ORIGINAL RESEARCH

# Racism and discrimination in the context of Totonaca women's health care in Veracruz, Mexico: the need for intercultural competencies

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## Introduction

Racism is a neglected health concern.1-4 Research in multiethnic countries has emphasized racism as a persistent cause of health inequalities.5-8 In the USA, for example, African Americans have a higher mortality rate than the white population.9 Anthropologist Eduardo Menéndez suggests that racism has been omitted in Mexico's public health discourse.10,11 In 2003, the Pan American Health Organization (PAHO) confirmed that, in the region, the causes of racism lead to public health inequalities and thus ethnicity has a significant impact on health.12 Roldán et al. identified a lack of attention and care towards indigenous peoples, who are marginalized and have poor access to health care in the country.13 Despite this finding, further research on the subject is rare.14

The present research was conducted in the state of Veracruz, in the indigenous region of the Sierra del Totonacapan (Image 1), with focus on maternal health in the context of the Mexican health policies.15


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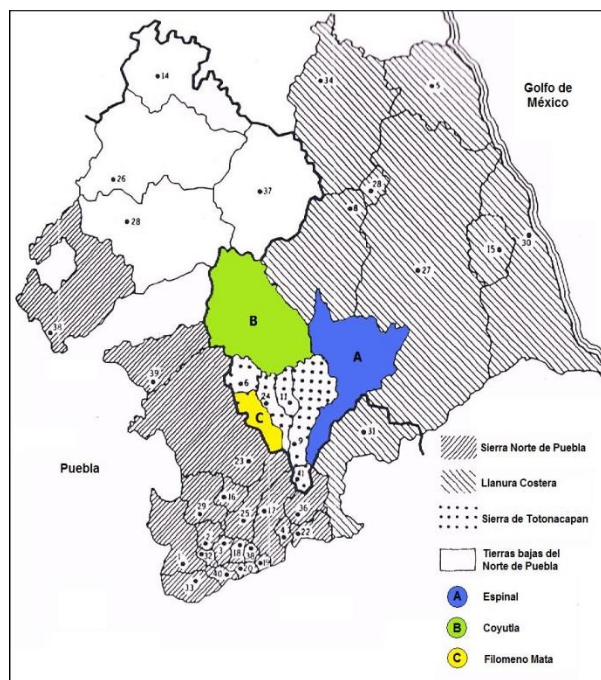
**Received:** December 28, 2020.
**Accepted:** November 3, 2021.
**Conflict of interest:** none.


The purpose is to analyze empirical materials through the analytical lens of discrimination and racism.

**Location map**




*1 Velázquez Hernández, Emilia (1995): When the muleteers lost their roads. The regional conformation of Totonacapan. Zamora: El Colegio de Michoacán. (Modified by Niels Dörr)*

The concept of discrimination encompasses unfavorable, unequal or disadvantageous treatment and undeserved contempt towards a certain person or group based on racial, cultural, ethnic, political or religious differences; sexual orientation, gender or sex;

place of origin, physical differences, age, mental condition, etc. It can happen intentionally or unintentionally. Therefore, discrimination occurseven if it is committed unintentionally or goes unnoticed. According to Camera Phyllis Jones an American physician, epidemiologist, and anti-racism activist, discrimination can be divers and take place at different levels.

The theoretical framework of this research is based on the concept of discrimination. Adopting a human rights approach and using Jones' concept of ”levels of racism",16 the author defines and situates racism at three levels: institutional racism, interpersonal racism and internalized racism (Table 1).

**Figure 2**
**Levels of Racism**

| | |
|---|---|
| **Institutional racism** | Discriminatory access, on the basis of racial difference, to facilities, goods, services and opportunities in multiethnic societies.<br>Characterized by both omission and commission.<br>It manifests in material conditions as well as in power relations. |
| **Interpersonal racism** | Prejudice and discrimination based on racial difference.<br>Interpersonal racism may be intentional or unintentional.<br>It can manifest as disrespect, distrust, devaluation, blame and dehumanization. |
| **Internalized racism** | Acceptance of racist practices carried out by individuals affected by racism.<br>Includes self-devaluation, self-rejection, resignation, helplessness and hopelessness. |

**Source:** authors
1
Jones CP. *Levels of racism: a theoretical framework and a gardener's tale. Am J Public Health*. 2000;90(8):1212–5. Available at:http://www.ncbi.nlm.nih.gov/pubmed/10936998.

The right to health comprises legally binding components, one of the most important of which is General Comment no. 14 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).17 The right to health encompasses essential elements assessed by four crucial indicators: availability, accessibility, acceptability and quality (AAAQ) (Table 2). This approach affords us the tools to address racism as a relevant health problem in Mexico and analyze its impact on health.

**Figure 3**
**AAAQ Theoretical Framework**

| | |
|---|---|
| **Availability** | Health services must be available in sufficient quantity and provided on a continuous basis. |
| **Accessibility** | Health services must be accessible to all, in terms of physical access, affordability, access to information and non-discrimination. |
| **Acceptability** | Health services must be acceptable to consumers, culturally relevant and sensitive to vulnerable groups. |
| **Quality** | Health services must comply with applicable quality standards. |

**Source:** authors
2
CESCR: General comment No. 14. The right to the highest attainable standard of health. Art. 12. Committee on Economic, Social and Cultural Rights. Geneva; 2000. Available at: https://www.refworld.org/pdfid/4538838d0.pdf

## Materials and methods

The Sierra del Totonacapan is a marginalized indigenous region of Veracruz, Mexico.18 Field research was conducted at the regional hospital in Entabladero, located in the municipality of Espinal, and at health centers in the municipalities of Coyutla and Filomeno Mata.

Methodologically, this study is based on participant observation carried out during nine months between 2011 and 2012. The main researcher (Dörr), was trainee at the regional hospital and health centers. Based on direct observation and interviews, a questionnaire (supplementary material) was developed in order to perform more detailed interviews. The research was conducted for four months each at the regional hospital and two municipal health centers.

**Figure 3**
**Individual Interviews**

| | Locality | | | Sex | | Age | Language | | |
|---|---|---|---|---|---|---|---|---|---|
| | C | FM | E | m | f | Years | s | t | s/t |
| **Physicians** | 3 | 9 | 5 | 11 | 6 | 32-51 | 17 | 0 | 0 |
| **Nurses** | 3 | 1 | 5 | 2 | 7 | 25-41 | 6 | 0 | 3 |
| **Others**[1] | 1 | 4 | 1 | 3 | 3 | 31-50 | 2 | 0 | 4 |
| **Traditional midwives** | 2 | 7 | 1 | 0 | 10 | 52-71 | 0 | 3 | 7 |
| **Patients** | 7 | 8 | 3 | 0 | 18 | 17-43 | 3 | 5 | 10 |
| **Total** | 16 | 29 | 15 | 16 | 44 | 17-71 | 28 | 8 | 24 |

**Source**: authors
3[1] translators, workers and social workers, pharmacists, laboratory assistants. Abbreviations: C = Coyutla; FM = Filomeno Mata; E = Espinal; m = masculine; f = femenine; s = spanish; t = totonaco; s/t = bilingual

Sixty individual in-depth interviews were conducted with health professionals, traditional birth attendants, patients and their families, each lasting approximately 10 to 60 minutes (Table 3). The interviews with health personnel took place at the corresponding health care institution. The rest of the interviews were carried out with participants who were contacted spontaneously, using a "snowball" sampling procedure.19

The patient interviews were conducted with pregnant Totonac women and their families. Traditional midwives are familiar with local living conditions and share them with their patients, as they grew up in the region and their first language is also Totonac. In contrast, the doctors in the health care institutions mostly grew up in the urban centers of the coastal regions of Papantla and Poza Rica, where the referral hospitals are located. Some doctors did not reside in the rural area, only traveling there for work, did not speak the indigenous language, and were general practitioners, lacking in intercultural training. Nurses and other professionals, such as interpreters, pharmacists and laboratory personnel within the facilities, could communicate partially in Totonac. Many of these individuals grew up in the region and were also familiar with local conditions.

In addition, focus groups of 15 - 18 pregnant women were conducted, with a focus on discussing the advantages and disadvantages of institutional delivery. The duration of each focus group was about 60 minutes; three other focus groups were conducted with health professionals, including presentations and discussions of the research findings. The interviews and focus groups were conducted in Spanish; in Filomeno Mata they were conducted in Totonac, with the help of a local interpreter (relying on her role as interpreter and gatekeeper to the indigenous population, we ensured trust between the researcher and the participants; we also discussed the interview processand content with her, for a more careful and contextualized analysis of the data obtained).

The data collected was continuously contrasted and expanded according to theoretical sampling.20 The methodological oscillation between data construction and analysis allowed for a gradual concentration on relevant categories (e.g., culture, family planning, maternal health, traditional birth attendants and maternal mortality). The validation of the information was

based on methodological triangulation: *etic* data from observations was contrasted with *emic* data collected in the interviews, which reflected the perspectives of the actors; both types were contrasted with each other; through the groups, the data was compared with the *emic* data collected in the interviews, thus reflecting the perspectives of the actors. In the focus groups21, tensions, contradictions and inconsistencies were also discussed. In this way, the categories and their meanings were deepened and saturated,22 using the ATLAS.ti software program for qualitative analysis.

## Results

### Institutional Racism

It has been documented that indigenous groups in Mexico are marginalized and have poor access to social security,13. The results obtained confirm this statement. A nurse was asked why so many pregnant women preferred to see a midwife rather than give birth in the hospital:

> *Look, because if there were a surgeon, a gynecologist, an anesthesiologist, but we don't have them here, the deliveries get complicated [...] there aren´t many things, we don't even have solutions, and people come and tell us 'They treated me badly, they treated me badly, this and that'... That's how the complaints are, but we as nurses, what can we do, if we don't have? Sometimes there is no doctor, what am I going to do? [...] Many times it is the lack of personnel, more than anything else, and of material.*

The staff blames the lack of human resources, such as specialized personnel, for the poor results obtained, and highlights problems of availability, expressing the lack of sufficient resources and the necessary quality in the health services they provide. An informant from Filomeno Mata explained why people refuse to go to the hospital:

> *They charge you! Although they say it is free, it is not true. They charge you a lot and then, as I tell you, because of lack of money, sometimes you are hungry, but you cannot go to eat, because they charge you a lot in the store, because, sometimes, as I tell you, here they pay very little and even though you are praying, you spend everything there.*

Many indigenous people cannot travel from their municipalities, because of the high direct and indirect costs, which is crucial when it comes to managing maternal health. This is a typical example of discrimination based on economic inequality.

In a focus group discussion with pregnant women in the region, about the advantages and disadvantages of the regional hospital, one participant stated that the implementation of contraception is a barrier:

> *Now they no longer ask when they do surgery, not there, in Poza Rica. There they don't ask you if they are going to perform surgery on you, they just operate you. That's what some people who go to the hospital tell. That's why I don't want to go, I'm scared. I've been told many times here at the clinic that I should go for surgery, but I haven't gone.*

Female sterilization has a great impact on family planning. Even young indigenous women face continuous pressure to be sterilized, depending on their age and the number of children they have, and sometimes they are forced to do so. This violation of their bodies and reproductive rights appears to be based on the belief that indigenous women do not have the right to decide about their own bodies, especially if they depend on economic support programs.23 They are infantilized by a health system that equates modernity with the mestizo upper-middle class and requires indigenous women to modify their reproductive practices in order to modernize. As a result, the local population shuns health care institutions because they are scared of the imposed family planning practices or technologies.

The following quote from a doctor corresponds to a conversation with a patient about to give birth:

*Well, my daughter, I heard that you don't want a interuterin device, here the hospital rule is to put it in. If you do not want it, then, after a month, two months or a year, you have the right to withdraw it at your health center, but here you are going to leave with the device, that is the rule. I am not saying it for my sake, the hospital's rule is to put it, I am telling you this so that you do not feel bad.*

Indigenous women in particular are affected by these practices, as staff assume that they reject contraceptives because of their customs or sexist husbands, because they are unfamiliar with the methods, or because they would prefer conventional methods. However, according to Ali et al, it is unlikely that any biological or cultural factor can account for this variant. Rather, it is a reflection of political choices about which methods to promote and biases in family planning services. 24

**Interpersonal Racism**

Through interpersonal racism, social hierarchies based on prejudice and discrimination become manifest.

The language barrier between Spanish-speaking professionals and Totonac-speaking patients is problematic, and because of the staff's equating of ethnicity, culture and language,25 the discrimination triggered by the indigenous language can be considered a racist practice. An interpreter from Filomeno Mata explained how a doctor treats his patients; this example demonstrates that patients are discriminated for speaking Totonac, even if resources for solving communicational problems are available:

*A doctor comes 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, the people, what are they going to say? They don't like if he treats them. For example, there are people who have stomachache, diarrhea, headache, and because he doesn't understand them, the doctor is giving them medicine based on what he understood, and the people do not get better.*

The language barrier means that children -schooled and therefore bilingual- become mediators between their fathers, mothers and staff; they must also accompany their younger relatives if there are seeking health care.

An informant from Filomeno Mata explained that the bilingual population also continues to suffer discrimination:

*Really, the majority do not speak Spanish and that is the problem. That is why there are also many people who do not want to go to the hospital. They think they are going to be mistreated because of the language [...]. I don't speak very well, but I do know how to express myself, I do know how to help myself when I go with my little sister, I know how to answer, but, at the same time, it scares me because one time I had to deal with bad experience in Poza Rica. They deceived me. They really deceived me very badly.*

The population is stigmatized based on its traditions, customs and culture. It is the indigenous culture, more than poverty, which is declared to be harmful to health, as the following quote illustrates:

*La costumbre! The custom is that they believe the midwife more than the doctor, if you have already gone to see the doctor and he 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.*

According to the staff, the indigenous culture, which includes the use of traditional midwives, has caused illness and disease for future generations, through the mediation of an anachronistic vision. The culture is held responsible for complex disease processes and rejection of family planning, thus stigmatizing traditional midwives and linking them to high risks. In addition, the staff associated indigenous culture with higher health costs and social

expenditure. These perceptions reflect interpersonal racism directed against indigenous women exercised by the mestizo upper-middle class who represent the Mexican nation-state.26

Interpersonal racism is also reflected in the use of contraceptive methods and their implementation. The issue illustrates the hierarchy that persists between health professionals and their patients. During a focus group, one woman described her experience:

> *In fact, they make us sign the consent that we want to have the [intrauterine] device. I say, there it is already negligence, they force you, and really, as the owners of our bodies, if we don't want it, no one can force us to do anything we don't want. That is precisely why many people do not want to go to the hospitals or to the doctor, because it is really the doctor who decides, not you.*

If during the doctor-patient interaction, both ethnic difference (between doctor and patient) and female sex are coincident, the efforts of the doctor to limit pregnancies through modern contraceptives are even greater. Even so, family planning preferences are subject of health policies effected by structural and institutionalized racism, which neglected vasectomy as an effective method, thus strengthening and preserving institutional sexism at the same time.

**Internalized Racism**

Internalized racism is expressed when the people recognize their ethnicity as detrimental, inferior or despicable. Western knowledge systems have replaced traditional knowledge and indigenous people have been forced to assimilate, as in the case of traditional midwives.27,28 The following quote demonstrates how a midwife internalizes and transmits inferiority:

> *All the doctors who are working at the Health Center know me. Everything they tell me in the courses, I am complying with. Everything I hear in the courses, I tell the ladies. Those who like the way I work, I tell them all that.*

When interviewing the midwives, they assured that they comply with health care demands and only implement what they have learned during the courses. The indigenous midwives and their female patients perceive their culture as inferior. At the same time, the required changes of their empirical practice by the semi-skilled personnel at local health facilities,29 have increased hospital transfers to supposedly more suitable facilities, such as the regional or referral hospital. This abuse of power by the public health system concentrates maternal health within health facilities to manage pregnancies and deliveries. In addition to forced transfers, mandatory, obsolete and harmful episiotomies are performed during institutional deliveries.30 This is an example of the biomedicalization and violation of female bodies.

A Totonaco-speaking informant describes that she does not like going to the local health center because of the communication with health professionals:

> *I can't talk to a nurse, because I can't speak Spanish. May God forgive me, because I didn't go to school, I just stand, they don't understand me, and I don't understand them, so we are the same in that we don't know. It is very difficult for me.*

Due to her native language, the Totonaco-speaking informant has differential access to health care and promotion. In general, the language barrier is co-responsible for the progressive loss of native languages. The native Totonac speakers' rejection of their own language is the result of of successful cultural and educational indigenist policies.31,32 For more than half a century, substitutive and transitory bilingual educational strategies were employed to first promote literacy and primary education in indigenous populations, while later, in secondary education, replacing Totonac language through a monolingual Spanish policy.

Consequently, many elders are ashamed to speak their native language, while their children or grandchildren adopt Spanish as the language of modernity. However, these new generations have different experiences at school and in health

institutions: even when they are integrated into Mexican culture and the Spanish language, they continue to suffer discrimination for being indigenous and are perceived as poor. Many young, literate Totonac youth internalize this mixture of intersectional racism and aporophobia,33 something that is imposed on them by the non-indigenous society and its institutions which they, in turn, end up reproducing by identifying with the dominant discourse.34

**Discussion**

Our analysis identifies omissions and human rights violations. As expressed by health professionals, there are relevant omissions regarding the scarce availability of health care and the respective human resources. Likewise, violations of the right to health were shown in relation to accessibility, along different dimensions: discrimination based on economic status, race, gender, ethnicity, language and, consequently, in terms of access to information. However, non-discriminatory access to health care is one of the most fundamental rights35. Menéndez focuses on the invisibilization of racism exercised in health care institutions11. These factors reveal forms of institutional violence and abuse of power, racist practices which are often justified by the nation-state's modernization process.26,36

In delving into the language barrier, the staff often believe they are doing their patients a "favor" by calling an interpreter, when, in fact, calling an interpreter is part of the indigenous patient's linguistic rights: to use his or her native language. Finally, our research acknowledges the lack of quality prenatal care.37 In applying a human rights approach, we emphasize racism as a relevant practice that constitutes a violation of the right to health.

We found that different levels of racism often overlap and reinforce each other. The experience of Totonaca patients with non-indigenous public health professionals in their region illustrates that they interact with their indigenous patients within an underlying, and implicit, but influential framework of persistent colonialism. Our analysis is consistent with findings in other indigenous regions of Mexico and the Americas,38,39 which emphasize the continuity and persistence of asymmetrical power relations. In these asymmetrical institutionalized contexts, health professionals tend to reproduce ingrained prejudices and stereotypes dating back to the colony, while their indigenous patients withdraw and/or surrender through avoidance strategies or minimal contact.

To dismantle these types of vicious cycles of institutional discrimination, personal stigmatization, and victimized internalization among non-Indigenous public health professionals and their Indigenous patients, the entire institutional health care system must recognize institutional racism. Our analysis shows, moreover, that racism at the three levels mentioned above is not an isolated phenomenon, but rather interacts closely and merges with other historically entrenched sources of discrimination.40,41

Our data, especially, reveal the persistence of sexism and misogyny against female patients, who are perceived as ignorant, passive and irresponsible towards their own health and that of their children and family members. However, this misogyny manifests itself as institutionalized sexism-racism. Our results focused on reproductive health, in the face of a sexist and racist health policy. In addition, conditional transfer assistance programs, such as the *Oportunidade*s program, from which most of the local indigenous population benefits, trigger or reinforce gender-specific role attributions, thus reinforcing sexism. Sociologist Molyneux mentioned the re-traditionalization of gender roles and identities by these types of assistance programs.42 In this context, it is also relevant to highlight the influence of *Oportunidades* on reproductive health; women who have this financial support are pressured to use certain "modern" or Western contraceptive methods.23 As a consequence, it has been shown that doctors treating women in rural areas who receive *Oportunidades* are more likely to perform cesarean deliveries.43,44

Consequently, the various sources of identity, e.g., race and/or ethnicity, gender, age, and class, must be perceived, at once, as distinct but also interrelated and often mutually reinforcing sources of discrimination. Only an anti-essentialist definition of these identities will contribute to generating diversity-sensitive training programs

for health professionals. This requires an intersectional approach to the analysis of racism in close relation to sexism, classism and other ideologies of asymmetry and group supremacy.45,46

In the case of the interaction of Totonaca communities with the Mexican public health system, an intersectional analysis reveals the confluence of racist and sexist treatments of indigenous female patients by health professionals, which are often linked to other phenomena, such as obstetric violence.47,48

Our case study reveals a worrying need for initial and continuing education and training measures for health professionals working in postcolonial settings of marked racial, ethnic, cultural, linguistic and gender diversity. Intersectional and anti-racist training in intercultural competencies is needed to prepare health professionals to generate interactive models and practices that are non-discriminatory and sensitive to the diversity of their indigenous patients, their families and their communities.49

Intercultural competency is defined, mainly, as the ability to communicate, perform and interact as a professional in diverse and heterogeneous environments with people and groups from different cultural or subcultural, social, ethnic, national, religious, age and/or gender roles and with different intellectual and functional abilities or capacities. These capacities are manifested in the daily work of health professional through their ability to overcome the ethnocentrism in order to perform "code-switching". In so doing, they transform their perception of patients, by identifying their own position and asymmetrical relationship, as well as by generating cultural and linguistic "translations" between different normative and cultural systems, including different systems and logics related to health, illness, healing and wellness.45

In conclusion, in the Sierra del Totonacapan, the health of indigenous peoples is affected by all the levels of racism described. We discuss the persistence of colonialism, which reflects the continuity of asymmetrical power relations in health care due to health disparities based on race, gender, culture, and ethnicity. In the context of intercultural medicine, the relevance of intercultural competencies and empowerment for the management of interpersonal and internalized racism is understood.50 In the realm of maternal health, for example, the impact of midwives and their link to social and structural determinants have been well researched.37,51

With respect to the applied framework of racism, in order to manage the three levels of racism in an intersectional manner, anti-racist training in intercultural competencies is required to prepare health professionals to develop non-discriminatory and diversity-sensitive patterns of interaction with their indigenous patients. This training does not replace existing models of public health care. Training aims to cross-culturalize health professionals in order to increase sensitivity to racism and sexism. Both are obstacles of culturally appropriate health services in contexts of cultural diversity and asymmetries of colonial origin. To dismantle the legacy of colonialism and resolve contemporary omissions and violations of persistent health disparities due to racism, Mexico requires public investment in functional health assets, skilled birth attendants, and intercultural competencies to address the availability, accessibility, acceptability, and quality of health care provided to its indigenous peoples.

**Acknowledgments**

To Dr. Francisco J. Pancardo Escudero, for his support during the field research and to the Totonac interpreter Ana García Pérez of Filomeno Mata, because without her support the dialogue with the Totonac-speaking population would not have been possible. We are also grateful for the support received by the Universidad Veracruzana Intercultural (http://www.uv.mx/uvi/), by the local research project InterSaberes (http://www.intersaberes.org/) as well as by the Institute for the History of Medicine of the Justus Liebig University in Giessen, Germany, where we especially appreciate the support of Dr. Michael Knipper. Thanks also to Paul Eisenberg, Margarita Alcántara Alemán and Mariel Guzmán Sánchez for their help.

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# Appendix.

# Questionnaire

**Questions for traditional midwives**

What can be done to improve health care in the region?
How long have you been working as a midwife?
How did you start working as a midwife?
How did you gain this knowledge?
What is a traditional midwife?
How much money do you charge?
How many patients do you have at the moment?
What kind of patients come to you?
What should a patient be aware of before, during or after delivery?
Do you work together with the local health center?
What are the differences between doctors and midwives?
Do patients like going to the regional hospital/local health center?
What kind of fears do your patients have?
Why do pregnant women not want to go to the regional hospital?
How do you evaluate the work of the doctors?
Why do you refer your patients to the regional hospital / local health center?
Since when have physicians participated in midwife training?
What has changed as a result of midwife training?
How do you rate midwife training?
How do your patients evaluate midwife training?
How do you envision childbirth with a midwife?
Do your patients attend prenatal care?
Why are women told to have fewer children?
Have women died during pregnancy or childbirth in the municipality?
What are the causes of maternal mortality?
How can the death of a pregnant woman be prevented?
What role does the husband play in pregnancy and childbirth?
What is your opinion about family planning?

**Questions for health professionals**

What are the relevant issues in the regional hospital?
What can be done to improve health care in the region?
What is the impact of the regional hospital?
What is the role of patient culture?
What are the main barriers between the regional hospital / local health center and the local population?
Do communicational problems affect health care?
Are there differences in care between indigenous and non-indigenous patients?
How do you perceive the work of traditional midwives?
How do you evaluate traditional medicine?
What makes a good midwife?
How do you perceive collaboration with traditional midwives?
Why do many women prefer a traditional midwife?

What has changed since the Seguro Popular de Salud[1] was implemented?
How do you evaluate the Oportunidades program[2]?
Why are many women concerned about going to the regional hospital?
How high is the maternal mortality rate in the region?
Why do patients die during pregnancy or childbirth?
How can the mortality rate be reduced?
Since when has maternal mortality been a priority?
Is there a link between maternal mortality and traditional birth attendants?
How do you get midwives into training?
What problems do you associate with family planning?
What is the role of the male population in family planning?
Why do patients fear family planning surgeries?
How do you approach Bilateral Tubal Occlusion (BTO) with patients?
Why do all women have an IUD (Intrauterine Device) inserted after giving birth?

**Questions for patients**

What can be done to improve health care in the region?
How do you perceive the health care at the regional hospital/local health center?
Have you ever given birth at the regional hospital/local health center?
What is your experience with the regional hospital/local health center?
Do you receive prenatal care?
What are the reasons for delivering with midwives or at the local health center?
Do you feel compelled to go to the regional hospital/local health center because of the Oportunidades program?
What are the barriers for going to a midwife or to the local health center?
Does giving birth make you nervous?
Based on what criteria do you choose your midwife?
Are midwives part of a tradition?
What are the differences between midwives and doctors?
What considerations should a woman take before, during and after pregnancy?
What are the causes of infant deaths?
What are the causes of maternal mortality?
Do you know of or have you been told about childlessness surgeries?
What have you been told about OTB?
What is your opinion about this surgery?
What is your husband's opinion about this surgery?

[1] Seguro Popular de Salud is a financial instrument launched by the Ministry of Health in 2003 and is under the direction of the National Commission for Social Protection in Health; Seguro Popular de Salud provides public health care to the population that does not have social security.
[2] Oportunidades is a Mexican conditional cash transfer program launched in 1997.