

Abortion Beliefs and Practices among Midwives (*Parteras*) in a Rural Mexican Township

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ABSTRACT

Reproduction and motherhood are among the most important components of women's identity throughout Mexico and, for many women, are the only vehicles for gaining recognition and status in the family and community. At the same time, however, abortion is a central experience in the lives of many women and carries with it the complexities and contradictions of women's reproductive and sexual health. This paper presents results from an ethnographic study conducted with midwives in one rural township of Morelos, Mexico to understand their conceptualizations of and practices related to abortion and postabortion care. Overall, midwives viewed miscarriage as a woman's failure to fulfill her primary role as mother and induced abortion as a grave sin or crime. Nevertheless, under certain circumstances induced abortion was justified for many midwives. Helping women to "let down the period" in situations when a woman's menstrual period was delayed was acceptable to midwives as it was not viewed as abortion and enabled women to regain health and well-being.

Keywords: abortion, midwife, rural Mexico, postabortion care

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Reproduction and motherhood are among the most important components of women's identity throughout Mexico and, for many women, are the only vehicles for gaining recognition and status in the family and community. At the same time, however, abortion is a central experience in the lives of many women and carries with it the complexities and contradictions of women's reproductive and sexual health. This paper presents results from an ethnographic study conducted with midwives in one rural township of Morelos, Mexico to understand their conceptualizations of and practices related to abortion and postabortion care. Overall, midwives viewed miscarriage as a woman's failure to fulfill her primary role as mother and induced abortion as a grave sin or crime. Nevertheless, under certain circumstances induced abortion was justified for many midwives. Helping women to "let down the period" in situations when a woman's menstrual period was delayed was acceptable to midwives as it was not viewed as abortion and enabled women to regain health and well-being.

INTRODUCTION

Reproduction and motherhood are among the most important components of women's identity throughout Mexico and, for many women, are the only vehicles for gaining recognition and status in the family and community (Atkin, 1999; Comité Promotor por una Maternidad sin Riesgos en México, 1999). At the same time, however, abortion is a central experience in the lives of many women and carries with it the complexities and contradictions of women's reproductive and sexual health. In Mexico, an estimated 40 per cent of all pregnancies end during early stages, one-half due to induced abortion and the other half due to spontaneous abortion or miscarriage (López, 1994).

The penal Codes in all thirty-one Mexican States and the Federal District (Mexico City) define at least one situation in which abortion is exempt from penalty. Women have the right, in all states, to an abortion when the pregnancy is the result of rape (TABLE 1). However, access to safe abortion services is restricted for women throughout Mexico, due to the high cost and the lack of health-care providers and institutions offering the service where legal. As a consequence, unsafe abortion is the fourth most important cause of maternal mortality in Mexico (Lezana, 1999; WHO 1995) and an estimated one out of every three women experiencing abortion requires hospitalization for emergency care, most often for treatment of incomplete abortion (López, 1994).

In Mexico, midwives play an important role in women's reproductive health as they provide direct and continuous care to women during pregnancy, labor and birth, and the

postpartum period (Castañeda et al., 1991; Castañeda-Camey et al., 1992; Castañeda et al., 1996a and 1996b; Marcos and Avilés, 1996; Mellado et al., 1989; OPS, 1994). Two categories of midwives, known as parteras, are important in Mexico: traditional midwives (or trained birth attendants (TBAs)) who learn their skills through experience or from other TBAs and work in the community, and empirical midwives who have limited and basic medical training gained through workshops and short courses and who work in the community and in maternity centers (Klein, 1995).

Health systems in Mexico recognize that many women utilize a variety of health care providers to meet their reproductive health needs, as noted in a 1994 study conducted by the Secretariat of Health (SSA, 1994:2), "The coexistence of traditional and modern medical attention is a reality in Mexico....Women do not separate themselves from traditional medical attention as they look for the warm and personalized care a midwife provides." With this recognition, health systems have developed training programs to improve the skills of parteras so that they can offer the services that women need and want. This has been particularly important to women living in rural areas (Mellado, 1989; SSA, 1994). The present project, however, is the first to describe, in depth, the role of parteras in abortion and postabortion care and to explore health systems issues in ongoing training sessions with parteras.

We present results from an ethnographic study conducted with parteras in one rural township of Morelos, Mexico, which explored their conceptualizations of and practices related to abortion and postabortion care. Morelos is a state situated in the central part of Mexico, south of Mexico City, with relatively good geographic access to health services. Nevertheless, a significant

proportion of obstetric care continues to take place outside of the formal health system: 24 percent of all births in cities with more than 20,000 inhabitants and nearly 50 percent of all births in communities with less than 2,500 inhabitants (Marcos and Avilés, 1996; SSA, 1997; SSA 2002a).

In addition, unsafe abortion and its consequences play an important role in women's health in Morelos where the maternal mortality ratio due to abortion complications (8 per 100,000 live registered births) is almost three times as high as the national rate (3 per 100,000 live registered births) (SSA, 2002b).

An ethnographic study served as the first phase of a larger pilot project that aimed to make emergency services more accessible to women with abortion complications living in rural areas of Morelos. The project began in 1995 and was conducted by the Secretariat of Health of Morelos (SSM) for the state of Morelos, the National Institute of Public Health (INSP), and Ipas. Since 1990, researchers and health care providers at the INSP and SSM have conducted in-depth studies about reproductive health with the same group of parteras. The pilot project, therefore, built on work resulting from earlier collaboration among the parteras in this rural township, the SSM, and the INSP and aimed to improve parteras' skills and abilities in:

- recognizing the signs and symptoms of abortion complications;
- stabilizing women experiencing such complications so that they could safely travel;
- referring women to the local general hospital.

Results of the ethnographic study were used to understand the role of parteras in abortion and postabortion care and to develop culturally appropriate training materials and teaching strategies for workshops with parteras and hospital personnel (Billings et al., 1999).

Concepts, beliefs, and practices related to abortion are set within social structures that shape the experience, from the perspective of both health care providers and women themselves. Thus, it was important to employ methods that enabled researchers to explore in-depth the meanings associated with abortion as well as the contexts in which such meanings are formed.

Subsequent to a brief exploratory study that served to evaluate the possibilities of carrying out the project and to design the final research instruments, two of the three authors (an anthropologist and physician) working from the INSP conducted a total of 9 in-depth interviews with different parteras. These women ranged in age from 20 to 62; the older women had no formal education while younger women had completed primary school. Three women from the same community also were interviewed about their personal abortion experiences. Pseudonyms are used throughout the text to present the results and to protect the confidentiality of the participants.

The semi-structured in-depth interviews were conducted with parteras who previously had participated in sexuality and reproductive health workshops offered by the SSM and INSP. Each interview lasted approximately four hours and was conducted over several sessions. The themes addressed flowed from a general exploration of reproductive health topics to a specific examination of parteras' beliefs and practices regarding abortion and postabortion care. The same author also attempted to conduct one discussion group with eight parteras in order to capture a collective understanding of key concepts including sexuality, maternity, abortion, the construction of gender identity, and popular paradigms related to gender roles. The discussion group was not successful in gathering information about parteras' beliefs and practices regarding abortion. Their reluctance to share experiences and opinions was most likely due to the fears and difficulties they had in speaking

openly with fellow community members about a taboo subject that can be accompanied by heavy legal and social penalties.

RESULTS

All of the informants included in the study clearly distinguished induced abortion from miscarriage or spontaneous abortion.

Miscarriage (Spontaneous Abortion)

Parteras viewed the occurrence of a miscarriage as a woman's failure to fulfill her primary role as mother. As Hammer (2001) observed in Peru, bearing and rearing children is considered tiresome but obligatory work and is central to women's identity. Women themselves were often blamed for the loss of their pregnancy. Doña Dominga noted, "these women don't know how to have children" and Doña Chely stated, "they don't take care of themselves and because of this they abort."

Causes associated with women's everyday lives were often mentioned by parteras in relation to miscarriage. These include lifting heavy objects or engaging in excessive movement, both of which are common occurrences as women work in the fields planting and harvesting, carrying children, and hauling water, firewood and loads of clothes to be washed. This confirmed findings from a previous study in which parteras explained the relationship between work and spontaneous abortion in the following terms. During the first three months of pregnancy "the fetus (criatura) is still delicate, it hasn't adhered well (pegado bien) and can easily separate itself [from the walls of the uterus] when the woman exerts a lot of force or carries heavy things" (INSP, 1992).

The shifting or displacement of organs, which results in corporal disequilibrium, is often

invoked in rural areas of Morelos to describe the origins of illness or pain. Many parts of the body are said to move or be displaced as an explanation for a variety of health conditions: the fontanela of children “falls,” the pulse “changes its place,” organs “rise, fall, or open.” These expressions are linked to a pre-hispanic cosmovision. (Castañeda et al., 1991). In relationship to miscarriage, women were said to have an “open” or “loose” waist or hips or a “fallen” womb or ovaries. Both are sometimes attributed to women engaging in heavy work, which can cause “the waist to open or the ovaries, which are tied with threads, to break...” (see also INSP, 1992).

Parteras turn to a series of resources and practices that combine herbal remedies with physical therapy to re-accomodate the organs and attempt to prevent the abortion from completing. These include sweat baths, massage with herbal and alcohol mixtures, covering the woman with a heavy blanket, and wrapping her waist tightly with a bandage in order to re-establish equilibrium within the woman's body. In general, these approaches are accompanied by rituals that emphasize the importance of women's fertility.

Fright (susto) and anger (coraje), two conditions commonly experienced by women and perceived as important explanations for general illness and disease in Mexico, were also noted as causes of miscarriage. So too was malnutrition, resulting from the conditions of poverty in which many women live and the practice highlighted by Doña Isabel that “women are the last to eat, after her husband and children, and eat the least nutritious foods.” Injury due to domestic violence was named numerous times as another significant cause of miscarriage.

Parteras also indicated that when left unfulfilled, compulsive desires (antojos), most commonly for certain foods, are an important cause of miscarriage. Through the mother's womb the

fetus itself experiences such desires and “becomes very unsettled and begins to move around too much” (Doña Esther). Uterine contractions begin since, as Doña Esther indicated, “the power of desire is very strong, enough so that the child may even come” i.e. miscarriage ensues. The remedy lies in “feeding” the antojo with the food the woman so desires. When this is not possible, food such as tortilla with salt, two grains of black corn or cinnamon tea are said to counteract its effects.

Induced Abortion

Induced abortion was referred to by all of the parteras interviewed as a “murder” or “grave sin” and women who induce abortion were known by community members as dogs/bitches or pigs and were accused of “eating” or “throwing away the child.” These labels were also placed on all women who abort repeatedly, whether the true cause was spontaneous or induced since, as Doña Chely noted, “people in the community suspect that if she is aborting time and time again it's because she must be doing or taking something that causes the child to be thrown away, or that she's not taking care to prevent the child from coming out.” Thus, women whose health status causes them to abort numerous times were placed within the same punitive category as those who actively induce their abortion.

The three women interviewed who had experienced an induced abortion held a similar stance to that of parteras. Each viewed her situation as “exceptional” and “forced because of circumstances.” In this way, women were able to justify their own abortion while continuing to work within their own social context to condemn other women who abort.

Reasons and Circumstances for Inducing Abortion

Exceptional circumstances for justifying induced abortion were expressed by two of the

three women who had previously induced an abortion and by six of the nine midwives interviewed in the study. While all continued to roundly condemn the practice, they noted that under a variety of circumstances abortion is the only route available to women. Such situations include rape, malformation of the fetus, and a pregnancy that presents a risk to the woman's life. Three of the parteras interviewed indicated that inducing an abortion is never justified regardless of the circumstances. Lourdes, who had undergone an induced abortion agreed, even in the case of rape, stating "It's not the fetus's (criatura's) fault. The woman has to resign herself to this [continuing an unwanted pregnancy] because God wanted her to remain pregnant for some reason, maybe as punishment for something."

Reasons for inducing an abortion also can vary according to a woman's marital status. For women without a steady partner, the fear of familial and societal condemnation and criticism is a primary motivating factor. Some noted that "having a child as a single mother makes it difficult to later find a formal partner," given that men are often reluctant to support a child that is not their own. Lourdes, stated, "many times the boyfriend doesn't understand the problem [of being pregnant but not married] and abandons the woman to her own luck." The prospect of finding herself alone, without access to resources, and eventually with a child to support also motivates many women to find a way to end their pregnancy. Fear of abandonment was also mentioned by Lourdes: "it is the boyfriend who obligates the woman to abort, or she knows that he does not want to have children and so she decides to abort thinking that if he finds out that she is pregnant he will abandon her."

Those interviewed found fewer reasons that would justify abortion when a woman is married. Doña Chely emphasized, "If a married woman wants to abort it must be because the

child is not her husband's. It must be from 'the street', from another man.” Doña Isabel: “If she's not getting along with her husband, let her leave him but not abort;” and Doña Dominga offered the option of adoption to women: “There are many people who want to have a child so if the couple doesn't want it then they should give it away to someone.”

Some midwives mentioned economic hardship as a reason that married women resort to abortion while, in general, the following statement by Doña Chely was indicative of the sentiment of all midwives included in the study: “One can understand why a single woman would induce an abortion, with all of the pressures which exist if she were to remain pregnant, but there is no justification for married women since they have their family to support them. If they already have a lot of children, it's better if she gets 'tied' (tubal ligation) and doesn't abort. The only way I would justify it is when the poor woman is all messed up because her husband is a drunk and beats her or runs around with other women. Then I could understand helping her not to have another child.”

None of the parteras interviewed admitted to inducing abortion and the majority denied knowing of any methods that could be used or even where women might have access to such services. Those who did mention substances or methods that could be used pointed to the following: A catheter inserted into the uterus; injections of methergine; Zoapatle (*Montanoa tomentosa*) with very hot chocolate complemented by a hot bath; hormonal injections, principally progestins; scraping of the uterus (*raspa, legrado*); “suction with a syringe”; carrying heaving objects (also a cause of miscarriage); and letting oneself fall.

Parteras identified infection and hemorrhage as being the most frequently seen short-term complications while sterility was often mentioned as the most common long-term complication of

unsafe abortion. As such, women who are infertile are suspected of having induced an abortion at some time during her life.

The Induced Abortion Experience

Fear was a pervasive sense in the abortion experience of the women included in the study. They turned to women outside of their immediate family for advice and guidance so as to avoid family members finding out about their plan to abort. Men/male partners were rarely involved in the decision to abort.

Speaking particularly of the experience of single women, Lourdes emphasized that social castigation worried her more than did punishment from God. “We are most afraid that our families and community will find out that we are pregnant. Other than this, one thinks that nothing is going to happen. God is going to punish us for aborting but He will punish us for other things as well and this punishment will come later; on the other hand, if community members find out that we have aborted they will condemn us here and now. This is what I'm really afraid of, the wrath of people who never forgive.”

Fear of the procedure itself was also common. Julia expresses the sentiments of the women who had undergone an abortion as she stated: “Women are frightened when they are going to have an abortion because others have said that it's worse than childbirth, that there are women who have even died from it. But we also know that many abort and nothing happens to them. Because of this, when one makes the decision she is not stopped by the fear.”

Bajando la Regla (Bringing Down the Period)

This practice has been documented in communities throughout Africa, Asia, Latin America and the Caribbean and its significance varies across contexts (Cosminsky, 2001; Hammer, 2001; Levin, 2001; Ngom, 1998; Renne, 1996; Sobo, 1996). For example in Northern Ghana, Ngom (1998) cited that the procedures used to induce menstrual flow are often used as ways to maintain one's health rather than as means to deliberately terminate a pregnancy. Prescription of emmenagogues (substances that bring on menstruation) to women is not necessarily linked to pregnancy termination. Thus, there seem to be varying social meanings of menstrual regulation. Levin (2001) notes that in Guinea menstrual problems (including delays) are most often regulated with plant-based medicines ingested in the form of a tea or infusion. This manner of “inducing late menstruation” can provide women with an acceptable alternative to clandestine abortions. In an ethnographic study examining the use of emmenagogues in rural Guatemala, Cosminsky (2001) suggests that parteras negotiate the ambiguity in the use of emmenagogues by diagnosing delayed menstruation (*detención*) or pregnancy, whether the use of these remedies is for bringing on one’s menstrual period because they have the condition, “*detención*,” or as an abortifacient to end a pregnancy.

In Morelos, flows of bodily fluids are a primary indicator of well-being. The interruption of the monthly flow of blood (and not necessarily explained as or linked to pregnancy) is a sign of illness that is often treated with herbal remedies. When menstruation fails to begin in a given month women worry that the blood is stuck inside the abdomen. This is often related to “cold” conditions, and women frequently take “hot” herbal emmenagogues. Different remedies exist and were never recommended beyond the period of three months after a woman’s period is missed, indicating that

bajando la regla is distinct from induced abortion for *parteras* included in the study. *Parteras'* conceptualization of the developing fetus is that it is 'a ball of blood' that takes on a "human" identity when small bones began to develop. For boys this occurs around the third or fourth month of pregnancy while in girls such development is stalled until approximately the sixth month.

'Remedies' mentioned by *parteras* for bringing on a delayed period included: Cinnamon tea brewed with oregano (*Origanum vulgare*); Zoapatle (*Montanoa tomentosa*), an herbal uterotonic, with hot chocolate; tea made of Hierbadulce de México (*Lippia graveolens*); chamomile tea (*Matricaria parthenium*); aloe juice (*Aloes mexicana*); hormonal injections, principally progestins; and aspirin with lemon juice taken over a period of five to six days. Many of the 'remedies' named by *parteras* are similar to those noted above as abortifacients. In the case of *bajando la regla*, however, a woman's pregnancy is not confirmed and injections or teas are taken at an earlier stage of menstrual delay such that the same substances and practices are not viewed as abortifacients. If a woman's period comes on after treatment, it is said, "Well, then she wasn't pregnant."

Midwives' ambiguous position as knowledgeable owners of substances that both contribute to fertility and abortion within a society where abortion is restricted legally and highly condemned socially affords them a position that enables them to provide support to women while also configuring them as threatening as they have the ability to challenge social and legal norms.

Care Provided by Parteras to Women in Their Communities

When women experience abortion complications, whether from spontaneous or induced abortion, *parteras* generally refer the woman to their nearest health center for care. Previous studies with midwives in a neighboring township indicate that few recognize risk factors related to women's

prior gynecological history or current pregnancy condition (García Barrios et al., 1993).

Only one of the parteras interviewed indicated that she had placed a glucose IV to stabilize the woman until she reached the attention of a specialist; another noted that she rehydrated the woman, gave her vitamins as well as an analgesic to bring down the fever. Reasons for such minimal treatment include the parteras' lack of knowledge regarding appropriate actions to take, the fact that previous workshops in which they have participated have emphasized referral as the only course of action, and the fear that parteras have in being labeled as 'abortionists' and thus suffering legal consequences. Parteras also noted that often times when they do accompany women to a health center or hospital, regardless of the health problem, providers ignore them or treat them as if they were unqualified to provide any sort of care to women. Feelings of ostracism and condemnation make contact with the formal health system uncomfortable and difficult. This works to further reify the divide between traditional and institutionalized health services.

Doña Ignacia described her experience of reluctantly helping two women who were bleeding profusely. She directly addressed the complications that two women were experiencing but was also accused of inducing the abortions for the assistance she offered.

“We [parteras] don't attend to these cases because it is very dangerous and can cause many problems. I have only attended two abortion cases in all the time that I have been a partera (more than 30 years) and these were for special reasons. The first was five months pregnant and she came to me with pains about eight days after her husband beat her. She came hemorrhaging and weak and for that reason I took her with me. The baby was halfway in and halfway out and she was bleeding a lot. I didn't want to attend to her because these things cause very serious problems but I did because

she was part of the project [of training parteras in Morelos in prenatal care]. Since I couldn't take out the rest of the 'product' I injected her with oxytocin and then was able to remove all of it. The other woman that I attended had also been beaten, this time by her landlord since she owed a few months of rent. I attended her because she arrived with a neighbor who begged me to help her and because it was the middle of the night and there was no way to send her to the hospital. She was also bleeding and I did a vaginal exam to see how her cervix was. It was dilated so I gave her oxytocin so that the 'product' would come out and then I put ergometrine to stop the bleeding. In both of these cases I had problems with the police. They put me in jail and pressured me many times to make a declaration but since I wasn't guilty, I never did so. But the police continued to bother me and they threatened to take away my permit to attend births. They finally left me in peace when witnesses and the women's families, as well as a nurse at the health center, told the police that they knew me well and that I was a partera with a good reputation. This still didn't save me from appearing on the front page of the newspapers for several days.”

CONCLUSIONS AND RECOMMENDATIONS

Women throughout the world continue to depend on the services of midwives and other community-based providers for their reproductive health care. Yet little work to date has been done to incorporate them into the process of delivering abortion and postabortion care services. The findings summarized in this paper indicate that parteras in one rural township in Morelos, Mexico have extensive experience with and ideas about abortion and related issues. They have a distinctive and privileged role as primary health care providers to women in their community and

their practices and beliefs regarding abortion must be understood if health programs aim to decrease mortality related to unsafe abortion. As emphasized by WHO (1995), “It is extremely important that cultural concepts and beliefs governing the practice of village health workers [*parteras*] in handling abortion be understood throughout the referral network of the health system' so that service providers in other sectors of the health system can work with [them] to address women's needs.”

Parteras' role in **preventing** abortion-related mortality and morbidity also should be expanded by enhancing their technical skills through appropriate training. Parteras can serve as important community educators and health promoters, informing men and women how to avoid the risks of unsafe abortion by safely regulating their fertility, how to recognize the signs and symptoms of abortion complications and to promptly seek treatment services. However, before such a strategy can be effective, the fear and reluctance that many parteras face in stabilizing and referring women with abortion complications to nearby hospitals must be addressed within health systems. Parteras must feel secure that they, and the women they accompany, will be treated with respect when they arrive at the hospital and that they will not be accused of criminal activities.

Lastly, the negative attitudes that parteras hold regarding women experiencing abortion complications, whether they are the result of an induced or spontaneous abortion, need to be addressed. The intimacy and confidence that characterize many women's experiences with parteras during pregnancy and birth do not seem to be present after an abortion. In part, such attitudes are intimately linked to parteras' fear of legal repercussions but are also shaped by their conceptualizations of women's identity and importance in society, in particular the emphasis that

is placed on motherhood in defining women's status.

Table 1. Circumstances in which abortion is legal in Mexico

Circumstances in which abortion is legal	Number of states in Mexico (n=32)
Rape	32
Risk to woman's life	27
Abortion due to an accident on the part of the woman	29
Congenital or genetic malformation of foetus	13
Risk to woman's health	9
Artificial insemination w/o the consent of the woman	8
Socio-economic reasons (woman has 3+ children)	1

GIRE, 2000

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