Luna Maya: Celebrating Motherhood through a Femifocal Model of Care

Abstract Research and practice experience shows that indigenous and non-indigenous women throughout Mexico continue to seek the services of midwives and out-of-hospital care, regardless of the improvements in access to public services. This observation alone raises important questions about the divide between the type of public services available to indigenous and low-income women, and their needs and desires around the lifecycle process of motherhood. It also expands the discussion around motherhood from an act of safely and quickly extracting a fetus from a mother, to a community event that involves the safety of networks and support rather than technology.

Introduction
Although Mexico is now considered a high middle income country, there remain disparities in health, wealth and social issues across the 32 federal entities. Situated in the south east on the border of Guatemala, Chiapas is one such region that presents challenges to Mexico’s image as a global economic power. On the one hand Chiapas is extraordinarily rich in natural resources and is the most geographically and culturally diverse state in Mexico. On the other, is amongst the top five most marginalized states, with the highest recorded unemployment levels and lowest educational attainment by gender (completing secondary school) of all thirty-two federal states (OECD 2015). Access to health services is particularly poor and is associated with wider political economic and social issues. Chiapas has the second highest maternal mortality ratio (68.1 per every 100,000 live births) and the highest infant mortality (17.9 per every 1000 children under 5yrs) in the country as a whole (INEGI 2013).

Around twenty-seven percent of the total population of Chiapas identify as indigenous Mexicans (INEGI 2010).

By highlighting the various ways in which indigenous women in the colonial city of San Cristóbal de Las Casas manage maternal health and birth care, in this chapter we intend to provide a counter-narrative to the dominant approach which conflates medicalized maternal health with low mortality ratios; regardless of the quality of interventions and the cultural preferences of diverse populations. Whilst the majority of the female urban indigenous population will access public services when they need to give birth, others seek out alternative models of care more closely related to traditional model of care. This occurs on a timeline, as indigenous women may migrate to the city and never find safety and relevance in medical maternal health models, or they may have always lived in a neighborhood where all women birth at home with traditional midwives. In other cases, some women have crossed the cultural boundary to the medicalized model and now desire a return to homebirth due to personal preferences related to family, respect and privacy. In such cases, they may no longer
find a traditional midwife and are confronted to choose a “postmodern midwife”, crossing a second boundary to being cared for by a mestizo or foreign midwife (Davis Floyd, 2001, 2005).

Established on August 25, 2004, Luna Maya Birth Center has provided over a decade of service provision to women and their families in San Cristóbal de Las Casas in Chiapas, Mexico and recently in Mexico City. In addition to expanding beyond traditional midwifery services, Luna Maya broadened the very meaning of midwifery: “We see birth as the beginning of a whole bunch of processes about becoming aware of your body, of your system, of your relationship to your health” (Alonso 2014). From its inception, Alonso understood that the state of maternal services in Chiapas necessitated a woman-focused, humanized intervention to employ the broadest meaning of women’s health. Since the medical model of pregnancy and birth took hold in Mexico, women have been offered an increasingly narrow set of maternal health services, which are highly medicalized and often obstetrically violent. Responding to this environment of limited care options, Luna Maya has not only stressed the importance of holistic care, which addresses the psychosocial needs of its clients, but has also provided alternative healing as an alternative to the allopathic framework of popular medical models of maternal care. Moreover, Luna Maya has created a model that understands that the individual is linked to and informed by her environment, which includes her family and community.

**Reproductive Rights, Choice and Opportunities**

This questionable impact on urban and rural MMR is steeped in the misconception, despite
much evidence to the contrary, that maternal mortality is a quandary to be solved by medicine alone. The reduction of maternal mortality to a distinctly medical – rather than social – problem, ‘means that the only outcome can be life or death’ (Berry 2010:1). The management of pregnancy and birth, in global and local policy becomes framed by a medical rhetoric of saving lives at any cost, death for the medical practitioner is synonymous with failure. This in turn leads to an over-emphasis in localised contexts on access to emergency obstetric services and a model of prenatal care that is hyper-sensitive to diagnosing and managing risk. Pregnant women, as principal benefit recipients and potential agents of social change become defined within a medical framework as difficult subjects with risky bodies – particularly in terms of their reproductive and sexual behaviour. This is further complicated by social prejudices based upon ethnicity, class and gender.

In everyday practice ‘risk’ is a tricky concept to pin down, it becomes not one measurable thing but a multi-layered relationship of things dependent upon the actors involved. The competing cultural metaphors of risk at play in the medical environment culminate in an oversimplified idea that women in need of CCTs equate to a potential danger to themselves and wider society. When these ‘risky bodies’, enter into a high pressured, under-resourced public hospital they are, in turn become subjected to a particular type of treatment. When we bring attention to the marked ethnic and class differences between patients and health professionals, we begin to see the ways in which women are framed by competing notions of risk. This terminology is part of a wider medical lexicon that in itself shapes ideas about women’s bodies as precarious at risk of harm or of harming. The type of interaction that takes place in the prenatal care appointment firmly positions the pregnant woman as passive yet at the same time responsible for recognising the warning signs that mean she is ‘at risk’ of giving birth.
Midwifery in San Cristobal

There is a popular assumption in Mexico that where possible women, (particularly in the case of mestiza women) prefer to give birth in a clinical environment in the presence of an obstetrician. The hiring of a midwife (to attend birth at least) in the dominant social imagination is associated with something that ignorant, uneducated and poor women do – those who have not yet learnt what it means to be a modern citizen of Mexico. Smith-Oka argues across Mexico ‘a tussle exists between tradition and past, represented by the parteras (traditional birth attendants), and modernity and the future, represented by clinicians (Smith-Oka 2013:83). In the urban environment this oversimplified dichotomy of traditional and modern is more readily challenged. As the focus of this chapter demonstrates, the reason why Luna Maya continues to thrive arises from the needs of women across the local social spectrum who for a variety of reasons seek out-of-hospital maternal health care and the inter-cultural knowledge base and practices of midwifery.

Each year there are fewer and fewer empirical midwives regularly practicing and attending births in the barrios of cities like San Cristóbal. There are various trends that contribute to a decrease in out-of-hospital births attended by an empirical midwife. These include women’s improved access to public healthcare as previously mentioned, the success of CCT programmes and Seguro Popular, and general changes in the perceptions of risk associated with childbirth. In addition, women are told directly that they will lose access to Seguro Popular/IMSS-PROSPERA and social benefit programs if they birth outside of government institutions. Although this is not stated anywhere in policy, it has become an “oral” policy and has perpetuated long enough for many physicians to believe this is actually the case. The overall aim of IMSS- PROSPERA is to ‘reflect the priority that births should be attended by qualified personnel in an institution as an effective
strategy for reducing risks in maternal and infant health’ (IMSS 2015).

In 2001 Robbie Davis Floyd described the postmodern midwife in Mexico which she describes as building an emerging identity of professional midwife (Davis Floyd, 2001).

By 2014, literature describing the midwifery movement in Mexico had described a new term, the “autonomous midwife” (Laako, 2015). According to Laako, the autonomous midwife “emphasizes the political and autonomous aspects of this type of midwife. The concept of autonomy is fundamental in the collective action of these midwives as their profession lacks autonomy in Mexico. However the concept of autonomy also emphasizes the anti-systemic character of these midwives: their critique of the bio-medical system with its pathological perspective of birth and the defense of a rights based approach to birth” (p.171, Laako 2015). Luna Maya was founded on a rights based approach, as witnessed by its vision and mission statements establishing humanized birth and respectful care as human rights. Women who had birthed with Doña Graciela, then shifted their care to Luna Maya without even realizing they had become activists of an emerging political movement, they just wanted peaceful births within their own home with a trustworthy midwife.

The establishment of Luna Maya occurred concurrently with a national movement that spoke of peaceful birth, respect for tradition and culture, women’s empowerment and continuity of care as essential aspects of millennial midwifery, which weaves traditional ceremony and technique with modern tools such as facebook, conferences, whatsapp conversations and websites.

**Luna Maya: A Femifocal Birth Center**

Luna Maya was founded in 2004 to provide humanized health services including respectful maternity care under the vision: “to achieve safe motherhood through the empowerment of
women” (Alonso cited in Banet Lucus and Tryon 2014). Established as a birth center and midwifery training program, Luna Maya has become a reference in Latin America as a model for out of hospital birth and integrative care. Highly informed by its international and regional context, Luna Maya’s founding vision outlined the ways in which it would adopt an evidence-based midwifery model of care in an effort to alleviate the burden of maternal mortality, lack of services and obstetric violence on the local level. Luna Maya’s model of care offers a continuum of women’s and maternal health services in a community setting, of which it is an integral part. Luna Maya set in motion a particularly innovative conceptual lens for the midwifery model of care.

Matrifocal, a term used to describe matrilineal communities and mother-centered political and cultural structures, necessarily hinges on the figure of the woman. The use of this term has extended beyond these initial fields and forums, becoming one that is used to describe kinds of ideologies relating to and guiding health care service and delivery. While this represents positive development in terms of the incorporation of a women-specific discourse, there is still the need for further development of the related concepts and phrases used to represent these philosophies. The most notable shortcoming is that the term does not represent all women; namely, it excludes all those who fall outside of the parameters of motherhood, no matter what the reason. Many health care services, globally, are geared specifically towards mothers, thereby excluding women who are not mothers. While the matrifocal movement has covered important ground in the way that it has created a politically palatable way to move the discursive focus towards women, from a legacy of male-centricity, there is still the need to broaden the focus to explicitly include all women. Therefore, in order to acknowledge motherhood as one option among many that are presented to women, we suggest the use of the term femifocal, thereby encompassing all those who identify as women, regardless of their relationship to having children.
Femifocal can be understood as a mindset, which can then inform policy and behavior. When we talk about femifocal care, we specifically are referring to how this mindset or lens is applied in terms of policy and best-practices development in the fields of medical and health care services and provision methods. Femifocal recognizes that a woman is at the center of her own social, political and cultural ecology. This includes women and girls who are mothers, have been mothers, those who have never been mothers, those who hope to become mothers, those who intend to never become mothers, and all girls and women who define their own category of relating to their experience as women. Femifocal care is humanized. It views a woman as containing many spheres of experience and existence, rather than solely as a biological machine that needs medical attention.

Similarly, femifocal care understands that humans are nested within larger contexts that can be positive and negative, often comprised of loved ones, family, friends, community, culture, political structures, built environment and natural geography. Femifocal care works with a woman within these multiplicitious contexts. Femifocal care works with a woman across and throughout her life-course, realizing that she is accumulating experiences and history as she grows and develops. The ability to understand the woman in many of her changes throughout her life-course is enabled by the fact that ideally she is seen by the same provider the whole time, thereby infusing the traditional patient/provider dynamic with more relational and temporally consistent elements. All femifocal care is rooted in a woman’s desire to participate (her informed consent) in the treatment and care, as well as on her elucidation of what her unique health goals are. Femifocal care is women-centered, and individually driven.

**Reaching out to the Barrios: El Molina, Peña Maria**

Through building relationships with individuals, Luna Maya became known within several outlying neighborhoods of San Cristobal. These neighborhoods are created by migrant indigenous groups who move to San Cristobal fleeing religious or political conflict, or simply
in search of better financial opportunities. What is characteristic of these neighborhoods is they often lack a traditional midwife. Two neighborhoods in particular stand out in their relationship with Luna Maya: Ranchería Peña María and El Molino. Both these neighborhoods are extremely poor, homes are precarious, made of plywood, plastic sheeting and lack indoor plumbing. Most homes have dug out latrines and do not connect to a neighborhood electric grid. Women marry young, often before 18 years old and have an average or 3 or 4 children. Men work in the service industry or construction and in some occasions migrate to the US.

Luna Maya began working with El Molino when one woman who was at a birth that had lasted two nights, decided to call one of the midwives to ask for assistance. The traditional midwife attending the birth was asleep and could not provide more support or diagnosis. The baby was in an asynclitic position, meaning the head was sideways, and posterior, meaning the baby’s back was lying towards the mother’s back. Using the reboso (Mexican shawl) to help better position the baby, the midwife helped the mother have a gentle, natural birth and avoid transport to the local hospital. From this moment, women from El Molino would choose to birth with Luna Maya midwives, or call Luna Maya when births were not going well to ask for assistance. Women who birth in El Molino attend late in their pregnancy and are mostly concerned with the baby’s position. They do not attend childbirth education classes and inherently believe that birth is a natural event that should occur at home with other women. They are afraid of the local hospital and believe that all women who birth there end up with cesareans and are mistreated.

The first birth attended by Luna Maya in Ranchería Peña María was a breech. It was the woman’s second pregnancy and she had been told by the hospital it would have to be a
Cesarean. She began asking for support for a vaginal breech birth and eventually found Luna Maya who offered to attend the birth. The birth went very well, and since then the women from Ranchería Peña Maria utilize Luna Maya for maternal, pediatric and family health care. The community has no traditional midwives or healers and is desperately poor—families eat on average one plate of beans a day. Alcoholism is rampant among males and therefore violence against women is at a high rate.

For six years Luna Maya worked with the Hogar Comunitario, Yatzil Antszetik (Community Home). The Hogar Comunitario was founded in 1994 to provide a safe house for single mothers. Although levels of sexual violence are extremely high, when indigenous women, and girls become pregnant, if they are not married they are forced to flee their communities. Abortion is not legal or available in Chiapas and before 2016 abortion was not legal in cases of rape without a judge’s order. The Hogar Comunitario therefore offered a safe space for pregnant women to live during the end of their pregnancy and after. Before Luna Maya was established, all births were referred to the hospital where women were further victimized, with obstetric violence and unnecessary cesareans. Luna Maya worked with the Hogar Comunitario from 2005 to 2010 to attend births in the safe house and apprentice the nurses who worked in the Hogar to learn midwifery skills. Water birth was included, as well as placental encapsulation. The Hogar nurses eventually became skilled enough to provide the care themselves and Luna Maya remained at a consulting role for the staff.

Luna Maya has provided a safe space to poor and victimized women to recover their power and strength. Through respectful care, informed consent, careful relationships based on mutual trust and communication, Luna Maya provides a unique space for women whose lives are difficult, violent and very sad, to find the joy in their own power and connect deeply with
their newborns. The work Luna Maya has done with each women from the Hogar and marginal neighborhoods embodies the essence of midwifery and is one of the aspects Luna Maya is most proud of- being able to bring the midwives model of care to any economic or social reality and find connection with women.

According to an indigenous woman who has had two children and well woman care from Luna Maya:

“Luna Maya midwives have more experience than traditional midwives. The midwives are very impatient in my community. I felt very safe when my babies were born, I wasn’t afraid, I felt very satisfied and felt that I had the birth I wanted. The midwives are kind, they are very loving. Doctors have never been an option for me to have my baby.” (Ana Elizabeth, 2016)

Luna Maya therefore provides a gap of privilege where women from all socio-economic and cultural backgrounds can access evidenced based care, that involved anti-hemorrhagic medications, diagnostic tests, resuscitation equipment and respect and honoring of cultural traditions and choice, such and when and how to cut the cord, the importance of massage and fetal positioning and the choice of who is at the birth. The following story illustrates an example of how the Luna Maya model of care extends into even the most disenfranchised women.

**Sara’s Birth Story**

Sara lived alone in one of San Cristobal’s poorest barrios having been sent by her family to the city to work and she was about to become a single mother. Sara had been sent to Luna Maya by Guadalupe, another woman who works at the market and had participated in a doula training at Luna Maya. She often referred market women to birth peacefully at Luna Maya and avoid the hospital, where it is common knowledge that young, single, indigenous
women are mistreated.

The labour was taking its toll on her body, with no family support and little physical will left to begin this new phase of her life she was pleading the midwives for help. Just as she thought she could take no more there was a powerful contraction and the head emerged. The midwife took Sara's hand and placed it under the water and between her legs to let her know there wasn't far to go. She rested for a few moments before the next wave of pain came along. Feeling the baby's head had given her hope that the birth would soon be over but at the same time filled her with dread at the realization she was about to become a mother.

The next contraction began with more force than the others bringing her back down to earth as the urge to push took over her body. The baby was born at 8.15pm rising from the warm water of the bath and being placed on her mother's chest without making a sound. The baby lay limp and motionless whilst her mother stared into space glad the immense physical pain had subsided. The midwife quickly checked and found a faint heart beat establishing that the tiny baby was alive. With umbilical cord still attached and the placenta yet to be born the midwife started resuscitation. Sara looked on without saying a word as the midwife worked to bring life into her child. The midwife told her to speak to the baby by her name, that she would respond to her voice. Sara replied that she couldn't think of a name and didn't know what to say. The apprentice midwife said forcefully "how about Daniella?" and so Daniella she became without any disagreement from Sara. Half an hour later with the placenta delivered and Daniella out of danger mother and daughter lay in bed together and contemplated what lay ahead. They slept til the following afternoon, the midwives decided not to disturb them, only to bring her more food, as they wanted to prolong Sara's return home to an empty house.

Expansion to Mexico City
In 2015 Luna Maya opened a second birth center in Mexico City after 10 years of successful practice in San Cristobal. The Mexico City birth center (Luna Maya DF) followed a similar model of femifocal care providing full scope midwifery services in a city where abortion is legal. Quickly, Luna Maya became a safe space for women seeking femifocal care for their health and that of their family. Most importantly, Luna Maya DF became a meeting point for Tequio Materno. On wednesdays new mothers requested space to meet and gather as a community. In urban environments where social networks are distant at best, and most commonly non-existent, wednesday afternoons in Luna Maya because a massive social gathering, frequently to the point where midwives had to leave due to the noise and the amount of children running around. In the fall of 2015 the mothers (Tequio Materno) came together to write a petition requesting:

1. Access to birth certificates to all children born in Mexico, regardless of place of birth,
2. Humane and professional treatment in the case of a transfer from an out of hospital birth,
3. Inclusion of the midwifery model in the public health system.

The mothers uploaded the petition on to change.org and within 10 days had secured over 2000 signatures. The petition caught the eye of independent Senator Martha Tagle who then worked with the mothers to organize a Senate Forum on March 14, 2017 to bring these issues to the forefront of health policy. Since then, Luna Maya, Tequio Materno and the office of the Senator have been collaborating to work to improve conditions for out of hospital mothers in Mexico, expand and regulate birth centers and encourage true midwifery to be included in the health system.

Most importantly, Luna Maya has created safe space for autonomy and self-determination-not just of midwives to practice their profession in its essence, but also for women to birth in
freedom and organize as activists for their own rights and values. The value of the physical space for these movements to birth, both in Chiapas and Mexico City surpasses the capacity of a facegroup group or a series of meetings with agendas. It speaks to the collective power of women connecting with their true selves, to themselves, their families and to a community who honors and celebrates this authenticity. Clearly, an empowered woman who speaks her mind and challenges the medical system with a public petition is a threat to a patriarchal colonial medical system, and it is evident through the social movements that have emerged in Luna Maya, that it is the physical autonomy and sanctity that enable voice and choice, for a person and for her community.

5. Conclusion

Recent focus on the experience of all pregnancies and births as valid and important, highlight the contradictions presented in this chapter. Where well intended improvements to access medicalized care have decreased maternal mortality rates, a global trend is beginning to be observed where women are opting to return to traditional midwives seeking kindness, human contact and rights based approach (Molina et al. 2016), signalling a reality that despite increased technology, women still perceive birth as an experience and may prioritize relationships and connection over medical safety. Within this landscape, birth centers like Luna Maya provide a viable, medically safe and equitable alternative where both evidence based care and culturally appropriate kindness are woven together bridging gaps between technology and ritual.

References

Banet Lucas A and Tryon J. (2014). The Luna Maya Model of Care: A Femifocal Family Care Birth Center MANUAL for REPLICATION August 2014


V. Appendix

*Vision:* To achieve safe motherhood through the empowerment of women.
**Mission:** Luna Maya works to ensure that all women of Chiapas have access to a safe and humanized birth and birth experience. They believe that the women of Chiapas have the right to make informed decisions about their bodies and access and the right to the necessary means to ensure their health and wellbeing. The believe that safe motherhood is a human right that contributes to the empowerment of women, the improvement of the quality of life, and the strengthening of families.

**Goal:** To contribute to the reduction of maternal mortality in Chiapas, Mexico.

**Objective:** To improve access to safe motherhood through the empowerment of women utilizing the Professional Midwifery Model of Care and access to the emergency obstetrical care, as needed, in Chiapas Mexico.

**Expected Results:**

1. An autonomous and sustainable birth center, run by professional midwives
2. Better knowledge and awareness about sexual and reproductive rights, including humanized birth, as it is defined by the World Health Organization
3. A training program for local, Mexican, and international midwives
4. A network of service providers, governmental institutions, and women’s organizations that aims to increase access to humanized birth through collaboration and referral