“Intercultural dialogue: Perceptions of the maternal health care of indigenous females in Veracruz, México”

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ABSTRACT

Cultural traditions in indigenous peoples about maternity, childbirth and puerperium are fundamental bases to their history and knowledge for the well-being of the community. However, government and private health services in general only offer Western birthing practices, making pregnant indigenous women fall between two systems: one based on their traditions and beliefs but weakened by poor resourcing and inefficiencies, and the other by policies of acculturation.

With the objective of studying the perspective and voice of indigenous women on maternal healthcare in Veracruz, Mexico, this research was carried out between December 2022 and February 2023 in a health organization which is implementing an intercultural maternal care system. The study subjects were made up of pregnant indigenous women and health providers who shared their perspective and experience on the topic through a process of individual interviews and surveys.

As a result, this research opens space for Non-Western standpoints: indigenous voices, focused on the well-being and dialogue to draw on the strengths of different cultures.
**Personal reflection**

This research project is dedicated to my dear husband Henrik and to my boys: Erik and Hugo.

I also want to thank my parents, Ana Maria and Vicente, that, despite the distance, they are always taking care of us and supporting my personal and professional projects.

*Additional thanks to:*

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1. **INTRODUCTION**

The main purpose of this research is to understand the perspective of indigenous women towards the Western maternal health service. To achieve this, the beliefs and traditions about pregnancy, childbirth and puerperium are taken as references, which play a transcendental role in indigenous communities through ancestral practices that participate in the integral care of women and their babies.

It is important to mention that in this study, I use the term *Indigenous* to refer to peoples who were neither sovereign towards themselves nor nationals of the colonizing state. This term recognizes the shared history that includes loss of land and culture (Niezen, 2003).

Regarding the terminology *maternal health care*, the WHO refers to the health of women during pregnancy, childbirth and the postnatal period\(^1\).

The fieldwork of this research was based in the *Hospital General de Tarimoya Dr. Horacio Díaz Cházar*, which is a non-profit health center located in the northern part of Veracruz, Mexico. This health center was chosen as the research location because it provides healthcare on a sliding income scale and most of the patients treated are below the poverty line and have indigenous roots. Besides, this healthcare organization is currently implementing a project called: "*Enabling environments for a positive experience during comprehensive maternal and perinatal health care*", aimed at women in the stages of pregnancy, childbirth and puerperium. The main objective

of this project is the conversion from the western obstetric care model to one with a humanized and intercultural approach. As part of it, the medical staff has been duly trained, including the healthcare community: nurses, medical technicians and midwives. To explain the latter, we will delve into the way in which the concept of interculturality is put into practice in the health system.

I carried out the research project through a mixed method to collect qualitative and quantitative data. Surveys and personal interviews were conducted to pregnant indigenous women during a period of eight weeks in the hospital mentioned above during Dec-22 to Feb-23. The findings obtained were useful to understand the experience of occidental childbirth care in indigenous communities. This analysis values subjective interpretations of reality that become structured practices, as stories that end up explaining actions, attitudes, prejudices, among others.

In the Literature Review section, I explore the current knowledge about the implementation of the western maternal health system in subaltern communities. This section focuses on understanding the current situation of the indigenous females and the cultural conflicts in healthcare for Indigenous communities. In this section I also include some case cases from intercultural health systems from other parts of the world.

The second part of this research includes the selected methodology and the analysis of the information obtained during the fieldwork, including the findings with their respective experiences and conceptions. As I mentioned before, this research seeks to give a voice to the participants in the maternal health care of this hospital, focusing
mainly on the key actors: indigenous women and health providers. In addition, this research analyzes the way in which the health providers take into account or exclude from their treatments and procedures the traditional indigenous medicine\textsuperscript{Annex}, such as use of amulets, medicinal plants and massages. Cases in which conflicts occurred between indigenous women and the Western health system will also be exposed. These disagreements include the indigenous women and health providers on the western health care vs traditional indigenous medicine.

In the last section, I share the conclusions of the research, which include the most relevant findings about the maternal care in the hospital where this research was carried out, concluding in the way in which indigenous females really conceive Western maternal health and the healthcare providers.

\textbf{Research questions}

This research is aimed to answer the main question:

- \textit{How is the maternal health system perceived by indigenous women in terms of their culture?}

Besides, to support the main research question, through this research I will also analyze and answer three sub-questions. The aim of these sub-questions is to go deeper in understanding the general experiences and thoughts of the subjects of study.
The questions are as follows:

- *Which factors influence the communication process between medical providers and indigenous women?*
- *How do these factors influence communication?*
- *What recommendations could be made to improve the communication relationship between the Western and non-western maternal health care?*

**ComDev relevance**

Communication for Development studies explore tools and theories that, if we land them to actions, become initiatives that reduce social and cultural barriers in multicultural societies.

The health system with an intercultural approach is relatively recent, which generates tensions between subaltern communities and governments. Therefore, the topic of this research is relevant when considering maternal health care as a culturally framed biological practice constructed differently in each society. Besides, this research will explore the recognition of indigenous communities in Mexico for the establishment of a health model that adequately responds to their real needs, beliefs and knowledge: a health model with an intercultural approach to reduce social and cultural barriers between multicultural societies.
**CONTEXT AND SCOPE OF STUDY**

In Mexico, there are currently around 25 million indigenous people\(^2\) characteristics that identify it as a multicultural country.

From the point of view of the doctrine of human rights, access to health can be considered itself as a right guaranteed in the international order. However, the indigenous communities accumulate a series of additional difficulties derived from their economic, political and social marginality.

For instance, in Mexico and Latin America, there is still an important gap in the adaptation of the national health systems to the linguistic-cultural characteristics of these communities, as well as to their specific and diverse social dynamics, as it is a reality that indigenous population in general faces a situation of vulnerability framed in social exclusion.

Western health systems generally approach Indigenous communities as at risk, vulnerable and lacking knowledge to solve their needs. This approach frames health promotion in Indigenous communities as new knowledge to be introduced by external service providers (Tuck, E. 2009). Damage-centered health research has been a source of distress for Indigenous communities\(^3\), who feel that focusing on their weaknesses and negative aspects reinforces a sense of inferiority.

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For indigenous women, particularly in remote villages, rural contexts, where they are the only skilled practitioners available for antenatal and delivery care, traditional indigenous midwifery is the most popular choice. Nevertheless, traditional Indigenous midwifery has become attenuated and does not on its own guarantee healthy childbirth in all cases\(^3\).

Since the mid-20th century, mainly in the urban context, this traditional midwifery model has been losing ground to the Western health model, which medicalized care, taking delivery to hospitals, incorporating care into a routine that includes doctors, nursing team and the use of technology, where also in most cases pregnant women undergo cesarean sections. Western birthing practices avoid taking into account the way in which the indigenous population understands the process of pregnancy and childbirth, considered from their worldview and culture\(^3\). This model can solve serious complications, but with a high culture and identity impact.

As a consequence, currently governments and private health services in general only offer Western birthing practices, making pregnant indigenous women fall between two systems: one based in their traditions and beliefs but weakened by poor resourcing and inefficiencies, and the other by policies of acculturation.

The current situation has increased awareness and valuing of cultural diversity and the accommodation of strategies to provide health services in spite of cultural differences. In Mexico there are programs that aim to recover and systematize a model of traditional indigenous maternal care with important contributions to both pregnancy
care, childbirth and postpartum, incorporating the use of interculturality in health, in
order to decrease the effects of Westernization in the system.

Although well intended, these adjustments nonetheless maintain Western cultural
dominance in health decisions of what has to be done, how to do it and whether it is
done at all.

- **About crossing social boundaries**

In this section I explore the way in which medical care can be used to understand
social inequalities and how this can be explained through the health system in Mexico.

Each culture has tactile norms (Van Dongen and Elema 2001). For instance, doctors
can touch patients by following social scripts (Henslin and Biggs 1971; Teman 2010)
in ways and in places that would not be allowed in other contexts or by other people.
As Prentice (2007) has pointed out, medical training simultaneously embodies
technical and social lessons.

Part of the medical training in Mexico to graduate as a doctor includes an internship
and a social service lasting one year each. This practice serves to connect medical
care to the country’s ideology of serving and developing the nation by sending trainees
to underserved rural regions of the country (Finkler 2001). It is important to note that
because most of the medical students hail from urban places, their social service
experiences and narratives often reinforce persistent prejudices about rural and
indigenous communities (Laveaga 2013).
The health system in Mexico clearly illustrates the breach of boundaries, as medical interactions are very different in each type of hospital. Social and economic differences are often mapped onto hospital types and spaces, which frequently reflect the intertwining of class and color. Public hospitals are government funded and usually serve the lower socioeconomic sectors of the population. These institutions tend to be quite large, usually have a high patient load and concomitant high patient-to-clinician ratio, and often operate in run-down facilities and with older technology. In contrast, the private medical system is reserved for those who can afford to pay the premiums or whose employers pay a private insurance company for care. Both types of hospitals share several characteristics that shape, in important ways, the training received by interns and residents, who spend a very large portion of their week in the hospitals.

In addition to the fact that the bodies being practiced upon are mostly poor and darker-skinned, and have less agency, is the troubling reality that those practicing on them are usually middle class, lighter-skinned, and educated, which include indigenous communities. The purpose of this system is to export practice from private hospitals to public ones, leveraging the high patient volume to their own advantage and bypassing legal, ethical, or moral concerns. Thus, underprivileged patients are vital to the production of medical competency. A similar structure can be found in the global health and medical programs in resource-rich countries that send their students for practicums to resource-poor countries, which Wendland (2012) refers to as “clinical

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4 Main text idea retrieved from:
tourism.” In her analysis, she argues that “the wretchedness of clinical practice” depends on “a contrast with medicine as practiced elsewhere, remembered or imagined”. Such social hierarchies have historically played a role in defining who gets to be the practitioner and who gets to be practiced upon. Ultimately, they argue, these systems look increasingly like colonial medicine rather than ones with an equal playing field⁴.

These medical models cross various boundaries in ways that map onto and reproduce social differences. This process, in turn, tells us about how certain populations are viewed and treated by society.

- **Global framework of the importance of indigenous females**

According to the United Nations (2023), despite their enormous assets and contribution to society, Indigenous women still suffer from multiple discrimination, both as women and as Indigenous individuals. In this section I include the following achievements in global agendas related to Indigenous women:

The 2030 Agenda adopted by the United Nations in 2015, contains six specific references to Indigenous Peoples: three in the political declaration, two in the targets under Sustainable Development Goals 2 on zero hunger (target 2.3) and 4 on education (target 4.5) and one in the follow-up and review section, in which Estates expressed their commitment to engage with Indigenous Peoples in the implementation of the Goals and were encouraged to conduct regular and inclusive reviews of
progress in achieving them, including at the national level, and to draw upon the contributions of Indigenous Peoples in those reviews.

Regarding indigenous females, the 2030 Agenda refers to gender equality in target 5, where I highlight sub targets 5.5 and 5.6, which commit in ensuring women’s full and effective participation and equal opportunities for leadership at all levels of decision-making and ensuring universal access to sexual and reproductive health and reproductive rights respectively.

Additionally, the Permanent Forum has included in its annual sessions a standing agenda item on the 2030 Agenda to gather input and suggestions on better integrating the rights of Indigenous Peoples and Indigenous women into the process at the global, regional and country levels.

Another achievement for Indigenous women is the Permanent Forum on Indigenous Issues, where the Committee on the Elimination of Discrimination against Women has been called up to adopt a general recommendation on Indigenous women. In answer of this, nowadays the Committee considers issues related to individual and collective rights to equality, non-discrimination and self-determination; social and economic rights, including the rights to decent work and to land, territory and resources; the right to water and food; cultural rights; civil and political rights; and the right to live free of any form of violence. Regarding maternal health care, the Permanent Forum welcomes the participation of indigenous midwives and it recognizes the important role of indigenous midwives in maternal and child health. The Forum states that practices and knowledge of indigenous midwives are crucial to the health of indigenous peoples,
but their criminalization persists, with a devastating impact not only on the midwives themselves, but also on mothers, children, and communities. It also urges Estates to respect the right of indigenous peoples to maintain their traditional health practices.

These initiatives by the United Nations draw attention and commitment to the needs and rights of indigenous women and call for actions to protect them, as indigenous women around the world are still among the most vulnerable and marginalized.

- **About intercultural initiatives in Mexico**

Nowadays in Mexico there is a very clear and detailed legal framework regarding the rights of indigenous peoples in the field of health, expressed in the *General Health Law, the National Health Development Plan 2019-2024* and resolutions binding international standards³.

Currently in Mexico, organisms as the Dirección de Medicina Tradicional y Desarrollo Intercultural (Directorate of Traditional Medicine and Intercultural Development), defined together with the Centro Nacional de Equidad de Género y Salud Reproductiva (National Center for Gender Equity and Reproductive Health) a model of comprehensive and intercultural care since 2009, which in 2012 received the name of "Model of care to women during pregnancy, childbirth and the puerperium with a humanized, intercultural and safe approach". This program included the participation of traditional midwives, which is carried out between the western health providers and
the traditional midwives\textsuperscript{5}. The meetings have been held in several states of the country, including in the hospital where this research was carried out. This methodology made it possible to recover and systematize a model of traditional indigenous midwifery.

This proposal also made it possible to reaffirm the value and validity of local knowledge, which can be accessible in close collaboration with the users. Likewise, it managed that the health providers assume the shared responsibility of imagining new ways of approaching traditional knowledge without idealizing, but willing to identify and recognize the contributions of a traditional indigenous care model for maternal health.

For this reason, the public issue that motivates this study consists of knowing the perspectives and needs of indigenous women towards the western model of maternal health, considering pregnancy, childbirth and the puerperium as a culturally framed biological practice. In this particular research case, my main thought was to understand the implementation of an intercultural process through the subaltern voices, discussing the main outcomes, whether positive or negative.

2. LITERATURE REVIEW

This section contextualizes the power of the Western influence as authoritative medical knowledge, highlighting the need for a culturally responsive healthcare system and exploring the role of maternal health in indigenous communities as part of the culture identity. To explain this, I explore the term hegemony within health care and I will address some cases of intercultural healthcare systems around the world. This literature contributes to the analysis of the case explaining the way in which the Western childbirth strategy has been implemented and the perception of indigenous women to it.

- **Hegemony applied in health care system**

This has long been a topic of interest in social sciences and its impact on healthcare for indigenous people cannot be ignored (Sarmiento I, Zuluaga G, Paredes-Solís S, 2020). Hegemony refers to the dominance of one group over another through the use of cultural, economic and political power. In healthcare, hegemony operates through the medicalization of health and illness, which privileges Western biomedical knowledge and practices over traditional indigenous knowledge and practices.

The healthcare system has a major role to play in perpetuating hegemonic norms and practices that lead to the marginalization of indigenous people, highlighting the need for culturally responsive healthcare systems. Therefore, this situation results in the marginalization of indigenous people and the erasure of their cultural beliefs and

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practices and leads to the exclusion of indigenous people from decision-making processes and the perpetuation of colonial power dynamics.

Emerging evidence suggests that active involvement of subalterns in health promotion increases access to care and improves health outcomes in these communities (Allen L, Hatala A, Ijaz S., 2020). Although well intended, these adjustments nonetheless maintain Western cultural dominance in health decisions of what has to be done, how to do it and whether it is done at all (Kirmayer LJ. 2012., Pon G., 2009).

- **Intercultural health systems across different subaltern communities**

In order to explore the situation of subaltern communities in other parts of the world regarding the health system, below I will share some cases of interculturality applied in the maternal health system, where my intention is to understand the context of each case and more important the outcomes from these intercultural movements.

*Inuit community - Canada*

Racism and colonization deeply impact the health of Indigenous communities in Canada. Inuit peoples traditionally resided in the territories above the treeline on the lands presently known as Canada, and compose part of the broader circumpolar Inuit population with traditional lands spanning Alaska, Greenland and Russia (Smylie, Smylie J, Kaplan-Myrth N, McShane K., 2009).
This case is particularly relevant for remote indigenous communities. Before the European colonialism, births were traditionally family-centred and assisted by a combination of birth attendants, elders, *ikajurti*\(^7\), husbands, or even done alone, where traditional midwifery was taught informally and experientially, much like other aspects of Inuit life (Archibald L, Bird P, Brann C, 1996).

In the 1970–1980s when air travel became normalised, evacuation of pregnancies became the new gold standard in an attempt to reconcile high perinatal mortality as well as to further medicalise birth and to displace midwifery as a legitimate practice (Douglas VK, 2019), (Kaufert P, O’Neil J., 1990). It took decades for midwifery programmes to emerge again. Evacuation remains standard practice in most parts of Canada. It should be noted that the high perinatal and infant mortality rate has been linked to a complex myriad of factors including: high health provider turnover rate in northern communities, lack of Indigenous health professionals and resources, limited infrastructure, poor housing and crowding, and long-standing socio-economic colonialism-related disparities affecting Indigenous families (Lemchuk-Favel L, Jock R, 2013) (Sheppard AJ, Shapiro G., Bushnik T., 2017). Furthermore, birthing away from home interferes with overall community support for expectant people. Since family members cannot attend the birth, the birthing person-to-be can experience isolation and loneliness in the city, and it disrupts the role of *ikajurti* and cultural naming practices\(^8\).

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\(^7\) *Ikajurti*: In the Canadian Arctic, Inuts communities call *ikajurti* to the midwives and birth helpers.

One of the problems pointed out from removing births from the community was that it divided the community between generations. Some Inuits felt the newborns born in the south lived different lifestyles due to their origin of birth. Others even feared that their children born off the land were less Inuit than their children born on the land in terms of self-actualisation as well as political land claim benefits. Over time, traveling for birth became the norm. Choosing other options became difficult for birthing parents, who were feeling pressure from health professionals to give birth in a tertiary hospital for the health of their baby, to the point where some birthing parents were afraid to give birth locally.

After many years and when health authorities and government decided to intervene, the Inuulitsivik Health Centre in northern Quebec was created, staffed by Inuit and Western-trained midwives. The success of the Inuulitsivik Health Centre has been attributed to the free-flowing exchange of knowledge between traditional Inuit midwifery and western midwife training (Lee E, Gudmundson B, Lavoie JG., 2022.).

From the Inut community case, I can conclude that it is necessary to problematize certain aspects of the participation of western health system in health issues that go beyond what is strictly medical, which cannot always be thought positively; for example, the fact of promoting social conflicts and emotional tensions in indigenous communities, which can become a metaphorical but at the end literal division within the members of the community.
Peruvian maternal health: Quechuan communities

Quechuan Indigenous peoples' lives are governed by the traditions of their ancestors, and never more so than during pregnancy and childbirth. The Peruvian Government initiatives to implement an intercultural maternal health model in the southern Andes and Peru include the introduction of antenatal waiting houses, voluntary sterilisation campaigns, and integration of modern and traditional birthing methods.

All women must report to a waiting house at 7 or 8 months' gestation where they will remain until after the birth of their babies. This policy ensures that health professionals can treat any complications during the birth and take care of the newborn baby. As a result, even though statistics are improving, Quechuan women share feeling “lonely” and finding the waiting centres “boring”. Local women also seem to resent the fact that there is a fine for giving birth outside of these clinics.

A similar picture emerges about the well-intended sterilisation campaigns. The Peruvian Government set up an initiative of voluntary sterilisation in 1985 to reduce the high rate of maternal deaths. The initiative included monthly quotas for doctors to meet, and as a result some of the Andean women saying they were bribed by doctors to agree to have the operations against their will.

Local birthing centres have also been set up in rural areas to incorporate traditional beliefs with modern health care and create an environment where women feel safe and comfortable. Most Quechuan houses have a large rope hanging from the ceiling for the women to pull themselves up on during labour. These ropes have been installed in the centres, and every care is taken to make the atmosphere as much like the
women's homes as possible. So far only 25 hospitals in Peru combine treatments in this way, but it is a positive start.

For this reason, I decide to share about this case because it represents the integration of western health practice and traditional medicine in a country from the South, showing the gaps in the process through perceptions of the users, but at the same time giving hope to create a truly intercultural model for the indigenous communities of Latin America.

Maori nurses - New Zealand

The Maori nurses illustrate that there are also situations of hegemony within the health providers of the western system. This development in terms of the New Zealand situation shows clearly the cultural dimension in health care is always located in a specific cultural context whose unique patterns structure interrelationships between the various ethnic groups involved.

Māori generally lack trust in the nation's health system and those who work within it, instead, Māori prefer to encounter familiar Māori faces they trust when engaging with health services (Barton, 2018; Wepa & Wilson, 2020). Māori nurses are a critical part of the health workforce because they know their communities and are trusted. But rather than being valued, they are often silenced, rendered invisible, and oppressed, driven by unfilled rhetoric in the Māori nursing workforce and endemic racism within nursing that other colonized Indigenous nurses also experience (Wilson, D., Barton, P., Tipa, Z., 2022).
Maori nurses developed the notion of cultural safety in the late 1980s, in order to reflect on their nursing practice from their point of view as the indigenous minority in the country. Cultural safety is defined as the recognition of the position of certain groups, such as the case of the Maori community, within society. Cultural safety supports the idea that the public health system for subaltern groups is less suitable than the one for dominant groups. As long as the health service is perceived as alien and not meeting the needs in service, treatment or attitude, it is culturally unsafe (Wilson, D., Barton, P., Tipa, Z., 2022).

This case was pioneer in recognizing the colonial and historical context of health disparities and the impact their own cultural identity and assumptions had in perpetuating these disparities. Today these practices are active in the Nursing Council of New Zealand, as part of the basic curriculum for nursing training\(^9\).

From the previous subsections of this Literature Review we can conclude that the quality of health services does not depend exclusively on the sufficiency of resources and technical capabilities, but also to a great extent on the interpersonal relationships established by the health providers with the users. At the same time, it also demands the inclusion of cultural competencies, abilities, attitudes and, more important, the availability of medical treatments that really meet the needs of subaltern populations.

This requires the recognition and incorporation of traditional knowledge and practices, as well as the inclusion of subalterns in the decision-making processes. By doing so,

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healthcare systems can begin to address the historical and ongoing trauma of colonization and promote health equity.

However, I truly believe that there is still a need to do more research on how other countries are trying to solve or reduce the effects of Westernization on health with the subaltern communities, ensuring that all individuals receive high-quality, and appropriate health care that meets their unique cultural needs.

3. THEORETICAL FRAMEWORK

In this section, I address the impact of postcolonialism in the health system, as a critical approach to understanding the historical and ongoing effects of colonialism on health outcomes for indigenous communities in Mexico. The postcolonial theory was chosen because it acknowledges that the ongoing inequities in health and social status among Indigenous people are a legacy of the colonial past (Browne, et al., 2005). Alongside with the above, this theoretical framework also aims to explain my initial thoughts regarding the implementation of the intercultural model of my research, highlighting the importance of decolonizing health addressing knowledge systems.

A health inequity means the differences in health outcomes that are caused by avoidable economic, social and cultural inequalities (Baum, 2017). Postcolonial theory emphasizes decolonizing the system to promote health equity and social justice. An intercultural program implementation such as the case that I present in this research reveals fundamental antagonisms between apparently fused groups. Each group has different ways of thinking about maternal health delivery. If it results in negative
perspectives from the indigenous females about health delivery, it means that not only being tolerant and accepting some traditional practices is enough to have a symmetric relationship between health systems and subaltern communities. With this, I can address the question: *How can these indigenous communities fully trust a health model created and implemented only by people outside their community?*

For indigenous communities it has been difficult to understand and take action in the processes that society and its development model, including the health system, offer to them, from which they are often turned into passive subjects within social, economic and cultural changes, negatively impacting their customs and identity\(^3\).

The processes of marginalization that indigenous communities have historically suffered have limited their resources to understand and respond to new intercultural initiatives. As antecedent, during European colonialism, Spain invaded many areas in The Americas, including what is now known as Mexico. The native people in Mexico, now called *Indigenous*, suffered a process of annihilation under the effect of war, economic and social upheavals and new diseases. From the 17th century, when the word *Indigenous* appears in European dictionaries, it is already impregnated with a series of derogatory meanings forged in the imagination of the colonialists: *barbaric, cruel, rude, ignorant, inhuman, aboriginal, cannibalistic, natural and wild*. The first Dictionary of the *Royal Spanish Academy (Real Academia Española)*, published in 1726, added other derogatory qualifiers: *silly and credulous*.

In this research case, interculturality from my perspective is initially conceived as a possibility to take the best of the western medical system and best of indigenous
traditional medicine in order to design a new system that allows the articulation of both, without minimizing the indigenous model. To decolonize the health system, there must be a process of dialogue with the communities, since we cannot say that it is an intercultural health program if it comes merely from Western society and indigenous knowledge must be validated from their perspective.

_Local knowledge_ is another term I want to address in this section. Indigenous local knowledge emphasizes the unique wisdom, practices, and cultural perspectives held by indigenous communities and underscores the importance of incorporating this knowledge to foster culturally safe, holistic, and effective healthcare. Drawing on scholarly works and relevant literature, this theory identifies key dimensions and strategies for integrating Indigenous local knowledge in health practices, which include: indigenous knowledge systems, community engagement and cultural safety (Kovach, M, 2009).

The proposed scenario would be to merge local knowledge with Western knowledge, recognizing the value of both systems and promoting their collaborative coexistence. Through ethical engagement and a recognition of power dynamics, the integration of local and Western knowledge can contribute to more culturally responsive, transformative solutions and, more importantly, reducing health disparities in subaltern communities.
4. **METHODOLOGY**

This research was carried out through a mixed method to collect qualitative (interviews) and quantitative (in-person surveys) data. These surveys and interviews were conducted to indigenous women in a hospital in Mexico during a period of ten weeks, where their narratives and stories were analyzed.

- **Study location**

Hospital General de Tarimoya Dr. Horacio Díaz Cházaró is a non-profit health center located in the north of Veracruz, Mexico. This health center was chosen as the research location because this organization provides healthcare on a sliding income scale so the majority of the patients treated are below the poverty line and have indigenous roots.

Alongside with the above, this health center is currently implementing a project called: "Enabling environments for a positive experience during comprehensive maternal and perinatal health care", aimed at women in the stages of pregnancy, childbirth and puerperium. The main objective of this project is the conversion from the western obstetric care model to one with a “humanized and intercultural approach”. As part of this project, the health center provides indigenous traditional midwifery and native language interpreters.
The permission to conduct this research in the hospital was approved by the administration some weeks prior to the fieldwork. During the fieldwork, indigenous females were motivated to have the interview with me prior to or after their health controls with the doctor. The participants were invited to have interviews and surveys with me inside a doctor’s office borrowed by the hospital administration. The process was individual, it means only myself as the researcher with the interviewee. Also, on some occasions, interviews were conducted with health providers.

The questions were conducted along the following issues: recognition of indigenous cultural values, knowledge in indigenous traditional medicine and respect for indigenous culture regarding maternal health. For instance, survey items assessing interculturality in maternal care included “I consider that the medical attention received is tolerant and empathic regarding my culture and traditions”, “Medical providers have taken my culture into account when making recommendations and treatments”, and
open-questions such as “Have you been allowed to participate in making decisions about the medical care of your pregnancy?” From these questions, I got interesting narratives to describe their experiences which I will share later on.

- **Subject analysis**

Surveys and interviews were carried out through a cross-section approach and with a non-probability sampling including a set of characteristics. These characteristics correspond to indigenous females over 18 years of age, as the age of majority in Mexico, who are currently receiving maternal care for their pregnancy or labor and that are localized in the state of Veracruz, as it is one of the most indigenous populated regions in the country.

The total number of participants in this research were 43 indigenous females and 5 health providers. Regarding the health provider interactions, one was a nurse and the rest were three doctors specialized in gynecologist-obstetric and one in epidemiology.

The average age of the indigenous females participants was 26 years old. The surveys and interviews had a response rate of 100%, which means that all the females invited to participate in this research actually did. Most of the surveys and interviews were carried out inside doctor offices but it was also possible to access the hospital area, where I had short interviews with females who were in the labor process or had one day after giving birth, so the study was enriched with their complete process experience of childbirth in this hospital.
• **Interviews and survey preparation**

Surveys and interviews were carried out in order to understand how indigenous women value and perceive the maternal care provided in the health center.

Based on these criteria, the following indicators were selected for the interview and surveys content:

1. **Openness regarding practices and beliefs**
   - **Indicator**: Females satisfied with the free expression and openness of their beliefs, concepts and practices within maternal care.
   - **Example of variable to measure**: Has the user used any indigenous traditional method to care for her pregnancy? Has the medical provider shown acceptance of any use of indigenous traditional medicine during maternal care?

2. **Perception about the health controls during pregnancy**
   - **Indicator**: Females satisfied with the medical examination and treatment received.
   - **Example of variable to measure**: Does the user consider the health provider to have been tolerant and respectful during the maternal health process? Does the user feel empathy from the health provider?

3. **Thoughts regarding distance and time to get the medical care.**
   - **Indicator**: Females satisfied with relation time-distance to get maternal health care?
Example of variables to measure: How does the user feel regarding the way and time to get medical care? Has the user had any issue about the location and/or journey to the hospital?

4.- Use of indigenous language in the health center.

- Indicator: Maternal care conducted in the patient's language.
- Example of variable to measure: In what language has the medical care being carried out? Does the health center provide a translator for the non-Spanish speakers? How does the user feel about not using her native language during the medical care?

5.- Satisfaction about free and informed decision-making regarding their pregnancy and labor decisions

- Indicator: Females satisfied with the decision making process during the health care that allows them to make free and informed decisions about their health and body.
- Example of variable to measure: Has the user been allowed to participate in the decision-making about their pregnancy? Has the user decided how to give birth?

For the questions, the Likert scale with five categories was included, offering the following response options: Very satisfied — 1, Somewhat satisfied — 2, Neither satisfied nor dissatisfied — 3, Somewhat dissatisfied (a) — 4, Very dissatisfied — . I also asked them to explain and exemplify their answers.
Additionally, in the surveys there was a section for comments and open responses in order for the participants to comment further information on each question.

- **Ethics**

Through this section I will share about the main ethics aspects respecting this research. Firstly, this research included respect for Indigenous culture as the starting point and absolute requirement for the study. The consequent mutual respect facilitated building trust and establishing a safe space for exploring answers, points of view and thoughts to the research questions.

Therefore, before conducting the interviews and surveys, I explained individually to each participant the objective of this research, voluntary participation, anonymity and exclusively academic use of the information.

Despite the fact that this research was only aimed at participants who meet the majority age in Mexico, during the fieldwork in the hospital I met several indigenous pregnant women who did not reach the age of majority. With these women, I only had a brief conversation, but I omitted their responses so these were not included in the analysis of this study.

Additionally, this research reports no conflict of interest. As the researcher, I am the only one who has access to the complete information of the questionnaires, and this information is under my protection.\(^{10}\)

In this section I will explain how the research analysis was conducted and the main findings. The analysis of the information collected with the different field techniques allowed me to identify the relationship established between the population and the maternal health service provided by the study hospital. In this part of the research, the questions raised about the indigenous females’s experience with the service provided by the hospital were discussed. Most of the interviews and informal conversations were audio-recorded, with the permission of the participant. In addition to the recordings, each of the interviews was transcribed in its entirety.

The fieldwork was only based in the hospital mentioned before. The language used during all the process was Spanish, since I am fluent in the language and the participants were bilingual in their entirety.

The bilingualism of the indigenous women who participated in this research is due to the fact that the indigenous communities that are closer to the cities have a greater incidence to learn and use the Spanish language, unlike the indigenous communities located in the mountains and populations distant from the cities.

Although the largest concentration of indigenous people is at the rural level, I must clarify that the situation of insecurity in Mexico made me decide to carry out the fieldwork within a city and therefore I looked for a hospital that within the city would perform an intercultural program.
**Hospital context**

The hospital selected is located on the suburbs of the city of Veracruz, an area that has an average social backwardness index. It is surrounded by some unpaved streets and houses in poverty. In front of the hospital there are small businesses such as pharmacies, *fondas* (small restaurants of traditional Mexican food) and grocery stores.

Fig. 1. Houses made of tin sheets along the hospital. *Picture taken during the fieldwork.*

Fig. 2 Railroad tracks located in the hospital surrounds. *Picture taken during the fieldwork.*

It is a public hospital that does not need affiliation by the population. This means that users do not need to be subscribed to the national health system. For the payment of services there are recovery fees that depend on the socioeconomic level of the population.
Due to its geographical location belonging to the city of Veracruz, the hospital is easily accessible to the population that lives in the surroundings. For those who live in other areas of the city, it is a long way to go to be taken care of, in addition to the cost. Regarding this, the 43 female participants commented that they use public transport to get to the hospital, so the irregularity of collective transport leads to having to spend half a day and be absent from their homes and jobs to go to their routine medical check-ups.

"I have to wait more than an hour to get to my check-ups in the hospital. I have to take three buses to get here, so coming here implies an expense for my family, we already have two kids and only one income."

In addition to the conditions of the journey to get to the hospital, it is added the fact that to schedule the first pregnancy control appointment, the females have to go through a long period of time in line, and once they go to their scheduled appointments they also complain about the waiting time, showing an overdemand and low capacity of the medical services in this hospital.

The professionals who provide the follow-ups in pregnancy and attend deliveries are the obstetrician-gynecologists, with support of nurses and other health providers. But those directly responsible and specialists in maternal health are the first ones. The gynecologist-obstetrician is a doctor who has studied the professional career of medicine and whose specialty is gynecological-obstetrics. Due to its academic training, their task is to attend pregnancies and births considered high risk. These professionals are the only ones authorized to perform surgical interventions such as cesarean sections.
All the services provided by this hospital are in Spanish. However, if necessary and for the convenience of the user, someone within the hospital staff can be contacted, including technicians, cleaning staff or health providers who know the language and serve as translators. In this way, the hospital is attempting to provide an intercultural health service.

**Context of the participants**

This section provides information on indigenous women participating in this research that reveal some of the unfavorable general conditions of marginalization of indigenous population in terms of education and economic resources.

Participating women are on average 26 years old, with the youngest being 18 years old and the oldest being 42 years old. Regarding the educational level, half of the participants had secondary education, while the other half had only completed primary school. Only one participant with technical career studies was registered.

Part of the initial data prior to the interviews and surveys was about the marital situation of the female participants, where most of them said they have a partner but without civil obligations. The rest registered themselves as single. Additionally, when I asked about their work activity, all participants except for two women are dedicated to the care of the home and their kids. The two exceptions work as artisans within informal trade: as vendors of Mexican crafts.
As part of understanding their context, I also asked them if they practice any religion. All participants mentioned that they did practice a religion, resulting in being the Catholic religion as the dominant, followed by Christianity.

**Use of traditional indigenous medicine**

Among the indigenous communities there is the practice of traditional medicine, which in the case of maternal health is practiced by midwives. Traditional indigenous childbirth is characterized by a set of practices combined with magical-religious actions by midwives. In Mexico, traditional midwifery is a substantive part of traditional indigenous medicine, which is considered a *complete health system*. This has a whole traditional model of care for women in pregnancy, childbirth and puerperium, as well as for the newborn. Besides, traditional indigenous medicine also offers other remedies to maternal health with practices such as herbalism and the use of artifacts.

According to the questions about traditional indigenous medicine during the interviews, most of the participants commented that in general they are satisfied with the attitude of the health providers towards their beliefs and the use of traditional indigenous medicine.

Regarding the questions, the first part of the research asked directly if the participants practiced traditional indigenous medicine and if until now they had used any method or form of traditional indigenous medicine during their pregnancy. The results show that more than half of these women had used some traditional medicine method in conjunction with Western maternal health practices.
To further explain this part, the participants mentioned that in addition to the medical care they receive from health providers of the hospital, on their own they had visited “trusted midwives”, who had given them massages, applied creams, advice and revisions.

"I had to go see a midwife who recommended my cousin to accommodate my baby, so she massaged me because my baby was flipped over. She was very good as some of relatives have met her before during their pregnancies."

During one of the conversations I had with a nurse at the hospital, she shared that currently as part of the hospital’s intercultural program, in the hospital there are two midwives who use traditional indigenous methods to treat pregnancies and births. Unfortunately I was not able to find them since they only come if a female requests them. However, the nurse I spoke with told me that the participation of these midwives is not at the suggestion or motivation of health providers, but at the initiative of the indigenous women themselves who decide how they want their birth to be.

In addition to pregnancy, childbirth and postpartum guidance, the two midwives provide free courses at this hospital to prepare females and their partners for the childbirth. They are also responsible for taking patients to the hospital in case they need extra help during labor. They also visit females directly at home for check-ups.

Participants reported feeling more reassured to supplement their hospital follow-up with a midwife’s visit. This shows that health care practices for this population are not exclusive and that in some cases they complement each other, by uniting the Western health system with the traditional indigenous one.
"In addition to my visits with the doctor in the hospital, I visit my midwife at least every month, she gives me massages and applies creams so that my baby comes out well".

Besides, all the participants included the use of amulets, medals with saints and a red ribbon. As the others are self-explained, I asked them about the use of the red ribbon. They explained that it involves tying a red ribbon around the pregnant woman's belly, and placing a golden pin in the center. Females commented this practice was by recommendation of their mothers or grandmothers, and the objective was to keep the bad vibes away from the baby. Other participants also related this practice to the moon.

About the amulets, the participants commented that they referred to the use of moonstones, quartz, natural vanilla branches, bells, among other artifacts that are intended to help fertility, pregnancy and childbirth.

Some participants also mentioned the use of medicinal plants, as it is very common by indigenous communities and health providers are aware of it. The health providers interviewed mentioned that they are not opposed to the use of medicinal plants or amulets, but during the health controls they mention to apply them only externally, not to ingest them.

_Perceptions on the hospital’s maternal care_
So far I have discussed interesting variables about the participants’ practices surrounding the care of their pregnancy. To continue with the analysis, I will share about the perception of the indigenous females regarding the maternal care provided in the research hospital.

Covering the aspect of trust in health institutions is very important, since it is a key factor for the users to be convinced to attend hospitals and any medical service within a country.

As part of the findings, I can say that for many of the participants of this research there is an initial resistance when going for the first time to the maternal health control at the hospital, since there are prejudices on the part of women about what they will "do" to them in the hospital. Although most of these women have no direct experience with public services, i.e. they have never been attended by health personnel at their births; Likewise, they have built their own opinion from the experiences of third parties, in many cases negative.

In contrast, some of the interviewees did mention feeling more willing to treat their pregnancy and childbirth in a Western way, recognizing that the service is less risky or more beneficial for both mothers and their newborns. Indeed, these participants have a different profile, since they have a higher level of education (secondary and / technical career) and support network. However, this group of participants does not fully agree with the protocols of the Western health system.
Among the medical procedures that participants feel fear or nervousness to are cesarean sections, dilation measurement, being naked during childbirth and being seen by strangers during childbirth. Similarly, they feel uncomfortable being seen by different health providers at the time of delivery, especially in cases where these people are practitioners or men.

Many of the participants also mentioned feeling prejudiced by the medical providers in the hospital on one or more occasions when asking treatment-related questions. In addition, participants mentioned that they feel that they have sometimes received discriminatory attitudes, feeling infantilized when receiving medical explanations and unsafe to ask questions. Another participant commented that she felt judged by the medical provider for criticizing her pregnancy decision because of her age situation.

"I feel like they scold me when I’ve asked something, I don't feel good when they do it, that's why I prefer to keep quiet and just listen to what they have to tell me in my medical controls."

"In the hospital I was told I was too young to get pregnant, that I shouldn't do it. For me it's normal and it's my decision to get pregnant at 18".

   Because of that kind of feedback, I don't like to come in for my monthly checkups."

As for decision-making regarding maternal health, this is reflected during the medical controls because some doctors can anticipate a cesarean and generate the order in the hospital.

This results in indigenous females generally feeling that they have little or no decision-making power, so they prefer to accept only the decisions of health providers. They
see this because they feel that the health provider knows more than they do and in the end it may be best for their baby and health. Among the emotions generated in the participants by these experiences are fear, ignorance and stress when going to the medical controls at the hospital.

With the above, I can conclude that the attitudes indigenous females take during the care of their pregnancies and births are usually of two types:

- **Passive attitude:** accepting Western protocol, only what is proposed by health providers.
- **Active attitude:** requesting to take care of their pregnancy and birth with a midwife, supplementing the Western maternal health system with traditional indigenous medicine.

During the questions that included how participants would like to handle their pregnancy and give birth, all agreed with the following demands:

- Have easy access to timely and truthful information about the birthing process and types of delivery.
- Avoid the admission of outsiders during childbirth care, unless the woman’s consent.
- Treat the pregnant woman and her family with warmth and empathy.

Regarding the participants I interviewed shortly after giving birth, they shared that in the midst of the unpleasant situation that compromised the pain of childbirth and
medical procedures, they were able to find certain moments of relief and support by the health providers. In this sense, these women felt that the doctors and nurses really cared about them, considering this type of relationship as the most suitable for the difficult time they were going through.

"Everyone was very kind, I feel very grateful to the doctor and nurse, to everyone. They treated me very well even though the labor was painful. My baby and I are doing great, everything went well and that's the most important."

This section can be concluded that the quality of care varies depending on each individual. Nor is the aspect of interculturality monitored, since health providers in this hospital are only evaluated according to coverage goals. For the above, it is necessary to work on the quality of this intercultural health model in order to create bonds of trust with the users and meet their expectations of attention.

**About the use of indigenous languages**

This section is essential to add despite the fact that all the research was carried out in Spanish, since the issue of including the language of the population using the health service represents an intercultural model. As I mentioned in the previous sections, the study hospital is located in the city of Veracruz, where the vast majority of indigenous women living in the area are fluent in Spanish. Therefore, none of the respondents commented that they had any problem with the use of Spanish during their medical controls in the hospital.
Previously it was commented that the hospital is in a process of interculturalization, so although health providers do not speak indigenous languages, they did comment that the hospital has people who could act as translators of indigenous languages in case patients require it. During the fieldwork I did not have the opportunity to meet and talk with this person.

In the hospital there are two clinics or areas dedicated to maternal health, where there are informative images for pregnant women that include explanatory images and text only in Spanish.

![Fig.1 Warning Signs in Pregnancy. Maternal health clinic. Hospital General de Tarimoya, Veracruz, Mexico. Photo taken during the fieldwork.](image1)

![Fig.2 Steps towards successful and happy breastfeeding. Maternal health clinic. Hospital General de Tarimoya, Veracruz, Mexico. Photo taken during the fieldwork.](image2)

In addition, within the maternal health clinics, there are inclusive images for deaf-mute users. One of them is about *Mexican Sign Language*¹¹.

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¹¹ *Mexican Sign Language ("Lengua de Señas Mexicana" or LSM, also previously known by several other names), is a natural language that serves as the predominant language of the Deaf community in Mexico. LSM is a complete and organized visual language, which is expressed with the hands, face, and body, with its own distinct history, community, and culture. LSM originated in the mid-19th century following the establishment of the first school for the Deaf in Mexico City, Escuela Nacional de Sordomudos (ENS), in 1869. The number of native LSM signers is estimated to be between 49,000 and 195,000 people. Source: DBpedia.*
The Mexican Ministry of Health (Secretaría de Salud) recognizes the language barrier to care in health services and recommends that strategies be established to hire translators of the indigenous language in hospitals. It is also recommended that medical and nursing staff demonstrate cultural competence. In reality, there is an important gap between what the health system recommends and what is put into practice.

**Perception of the health providers to indigenous women**

This section includes health providers' thoughts regarding indigenous traditional practices. Therefore, in this part of the study I want to explore the conceptions that health providers have about their indigenous female patients in order to explain the type of relationship and the treatment/use regarding maternal health.

In the conversations I had with the health providers, all of them pointed out that interculturality in health is essential, given that main users of this hospital carry out cultural practices in their daily lives. They also understand the context of the users, as
most of them are illiterate or semi-illiterate, and they come from poor socioeconomic situations or extreme poverty.

In general, the health providers interviewed commented that they agree that both traditional indigenous medicine practices and those of western biomedical science should be merged. They also reported openness to working with midwives in the whole pregnancy process, but so far they had not had the opportunity to do so.

Additionally, despite having openness about attending deliveries alongside with traditional midwives, the health providers have some concerns when commenting that more medical difficulties may occur due to the lack of hygiene during the delivery process through traditional indigenous methods and the health conditions of the indigenous females in general because, as they commented, most pregnancies in indigenous communities women are very young, some even minors, have problems of overweight or malnutrition, as well as may have other undiagnosed diseases that could hinder pregnancy and childbirth, and even put the lives of the mothers and baby at risk.

Thus, among the comments that health providers also shared during our interviews, there were different descriptions for the indigenous women in general, which could be included in one: ignorance regarding health.

This reinforces the supposed need for a guardian or someone with legitimacy to be able to direct or influence their pregnancy and labor decisions. For this reason, it could be said that this figure of tutelage is very present in the females, resulting in the possibility that the health providers feel the legitimacy to decide when planning or
attending births. As a consequence, the treatment provided by the hospital and the trust that women have in the service would be affected by this type of asymmetrical relationship that health providers maintain.

**Limitations and challenges**

I also would like to share about what I perceive as main challenges and limitations during the fieldwork. An initial challenge I faced was the limited number of participants representing both the patients and health providers. Initially, I planned to interview more people, nevertheless the hospital's demand for morning hours was overestimated and I had to follow the timing of the hospital's activities, which include patient registration, waiting time before consultations, among others.

Another challenge during the fieldwork was non-verbal communication. With this I mean that non-verbal communication was not investigated during this research. Non-verbal communication such as posture, facial expressions, and eye contact also influences the result of intercultural doctor-patient communication. Previous research has shown that cultural differences exist in the use of nonverbal communication. More specifically cultural variation exists in the manner in which cultures touch, utilize interpersonal space, react to time, and move their bodies (Richmond & McCroskey, 2004). Considering this, more research is needed to explore the influence of non-verbal communication on intercultural communication within health care.

Finally, the examined hospital may be atypical of most health organizations in Mexico, as it is one of few health centers located in an urban area which is conducting an
intercultural approach. This fact makes the intercultural process easier with patients who, despite having indigenous roots and want to continue with their traditions, are not people who only perceive their traditions as correct, but are trying to engage, by own decision or by the system, with the occidental maternal care.

5. CONCLUSIONS

In this research the difficulties perceived among Mexican indigenous women are visible, since these communities have social and economic disadvantages compared to the non-indigenous population, which are derived from the colonial past of the country.

Regarding the main question of this research: How is the maternal health system perceived by indigenous women in terms of their culture?, The analysis shows that perceptions of indigenous women about the western maternal care are varied, but it depends to a large extent on the cultural relationships established by health providers that respond to their culture and traditions. Empathy, active listening and warmth during pregnancy follow-up controls and during the labor process were related as the main components of intercultural communication between participants and health providers.

Regarding the use of Spanish as the exclusive language during medical check-ups in the hospital, in this research the participants are not greatly affected since they are in the urban context, so they are bilingual and fluent in this language. However, this fact represents a gap that still needs to be covered in order to achieve a true intercultural model for indigenous peoples, by making them adapt to the dominant model.
The responses obtained from the participants in few words reflect that the humanization and intercultural adequacy of pregnancy and childbirth care make it possible to overcome some of the barriers that prevent indigenous women from accepting the Western health system. According to the responses, the implementation of traditional midwifery with the Western maternal health system has a positive role in these communities, increasing trust and collaboration of roles in both approaches.

As for the participating health providers, they understand intercultural health as allowing some indigenous customs during pregnancy and childbirth, but always under Western medical parameters. This justifies doctor-patient relations as a power relationship, where the health professional has the authority legitimized by the social system as by the patient herself to decide on the health of her patient. Therefore, the maternal care provided and women's trust in this would be affected by this type of asymmetrical relationship.

In general words I can say that studying the implementation of the interculturality strategy in this hospital, I found several gaps between what was proposed and what was actually happening, between what the users expected and what they ultimately experienced.

Not feeling one hundred percent identified with the medical service, females seek alternatives from their indigenous traditional medicine to meet their needs not only regarding health but culture. For that reason, this research is considered an opportunity to reflectively listen to both parties involved in maternal health, considering
that both voices (indigenous women and health providers) are valid, but in order to adjust the lexicon around maternal health care to be culturally safe.

This research is relevant within ComDev studies as it focuses on some of the collateral effects of Westernization: leaving behind the marginalized or minority groups. The research was based in Mexico, but this study shows that intercultural health models are being replicated in other countries. In addition, this research aimed at bringing something relevant to the table by focusing on the health promotion discourse in multicultural societies.
6. **ANNEX**

A brief description to understand some terms mentioned in this dissertation.

- **Western health system**
  Faced with the difficulty in defining and characterizing a system of modern medicine, the World Health Organization (WHO) refers to it as the prevailing biomedical model, official in the ministries of Health, and validated by the academic training of the world's medical schools.

- **Indigenous Traditional Medicine**
  For a health system to be considered traditional, in addition to its theoretical-practical elements, it must meet the requirement of having historical, cultural and social roots, in the framework of the tradition of a people. Thus, traditional medicine is defined in accordance with the tradition of the people who use it.
  Greebe (1988) proposed that traditional medicines constitute an anonymous heritage of a people, that they are transmitted from generation to generation by oral transmission, that their beliefs and practices are enduring, that they are based on empirical knowledge about the environment based on, which encompasses a small number of resources and components on which each culture differs by its particular use.

- **Multiculturality**
  *Multiculturality, multicultural:* Including people who have many different customs and beliefs, or relating to a society, organization, city, among others.

**SOURCES**


7. BIBLIOGRAPHY


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