sessions is that *parteras* are there to learn. Their traditional knowledge is not typically valued, and *parteras* do not change their practices as a result of these training sessions (Sesia, 1996).

Similarly, Davis-Floyd (2001) traces the history of midwives in Mexico and identifies several kinds of *parteras* that operate in Mexico. *Parteras tradicionales* are traditional midwives, who find themselves outside of the biomedical model of birth. The World Health Organization would classify them as Traditional Birth Attendants (TBAs). By the 1970s, they were attending 43% of births in Mexico. However, as of 1996, they attended 17% of births. The majority of midwives are over 65 years old and not training replacements. In this way, “biomedicine has not only taken over childbirth, it is also redefining its very nature” (Davis-Floyd, 2001, p. 192). Furthermore, *parteras tituladas* (professional nurse-midwives) attended the majority of hospital births in the 1950s but subsequently lost autonomy in their positions in the 1960s. They were replaced by *Licenciadas en Enfermería y Obstetricia* (known as LEOs), who have three years of training as a nurse and one year of training in obstetrics, rather than training in midwifery. However, *parteras profesionales* are a newly developing role in Mexico, and are attempting to fill the gap between *parteras tradicionales* and LEOs.

*Parteras tradicionales* have been the principal means of healthcare for mothers since pre-Hispanic times, both in terms of number of practitioners and the status that they hold in communities (Casteñeda Camey et al., 1996). However, *parteras* are used much more commonly in rural areas than urban areas and are used more commonly in Mexico.
than in most of the world (Buekens, Hernández, and Infante, 1990). Midwifery is often chosen as a calling through magic or religion and is learned through apprenticeship (Sesia, 1996). Jordan (1993) identifies activities typical of prenatal care with *parteras* as: defining the probable date of birth, learning about the woman’s reproductive history, gauging family relations and attitudes, and the *sobada*, or massage, which is central to prenatal visits and is used to make sure the baby is positioned correctly in the womb. Jordan also argues that births are typically at home and are attended by the woman’s husband and mother. Furthermore, birth is seen as a family activity (Jordan, 1993) and a natural process (Elu, 1995).

**Indiana**

The second community that I studied was in rural Indiana County in Pennsylvania. It is comprised of Stauffer Mennonites, who live interspersed with non-Mennonite families, though still all live geographically close to one another. According to church records, there are 19 families in the community, with 44 people baptized into the church, and 150 people total.

*The Stauffer Mennonites.* The Mennonites’ beginnings can be traced to the Protestant Reformation in Europe (Bender and Smith, 1964). Martin Luther attempted to create a church of believers, but some thought that his standards lowered over time. The group in disagreement was to become the Mennonites. Therefore, the Mennonite Church had its beginnings in Zurich, Switzerland in 1525 (Scott, 1996). (See Figure 1 for the European roots of the Pennsylvania Mennonites.) As time went on, there were many factions in the Mennonite Church. The Stauffer Mennonite Church was established by Jacob Stauffer, who “maintained that the main Mennonite Church had been in a state of
decline since its first establishment in America, and he sought to reestablish the 'true' Mennonite Church with more rigid and strict discipline [sic]" (Smith, 1963, p. 10). (A rough diagram of divisions of the Mennonite Church can be seen in Figure 2.) There are several Stauffer Mennonite communities in the United States. The first was in Iowa but no longer exists. Communities also began in Lancaster, Snyder County, Maryland, Missouri, Ohio, Minnesota, Illinois, and New York.

Figure 1. European roots of the Mennonites in Pennsylvania

Catholicism

- Protestant Reformation
  - Dutch-North German Anabaptism
  - Swiss-South German Anabaptism
  - Austrian-South German Anabaptism
  - Mennonites
    - Amish

Based on diagram from Kraybill and Hurd, 2006, p. 5
Old Order groups see the church as the primary social unit; do not participate in the government nor accept government assistance, instead relying on the church; and are preindustrial, production-based economies (Kraybill and Bowman, 2001). The central religious tenant is the requirement of “a genuine change of life, a newness of living, which was true holiness in full obedience to Christ” (Bender and Smith, 1964).

Donald Kraybill and Carl Bowman (2001) argue that these Old Order groups are not just an American subculture, but rather a counterculture, as they reject many core American values, such as individualism, and replace them with values and symbolic actions of their own. Furthermore, a foundation stone of the Mennonite Church is the nonconformity of the church to the world (Bender and Smith, 1964). One could argue that this rejection of core American values also applies to their views of prenatal care and birth.

The Stauffer Mennonites are now considered Old Order horse-and-buggy Mennonites and the most conservative group outside of the Amish (Scott, 1996). They
limit technology and do not use or own cars. My informant, Sarah, said that batteries, wood, coal, natural gas, and propane are all used in the communities, and convenience items such as refrigerators and gas lights are common. Recently, electric fences for livestock control have started to be used. Plain clothing is required, with men wearing plain button-down shirts, pants, and wide-brimmed hats, and women wearing homemade dresses of plain colors or small prints, aprons, head coverings, and shawls in the cold. Schooling is completed through the eighth grade, typically in one-room classrooms in the community. Horse drawn buggies and bicycles are used for transportation.

Physical. Members of the community live in houses and trailers that are dispersed along the sides of several highways. Dwellings are typically comprised of a central building, which holds all of the main rooms for the family including bedrooms, the kitchen, the bathroom, and living rooms. There is no electricity used in the houses, though there are gas powered appliances and lights. Most houses also have running water. Furniture in the houses is often wooden and handmade, with homemade quilts and crocheted blankets. However, most families have smaller structures in addition to their main living areas. Barns are common, as horse-and-buggy is the most common form of transportation. Other smaller structures used for storage are also common.

There are now two one-room schoolhouses in the community. However, for the first few years after the community was founded, everyone home schooled their children. Then, school was taught in a trailer, and the next year a school was built. As the community expanded, another school was built to accommodate the extra students. These each house grades one through eight, with one teacher, who is usually a young, unmarried woman in the community, and older students assisting the younger ones.
These schools are run by a school board comprised of members of the local Mennonite community.

Many members of the community sell goods out of their houses, but there is also a free-standing store in the community run by a Mennonite couple. One half of the store sells local baked goods and discount groceries, and many of the local women shop there for groceries in addition to shopping at larger chain stores nearby, such as Wal-Mart.

_Familial Organization._ With regards to familial organization, the community in Indiana was very similar to the one in Mexico. Here, too, my informants' families often have seven or more children, women tend to marry around the age of eighteen, and women have their first children in their early twenties. Patrilocal residence is also the norm here. Neolocality was very rare, as family is an important to members of this community, and being near family was a common reason given for relocation.

_Religious._ All members of the community are of the Stauffer Mennonite faith. That is, all adults have been baptized and all children are being raised by church members. Individuals are not considered members of the church until they choose to be baptized into it, usually as teenagers.

There is one religious meetinghouse in the community. Services are held there every other Sunday. They last from two to three hours and are given in German. Most of the community attends church, but events like having a sick child may occasionally prevent members from attending. Stauffer Mennonite churches are plain, one-story buildings with segregated seating and entrances for men, women, and children.

_Economic._ Most of the men in the community run their own small businesses. Some work with wood or stone, while others run various repair shops. For example,
some men in the community build wood furniture, and one works in hydraulics. In short, for Old Order Mennonite groups, "work is not pursued to pile up personal credits; it is a calling that contributes to the common good" (Kraybill and Bowman, 2001, p. 193). These businesses are not large, though some serve clients across the country. Instead, they are smaller enterprises, typically run by a few people.

Women in the community are primarily expected to take care of domestic responsibilities. They take care of the home, watch the children, and cook the meals. One of my informants even chose to home school her children. Furthermore, women often have ways to bring in money outside of their household activities. Some sell baked goods or do extra sewing for others.

Men and women also share responsibilities in some economic activities. Gardens are tended primarily by women, though at times the whole family will work on them. Additionally, some families' businesses are run by both the male and female heads of the house. For example, one family sells vegetable plants and hanging flower baskets from their home. The male and female heads of the household work together to plant, raise, and sell these products.

Community members also participate in volunteer activities, as volunteerism is part of Mennonite tradition and values (Hostetler, 1959). One husband and wife in the community volunteer as house parents at a facility for mental health for Plain People. Another informant spends time knitting caps for the maternity ward of a hospital where her baby spent time in the NICU.

Pregnancy in Mennonite communities. There is less scholarship available on birth in Mennonite communities than on birth in communities in rural Mexico; however, some
work on prenatal care and birth has been done in Mennonite communities. A study of Kanadier Mennonites, a group less conservative than the Stauffer Mennonites, in Canada characterized pregnancy as a private topic in the community (Kulig, Hall, Babcock, Campbell, and Wall, 2004). It is not a topic generally discussed in public and is learned about through books, healthcare professionals, and women's mothers and friends. A midwife who converted to the Hutterian Brethren church emphasizes birth, as with many other aspects of life in Plain People communities, as a “sacred [gift] from God” (Sorensen, 1990). She cites difficult access to care and the proliferation of folk remedies as general characteristics of healthcare in these communities.

Findings

Mexico

Community perceptions of pregnancy. The women almost always reported having no support system and receiving little to no advice from friends and family. Women still do hard work until the end of their pregnancy, though they always told me that they knew they should not do things like carrying heavy objects. I often saw one informant, six months pregnant, carrying buckets of water and making tortillas, both physically straining tasks. This seemed to me to be the standard in the community; most women simply did not have a choice because they were running a household by themselves.

Use of midwives. It seems that parteras are a popular choice for both prenatal care and birth in the community. There were parteras in two neighboring communities, but the community itself was too small to have one. One partera made home visits for care, while the other had a room in her house with two beds where she saw women.
Women visit the *parteras*, it seems, partly out of tradition and partly out of putting trust in someone who is familiar to them. *Parteras* are people these women can relate to. They live near them, have lifestyles similar to theirs, and share the same cultural customs. Also significant is that *parteras* are women, as male healthcare practitioners are often seen as untrustworthy. Furthermore, these midwives have helped their mothers and friends through their pregnancies.

This trust is important to the point that women will go to *parteras* even when it is more expensive than visiting the clinic or going to the hospital. Some women also told me that they worry that the *parteras* may not be able to handle emergencies that may come up during birth but find this risk to be less important than giving birth with a trusted member of the community.

*Use of biomedical practitioners.* A doctor, a nurse, and a healthcare educator come to the community about once a month to provide prenatal care as a part of the *Oportunidades* program. The healthcare professionals are able to reach 23 communities through stations in 11 of the larger communities. The other 12 are said to be in walking distance of at least one of the aforementioned 11. This program began in 1999 under the name *Progresa*. (When Vicente Fox came into power, he kept the program, but changed the name to *Oportunidades.*) This is a federal program that emphasizes healthcare, nutrition, and education for women and children. This program is able to provide healthcare to pregnant women, children under five years old, people with diabetes, and people with hypertension. Mothers are also able to receive money to help keep their children in school. Girls get more money because this program focuses on helping women; it is intended to lessen the gender inequality in Mexico. Families may also
qualify for money to buy nutritious food for their children. The women get monetary benefits for going to the programs, but seem to also trust what the doctor tells them to a certain extent.

Women still have reservations about trusting the doctor, even though the doctor has been visiting the community for five years. For example, the day I conducted the group interview, the women asked me a question that they were too embarrassed to ask the doctor: Can we have intercourse with our husbands while we are pregnant? The women just are not comfortable enough with the doctor to ask her potentially important things of this nature yet. Furthermore, the women favor traditional beliefs in their culture over recommendations of the doctor. For example, the women believe that they should not rest too much during their pregnancy or their hips will not be able to expand when it is time to give birth. The doctor tells them that this is not true and that they need their rest. She explains that resting is tantamount to taking their medicine. The women either have no time to rest or refuse due to a traditional belief that too much rest during pregnancy will make the birth more difficult.

The women often say that they appreciate the emergency care available during birth at the hospital, but are also scared of the hospital. The trust that the doctor in El Gusano is earning with these women does not transfer to the hospital. The women told me that the doctors are angry and always scold them for having so many children. Furthermore, they always associated the doctor with being a man, which made them uncomfortable. They also told me stories about women who went to give birth in the hospital, were told that they were not going to give birth for quite a while, and were sent away only to give birth on the way home. Furthermore, they were scared of unnecessary
surgery; they said that the doctors would perform unneeded cesarean sections on the 
women in order to make more money. With one of the highest cesarean rates in the 
world, at 40% as of 1999, this is a very real possibility (Davis-Floyd, 2001).

Private doctors are another option available to women for prenatal care and birth. 
This is seen as a favorable option to some women in the community, as they feel the risk 
of unnecessary procedures is lower with private doctors than at the hospital. They also 
feel that they will get more personal attention. However, this option is prohibitively 
expensive for most women.

Conflict between healthcare systems. Parteras are largely not incorporated into 
government healthcare plans for maternal/child health. The only indication that there had 
been any cooperation between the parteras and the biomedical healthcare system is that 
the parteras that I spoke to attended government training classes either in the past or on a 
continuing basis. I am unable to ascertain the extent to which these training sessions 
affected the parteras’ practices. However, the literature suggests that these classes tend 
to be ineffective (Sesia, 1996).

The healthcare professionals who visit the community monthly tell the women not 

to visit parteras for either prenatal care or birth. Women are warned, for example, that 
the sobada will cause harm to the baby. An attitude of conflict exists between the 
biomedical healthcare practitioners and the parteras. However, parteras will refer 
women to the clinic or to the hospital in a nearby city if complications are detected in the 
pregnancy.

Changes in communities over time. Everyone I spoke to said that the way things 
are set up in the community now is much better than it was in the past. Around 50 years
ago, the only prenatal care that occurred was the monthly visit from the *partera*, and not everyone even used that service. Women continued to do strenuous physical tasks and did not take special precautions about their health for the entirety of their pregnancy. They almost always gave birth at home with either a *partera* or just family members present. The only time that special care was given to the mother was for a few weeks after she gave birth. Now, there has been a shift to emphasize prenatal healthcare for the women. The women have several options for prenatal healthcare that they can choose from and combine as they see fit. They also have several options for when it comes time to give birth.

*Indiana*

*Community perceptions of pregnancy.* Pregnancy is seen as a private matter in the community. Women identified their mothers and sisters as people whom they could ask questions about pregnancy, but information is sought out more often from doctors, midwives, books, and classes. One informant even indicated to me that her sister-in-law was the only person who gave her advice about pregnancy, though she viewed her as a know-it-all. Furthermore, birth is not traditionally discussed with young people and children in the community and is seen as secretive. One informant’s husband told me that when he was young, he thought the doctor who made house calls brought new babies to the house in his bag. However, this behavior was identified as a custom that was changing in the community, and now children in many families make their children more aware of pregnancy and birth.

*Use of midwives.* Midwives are also an important part of pregnancy in the Mennonite community. One Amish lay midwife, who lives about half an hour away by
car, is available to this community. However, midwives are not always available to Mennonite communities, as communities where several of my informants lived previously had no midwife nearby.

Women generally expressed a preference for midwives. They are typically less expensive than other options, use fewer medical interventions, are old fashioned, have less commotion involved in surroundings, and create a "homey" environment. Ruth also told me that it was important to her to use an experienced midwife, and that she enjoyed them because she saw them as supportive mother figures.

This can be seen as linked to Mennonite religious values, which are what fundamentally hold the community together. When Ruth was asked about her preference for midwives and how she makes choices about healthcare options, she told me that God is control. Mennonites don't need to worry because He will take care of them; everything that happens is ultimately for their good.

Use of biomedical practitioners. Doctors are used fairly commonly in this population. Many of the women see a doctor at some point during their prenatal care to assist in screening. When complications are identified with a birth, women will visit a biomedical practitioner, but only if they personally deem it unavoidable. For example, ten weeks before Ruth's due date, she started hemorrhaging. She went for an ultrasound at an OB who wanted to put her in hospital. Instead of following his advice, she stayed at home in bed.

A common concern about using biomedical practitioners was the use of unnecessary medical procedures. Also, Sarah felt that procedures were not explained enough to her at her birth in the hospital. Furthermore, several women told me that they
felt safer giving birth for the first time at the hospital, but after successful births at the hospital, they preferred going to the midwife. Other informants told me that as they aged and births became more risky in general, they preferred to go to doctors for birth.

However, doctors are a very expensive option for Mennonite women. They do not hold health insurance, and often must pay a neighbor to act as a taxi to take them to the hospital or doctor's office. Programs are available to reduce the price at some locations, and facilities are usually willing to set up a payment schedule for the families. However, families still find themselves paying these bills for extended periods of time, placing stress on families' often limited resources. Additionally, there are extra costs involved when women are referred to specialty hospitals farther away. For example, one informant's baby needed to have a prolonged stay in a hospital in Pittsburgh; it cost the family $80 in transportation every time they went to the hospital. Community members donate to a church fund whenever they can to help defray costs, such as expensive medical bills, for whoever needs help.

**Conflict between healthcare systems.** Direct entry midwives (or lay midwives), which are commonly used by Mennonite communities, occupy a precarious legal status in Pennsylvania. The statute does not require midwives to have a nursing credential, but regulations do, thus making lay midwives effectively prohibited (American College of Nurse-Midwives, 2005). In other words, direct entry midwifery is unregulated in Pennsylvania, and so has no legal regulatory protection; instead, it can be ruled as legal by judicial interpretation or statutory inference (Pulley, 2006).

Most likely as a result of this precarious legal status, doctors vary on their willingness to work with lay midwives. One doctor who works near the community
actively collaborates with the local midwife. He conducts a prenatal visit for every woman who primarily uses the midwife. He also takes referrals from the midwife for higher risk births. However, my informants could not name any other doctor in the area who was willing to work with the midwife, and only a few others who were willing to work with women without health insurance. Bethany even likes to joke that other doctors won’t work with midwives because they are afraid of the midwives putting them out of business.

*Changes in communities over time.* Since the Mennonite community that I studied has only existed for 10 years, it is difficult to track any changes in prenatal care in the community in any meaningful way. However, informants were able to articulate differences in options using the frame of reference of when their mothers gave birth versus their experiences with birth. My eldest informant said that there are many more midwives available today than there were in her mother’s time, when it was standard for doctors to make house calls for births. She believes that this shift is indicative of a return to the “old ways.”

**Conclusion**

It can be seen that both research populations are struggling with the intersection of traditional and biomedical healthcare systems in the context of prenatal health and birth. Women in both communities have strong ties to traditional birthing practices and methods of prenatal care. Both groups of women emphasized that they felt more comfortable dealing with traditional midwives than with biomedical healthcare practitioners. Women in these communities identify traditional midwives as familiar and as synonymous with their cultural values. This is important because women have a deep
trust of midwives and feel a connection with them, which means that women have a strong motivation to visit them during their pregnancies. However, none of the women in my study totally discount biomedical approaches to pregnancy, instead identifying advantages to the system. These advantages lie in the realm of screening and when significant complications arise during pregnancy and birth. Biomedical practitioners are backed by technology, which often holds promise for births seen as outside of the norm. As a result, women make use of both systems as they see fit, with each system having authoritative knowledge in certain situations. Because of this, women use embodied knowledge, combining elements from each system in ways that fit their personal needs and interpretations of their cultures.

Implications of Findings

Raymond De Vries (2004), who has done comparative research on birth in the United States and the Netherlands, argues that “all health policy rests on cultural foundations and that policy proposals that do not match cultural ideas are doomed to failure” (245). However, a World Health Organization (2003) report indicates that most prenatal care programs in developing nations have not been adjusted from the form they take in developed countries. This is problematic, given that my and others’ research suggests that cultural values play an important part in healthcare decision-making. My findings indicate that women in the communities studied are already combining healthcare systems during prenatal care and birth. It is, therefore, logical that healthcare policy that works to combine these systems in a culturally relevant manner to improve health outcomes would be ideal in communities such as these. It is hoped that changes in models of maternal healthcare in these communities could have several effects:
1) To create prenatal and birthing situations that women are comfortable utilizing
2) To improve access to desirable healthcare that has previously been restricted due to cost and/or rural location
3) To integrate biomedical techniques that can improve birth outcomes

Possible Models

The literature on birth in communities in rural Mexico and in Mennonite and Amish communities offers models that have potential for use in the communities that I studied and others that are similar. While none of the literature has looked at the applicability of similar models to Mennonite and non-Mennonite populations, I argue that there is enough similarity between my two research sites to warrant this.

Mexico. There is a sizable body of literature that includes recommendations for improving prenatal care and birth in rural Mexico. Most authors advocate creating a space for parteras and doctors to work together rather than remain in conflict, as is the current norm. Ariadne Sole (2004) emphasizes the importance of an open dialogue between the two groups and their ability to build bridges between the disciplines, reminding us that simply blaming parteras for poor birth outcomes is simplistic and unfair. Creating this environment is a challenge that has yet to be accomplished in El Gusano, but, given women's strong feelings about parteras, doing so will be key to improving birth outcomes in the community. After this foundation is built, "a combination of the standard procedures from the medical norms [should be] combined with those practices derived from the TBAs and women's paradigms" (Castañada Camey et al., 1996, p. 206). It is important that the contributions of parteras not only be tolerated but seen as vital components to healthcare efforts (Parra, 1993). Lastly, it is
essential to reach this goal while expanding coverage of services and ensuring more births occur in sanitary conditions (Sánchez-Pérez et al., 1998). The application of these concepts in El Gusano would address the problem of women having to choose between two forms of care that are seen as incompatible by the government but complimentary by women in the community.

Indiana. One model presented in the literature is the development of freestanding birthing clinics that serve only Amish and Mennonite communities (Kreps and Kreps, 1997; Showalter, 2000). These centers are staffed by doctors and nurse-midwives, but feature a relaxed atmosphere, holistically minded doctors, and accommodations for buggies and horses. They represent a combination of the traditional values that the Amish and Mennonites associate with birth and the biomedical model of birth used by the dominant culture. This model is often initiated by residents in the community, thus ensuring community interest in the model, rather than an imposition by the dominant culture. It features the relaxed atmosphere identified by my informants as preferable during birth. However, lay midwives, whom my informants in Indiana trusted, are not incorporated into the model.

Freestanding birth clinics have much potential, but would not necessarily be useful in a setting like Indiana, where the community is small and likely unable to raise the funds necessary to build a clinic. For situations such as these, I argue that it would be useful to create a model similar to that presented for rural Mexico, one already partially in place in the community. A focus on cooperation among healthcare providers would be a realistic one for this community. However, part of the problem in the community comes from government restrictions on midwifery and the difficulty in dealing with
hospitals and doctors when one does not have insurance. This willingness by officials to work with culturally important concepts of the Mennonites and their financial realities would be ideal.


Appendix

Interview Questions

Mexico

*Parteras*

- What is your name?
- What training do you have?
- How long have you been practicing?
- Do you see women before they come to you to give birth?
  - How often?
  - What happens?
  - How many times?
- What healthcare advice do you give women if they come to see you before they give birth?
- How much do your services cost?
- Why do women prefer to see you for their births than to be with a doctor?

Biomedical Healthcare Practitioners (Clinic)

- What are your names?
- How long have you been in the healthcare field?
- What training did you need?
- What is your current title?
  - How long have you had this title?
- What is the name of this program?
  - How does it work?
  - What special challenges are there?
  - Who sponsors this program?
- How many times should a woman have a check-up during her pregnancy?
- What happens at the check-ups in this program?
- What healthcare guidelines do you give to the women who see you?

Older Women Informants

For a specific informant. Interview 1:
- What is your full name?
- How old are you?
- How many pregnancies have you had?
- What age were you at these pregnancies?
- Did you have check-ups for your pregnancies? Where?
- How did you access the *partera*?
- How was it different to give birth in a hospital than at home with a *partera*?
- What advice did the *partera* give you?
- What other advice did you receive?
- What do you think of prenatal healthcare in the community today as opposed to when you were having children?

Interview two
- Where, when, and how were you born?
- Where and when were you married?
- What is your education level?
- Have you lived in El Gusano for your whole life?
- How many years did your husband migrate?
  - When did he begin/end?
- In the last interview, you indicated that one of your babies died. What happened?
- Have you had any other complications with your births?
- Did your diet change when you were pregnant?
- Last time we talked about your friends giving you advice, what about your family?

Currently Pregnant Informants

For a specific informant. Interview 1.
- What is your name?
- How old are you?
- Is this your first pregnancy?
- How old were you for your other pregnancies?
- How far along are you in your pregnancy?
- How many check-ups have you been to?
- How were your last babies born?
- How much did the check-ups and birthing cost at the partera?
- How often were her check-ups with the partera for her past pregnancies?
- What happened at the partera check-ups?
- What advice did your friends give you?
- What advice did your family give you?
- Was there a difference between your pregnancies?
- Have you had any complications with your pregnancies?
- Does your diet change when you are pregnant?
- Do you have a support system?
- What do you think are the advantages and disadvantages to giving birth in a clinic versus with a partera?
- How do you plan to have your next baby?
- Where were you born?
- Where did you grow up?
- When and where were you married?
- Does your husband migrate?

Interview 2
- What are the years and months that your husband migrates?
- What are the months of the births of your children?
- Is there a link between birth and where your husband is?
- For one birth, the partera came to you. For the other two, you went to the partera. Why the difference?

Indiana

Women Informants

Interview 1
- How old are you?
- Where were you born?
- Where did you grow up?
- (If any moves) Why did you move?
- What is your level of education?
- How did you meet your husband?
- When/where did you marry?
- What work do you and your husband do?
- Do you have any children?
- Where did you go for prenatal care and births?
- What do you do for healthcare in general?

Interview 2
- For every place the informant has given birth/lived while pregnant:
  o How many children?
  o How long ago?
  o Were there complications with this birth(s)?
  o Did you receive prenatal care? If so, where did you go/who did you see?
  o How many visits were there?
  o What happened at these visits?
  o What other choices did you have?
  o What are the pros/cons of these options?
  o Where did you give birth?
  o What were your other options for places to give birth?
  o Why did you choose to give birth where you did?
  o What happened at your birth? (What procedure was generally followed?)
- Did your family give you advice about your pregnancy?
- Did your friends give you advice about your pregnancy?
- Did you receive conflicting information/advice about your pregnancy?
  o If so, how did you choose what the best information/advice was?
- Have options changed for you over time?
- How do you feel about any changes that you have seen?