ORIGINAL RESEARCH

Health professionals' perception of maternal health: an ethnography in the Sierra de Totonacapan, Veracruz, Mexico

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Abstract

Maternal health is a complex issue. In Mexico, the population living in poverty and indigenous peoples are especially affected by health disparities, in particular, demonstrated by skilled birth attendance. The determinants mentioned by health professionals, especially structural barriers, characterize their perception. However, there are other barriers. The concept of intercultural medicine is understood as the adaptation of medical care to local reality to overcome cultural barriers. This article will conclude with a perspective that focuses on the possibilities and limitations of intercultural medicine for maternal health. Key words: maternal health - maternal mortality - indigenous people - intercultural medicine - perception

Introduction

Maternal health is a complex issue. In 2010, the global maternal mortality rate (MM) was still 240 deaths per 100,000 live births. In Latin America, according to the UN (UN, 2013), this rate was 72. Despite positive advances in the areas of "skilled birth attendance", "prenatal care" and "use of modern contraceptive methods" (MCM) (UN, 2013), it is reasonable to question why maternal health in the region has not improve to an adequate extent when taking into account MM (Lozano et al., 2011). It is necessary to examine the way in which the vulnerable population groups, such as people living in poverty or who are a part of indigenous peoples, are being affected by this problem. In 2008, 20.9% of all Mexicans lived in extreme poverty, which was concentrated in rural areas, where 33.5% of its population is located (Iniguez-Montiel and Kurosaki, 2018). In 2005, it was estimated that 9.8 million indigenous people lived in Mexico, representing 9.5% of the total population (UNDP, 2010) In 2002, extreme poverty in indigenous communities (in which more than 70% of the population is indigenous) was around 68,5% (Hall and Patrinos, 2006). When considering the complexity of the debate about identity and ethnicity, statistical surveys must be critically evaluated (Schmal, no date). Various publications have shown that the health status of the indigenous population is lower than that of other population groups. In terms of maternal health, maternal mortality and morbidity rates are significantly higher (Gracey and King, 2009). A 2006 survey by the National Institute for Women showed that indigenous women used MCMs much less frequently than non-indigenous women. In rural areas, only 48.9% of indigenous women of reproductive age use MCMs, compared with 61.1% of non-indigenous women (INMujer, 2009). In 2012, the indigenous

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population received more support from social programs than the non-indigenous population. Notably, more than 50% received support through a nutrition program or the Oportunidades program. However, the insurance situation of the indigenous population improved significantly between 2006 and 2012 because, although 64.9% of the indigenous population still did not have health insurance in 2006, this proportion decreased to 22.1% in 2012. By 2012, 61.9% of the indigenous population was affiliated with the Seguro Popular de Salud (Leyva-Flores et al., 2013).

This publication is based on empirical data from a major German study for the purposes of a doctoral thesis in medicine (Limits and possibilities of intercultural medicine for maternal health in the Sierra de Totonacapan, Mexico; http: //geb.uni-giessen .de / geb / volltexte / 2018/13910 /), presents a perspective on maternal health in a rural region of the State of Veracruz. It focuses on structural and sociocultural barriers between the local population and medical attention (MA), and the perception of medical personnel (MP) regarding the patients seen. Most of the research on this topic addresses patients' barriers to equitable health care, for example, socioeconomic aspects which contribute to limited access.

(Titaley et al., 2010). In contrast, research on the factors that affect MP is underrepresented to date (Holmes, 2012). The perception of the MP regarding MA in rural regions is of particular interest in this publication. This article concludes with a perspective that focuses on the possibilities and limitations of intercultural medicine (IM).

Theoretical framework

The concept of IM has a tradition in Mexico in the context of the MA of the indigenous population (Lerín-Piñón, 2004). The work of the anthropologist Gonzalo Aguirre Beltrán is considered of particular relevance. In 1954, Aguirre Beltrán requested to include the concept in national health programs (Aguirre Beltrán, 1994). It is especially used today in the context of indigenous culture and traditional medicine (Menéndez, 2006). Other features are less frequently associated with IM. For examples, populations living in poverty have been neglected in this sense (Ramírez Hita, 2011). In Mexican health policy, the concept is generally understood as the adaptation of MA to the local circumstances in order to overcome cultural barriers, thus helping improve MA, mainly for the indigenous population (Campos Navarro et al., 2017). But in general, there is no common definition (Salaverry, 2010). Political understanding and the subsequent application of IM are criticized in the anthropological literature. One criticism is that the concept is applied without significant evidence (Salaverry, 2010). Thus, the question arises as to whether the concept should continue to be used, since there has not yet been any perceptible improvement with respect to community health (Ramírez Hita, 2011). Therefore, this publication attempts to clarify the following questions: What are the possibilities and limitations of the concept of IM? What benefits can the concept have for MA? What applications are favorable and how can they be implemented?

"... the doctor is the one who decides"

This article is based on extensive ethnographic field work. For the first focus group, a health training was carried out within the framework of the *Oportunidades* program. These trainings were mandatory for pregnant women receiving welfare. The main topics referred to risk factors for pregnancy and childbirth, awareness of symptoms and preventive measures. The group was made up of 19 pregnant women, a husband, a Totonac-speaking interpreter and the male researcher. The objective was to investigate the perception of the participants regarding the advantages and disadvantages of institutional delivery. At the beginning of the focus group, the participants were surprised by the format of the event, which was usually oriented towards training. Also, it seemed unusual at first that they would reveal their opinion regarding MA. Participants' reluctance was evidenced with the statement *"So everything is fine at the hospital."* Particularly impressive was the argumentation of one participant:

> *"In fact, they make us sign the consent forms that we want to have the [intrauterine] device and if one cannot, then the husband does so. I say there is already negligence, they force you and*

really we as the owners of our bodies, if we do not want to, no one can force us to do anything we do not want. Precisely for this reason many people do not want to go to be treated in hospitals or by the doctor because really the doctor is the one who decides, not us. They put it in just like that, even if it doesn't fit. "

Participant observation had previously been carried out at the regional hospital, but no complaints had ever been made in such a way. After the focus group, some questions arose that influenced and focused the research discourse: Why was the doctor-patient relationship so patriarchal? Which factors prevent a successful interaction? What effect does this practice have on maternal health? Why have there never been any complaints or reports during the participant observation at the regional hospital? Why do women continue to attend the regional hospital daily to give birth?

Methods

The field work is based on prolonged participant observation in the Sierra de Totonacapan (SdT). The research was carried out in medical institutions in three municipalities in the region: in the regional hospital of the SdT in Entabladero (Hospital de la Comunidad Entabladero) and in municipal health centers in Coyutla and Filomeno Mata. Medical institutions in the region offer the opportunity to observe and understand the core values of the local society (Long et al., 2008). For a total of nine months in 2011 and 2012, the principal investigator, a male medical student trained in qualitative research methodology, participated in both the regional hospital and the health centers. He was an active member of the medical team, as well as a passive observer, lived next door to the hospital and participated in daily life. The methodology and methods were chosen and applied in order to provide a comprehensive view of maternal health care. The investigation was carried out for four months at the regional hospital, as well as at the health centers in Coyutla and Filomeno Mata for another four months. During the investigation in Entabladero and Filomeno Mata, the principal investigator lived in the community. While working in Coyutla, he continued to live in neighboring Entabladero. The results of this publication are based on 62 semi-structured individual interviews. In addition, 24 structured interviews were conducted with the MP at the end of the field work, three focus groups each with pregnant women and in the three medical institutions with MP. Interviews and focus groups were conducted in Spanish or the Totonac indigenous language. The Totonac interviews were carried out with the help of an interpreter and later translated and analyzed in detail with her collaboration.

The authorization to carry out the field work was obtained through the Intercultural Veracruzana University (Universidad Veracruzana Intercultural) in Xalapa and by the Veracruz Health Department (District No. III Poza Rica). Informants' anonymity was respected without changing the content of the interviews. All informants were informed about the record of the data collected and they agreed to its use.

Introduction to the field

The SdT is an indigenous region of Veracruz (Valderrama, 2005). Historically, the vulnerable population is concentrated in this marginalized region (Ortiz Espejel, 1995), largely living in extreme poverty (CONEVAL, 2015). All municipalities in the region are officially classified as indigenous (CDI, 2006). Both Spanish and Totonac, an indigenous language, are spoken. In Filomeno Mata, for example, 97% of the population speaks an indigenous language and 32% speaks only their indigenous native language (INLAI, 2008). Ten years before the research, the regional hospital, a public institution, was built in order to improve MA in the region. During the research, the regional hospital offered MA to patients who were both entitled and not entitled to the *Seguro Popular de Salud.* Pediatric, internal medicine and gynecological consultations were offered on different days of the week. Apart from an area for hospitalization, the emergency room and the delivery room can be mentioned as the most important units. The hospital is the only medical institution in the region that is open around the clock. The health centers of the Coyutla and Filomeno Mata municipalities offer prevention

programs in the form of family planning, health training, vaccination campaigns and prenatal examinations, as well as general medical consultations and rooms for examinations and deliveries. From Filomeno Mata it takes up to two hours to get to the regional hospital. At night it is impossible to leave the place without your own vehicle. During the field work in Filomeno Mata, three consultations were offered until every day through the afternoon and Totonac interpreters, without medical training, were present in case communication problems were to arise. In Coyutla, medical consultation was offered from Monday to Friday for eight hours a day. Interpreters were not used. In addition, the Filomeno Mata health center is the only one that attends deliveries occasionally. Other health centers such as Coyutla refer pregnant women, at the time of delivery, to the regional hospital. The doctors mainly grew up and studied in the urban centers of Papantla and Poza Rica. Some only come to work at the SdT because they live in urban centers. A small part comes from the region and belongs to the mestizo population. The doctors do not speak Totonac. A minority of the nursing staff and other professional groups can communicate in Totonaco. Many of them have grown up in the region and are used to the local conditions.

The perception of the medical personnel

The MP encounter several structural problems. One of these problems is due to the marginalization of the rural region. The consequences for MA are mentioned by a doctor, who worked in the city for a long time.

> *"As you have seen, we have what is necessary but we lack medical personnel. Medical personnel who do not want to come to work in a place where the telephone does not work well and the road is in terrible condition. The hospital is beautiful, the building, because there are much uglier buildings, in Poza Rica it's ugly, but they don't want to move from Poza Rica. In Poza Rica there is a lot of work, there is a great need for specialists, so the big cities absorb them. "*

As the salary in public institutions is low and the economic situation of the region means that there are hardly any opportunities to obtain additional income – from a private consultation, for example - specialists, in particular, avoid the rural region. In addition, working in the SdT implies separation from family, a life outside the usual environment, with the deprivation of many resources and the demand to adapt to difficult circumstances. The resulting understaffing means that the present doctors have to provide services for which they have not been trained. This results in a reduction of quality and satisfaction among the MP. Marginalization not only implies a limitation of personnel, but also translates into a lack of materials and medicines. A doctor from Coyutla explains why the work in the SdT is a challenge for the MP.

> *"Another important thing: most of the time the basic chart used at the first level, which is a health center, is not always complete; that is, medications are needed. Pharmacies have improved a lot with the popular insurance program. Before they were state pharmacies. Now the drugs are almost 100% but there is always a lack of drugs. Before it was the most basic; antibiotics were penicillin and nothing else. "*

Lack of medicines and materials makes MA difficult. Often the MP must improvise and initiate less effective therapeutic measures. Despite the *Seguro Popular de Salud*, patients sometimes have to buy their medicines and supplies from private pharmacies. In the regional hospital, this is common in the case of delivery, although coverage of costs is suggested. This situation leads to conflicts between the patients and the MP. Another barrier, especially when working with indigenous patients, is the language barrier. Spanish-speaking doctors and Totonac-speaking patients sit opposite each other, without adequate communication being possible. Even in situations where an interpreter could support mutual aide in successful communication, it is frequently rejected by doctors. An interpreter of Filomeno Mata tells of his work.

> *"For example, a doctor comes in on Saturdays. He doesn't ask you to support him, but he doesn't understand the dialect. Who knows how he does it. He behaves very aggressively. Well, what*

are people going to say? They don't like the fact that he gives the consultation. For example, there are people who have a stomachache, diarrhea, headache, and because he does not understand them, the doctor gives them the wrong medicine and they do not get well."

Interpreters are often disposed of due to lack of time or interest. In some cases, Totonac-speaking patients bring their bilingual children to the consultation. In exceptional situations, bilingual nurses are consulted. Although the Totonac nurses and interpreters employed at Filomeno Mata come from the region and know the local circumstances, it should be mentioned that at the time of field work, there were no trained interpreters.

The perception of the MP influences their interpretation and behavior. These perceptions must be analyzed in their respective frameworks. In the case of prenatal care and in the context of diagnostic procedures, discrepancies frequently occur. While the MP would like to perform at least four exams, the population tries to limit them to a minimum, because they are forced to travel for a blood test or ultrasound. Furthermore, the socioeconomic status of the patients is relevant. Although child exploitation is rampant, usually men are in charge of economically supporting the family. Many families are supported by the *Oportunidades* cash transfer program. A large part of the population supports itself through occasional work, especially through harvesting or construction, making it nearly impossible to save. This means that a consultation with the doctor must be carefully weighed when taking into account direct expenses and lost wages. The following quote from a doctor from Filomeno Mata is intended to illustrate the problem.

"There is a lack of specialists in the hospital, because it is a reference. When people arrive and cannot find the specialist, what happens? Many return to their units and if they overcome the problem, fine. But if not? After we insist on sending them to the hospital for a simple laboratory test, they no longer want to go. Why? Because they remember that there are no specialists there and they are going to waste their time and money. For them it is a total loss because they work every day. That is our main need: the support of specialists in hospitals. "

The statement shows that this informant associates the performance of a blood test with poverty and absence of personnel. Although this reasoning seems realistic at first, it conceals the multifactorial influence of the population. Regarding prenatal diagnosis, resources are only one of the reasons for the discrepancy between MP and patients. During another interview with a doctor from the same health center, a completely different perception arises.

"They don't realize if they are pregnant, because most patients don't go down to the valley for an ultrasound. They are afraid to travel. Not a single analysis will be done. Most don't travel, they just don't want to. They don't do their analysis, ultrasound, nothing. Therefore they lose so much time and when the labor pains start, their baby is already dead. "

In fact, part of the population does not go down to the valley. Some of the informants had never left their communities. The aforementioned informant argues that this behavior makes work difficult and denounces his patients for endangering the lives of their children. The decisions and actions of the local population are often interpreted by the MP in the context of alleged habits, traditions, customs and culture. Trust in the traditional midwives of the local population is understood literally by the MP as an act based on "cultural roots".

"Custom! The custom is that they believe the midwife more than the doctor. If you have already gone to see the doctor and the doctor tells you that you have to go to the hospital. No! They are very closed in their customs and one of their customs is the midwife. "

The fact that many people in the SdT consult traditional midwives is strange to most of the MP. The understanding and resulting actions of the local population are considered inferior to institutional MA and are punished as dangerous

for maternal health. This perception is reinforced by the assumption that these are anachronistic habits in the form of "cultural roots." Although it is possible for pregnant women to give birth in the Filomeno Mata Health Center, they frequently seek their traditional midwife at the time of delivery. In most cases, the midwife has already cared for them during the pregnancy. Comparatively few women tend to give birth in the health center. Due to this observation, decisions at the time of delivery were further investigated. A doctor from Filomeno Mata explains the behavior of pregnant women with the following casuistry.

> *"They are very modest. I tell you, everything has to do with their ignorance. So in the deliveries that I have attended here, I just tell her 'Let's see, lady look, you're about to have your child, pull your dress up'. They don't want to do it. She's embarrassed and I say things like 'How are you going to have your child?' I say 'Spread your legs!' They do not want to. I have had several such cases. 3 or 4 years ago a lady was already upstairs. She was already in the expulsion room and I said to the nurse 'Talk to her!' and the other nurse arrives and says' Open your legs, if not your child will not come out like this, open your legs! She did not want to and she kept pulling down her dress, and she was very close to delivering. Then later the midwife says 'Doctor, she doesn't want to have it there, she says. She's prefers to get off, and give birth on the floor. ' I tell her 'What are you thinking, how could she do that, first of all I will not allow it and if she wants to have it on the floor, she won't have it here. If you want to have it on the floor, then go home. Here in the clinic we are going to do as should be done, in the expulsion room up here, in bed, here she will have it. ' The midwife said, 'Well, she doesn't want it, she won't have it, she won't have it up there, she says it's better to have it down there.' They put a lasso on them, they grab the lasso and have the baby down on the floor. I say 'But not that! We are doctors and nurses, and we are not going to do it as she wants or as her husband says.' This day she just didn't want to 'You know what? I'll write the reference for her, Go ahead, let's go!' They took her to Poza Rica. She wanted to have the baby down on the floor at all costs. There was a translator, there were two nurses who speak Totonac and they told her, and her husband was just quiet, he didn't say anything 'You know what? If you don't talk to her, let's go! You're going to the hospital, because the lady does not want to spread her legs, she does not want to collaborate, she does not want to push, she does not want anything, she just wants to get off, but not here, she will not have it like that.' As I tell you, ignorance is one of the main reasons for the main factors."*

The doctor highlights the ignorance and shame of the pregnant woman. In addition, he reports on vertical birth *("They put a laso on them, they grab the laso and have the baby down on the floor").* In his view, it is not compatible with institutional medicine. The casuistry shows that, above all, the patriarchal behavior of the doctor should be considered responsible. This assumption is intensified during interviews with the population. Some informants report similar situations. In the present case the negligence consists of the transfer to another hospital, which is costly and risky at the same time.

Family planning and MCM are central themes of MA within the region and for the reduction of maternal mortality (Cleland et al., 2006). The MP's perception of family planning varies widely. A doctor from the regional hospital perceives the problem as follows.

> *"They know that there are contraceptive methods. They know that these exist and that they can be obtained in the health center, but they do not go because they do not have time and because they have many children. They do not go to the health center because her husband gets angry. The men find out that they haven't been home. Machismo! They don't come because they don't know how to ask us for a method. Because we can't speak the indigenous language. It's a*

matter of trust. Many women come and say: 'I don't want to have more children, but don't tell my husband. What we are talking about right now no one should know because if my husband finds out ... 'There are many people who can and want it, but there are many barriers. Sometimes there is no doctor when they need it. Women sometimes visit you when you're not working. Because we don't know, we reject them and don't help them. But if we had known they wanted a method, I think we would all have been willing. "

The doctor explains that the reasons for this unmet need are multiple. In particular, one reason is the hierarchy between men and women, which is expressed in terms of stereotyped genders roles. The statement of a physician from the same institution contradicts the statement of the aforementioned physician.

"Lately we see that the hormonal method is rarely used. It is very little, now all the women who give birth return with the device. Not with pills nor injections anymore. The population is already accepting the device. And that is why we here in the hospital place the device on every postpartum woman. Other methods are no longer used. "

While one informant perceives family planning as a problematic issue in MA, another explains that the population "accepts" MA. Both perceptions must be considered in the context of the empirical material of the focus group described at the beginning of this manuscript. The perception of MP is determined by several factors. During research in medical institutions in the region, different experiences, more or less striking, lead to a perception that is condensed into a stigmatizing and stereotyped image.

Beyond the evidence, taken from participant observation and the contextualization of interviews, the field work also identified less obvious factors that required a basis of trust between informant and researcher. The following doctor's appointment provides an in-depth insight into MA.

"When we started the maternal mortality prevention program, our bosses told us that if a pregnant woman dies, we will go to jail. You lose your job and your work permit, so our priority is to take care of the pregnant woman and prevent her from dying. That is why I have the impression that we as doctors are always afraid that a pregnant woman will die. "

This quote shows that the structural factors that influence MA and MP perception are directly linked to fundamental fears. The influence of higher structures leads to an essential fear.

Determinants of health beyond medical control

The MP rationalizes poor maternal health and MM by referring to factors beyond their control (Allsop and Mulcahy, 1998). In particular, doctors blame the lack of human resources for inadequate care. They also argue in terms of availability, the need for sufficient quantity and quality of health goods. Previous literature points to similar evidence, since the quality of MA is the most important factor in the reduction of MM (Maine, 2007). While the nursing team perceives the quality of MA and high MM to be related to poor training of physicians, physicians do not address this issue at all. However, there is a significant relationship between skilled birth attendance and MM (Holmes, 2012). Furthermore, the perception of the MP is influenced by the media. Anthropologists Menéndez and Di Pardo analyzed the perspective on health through the Mexican media. The authors consider that issues related to maternal health are presented as catastrophic (Menéndez and Di Pardo, 2009). One of the results is the construction of a fearful perspective of pregnancy and childbirth that makes it a potential risk (Smith-Oka, 2012). On the one hand, the MP assesses the conditions within the institutions, but on the other hand they blame the poverty, behavior and culture of the patients. Poverty is related to a shortage of prenatal care, lack of financial resources to pay for transportation or health goods, poor living conditions, lack of health-related education, etc. Also, the MP blame the culture of the patients. The ability to speak an indigenous language or the willingness to go to a traditional midwife, based on the existing power structure, is considered to

blame for the high rate of MM among the indigenous population, rather than interpreting it as a representation of structural violence. This perception is already established during medical school when future doctors normalize a clinical view based on hierarchical power structures in society (Foucault, 1994). Such relations should be especially considered when working with vulnerable indigenous patients (Jenks, 2011).

This can lead to stereotypes and an essentialist understanding of culture. In addition, the MP's own cultural identity plays a central role, conditioning models of thought and action, perceptions and moral values. However, it must also be taken into account in both cases that they are very heterogeneous groups, so that generalizing statements is practically impossible. However, MP (although they are often considered the most objective, scientific and thus neutral professions) can be biased and impartial due to societal, cultural and economic structures. Even scientific, medical professions remain unimmune to prejudice.

Possibilities and limits of Intercultural Medicine

Culture and the encounter of different cultures are often important in the medical context (Kleinman & Benson, 2006). At the same time, IM must be seen as a human rights issue, since it links the right of indigenous peoples and ethnic minorities to preserve and develop traditional medicine and the right to health. Therefore, the concept serves as an instrument for the respect of human rights (Anderson, 2011). If culture is considered a human right, justice will only be done if the understanding of the concept of culture is adapted to its real existence. If culture is considered relevant in the medical context, the human right to health can only be realized if the necessary attention is also paid to the cultural dimension. Therefore, two aspects must be taken into account. On the one hand, what concept of culture is used? On the other hand, what aspects of culture are considered?

It is often shown that the MP has an essentialist conception of the culture of others. The synonymous use of culture, language, ethnicity and nationality, frequently used in the medical context, leads to "dangerous stereotypes" (Kleinman and Benson, 2006: 1673). It can be said that the synonymous and thoughtless use of the terms leads to an essentialization of ethnic and cultural belonging. Most of the programs and projects in the context of IM focus on the visible expression of traditions (Castañeda, 2010). For this reason, a large part of them deals with the practical knowledge of traditional healers and their medicine (Menéndez, 2006). This perspective goes beyond the material dimension, which is often ignored or avoided. However, knowledge of cultural facts produces ethnocentrism and encourages discrimination (Jenks, 2011). This is precisely where IM's ambivalence and challenge lie. The first objective of IM should be, in this sense, to establish a realistic concept of culture. Cultural symbols described as foreign can be useful to convey the concept of culture. A differentiated perception of traditional midwives can be an argument both for a repertoire of models of thought and action, perceptions and moral values that cannot be objectified, and for the continuous transformation of the alien. Research in the SdT has shown that the MP tend to culturalize the problems of the region. Furthermore, determinants of health that are beyond medical control are often referred to as causal. Many of the problems the MP faces have been shown to be political, socio-economic or structural in nature. It is particularly notable that precisely those people who are affected by social determinants of health are considered responsible for inappropriate MA. Consequently, this interpretation represents the reproduction and continuity of colonial structures (Mignone et al., 2007), since *"the act of colonization itself was legitimized through postulates of difference"* (version in the original language: Akt der Kolonisierung selbst wurde durch Differenzpostulate zu legitimieren gesucht) (Kerner, 2012: 29). Dichotomies such as traditional and modern, black and white, progressive and primitive, used to separate what is culturally proper from what is alien, express hierarchies and sustain (post-) colonial structures. In MA, the understanding of individuals as *"determined incarnations of their culture"* should be avoided (version in the original language: determinierte Verkörperungen ihrer Kultur) (Randeria, 1999: 426). The effort of health

programs and projects with an intercultural approach that integrate traditional medicine into institutional medicine is also questionable. The obligation to protect a culture based on human rights is often used as an argument for integration. However, the broad dimensions of local culture cannot always be understood by foreigners as they are inevitably interpreted within the framework of their own cultures. In general, the institutionalization of the traditional medicine systems that have survived to date should be discussed in the context of IM, since they have been maintained and developed independently without the active participation of institutional medicine and the support of health programs (Knipper, 2007). Therefore, a useful definition of IM must be based on a realistic concept of culture. The subject area of IM is concerned with any interaction in the medical field between actors from different cultural contexts. In order to do justice to this situation in terms of human rights, two fundamental conditions must be created: On the one hand, in medicine, a concept of culture based on the social sciences must be established. On the other hand, the relevant aspects (social, political, historical and structural) must be differentiated from the cultural aspects in order to make culture usable as an analytical concept in medicine. IM's task is to create these conditions.

IM does not only play a role in the care of ethnic minorities or patients with immigrant backgrounds. In all cases, there must be a sensitivity to culture within medical contexts. Furthermore, this means that the issue of IM should not focus solely on the doctor-patient relationship. Culture should also be considered in health decisions, programs and projects, in epidemiological surveys (Ramírez Hita, 2009) or in the analysis of MA for pregnant women in an indigenous region such as the SdT. The term "Analytical concept" implies the recognition and differentiation of relevant aspects, but also recognizing when cultural aspects are not relevant to the interaction. In this way, the MP has the opportunity to obtain a more differentiated perspective on the behavior of patients, thus being able to adapt MA to the real living conditions of the population (Holmes, 2012). In this way, the essential aspects of MA can be reinforced: acceptance and respect, horizontal relationships between the different actors, inclusion and integration of disadvantaged population groups, and solidarity among and with them (Torri, 2010). Stereotypes, stigma, discrimination and racism can be overcome. This in turn contributes to the recognition and respect of human rights, pivotal in the access to medical care. In addition, the ability to differentiate between the various relevant aspects allows for a comprehensive view of real causes, including those of MM. Empirical material has shown that the established use of an essentialist concept of culture favors dichotomies instituted by violence. Overcoming this violence must be the political moment of IM.

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