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La Tecnología y Las Monjitas:  
Constellations of Authoritative Knowledge at a Religious Birthing Center in South Texas

In this article, I contrast conceptualizations of authoritative knowledge in pregnancy and birth between U.S. midwives and their Mexican immigrant clients at a religious birthing center in south Texas. Although the two groups share certain orientations to pregnancy management, essential differences in prenatal care and birth epistemologies underscore distinct social and economic positions. I use narrative data to document and explain these differences, which throw into relief the hierarchies of identity and need that structure immigrant women’s reproductive experiences. Unveiling the different epistemologies can also help to explain sometimes radically divergent ideas that have impacted the very survivability of the birthing center. By focusing on Mexican immigrant women’s reproductive decision making in an alternative birthing center, this analysis responds to feminists’ call to look to the margins to understand the diversity of women’s responses to what Rapp and Ginsburg have called “stratified reproduction.”

Keywords: [pregnancy, birth, political economy, midwifery]

For several decades, anthropological research on pregnancy and birth among women in diverse cultural settings has critically assessed U.S. biomedical approaches to pregnancy and birth. It has emphasized the multiplicity of local responses to the increasing medicalization of prenatal care and birth. Pregnant women in both alternative and traditional biomedical settings strategically appropriate various discourses to negotiate the medicalization of pregnancy, birth, and women’s bodies (Abel and Browner 1998; Craven 2005; Ketler 2000; Lock and Kaufert 1998). In alternative birth settings, women and their birth attendants frequently vest authority of pregnancy, labor, and birth in experiential and gendered knowledge, rather than biomedical clinical training and expertise (Davis-Floyd and Davis 1996). Considering women in alternative birth settings is in keeping with third-wave feminism’s call to look to the margins and discontinuities in an attempt to understand the lived reproductive experiences of diverse women (Inhorn 2006; Rapp 1999, 2001). Yet, in the United States, such research has most often focused on women and their birth attendants with similar class and ethnic identities: middle-class, non-Hispanic white women born in the United States or Canada. Anthropologists rarely have looked at...
the margins within the margins: low-income women of color choosing pregnancy and birth options other than mainstream biomedical care.

Holy Family Birthing Center is a religious birthing center in south Texas that primarily serves low-income women of Mexican descent. It is staffed entirely by U.S.-born certified nurse–midwives. Many of Holy Family’s clients are undocumented, or so-called “illegal,” immigrants. Holy Family’s midwives and its Mexican immigrant clients share certain orientations to prenatal care, such as female-focused pregnancy management. But surface similarities mask essential differences in prenatal care and birth epistemologies between them. In this article, I use narrative data to document and explain these differences, which throw into relief the hierarchies of identity and need that structure immigrant women’s reproductive experiences. Unveiling the different epistemologies can also help to explain sometimes radically divergent ideas about prenatal care and birth between midwives and their clients that have impacted the very survivability of the birthing center. Despite these differences, Holy Family offers prenatal care that is locally relevant and distinct from that offered by most traditional and alternative obstetrical care providers in the United States.

By choosing Holy Family, Mexican women, particularly those who are undocumented, are strategically responding to what Ginsburg and Rapp (1995:1) have called “stratified reproduction.” Hegemonic forces, including U.S. immigration, welfare, and health care policies, limit most undocumented or poor immigrant women to a life of poverty and constrained geographical and social mobility. Paradoxically, these women are responsible for their families’ domestic welfare yet live in social, economic, and political isolation. If they are able to leave the house regularly and safely, their prenatal health care options are limited to county health clinics that have local reputations of being short on patience, respect, and comprehensive care. In this environment, reproductive behavior is frequently less about choice based on pregnancy and birth epistemologies than about practical decisions centering on individual and family needs (Rapp 1999).

As a result, many immigrant Mexican women choose Holy Family for the breadth of its services, rather than its status as an alternative birthing center. Unique in South Texas, Holy Family not only offers comprehensive prenatal care but also other medical, financial, and material resources for its clients and their families. Its clinical care also explicitly incorporates a woman’s religious faith, if she so desires. Midwives, in contrast to their clients, come to Holy Family for very specific ideological reasons about a woman’s agency, self-knowledge, and a noninterventionist approach to prenatal care and birth. They believe that prenatal care should be holistic and supportive by providing clinical, psychosocial, and material support for a woman and her family. The midwives do recognize that what draws some immigrant women to the birthing center is their range of services. However, the midwives also hope to educate women about their bodies and their reproductive choices to increase their clients’ agency and confidence in their pregnancies, labors, and births. Part of the midwives’ approach is to promote unmedicated, woman-guided labor and birthing. In spite of this approach, Mexican women and their families increasingly participate in the birthing center’s prenatal care only to go to the hospital to give birth. Their choice to give birth in the hospital represents a de facto rejection of the birth model put forward during prenatal care. This choice also impacts the future sustainability of the center because of the loss of revenue. Nevertheless, Mexican
women’s decision to attend Holy Family for prenatal care and then give birth at the local hospital speaks to their conscious agency to navigate multiple, but limited, options for social and medical resources for undocumented or poor immigrants in Texas.

Literature Review

Inasmuch as “knowledge about childbirth is inextricably related to medical hegemony and social class” (Lazarus 1994:26), so, too, is academic categorization of approaches to pregnancy and birth. Barring a few notable exceptions (e.g., Fraser 1995), literature on midwifery in the United States has treated midwifery and its clients as a more or less singular entity, standing in contrast to a monolithic biomedical industry. Although recent research has pointed toward the variability in women’s approaches to mainstream biomedical care in pregnancy and birth (e.g., Davis-Floyd 1992), there is relatively little research on variability in women’s approaches to midwifery and, specifically, utilization of alternative birthing centers in the United States (Taylor 2003). There is a complete absence of research on undocumented women’s approaches to midwifery and alternative birthing centers in the United States.

Recent research on pregnancy and birth is united by common political economic and feminist theoretical perspectives that emphasize the processual nature and variability of birth and reproduction beliefs. Behavior related to pregnancy and birth is experientially located in cultural orientations, and it raises questions of women’s access to political, economic, and social resources (Browner 2000). Research on birth attendants, prenatal care, and birth are considered within larger sociocultural and historical processes, such as gender relations and socioeconomic stratification, reproduced in the globalized hegemony of biomedicine (e.g., Davis-Floyd 2001; Davis-Floyd et al. 2001; Matsuoka 2001). Much of this research supports the notion that in postmodern understandings of the world, multiple models of pregnancy and birth may be accessed simultaneously to produce a coherent understanding and narrative of pregnancy and birth (Craven 2005; Krause 2004; Obermeyer 2000).

In South Texas, Mexican women’s choice to attend Holy Family is based on both practical assessment of need as well as a certain constellation of ideas about authority in pregnancy and birth. Brigitte Jordan’s concept of authoritative knowledge argues that the fluid construction of pregnancy and birth experiences is intimately connected to political, class, and ethnic identities (1978, 1989, 1990, 1997). Authoritative knowledge refers to the hierarchical distribution of knowledge and power in pregnancy and birth reflective of larger social, economic, and political hierarchies. In the United States, authoritative knowledge of pregnancy and birth is typically vested in physicians, and, as such, it often seeks to invalidate other forms of knowledge, such as gendered and experiential knowledge of the body. Women and their birth attendants, however, often mutually accommodate biomedical and experiential knowledges to create a meaningful narrative of pregnancy and birth (Davis-Floyd and Davis 1996; Ketler 2000).

Critiques of biomedical hegemony in the authoritative knowledge of conception, pregnancy, and birth (e.g., Davis-Floyd 1992; Inhorn 1994; Martin 1987; Rapp 2001) have deepened cross-cultural, descriptive ethnographies of birth focusing on gendered knowledge, beliefs, and behavior (Davis-Floyd and Sargent 1997;
MacCormack 1994). Extant research on pregnancy and birth also recognizes, if not focuses on, existing and increasing reproductive health disparities in women of color and low-income living in an economically and socially stratified world (e.g., Phillips 2005). Yet, the research rarely examines reproductive behavior of low-income women of color who seek prenatal care in alternative birthing centers in the United States. As a result, the literature tends to “homogenize the history of reproductive health care” (Fraser 1995:55) as well as today’s reproductive decision making in other than mainstream biomedical clinics and hospitals. Except for Fraser’s research on African American women’s responses to midwifery (1995), recent work in midwifery explores the racial inequalities (re)produced in midwifery movements with a focus on midwives (e.g., Nestel 2007), rather than their clients. Most analysis among pregnant, low-income, minority or Mexican women in the United States has principally focused on their prenatal care strategies and preferences within mainstream biomedical care. Specific topics have included time of entry into prenatal care (Torres 2005), patient satisfaction (Handler et al. 1996), and use of reproductive technology (Browner 2000; Browner and Press 1997).

The analysis here considers how Mexican women in an alternative birth center setting approach their reproductive care decisions. It shows the practical implications for prenatal care for a population thrice restricted by class, ethnicity, and citizenship. Following Rapp’s analysis of the criteria women use in reproductive decisions (1999), I contrast what prenatal care and birth mean to a low-income, undocumented, pregnant Mexican client with what they mean to a middle-class, U.S.-born, and formally educated midwife. For the immigrant women, decisions about pregnancy and birth are intricately bound to issues of citizenship, gender roles, and access to resources for their families. Their epistemologies of pregnancy, prenatal care, and birth can only be understood within the larger framework of these priorities embedded within their life experiences in Mexico and the United States. In contrast, the midwives’ conceptualizations of authoritative knowledge in birth and pregnancy are much more explicit and focused on beliefs about women’s intuition of their pregnant bodies. The midwives’ epistemologies are reflective of professional training and a personal commitment to critical social praxis within medically underserved populations.

Methods

In the early to mid-2000s, I spent eight weeks on the Texas–Mexico border conducting formative research on birth and pregnancy at Holy Family Birthing Center. Methods included participant-observation, surveys, ethnographic interviews, and a focus group with clients as well as ethnographic interviews and a research meeting with the staff. I conducted participant-observation at Holy Family for 12 nonconsecutive days, principally through volunteer clerical work and making and joining in communal lunches with the staff. I observed prenatal care and birthing classes, patient–provider clinic interactions, waiting room interactions, and formal and informal conversations among staff and clients, and I attended a birth. I conducted interviews in Spanish, English, or both, depending on the preference of the woman interviewed. On consent, interviews were recorded. Recorded interviews were transcribed by a bilingual graduate student, which I regularly checked for accuracy.
Transcripts were analyzed for themes and related quotations using ATLAS.ti (ver. 4.2) textual analysis software. Themes were initially based on interview topics noted below but then expanded or modified to include subjects regularly raised by the interviewees. For example, the theme of prenatal care experiences in Mexico was refined to include sections on sonograms and medical technology, a comparison of lay midwives, certified nurse–midwives, and ob-gyns, and roles of female relatives.

I interviewed 15 clients who were from Mexico and three who self-identified as Mexican American or Latina. Each woman attended Holy Family at the time of research. Interview topics included: (1) demographic profiles; (2) open-ended questions about pregnancy, prenatal care, and birth beliefs and experiences; (3) observations of pregnancy, prenatal care, and birth in Mexico and the United States; and (4) open-ended questions about perceptions of U.S. and Mexican health care systems and their providers. Twelve of the women interviewed were undocumented immigrants from Mexico whose annual household income was $15,000 or less and who ranged in age between 18 and 37. I focus on their narratives in this article. All 12 women were paying for their care with personal monies, rather than with private insurance or Medicaid. They did not work outside the home. Each had at least one child. All but two were from urban centers in Mexico. Five women were from areas bordering the United States. Time with a permanent residence in the United States varied between one and 27 years. Two women spoke both Spanish and English; the rest spoke only Spanish. Eight of the ten women who said they were religious were Roman Catholic.

I also interviewed the five certified nurse–midwives (CNMs) working at the birthing center. Interview topics included training and work experiences in pregnancy and birth; open-ended questions about prenatal care and birth beliefs, experiences, and observations among their client populations and in contrast to mainstream biomedical approaches; and open-ended questions about perceptions of the U.S. health care system and its providers in relation to prenatal care, birth, and maternal and well-child care. All five were female. Each was born in the United States, although not in Texas. Two self-identified as Latina, originating from Midwestern and Southern urban centers in the United States. One midwife identified with Puerto Rican descent and one with Mexican descent. The remaining three CNMs were non-Hispanic white women from northern coastal states in the United States. Each midwife held a graduate degree in nursing or related field. Midwives were variably bilingual. Four midwives had at least a basic command of conversational Spanish related to pregnancy and birth.

After ethnographic interviewing and preliminary data analysis, I conducted a focus group in Spanish with 11 different immigrant Mexican clients to check initial conclusions and gather more information on beliefs and behaviors regarding prenatal care, pregnancy, and birth. The focus group was not recorded; I took extensive notes throughout the guided discussion. I followed the focus group with a research report of initial conclusions with the staff. The staff also responded to and expanded my analysis. This research builds on 230 structured interviews about choice of obstetrical care providers that I conducted in 1996 with Latina and non-Latina women from the birthing center and two other biomedical prenatal care providers in the same geographical area (Medrano 1997). In the 1996 research, I analyzed why women decided to attend a private biomedical clinic, a public community
biomedical clinic, or Holy Family. I found that women who preferred midwifery care were more likely to be poor and recently immigrated with no prior pregnancies. In the current research, I was interested in exploring how these characteristics were reflective of the women’s birth epistemologies and their political, economic, and social realities.

Holy Family, the Midwives, and Their Mexican Clients

Holy Family Birthing Center was founded in 1983 by four Franciscan Sisters of Mary in Brownsville, Texas, as the first freestanding birth center in Texas. It is currently located in rural Hidalgo County, bordering Mexico. Sister Angela Murdaugh, one of Holy Family’s founders, said they chose Hidalgo because of its historically high maternal mortality rate, its high rate of poverty, and the number of undocumented immigrants needing medical and social services. Hidalgo County and neighboring Cameron County are, respectively, the two poorest counties in the United States with populations of 250,000 or more (Webster and Bishaw 2006:14). The Hidalgo poverty estimate in 2005 was 41.2 percent (Webster and Bishaw 2006:14). Hidalgo is also officially designated as a Medically Underserved Area and a Health Professional Shortage Area by the state of Texas (Texas Department of Health 2002). The birthing center’s clientele is currently 65 percent monolingual Spanish-speaking immigrant women from Mexico. More than 90 percent of its client population is classified as poor, based on state and national poverty designations (Sister Angela Murdaugh, personal communication, summer 2003).

Holy Family sits on an unpretentious half-acre lot of rural land on a farm road outside of a small town, 12 miles from the Mexico border. The bright yellow walls of the wooden clinic and residential staff buildings, small birthing cottages, and small circular chapel make the birthing center a distinctive fixture on the otherwise blended farm, residential, and commercial landscape. Locally, it is known as the place “where the monjitas [nuns] live,” although only two staff members are nuns. Sister Angela directed the birthing center until 2006. She is known throughout local immigrant communities as a woman of faith, compassion, and spiritual strength, which attracted many of the Mexican clients. She is also well known throughout U.S. midwifery circles as one of the founding mothers of the modern midwifery movement, which, in turn, attracted many of the certified nurse–midwives.

Pregnant, undocumented immigrant women from Mexico hear about the monjitas, or nuns, and the birth center chiefly through female relatives. Recommendation to the birth center by female relatives underscores the importance of the female social support system during pregnancy among the women. Julia, an 18-year-old pregnant mother of two from Veracruz, first sought care at clinics for undocumented immigrants but then relied on recommendations for a friendlier place. As another woman explained, “I went to other clinics before I came here...then my husband’s aunt, she recommended this place. She was like ‘go over there, they’re really nice...They treat you like family and everything. They help you out as much as they can. And I was like, ‘ok, I’ll try it.’ And I came here, and I liked it a lot.”

The theme of gender runs throughout women’s reasons for attending the birth center as do practical considerations. The staff is entirely female, and females are considered authorities on healthy pregnancies. Also, nuns are available for
consultation and prayer requests, a consolation for many religious clients. In addition, many Mexican immigrant women are drawn to Holy Family for its social services, most notably its material aid for families and sliding scale and in-kind payment options as well as its commitment to serving all women, regardless of their citizenship, marital, or income status. Some undocumented women feel safe from authorities when they are at the convent, which they see as a place of refuge. Families who cannot pay reduced fees are asked to volunteer time in helping staff maintain the center. As one woman explained, she came to Holy Family because “when I went to the hospital, they asked me [to pay] so much, and here, they don’t ask you [to pay] anything, and they [still] treat you for the entirety of the pregnancy.”

The birthing center conducts outreach to the surrounding community through food and clothing banks. During clinical encounters, the staff regularly distributes food, toys, and clothing. One client said to me that she returned to Holy Family for each pregnancy because “in the first place, I don’t have any [immigration] papers, and because the other clinics are so expensive. And here, I have the opportunity to pay when I can. Here, there are toys for the babies, and there is clothing for the babies, even food. They do what they can to make sure everyone is doing well.” In fact, all clients mentioned cost, affective care, and material aid as three essential criteria for deciding on Holy Family.

The birthing center offers full prenatal, natal, postnatal, and well-woman care to its clients. Holy Family’s philosophy of prenatal care is based on the principles of the Centering Pregnancy Program, a model of prenatal care developed by Sharon Schindler Rising, a certified nurse–midwife (Centering Pregnancy and Parenting Association 2007). The Centering model promotes empowerment of the pregnant woman through peer group care, support, education, and self-assessment. The Centering model of prenatal care has three primary components, all of which are manifested in group settings at Holy Family: clinical assessment, psychosocial assessment and support, and education. The Centering model is aimed at providing the pregnant woman with the knowledge and authority to understand her pregnant and laboring body in an environment of other pregnant women.

As Sister Angela phrased it, “autonomy and power are closely linked. If you’re in a setting with low autonomy, then it’s not like Holy Family.” Each of the midwives at the birthing center has made a conscious choice to work at the birthing center because of this approach to prenatal care and birth, the opportunity to work with Sister Angela, and their commitment to work with medically underserved populations. Once at Holy Family, midwives receive a relatively low salary and live in communal housing with the rest of the staff. Prior to 2004, certified nurse–midwives could work at Holy Family to relieve nursing school debt. Yet once at Holy Family, several of these midwives became committed to the population. One midwife, Juliana, said that at Holy Family she was able to carry out what she taught: “to develop a relationship with your client, with the woman you work with. And to encourage her, her freedom, her choice, her right to choose, independence.” Another midwife, Lydia, served two-and-a-half years as part of the debt reduction program and stayed on for another two years. She chose Holy Family because of Sister Angela’s reputation, its focus on medically underserved minority populations, reliance on the centering program, and holistic care of the woman and her family. Lydia was particularly drawn to Holy Family because it values the “idea that women learn
better from each other rather than from their provider.” Lydia’s personal and clinical experiences at Holy Family contributed to an elaborated feminist epistemology that recognized the daily challenges faced by low-income Mexican women. To varying degrees, each midwife saw pregnancy and birth as Lydia did, as part of larger matrices that impact a woman’s autonomy and knowledge of her body. In contrast, not one of the Mexican clients mentioned prenatal care and birth philosophy as a reason for choosing Holy Family.

To propose that patients and providers have different motivations in the same clinical encounter is not new. Yet at Holy Family midwives and their clients advocate fundamentally different epistemologies of gender and technology in pregnancy and birth. In the next sections, I discuss each of these differences in conceptualizations of authoritative knowledge in detail, using the midwives and clients’ narratives of pregnancy, prenatal care, and birth. These differences are then discussed in terms of their impact on the sustainability of the alternative birth center and as a model for prenatal care for similarly medically underserved populations.

Conceptualizations of Authoritative Knowledge of Females and Obstetrical Care Providers

Both clients and midwives at Holy Family believe that the authoritative knowledge of pregnant (vs. laboring, see below) women and obstetrical care providers ideally work in concert to maintain a healthy pregnancy. They also agree that the clinical expertise of the obstetrical care provider alone has the authority to conclusively determine the risk level of the pregnancy and to diagnose any problems in pregnancy and the birthing process. However, unlike most of the clients, midwives believed that both the midwives’ and pregnant women’s intuitions can be as powerful as, sometimes even more powerful than, information derived from medical technology. For midwives, this authoritative intuition extends to the birthing process, as well.

Mexican clients’ conceptualization of authoritative knowledge of females includes the advice of female kin in choosing obstetrical care providers and maintaining a healthy pregnancy. All of the women were referred to Holy Family by female relatives, most often in-laws. This recommendation in part reflects recognition of the authoritative knowledge of female relatives during pregnancy in this population (Winston and Oths 2000). It also shows how many of these women were encapsulated within their husbands’ families. Most undocumented women at the birth center immigrated with their in-laws. They had few non-kin female social networks and virtually no non-kin male friends. Most did not leave home except to attend church or go to the grocery store. Women were tied to their homes for various reasons, including a lack of transportation and funds, a fear of the Immigration and Naturalization Services (INS), and a husband’s edict not to leave the home. Thus, female kin were typical sources of instrumental and emotional support for immigrant women, and their influence was heightened by the women’s undocumented status and poverty.

Instrumental support included advice on maintaining a healthy pregnancy and troubleshooting potential problems. Clients saw female friends, family members, and midwives as sources of instrumental support. All clients said obstetrical care providers were authorities on pregnancy, including advice on diet, exercise, and
emotional behaviors. Additionally, all but two clients said they would turn to the midwives and female social networks if they had a pregnancy question or worrisome symptom. One woman said she would ask her husband and the midwives. One other woman said she would ask her mother only. Six of the 12 women included female social networks as knowledgeable sources about behavior to maintain a healthy pregnancy. Only two women also relied on non-kin and nonclinic resources for pregnancy advice and information; these two women said they consulted the midwives, female friends and family, and books, magazines, or television shows.

Social and emotional support provided by the midwives frequently met the criteria for social support provided by female relatives, as well. Patricia emigrated from Mexico City when she was a child and, now at 35, was pregnant for the fourth time. In her discussion about her choice of the birthing center for prenatal care, she dovetailed the feeling of family at the birthing center with her own family’s involvement in prenatal care:

My mom gave me the opportunity, she gave me the choice, “do you want to stay with [the birthing center] or would you like to go to a doctor?” But I just love the environment here. The love, especially since I was going through a hard time because my husband had run away with my best friend and I was pregnant and he wanted nothing to do with my daughter. And at that time, I didn’t know what to do. And every time I would come to my visits I thought it was only me. I would walk through the door and “Oh, here she is!” and they would hug me and see how I was... the midwife was always making sure that I didn’t have any questions or any doubts in my mind.

In Patricia’s case, midwives had two sources of authoritative knowledge about pregnancy: as female members of the women’s extended social network and as obstetrical care providers. As female members of the women’s extended social network, midwives shared in the authoritative knowledge that women in general have about how to maintain healthy pregnancies. As obstetrical care providers, they had the authority and responsibility to ensure that a pregnancy was progressing normally. When asked about the role of obstetrical care providers, nine of the 12 women said the first responsibility was to use tests (hacer analisis, pruebas, or chequeos) to ensure the health of the pregnant woman and the normal growth of the baby. Three women disagreed, saying the primary role of obstetrical care providers was to give advice. One of these women said advice should follow the tests. Only one woman did not mention tests in her answer.

But authority associated with the tests and attendant technology was not sufficient to keep women returning to Holy Family. The authority had to be wielded with respect, personalized care, and kindness. Seven of the 12 women said that the responsibility of the obstetrical care provider was to be kind and understanding and give pregnancy-related advice. In fact, several Mexican clients saw their continued participation in prenatal care at the birthing center principally as a product of the midwives’ warmth and familiarity toward them. Clients frequently described the care received at the birthing center in contrast to what they had received at hospitals or public clinics. All of the women, except one, were aware of other clinics for pregnant, undocumented women but had rejected them. The women saw these
places and their associated hospitals as “cold,” where one is treated “like a number” and the staff “does not know your name.” Women placed little emphasis on actual clinical care delivered and focused instead on the emotional tenor of interactions between them and their obstetrical care providers. When asked to describe the ideal obstetrical care provider, 11 of the 12 women said the best obstetrical care provider was one who was friendly and treats the patients with respect and understanding. Interestingly, this question came immediately after questions about the role of the provider, in which most women first mentioned their use of medical technology to assess the health of the mother-to-be and baby.

One client, a 39-year-old woman from Queretaro who had been in the United States for 18 years, commenced her description of the best obstetrical care provider in general terms and then began to explain it in terms of her experience with midwives at the birthing center: “Very caring, loveable, understanding, always there…whenever you need them. Ready for any question you throw at them, with a reasonable answer…Everywhere we see them, we say hi to one another, and they know my children by sight. It’s like family.” A good prenatal care provider for another client was “more than anything, how they treat you.” The emphasis on the affective nature of the provider–patient relationship is not unique in and of itself. Regardless of class or ethnicity, women frequently validate their choice in obstetrical care provider in terms of affective care (Lazarus 1994; Davis-Floyd and Sargent 1997). However, the Mexican clients at Holy Family were using the contrast in affective care as justification for their continued participation at Holy Family.

In addition to the caring environment of the birthing center, all of the Mexican clients valued the all-female staff for their gendered authoritative knowledge. The women were more comfortable with female providers during the clinical exams and believed female obstetrical care providers to be more patient and intuitively knowledgeable than male ones. Clients repeatedly expressed the belief that women by virtue of their gender know what is supposed to happen in pregnancy. They therefore should be considered the experts in low-risk pregnancy. For example, Julia stressed the importance of having females attend the pregnant woman because of the experiential knowledge women have about their bodies:

My family taught me that women are the ones that have the babies, women are the ones that know what happens. Men don’t know what it is to go through an experience like that, so that women know best…It’s more of a connecting issue. I can connect with them and they can relate to me and I can relate to them…Being with a [male] doctor is more like, you gotta talk…in medical terms and it’s not like you can relate with them…like, how do you explain to a guy your period?

Julia’s quotation underscores two important issues in the women’s approach to pregnancy and birth. First, for many women, like Julia, there is a subtle conflation of the authoritative knowledge of medical technology and professional status with gender. Ob-gyn’s are expected to be male and have medical technology at their disposal. Nurses and certified nurse–midwives are expected to be female and, particularly in the case of Holy Family, not necessarily associated with control over
medical technology. The clients also saw female obstetrical care providers as more likely to establish closer, more personal relationships with their clients, another criterion they deemed important for good prenatal care (but not birth).

The emphasis on the genial support expected from obstetrical care providers connects to another belief of all of the clients: pregnancy was a time of privileged status for a woman. This elevated status should be recognized and encouraged by family and friends as well as obstetrical care providers. One client, Claudia, noted that family and others around the pregnant woman should help create “an environment where we can be together, chat, enjoy each other, a normal atmosphere . . . that there are no misunderstandings or don’t make a big deal of anything.” Many Mexican clients thought ob-gyn clinic and hospital treatment disregarded women’s experiential knowledge about their pregnant bodies and concurrent elevated status.

The midwives agreed that both the family and clinic environments should be supportive of the mother-to-be: “your emotional status when you are pregnant can really affect your pregnancy. If you get a lot of support, then I think you will have a positive outcome. And, if someone [like a midwife] is understanding to you and is open to listening to you about your fears, about your desires, then . . . you have a more positive experience” (Christina, midwife). ‘Supportive,’ according to the midwives, was not about providing a specific kind of clinical care as much as it was the affective component of the clinical care received. For the midwives, such support included an overt recognition of the pregnant woman’s authoritative knowledge of her body. They overwhelmingly advocated this authoritative knowledge to the exclusion of medical technology—after the pregnancy had been designated “low risk” by the clinical authoritative knowledge of the midwives. Midwives rely on the women’s intuition and experience to direct their prenatal care and birth. At Holy Family most women “dictate how much prenatal care they want,” based on “how much they learned from their previous pregnancies, how healthy they are, and how many chronic social stressors they have” (Sister Angela). As Juliana explained, “Here, we are especially good at saying, ‘this is what is recommended, would you like this done?’” Midwives also use their own intuition to guide their care. Christina once explained it thus to a medical student who had downplayed the midwife and laboring woman’s intuitions: “You can be book smart but it comes down to common sense. [I said to her], ‘Just look at the woman. Does she look like she’s in labor? I mean, just look at her’ . . . I’ve seen it time and time again. We believe in it, ‘cause we’ve seen it time and time again.”

For the midwives, professional expertise of the obstetrical care provider should be limited to clinical skills that help identify and manage risk, which can only be fully engaged when they have a close, personal relationship with their clients. Their authoritative knowledge does not rely exclusively on their clinical expertise. Tanya, a midwife, explained how her ability to manage risk was based on her relationship with her clients:

I like somebody to come in enough times so we could do sort of the basics. Get their initial lab work done, and their physical exam, and everything we do on the first visit. Have them see the social worker and start counseling and a series of childbirth classes if it’s their first pregnancy, or if they want them, if it suits the pregnancy . . . I always want my moms to feel comfortable in
this setting... by having a chance to meet every one of their providers so that they are going to know who their girl is, who will be on call for the delivery. And that they feel comfortable knowing that they can call anytime with questions or concerns. So that they really understand we are here for them.

The midwives use the relationship with the pregnant woman as a means to increase their own familiarity with a woman’s pregnancy and birth but not to the detriment of the client’s embodied knowledge of herself. That is, midwives see their own authoritative knowledge as complementary to the pregnant or laboring woman’s authoritative knowledge of her body. If the midwife and client have a close, personal relationship, their respective authoritative knowledges will bolster one another.

**Conceptualizations of Authoritative Knowledge of Medical Technology**

Clients and midwives differed in the kind and amount of medical technology they believed to have diagnostic authority. Mexican clients balanced their belief in the elevated status of pregnant women with the authoritative knowledge they vested in medical technology. Clients defined the authority of the obstetrical care provider in part by how much access they had to medical technology. For many of the Mexican clients, the midwives’ authority as obstetrical care providers was limited by the lack of regular use of certain technologies, most notably sonograms.

For most Mexican clients, “medical technology” meant sonograms throughout the pregnancy and, during labor and birth, fetal monitors and basic apparatus of a hospital delivery room. “Tests” (chequeos, pruebas, or análisis) during prenatal care, such as blood draws to measure blood glucose, were also considered medical technology. Both midwives and clients agreed that these tests were fundamental to risk assessment. However, midwives equally listened to the women’s intuition about their bodies, believing that comments from pregnant women themselves constitute a corresponding method for risk identification. As midwife Christina explained, “If a woman comes in here at 30 weeks, having pains, and saying, ‘I’m feeling like I’m going into labor, and I’ve had five other children, and I’m feeling sick.’ Well, you need to listen to that...if a woman says, ‘I’m not feeling right, or just something is not right.’ I always listen, because I would say they know best. It’s [sic] their bodies.” Contrary to the midwives, the Mexican clients, in general, did not attribute authority to a woman’s intuition about problems with a pregnancy. Gendered authoritative knowledge of pregnancy was limited to pregnancy restrictions that were thought to prevent problems in pregnancy, for example, do not lift heavy things and do not get overly emotional. Most women believed in the authoritative knowledge of medical technology for monitoring low-risk, healthy pregnancies, identifying and managing pregnancy and labor–birth problems, and ensuring the healthy development and safety of the fetus.

Professional status distinctions between a medical doctor and a certified midwife seemed to be based on perceptions of their access to medical technology. For example, during discussions about experiences and expectations of pregnancy in Mexico, all clients, except two, talked about birth, not prenatal care, and would choose MDs over midwives. Eight of the 12 women said that if they were in Mexico, they would
seek out ob-gyn care in a hospital for birth, rather than a certified or lay midwife. Two said they would want a certified nurse–midwife, “if there are any,” because they believed CNMs, as females, are more understanding and friendly. For these two women, authoritative knowledge was enhanced by female gender, as discussed above. For the other women, reasons for wanting a doctor to attend the birthing process varied. Several women believed it was an issue of availability. They believed lay parteras, or midwives, simply did not exist anymore except in very rural and low-income communities. Some also thought parteras were illegal, or that certified nurse–midwives were not and had not ever been present in Mexico.³ This is in contrast to current anthropological literature on midwifery in Mexico, particularly that of Davis-Floyd (2001), that has documented an increasing number of professional midwives that work in hospital settings. Yet according to Holy Family clients, their expectation for a pregnancy in Mexico was a birth in a hospital with an attending obstetrical doctor.

For the midwives, a woman’s authoritative knowledge and intuition of her body was the dialectical opposite of medically unnecessary use of technology during prenatal care, labor, and birth. Sonograms for low-risk pregnancies and without medical indication were emblematic of the overuse and undeserved symbolic power of technology. They thought sonogram use was even more widespread and common in Mexico. Indeed, sonograms are easily accessible in Mexico, not requiring a doctor’s referral. Women can walk into a sonographer’s office and have a sonogram whenever they desire. Immigrant women at the birthing center said that if they or their friends were pregnant in Mexico, the pregnant woman would get a sonogram once a month, because the sonogram would tell them that their baby was healthy and that labor and birth would be normal. Beatriz, a 27-year-old woman from Monterey, Mexico, saw this as a means to reassure her: “sometimes, an ultrasound makes you feel better,” more than listening to the heartbeat of the baby and measuring the woman’s stomach, as they do at each visit at Holy Family.

To be sure, the midwives were frustrated by the authority Mexican women placed in sonograms: “On the [Mexican] side of the border, you just go and say, ‘I’m pregnant, can you do an ultrasound?’ There are patients that come here and have had 10—they get an ultrasound every month. And you’re like, ‘you had 10 ultrasounds and no blood work?’” (Christina, midwife). The midwives were uniformly opposed to sonograms for low-risk pregnancies. As Marie, a midwife, put it, “I don’t believe in [technological] intervention and don’t want to do an ultrasound, unless there is a medical reason.” She said that many Mexican clients “come (to Holy Family) and they’re like, ‘when am I going to get an ultrasound?’ and we’re like, ‘you’re not going to get one unless there’s something—unless the baby is bigger than what it should be or smaller than what it should be for this particular time or unless your cycles are so irregular that we can’t figure out when you ovulated.’” According to the midwives, unnecessary medical technology draws power away from a woman’s intuition. There is “a point of knowing too much . . . sometimes knowing too much can be detrimental to letting things just happen,” whereas “our ladies . . . know natural things . . . and so they’re more intuitive and they listen more to their motherly instincts” (Christina, midwife). Not one client referred to the experiential knowledge of midwives as a means to identify risk, only tests.
According to many of their Mexican clients, however, sonograms during pregnancy were considered the most accurate means of risk assessment during pregnancy, even low-risk pregnancies. For these women, a fundamental component of prenatal care should be sonograms on demand, situating authoritative knowledge in the medical technology itself. Raquel, for example, had given birth to her first child at the birthing center, her next two in the hospital, and had returned to Holy Family for her fourth pregnancy for financial reasons. Her qualms about returning to Holy Family revolved around its lack of technology, commenting that the birthing center needed “more technology,” particularly sonograms and increased “tests” for possible problems with the baby. Similarly, when asked what she would have different about her experience at the birthing center, another client, Marisol specifically mentioned sonograms: “Well, I would like a sonogram to be done to see if everything is OK, you know? Healthy and everything.”

Much of the Mexican clients’ beliefs in the presumed predictive and protective power of sonograms and, more generally, about pregnancy and birth developed in Mexico, prior to immigration to the United States and experiences with the birthing center. Whether in Mexico or the United States, however, birth was the domain of doctors and hospitals for many of the Mexican clients. Most clients switched their locus of authority from self to birth attendant and, equally important, medical technology when they talked about labor and birth. Many Mexican clients saw themselves as unsure about the birthing process. The hospital was seen as having superior technology that could prevent or solve problems during labor, even by those women who chose to remain at the birthing center for birth. Birth attendants were expected to be authorities, able to foresee risk and complication based on their professional training and experience and their access to medical technology. Birth attendants had the authority to reassure and direct laboring women.

Nevertheless, there were two women confident in their abilities to birth without biomedical intervention. They both were repeat Holy Family clients. Their reasons for rejecting hospital births centered on the loss of personhood and respect they felt in hospital settings, rather than a denial of doctors’ authoritative knowledge of birth. One of the women said that doctors “don’t show any humanity . . . it’s like, here’s your baby, bye-bye . . . Even though there is less technology and medicine [at Holy Family], there’s more care” (emphasis added). This woman wanted the option at Holy Family to have sonograms on demand, because “they are very, very important.” Even still, for her, Holy Family’s personalized, caring approach to the woman and her family, their classes on childbirth and parenting, and its social services for families outweighed its lack of technology.

All of the midwives saw birth as the domain of the laboring woman. For low-risk births, midwives emphasized a woman’s inner strengths, intuition, and supportive social networks, not medical technology. Safety in birth for midwives meant the woman’s knowledge about her laboring body, her ability to call on emotional and spiritual strength, and the ability of the midwife to recognize situations where medical intervention might be necessary for the safety of mother and baby. Midwife Christina contrasted the midwifery approach with that of traditional biomedicine:

I think the difference in midwifery, it’s more nonverbal [rather than concrete tests] . . . I can sit there and watch the woman, I can tell you she’s probably
dilated just by looking at her, from here . . . you can see the difference in character, you know . . . We look at the women, we listen to the women instead of going in there and just seeing the person and wanting to get this baby out . . . they just don’t listen to the woman.

Conceptualizations of Authoritative Knowledge of a Higher Spiritual Power

For many of the religious clients, pregnancy and labor were recognized as a form of spiritually elevated suffering connected to motherhood. For example, Roman Catholic women during labor frequently called on the Virgin Mary for support for their pain, identifying their discomfort and pain during labor as analogous to Mary’s suffering for her son, Jesus Christ. One midwife recounted a birth in which the woman “was sitting through her whole pain, she was crying, thanking God, she said, ‘thank you thank you [for letting me be] privileged to be able to bring a child into this world, for allowing me to be a mother.’” Later, midwife Christina added, “during labor . . . they pray for strength because they know they have to be strong in order to be good mothers.”

These clients also believe that the ultimate authority in pregnancy and birth outcomes is their god. While discussing how most women do not want the Maternal Serum Alpha-Fetoprotein (MSAFP) test to see if their babies have genetic abnormalities, midwife Tanya talked about how “most people here feel like ‘I’ll take what God gives me . . . If [that’s the baby] God wants me to have, then that’s the baby I should have.’” During interviews, Mexican clients would qualify predictive statements about the health of their babies with “if God wills/wants it” (si Dios quiere) and descriptions about babies born healthy, “thanks be to God” (gracias a Dios). Although “thanks to God” is also a common linguistic tag in Spanish, these women did not qualify other predictive statements or descriptions about other areas of their lives, such as marital status and partner behavior or employment. On review of interview transcripts, in fact, the only time a thanks-to-God phrase was used was in the context of pregnancy and birth.

The midwives encouraged women to use their religious faith to help make sense of their pregnancies and birth experiences. The midwives’ recognition of the potential of spirituality to help pregnant and laboring women complemented the religious women’s belief in the authoritative knowledge of their god. Several midwives spoke of the importance of a woman’s spirituality during labor and birth. But, they did not explicitly advocate the authoritative knowledge of a higher power over pregnancy and birth, as many of their clients did. Christina remarked, “If you are spiritually connected to whatever you are connected to and you get strength from that, I think you can pretty much do whatever.” Laboring women “draw strength from birth and creation and god and the whole cycle. . . . I think you need to be at peace spiritually in order to have a good experience.”

Tanya, a midwife, expanded these notions, speculating that the higher acceptance of labor pain and confidence in their ability to give birth without medication were a result of several different cultural emphases and Roman Catholic metaphors: suffering in motherhood; women’s regular exposure to pregnancy, birth, and children; and an emphasis on families. Tanya discussed labor in terms of class and cultural differences, saying,
There is something that is not broken or backwards in Latina culture that I really love. It just doesn’t feel like it... needs to be healed. It just feels like [labor and birth] are part of life and really acceptable. Like people know it’ll be hard, but then it’ll be over... [In part, it’s because] the family structure is really strong, especially among the women... how they seem incredibly loving and supportive... and just having a lot of trust in God. I think God still helps, but there is just a lot more social support just to get through the hard times, even in labor.

The midwives saw themselves and the nuns as, respectively, clinical and social resources, which included a respect for a woman’s spirituality. All of the midwives felt strongly that spiritual faith could help a woman have a healthier pregnancy and easier labor and birth. They themselves varied in their personal religious affiliations and degrees of religiosity. Gina, an experienced midwife, related that at Holy Family spiritual health was considered the “ability of a person to call upon their religion as they understand it—this is of extreme importance—and to give expression to it.” A Jewish midwife, Tanya, noted:

I don’t think (spiritual health) gets recognized in other settings the way it does here, it’s a convent... we have a chapel here and (some women) come for the prenatal visit and go and spend time in the chapel, just for some peace. I've had people call and want to talk to a nun just so that they have somebody who can say a prayer for them...

Irrespective of their own faith, the midwives respected and encouraged the women’s religiosity, if it were important to the woman. It extended to all aspects of the birth process. Tanya recounted this story:

(O)ne of the first deliveries that I did here was for a client who was originally pregnant with triplets. And then two of them died in utero and she gave birth to one full-term baby... when the placenta came out, we looked and found what was left of the other two fetuses... [We asked if she and her husband would like] to have some kind of a ceremony here... she decided that she would like to have something, so Sister Angela wrote a page-and-a-half long prayer and all of the clinic staff here did a burial outside the birth room. And everybody got to say something individually as a prayer. We all sprinkled holy water on it and planted a gardenia... when she comes back for her follow ups... she goes out there and spends some time.

Supporting a woman’s connection between her spirituality and pregnancy–labor–birth was but one way the midwives tried to create an emotionally nurturing environment. In contrast, standard ob-gyn care and clinical environment were seen by many of the Mexican clients and the midwives as ignoring psychosocial or spiritual health as well as the pregnant woman’s altered, privileged status as a knowledgeable authority about her pregnant body. The clients saw traditional mainstream biomedical care for pregnant women as rejecting the authority of the spiritual. Combined
with their perception of impersonal and hurried care, the women and their midwives viewed the clinic–hospital as the antithesis of good prenatal care.

**Discussion**

Even in areas of apparent overlap in beliefs in female support during pregnancy, midwives at the birthing center and their largely undocumented immigrant clientele had profoundly different underlying ideologies about authoritative knowledge of obstetrical care providers, medical technology, and the laboring woman. These differences are rooted in different epistemologies of gender, technology, and religion, in general, demonstrating the different worlds in which they live. The Mexican clients’ emphasis on gendered care and social support during pregnancy stems from a belief that pregnancy is the visible sign of a woman’s primary role and responsibility in life as a child bearer and mother. Although pregnancy experience does imbue the woman with authoritative knowledge of her pregnancy, however, it does not extend to birth. Additionally, many of the Mexican women believe that medical technology has the ability, and thus authority, to accurately assess risk and problems in pregnancy and even more comprehensively during birth. As Georges (1997) found in Greece, and Browner and Press (1997), Taylor (2000), and Davis-Floyd and Davis (1996) in the United States, ultrasound imaging and its ubiquitous use in biomedicine reinforces the authoritative knowledge of biomedical professionals and the biomedical industry. It downplays, if not rejects, the authoritative knowledge of the pregnant woman.

Unlike birth in Mexico and prenatal care and birth in the United States, prenatal care in Mexico is rarely formalized for low-income women. The apparent presence of widespread pregnancy knowledge along with ubiquitous barriers to formal care for low-income, rural Mexicans might account for the fact that in Mexico, few women seek prenatal care before the second trimester (Sesia 1996). The one form of desired technology during prenatal care, sonograms, is available without a doctor’s script. As a result, for most women in Mexico, prenatal care is informal and relies on knowledge about pregnancy from close female friends and relatives (Browner and Press 1996), whereas a hospital birth and its concomitant loss of agency and authority of the laboring woman is commonplace and expected. There is evidence that medicated, painless births are being encouraged, as well. According to the National Council on Reproduction in Mexico (1997:86), 85–97 percent of Mexican births, except in the states of Chiapas and Oaxaca, are in hospitals. Only one woman in this research was from Chiapas and none was from Oaxaca.

Holy Family midwives, like many lay midwives in the United States (Davis-Floyd and Davis 1996), believe labor and birth should be guided by the women’s intuitive knowledge of their bodies and the midwives’ intuitive connection with the mother and baby, rather than by medical technology and its attendant industry. Midwives also believe in the power of social support during pregnancy and birth. They see their roles and that of the birthing center to be, in large part, additional social support. Part of that support is ongoing education about a woman’s pregnant and laboring body and her intuitive ability to monitor and assess it. As Holy Family midwives seek to empower the women, many of their clients continue to see medical technology as an additional and more powerful means to monitor and assess their bodies.
Although midwives and their Mexican clients clearly diverge on issues of authoritative knowledge of women in birth and medical technology in pregnancy and birth, their differences on the importance of spirituality in pregnancy and birth are more nuanced. The birthing center’s emphasis on the pregnant woman’s spirituality stems from a philosophy that recognizes the importance of a more holistic approach to a positive psychosocial environment. Spirituality is seen as one component that can enhance a woman’s psychosocial state during pregnancy and birth, but it is not tied to a certain religion and its associated gender roles. Spirituality for midwives, then, has less to do with a belief in the authoritative knowledge of a higher being. Yet, for many of the Mexican clients, their labors and birth outcomes were in the hands of God, *como Dios quiere* (what God wants) and *solo Dios sabe* (only God knows). God has the ultimate authoritative knowledge.

The question then arises, if there is such a divergence, at least initially, in conceptualizations of authoritative knowledge between the Mexican women and their midwives about prenatal care and birth, why are the women coming to Holy Family in the first place? Although the tendency to combine embodied and biomedical knowledges during pregnancy and shift to a singular biomedical frame during birth is common for American, non-Hispanic white women (Browner and Press 1997), the choice for prenatal care is still overwhelmingly mainstream biomedical. Class and legal differences are as much implicated as different cultural orientations. Lazarus (1994) found that one influence of class on American women’s conceptualizations of pregnancy and birth is that low-income women are more likely to seek continuity of care, rather than control over their prenatal care and labor and birth. As Lazarus also notes, other research among low-income women (e.g., Martin 1987; Nelson 1986) has shown that their reproductive care strategies are profoundly influenced by cost concerns.

In the case of these Mexican women, it is an even more complex reproductive strategy. As the narratives above demonstrate, the Mexican women are using criteria for reproductive decision making that include their families’ material and social needs. The fundamental needs for many of the birthing center’s clients are: paying for care, providing for their families in the short term, and acquiring skills that will help them provide for their families in the long term. Unlike middle-class white women who choose alternative birth centers for their reproductive epistemologies, these low-income, undocumented Mexican women are choosing Holy Family as an optimal resource for both their pregnancies and their existing families. They are not actively rejecting the mainstream biomedical model of prenatal care and birth, as the midwives at Holy Family are. The birth center offers material and social aid to empower the women, contributes to a positive prenatal psychosocial environment, and helps families in need. The Mexican clients see these forms of instrumental support as helping to meet demands of their daily lives, including childcare and feeding their families, rather than restructuring existing gender hierarchies.

**Conclusion**

“(W)omen have always had to learn how they may best use what is available to them” (Lock and Kaufer 1998:2). “People everywhere actively use their local cultural logics and social relations to incorporate, revise, or resist the influence of
seemingly distant political and economic forces” (Ginsburg and Rapp 1995:1). Following Lock and Kaufert (1998), Ginsburg and Rapp (1995) and Browner (2000), among others, I have treated the Mexican women at Holy Family as active agents in their reproductive behavior who use their reproductive decisions to pragmatically shape other arenas of their lives. Reproduction is but one possible facet of any woman’s life, and it is never isolated from other facets, health, economic, or otherwise (Lock and Kaufert 1998). Similarly, a woman’s choice to participate in alternative reproductive health care cannot be glossed only in terms of an epistemology of difference from the medicalization of pregnancy and birth. Women’s choices in reproductive health care are best explained, instead, by “their daily experiences as part of a domestic group, a community, or a society” (Lock and Kaufert 1998:18). Browner (2000), for example, has demonstrated that a woman’s agency can be constrained or encouraged not only by structural factors, such as available reproductive care to undocumented immigrants in the United States, but also by the influence of their close others.

In fact, the myriad sociostructural environments in which they find themselves clearly impact how low-income Mexican women at Holy Family interact with the epistemologies of U.S. midwifery. The midwives, in turn, arrive at Holy Family with distinct ideas about prenatal care and birth that influence their interactions with the Mexican women. The midwives occupy professional and social spaces aligned with an alternative, holistic model of birth that encourages unmedicated births in homes or homelike atmospheres and the authority of a woman’s intuition. Their professional reality is one of ongoing education about female agency during pregnancy and birth predicated on a belief of gender equality. Yet, most of their Mexican clients immigrated to socially and economically marginalized spaces manifest for undocumented immigrants in the United States. Within these spaces, they struggle to carve out a life for themselves and their families, exercising agency in choosing a prenatal care provider that conforms to some of their expectations and also provides much-needed resources for their families.

Epistemological differences can become material, however, and such reproductive decision making by some of its Mexican clients has its downside for the birth center. There is an increasing pattern of Mexican clients choosing to birth in the local hospital after receiving prenatal care at Holy Family. These women are acting on expectations of a highly technical birth where they consciously relinquish their authority to doctors and medical technology. Precisely because the birthing center actively discourages the use of unnecessary technology in low-risk births, does not advocate sonograms in low-risk pregnancies, and promotes the laboring woman’s own self-knowledge and authority during the birthing experience, the birthing center does not meet some of its Mexican clients’ expectations of birth. Clearly a profound philosophical issue for the midwives, the decision for a hospital birth is also a significant financial problem for the birthing center. Reimbursement for the birth center is based in large part on the client birthing at the center. Reminiscent of Morgen’s (2002) discussion of feminist health centers’ struggles to incorporate racial and class diversity into their policies and management, the challenge now for Holy Family is how to reconcile different practices of agency by two sets of women in the same ‘alternative’ social space but with very distinct positions of power: middle-class, U.S. certified nurse–midwives and undocumented, low-income Mexican women.
Despite these differences, Holy Family represents a rare model of prenatal care that is politically engaged and responsive to the express needs of the local medically underserved population. Mexican women initially come to Holy Family because it is affordable and provides material and social aid for their families. It is also considered a place of refuge. At Holy Family, prenatal care includes English classes, parenting resources, meetings with a social worker and nutritionist, and a social network of supportive women. Together with clothing, toy, and food banks, these services help immigrant women meet the daily challenges of being responsible for a family with limited financial resources in a new country.

Notes

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1. The founder and director of Holy Family Birthing Center, Sister Angela Murdaugh, agreed that she and the center would be identified by their true names in this article. The center is unique in south Texas, and the description of it herein would reveal it to anyone familiar with birthing centers and reproductive health in south Texas. However, all names and identifying features of the midwives and immigrant women have been altered to protect the anonymity of the women, except for Sister Angela.

2. After 2004, only clinics or centers with professional liability insurance could participate in the debt-reduction program. Holy Family does not have professional liability insurance.

3. In subsequent research, it would be fruitful to explore why women made this distinction. Following Fraser’s work on African American reproductive decision making, it could be that the Mexican clients associate Mexican midwives with poverty and low social status. Although my earlier research (Medrano 1997) pointed to this, as well, the sample size was too small to generalize.

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