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“Traditional Mexican Midwifery” Tourism Excludes Indigenous “Others”

Abstract

Drawn by the allure of “ancient cultures,” tourists inadvertently consume deauthenticating indigenous practices, including ethnomedical traditions such as midwifery. This is especially true in the case of “Traditional Mexican Midwifery” since stark differences exist between how midwifery practices unfold in indigenous contexts and how they are represented to global tourists. “Traditional Mexican Midwifery” tourism is a unique lens for examining some of the underlying, intersectional issues threatening “sustainability” in ethnomedical tourism. When nonindigenous individuals position themselves as representatives of “Traditional Mexican Midwifery” and indigenous midwives are excluded from profit chains, this type of tourism not only fails to meet the needs of the indigenous people it fetishizes, it actually excludes them from the equation entirely. While overt prejudice and racial discrimination of the colonial era no longer exist, neocolonial tourism in the form of “Traditional Mexican Midwifery” tourism subtly reinforces romanticized stereotypes of the indigenous “Other.” Ethnographic examples, gleaned from multi-sited research in Mexico and Brazil, demonstrate the usefulness of “Traditional Mexican Midwifery” for critiquing existing misapplications of responsible tourism and proposing more sustainable futures. Tourism can be an indigenous process (in which local residents both motivate and reap the benefits of tourism), or it can serve a neocolonial agenda (in which tourism development and profits unequivocally favor transnational elites). Current forms of “Traditional Mexican Midwifery” tourism are unsustainable due to intersectional exclusion of indigenous women based on race, class, and gender. To dismantle intersectional inequality in “Traditional Mexican Midwifery,” coordinated efforts by Mexican Secretary of Health’s Traditional Medicine and Intercultural Development (TMID), Mexican Midwifery Association, and critical tourism scholars and activists are required.

Keywords:

Migration, Tourism, Reproduction, Indigeneity, Latin America

Introduction

While traditional Mexican midwifery is deeply rooted in Mexico’s indigenous cultures, these practices have recently become a draw for tourists globally. The version tourists consume is often deauthenticating, as individuals offering themselves as representatives of these practices

do not belong to the communities from which the practices originate. I have placed quotation marks around “Traditional Mexican Midwifery” when referring to this type of tourism to highlight the stark differences between how midwifery practices unfold in indigenous contexts and how they are represented to global tourists. In essence, traditional practices have been usurped from their original contexts and reconfigured for tourists’ consumption.

This article provides ethnographic examples of how “Traditional Mexican Midwifery” tourism is unfolding across Mexico, and how it has been “offshored” to Brazil, tracing the multiple ways Mexican midwives and indigenous women are excluded from such tourism and its profit chains. These unequal power structures evidence colonial legacies continuing to unfold in Mexico today, suggesting “Traditional Mexican Midwifery” may be neocolonial in nature.

By questioning whether “Traditional Mexican Midwifery” tourism is an example of neocolonial tourism, I am not only querying the economic impacts (or lack thereof) on the “destination region,” but also its potential effects on “race” and class inequalities. Since tourism is a *process*, this article examines the directional flows of ideas, people, and capital. Has “Traditional Mexican Midwifery” tourism been developed to meet the needs of the Mexican midwives it represents? I argue it not only fails to meet the needs of the indigenous people it fetishizes (from an extended distance), it actually excludes them from the equation entirely.

This article is about multiple, contingent *intersectional racialization processes* (Crenshaw, 1995 and 2014; Bridges, 2011; De Genova, 2005). I extend Kimberlé Crenshaw’s concept of “intersectionality” to explore ways in which race makes class and class makes race. Intersectionality is a conceptual tool for understanding how different dimensions of inequality co-construct one another (Granzka, 2014). I use intersectionality as a way of thinking about the problem of sameness and difference in relation to power, a foundational logic of interlocking oppressions, and an examination of systemic domination overlapping race, gender, and socioeconomic class (see Yuval Davis, 2006; Granzka, 2014; Cohen, 1997). Merging Crenshaw’s concept of “intersectionality” with Bridges’ perspective on pregnancy as a “site of racialization” and “race as a process,” I draw attention to the ongoing, interfacing processes leading to the material (re)realization of racial inequality.

Elsewhere, I use an intersectional approach to problematize notions of “empowerment” and “free choice” (Author, 2018). Interest among nonindigenous individuals in “Traditional Mexican Midwifery” is intimately intertwined with the humanized birth movement in Mexico—

a movement inspired by alternative birth in the Global North (see below). Empowerment is so central to the ideological underpinning of the humanized birth movement that the 2014 World Week for Humanized Birth's slogan is, "*Parir es poder: empoderate*" ("To Give Birth is to Be Empowered: Empower Yourself," my translation). My intersectional approach reveals, contrary to the intentions of multiple public health programs in Mexico, hegemony is reinscribed when transnational midwives "empower" indigenous midwives living in rural settings with ideas from the Global North. Labeling some women as "empowered" and others "disempowered" produces a false binary, obscuring more about agency and dynamism than it reveals. Instead, an intersectional approach allows for nuances to emerge from multiple intersections among gender, race, and class.

An advantage of intersectional approaches is insights gleaned are place-based and specific to the study population. With these insights, I argue the notion of "empowerment" is based on neoliberal values originating in the Global North (e.g. individualism and choice). For most Mexican women, choices are either nonexistent or prestructured. The very idea of "choice" emerges from a middle- and upper-class perspective—"choice" is a privilege of those affording private medical services.

This article builds upon prior publications. I use "Traditional Mexican Midwifery" tourism as a unique lens for examining underlying, intersectional issues threatening "sustainability" in ethnomedical tourism. Analyzing the physical and social mobility of some individuals and the relative immobility of others, I argue "Traditional Mexican Midwifery" is unsustainable due to the intersectional exclusion of indigenous women based on race, class, and genderⁱ.

This study uses the lens of "Traditional Mexican Midwifery" tourism to offer an overarching critique regarding responsible tourism. This critique can be applied to a range of medical tourism practices, along with "ethnic" tourism practices more generally. I propose reconfiguring responsible tourism to emphasize the cultural aspects of sustainability. Responsible tourism, when applied to medical tourism, holds potential for (re)defining social sustainability.

Humanized Birth vs. Traditional Birth

Focus is primarily on two contrasting types of birth: “humanized birth” (a type of alternative birth that has become a marker of cultural capital among affluent Mexican couples) and “traditional birth” (a type of alternative birth practiced among indigenous communities for generations). Both humanized and traditional births represent alternatives to medicalized births the majority of Mexican women experience when birthing in a hospital setting. Couples having a humanized birth value their ability to choose the particular professional attending the birth, which family members will be present, which physical positions they prefer for various stages of the birthing process, and the type of environment in which they will give birth. In contrast, as recipients of conditional cash transfers, women who have traditional births are actively defying Mexican Secretary of Health’s mandate that *all* births take place in hospitals since *every* birth can potentially involve life-threatening complications (Author, 2017 and 2018a). Their births are less about choosing details of the birth and more about resistance to the subjugation of their bodies (Foucault, 1990[1978]).

By studying humanized and traditional births together, I bring unequal power structures into stark relief. Nader (1972) critiques the tendency among anthropologists to denounce unequal societal power structures through ethnographic observations of marginalized, disempowered, and lower-class individuals. This tendency is considered “studying down” because anthropologists are casting their analytical gaze down toward the bottom of the socioeconomic spectrum. She suggests anthropologists harness the ethnographic method to shift their gaze toward the top of the socioeconomic spectrum, thus opening up new possibilities for critically analyzing how inequality is produced from within seats of power. By “studying up”—conducting ethnographic research within spheres of affluence—I am heeding Nader’s 1972 argument. The alternative births I describe are accessible only to the wealthiest Mexican couples. The costs associated with a midwife-assisted alternative birth, including prenatal care, homeopathic treatments, and biodynamic sessions, are 31,600 pesos. Considering minimum wage in Mexico was 67 pesos daily during my research, this birth package represents 1.3 years of earnings. These births were commonly called *partos humanizados* (humanized birth) by parents, obstetricians, and professional midwives. The women I refer to as “professional midwives” self-identify with this term, are classified as such by their clients, and some (with important exceptions) have undergone formal training and licensure. Their categorization as “professional midwives”

distinguishes them from “traditional midwives” who practice in rural and indigenous contexts (described further, below).

As described by Davis-Floyd (1992), humanized birth is used in Mexico and elsewhere in Latin America to describe birth that purposefully resists medicalization and technocratic practices. The terms “humanized birth,” “gentle birth,” and “tranquil birth” are used interchangeably to describe a movement aiming to “empower” women and eliminate obstetric violence, and is analogous to the home and water birth movements in the United States, Canada, and Western Europe. Births are often attended by professional midwives (although some obstetricians have joined the movement) and accompanied by doulasⁱⁱ. Proponents criticize power inequality inherent in physician-patient relationships and denounce medicalized practices such as unnecessary cesarean sections, episiotomies, isolating birthing mothers in labor and delivery areas, labor induction (including use of hormones such as Pitocin), and repetitive insertion of medical personnel’s fingers into vaginas to assess dilation.

My study’s participants choosing humanized birth distance themselves from the majority of Mexican society they characterize as entrapped in a political and educational system limiting intellectuality. In line with Currid-Halkett’s (2017) theory of the aspirational class, these participants value education and New Age bodily practices as mechanisms for accruing cultural capital (Molinié, 2013; Aguilar Ros, 2013). With help of professional midwives representing a foreign or transnational identity, they aspire to join a transnational affluent, cultured community. Many professional midwives in Mexico are either foreign nationals or foreign trained.

Most couples hold advanced degrees in the sciences and humanities (as opposed to technical) fields, and has read widely in English or French. Their commitment to the humanized birth movement is based in their admiration of French obstetricians such as Frédéric Leboyer and Michel Odent, English and American midwifery and “gentle birth” advocates such as Sheila Kitsinger, Ina May Gaskin, Barbara Harper, Thomas Verney, and Robbie Davis-Floyd, and New Age birth methods such as hypnobirthing. Shared passion for humanized birth connects them to global communities in the United States, Canada, England, France, Holland, Spain, Chile, Argentina, and Brazil..

In contrast, the midwife-assisted births of indigenous women in rural contexts were referred to as *partos tradicionales* (traditional births). In referring to births as “humanized” and “traditional,” I am using terms I encountered in the field. “Traditional midwives” is the term

these practitioners use for themselves; I am not extending an essentialized notion of traditional birth. Findings of my larger ethnographic research project belied the traditional/modern binary (Author, 2018). However, for many indigenous people across Mexico, certain birthing practices are widely referred to as “traditional.” Recently, the Organization of Indigenous Doctors of the State of Chiapas (OMIECH) reiterated the sentiments of many of my indigenous informants when describing traditional birth as being threatened and worth defending.

The traditional births I observed involve indigenous midwives attending indigenous mothers either in the midwife’s home-clinic or the birthing mother’s home. Since indigenous mothers often arrive with extended family in tow or are surrounded by family members in their home birth environment, these births are sensitive to how complex gender- and generational-hierarchies unfold in specific local contexts. The births often include herbal remedies and massage techniques. Some incorporate biomedical techniques by applying traditional medicine logic to “modern” resources. I observed a traditional midwife apply a postpartum IV to “replace vitamins”—administering IV fluid is cast as a more direct method of providing blood tonic than postpartum soups and teas. Traditional birth is a medically pluralistic form, and, thus, the IV is combined with a postpartum herbal bath. Payment schemes are flexible in quantity, timing, and type, often reflecting the socioeconomic realities in rural indigenous villages.

“Traditional Mexican Midwifery” tourism is unfolding within this context, on both a national and international scale. Tourists are humanized birth proponents, passionate about natural birth and often striving to lead organic lives with an emphasis on holistic health. Their curiosity about “traditional Mexican midwifery” is fueled by a desire to “go back to nature.” In their collective imaginary, indigenous birth is not (and should not be) medically pluralistic and does not make use of “modern” resources. Violations to this imaginary can be met with moralistic judgments—one informant openly criticized an indigenous midwife who, in her opinion, was corrupting the traditional art of midwifery by wearing surgical gloves and a sterilized gown while attending birth. From the perspective of humanized birth proponents whom I have interviewed and observed, indigenous birth should be performed as it has been for centuries, thus preserving “Mexican tradition.” In this way, indigenous women and their midwives are interpellated as representatives of the precolonial roots of Mexico. Given these divergencies in economic and material resources, moralistic expectations, geographic space, and

fictive time, this article uses an intersectional approach to evaluate the effects of “Traditional Mexican Midwifery” tourism on individuals with different positionalities in society.

Intersectionality and Responsible Tourism Studies

Intersectionality is a multifaceted concept rich with interdisciplinary applications. Here, I explore how the concept has been put to work within tourism studies and adjacent fields of research.

In her recent article (2018), Shelagh Mooney asserts, “The adoption of an intersectional approach by tourism researchers has been relatively limited” (175). She notes a similar underutilization of the concept in hospitality and leisure studies. Likewise, McBride et al. suggest researchers of work and employment relations are not “taking enough notice” of intersectionality as a valuable theoretical tool. Bowleg argues intersectionality is an important theoretical framework for public health, yet “public health studies that reflect intersectionality in their theoretical frameworks, designs, analyses, or interpretations are rare” (Bowleg 2012:1267). In their respective fields of studies, researchers have tended to study each social category (e.g., race, ethnicity, gender, socioeconomic status, etc.) in isolation. Returning to tourism studies, Mooney advocates an intersectional approach for tourism researchers since exploring one aspect of diversity in isolation is akin to seeing merely one piece of a complex puzzle.

One example of intersectionality being powerfully deployed in tourism studies is Cole’s intersectional analysis (2017) of the gender-water-tourism nexus in Labuan Bajo, Indonesia, an emergent tourism destination. Cole, a feminist political ecologist, notes how women bear the brunt of burdens of water scarcity, and examines which women, why, and to what effect. Cole’s ethnographic research with over one hundred respondents reveals how patriarchal cultural norms, ethnicity, socioeconomic status, life stage, and proximity to water sources intersect to (re)produce gender inequality. She concludes tourism outcompetes locals for access to water, exacerbating women’s suffering.

Identifying a need for more intersectional approaches among tourism researchers, Chambers (2017) suggested “a more critical unpacking of [gender’s] ability to produce and (re)produce power relationships in tourism and travel” (as cited in Mooney, 2018). Figueroa-Domecq et al. (2015) argue the tourism academy must replace its Western-centric focus with

more critical perspectives when exploring race, gender, and other aspects of identity in diverse tourism contexts (as cited in Mooney 2018).

In direct response to these exhortations, I turn to intersectionality as tool for “decentralising the tourism universe” (Ateljevic et al., 2007:24-26; also Tucker and Hayes, 2019), framing intersectionality “as a form of social critique so as to foreground its radical capacity to attend to and disrupt oppressive vehicles of power” (Dhamoon, 2011). The ultimate aim of using an intersectional approach is to uncover new insights for creating responsible tourism through social sustainability.

Studies have described responsible tourism as a product consumed by an ethically oriented market segment (Goodwin & Francis, 2003; Weeden, 2013). Grimwood et al. explain, “The term tends to denote a process of planning, policy, and development that prioritizes the community-level involvement, sustainable resource management, equitable distribution of benefits, and minimal negative impacts to local contexts” (Grimwood et al., 2014:22-23; also Goodwin, 2011; Pickel-Chevalier et al., 2019). Leslie (2012) asserts responsible tourism generates tourism experiences underpinned by holistic, moral concern at multiple levels: the well-being of individual, community, and broader social and physical environment. Criticisms of the practice include it more often serves as a marketing ploy than an ethical planning mechanism (Wheeller, 1991), it aids in the expansion of neoliberalism (Duffy, 2008), and it reproduces power differentials reminiscent of colonial regimes (Sin, 2010). By bringing intersectional theorizing to bear on responsible tourism, my hope is responsible tourism efforts will not merely serve as public relations tactics, but will ameliorate the neocolonial effects of tourism by disrupting existing power inequalities.

Kimberle Crenshaw, reflecting on intersectionality, the concept she first developed, has observed, “It is easier to call for intersectional analysis than perform it” (2011:230; as cited in Mooney, 2018). Crenshaw notes there is not one singular theory of intersectionality, leading to a lack of agreement regarding the intersectional research design process. Additionally, Crenshaw argues we resist moves toward standardization, stating, “intersectional analysis may take us down many roads, but we will only discover what it is by using it” (2011:233). Next, I describe the ethnographic research methods I used for studying intersectionality and “Traditional Mexican Midwifery” tourism.

Methods

My fieldwork, from October 2010 to November 2013, was conducted as part of my dissertation research. The dissertation was later published as an ethnographic monograph (Author 2018). My research produced valuable data regarding tourism—specifically, (im)mobilities; the effects of intersectional relationships among gender, class, and race; and lacking sustainability practices—that I have not discussed in publications prior to this article.

Since the founding of anthropology as a discipline, ethnographic fieldwork has been the primary method used for data collection (Malinowski, 1922). Specific methods include in-depth interviewing and participant observation. These generally require anthropologists to live among the population they are studying for an extended period of time. Following in the footsteps of Marcus (1995), Menéndez (1996), Rapp (2000), and Wilson (2004), I used ethnography to create a cartography of midwifery and humanized birth in Mexico, thus identifying different “windows” through which recent shifts in birth practices and health care can be examined (Table 1).

< Insert Table 1 - Caption: **Setting where data was obtained**, Source: Authors >

I began with professional midwives in Mexico, a contained and connected group of women, subsequently gaining access to their clientele. Concurrently, I interviewed different transnational humanized birth leaders about their respective roles in the movement, both globally and specifically in Mexico. To trace the contours of the cohesive social network emerging around humanized birth, I used a snowball sampling technique to recruit more couples and humanized birth attendants, including physicians and obstetric nurses, to my study (Clatts et. al, 1995). This technique is also called respondent-driven sampling or personal network sampling, since respondents refer the researcher to other members of their personal network.

Throughout my fieldwork, I attended multiple humanized birth conferences and volunteered at two different transnational NGOs, gaining access to training workshops for indigenous traditional midwives. Having befriended a few indigenous midwives, and while staying as a guest in their homes during repeat visits to their villages, I witnessed their interactions with indigenous women and the traditional midwifery care they provide. Finally, I

observed medical professionals and maternity patients in both private and public hospital settings and solicited interviews with physicians and policy makers (see Table 2).

< Insert Table 2 - Caption: **Types of participants in the study**, Source: Authors >

This process led me to the States of Guanajuato, Guerrero, Jalisco, México, San Luís Potosí, Veracruz, Chiapas, Oaxaca, Quintana Roo, Morelia, Querétaro, Puebla, Michoacán, and Nuevo León. I traveled to California for interviews, and Brazil for participant observation in "Traditional Mexican Midwifery" tourism (see Table 3). While the geographic breadth of this "field" was enormous, I traveled to meet, observe, and interview specific people who were conscientiously members of a cohesive transnational community. Individuals in my study have acquaintances, and often great friends, among other individuals in my study.

< Insert Table 3 - Caption: **Geographic distribution of participants in the study**, Source: Authors >

Interviews were semi-structured, lasting from 15 minutes to three hours with the average being approximately forty-five minutes. I tailored my questions to the interviewees' positionality within the humanized birth movement (whether the interviewee[s] was/were a mother, a couple, a humanized birth attendant [professional midwife, obstetrician, obstetric nurse], a traditional midwife, or a policy maker), but usually included questions to help me understand the interviewee(s)' positionality in society (education level, socioeconomic status, ethnicity, etc.). My questions generally followed these themes: his or her occupation, life history, perspectives on gender, the Mexican health system, positive and negative experiences with birth, and the shifting political climate regarding midwifery. By not overstructuring the interviews, I resisted scripting or leading the informants, allowing them to speak for themselves (Briggs, 1986).

Each day, after concluding in-depth interviews and participant observation, I typed up fieldnotes (Emerson et. al, 1995). By the end of the 28-month research period, my fieldnotes spanned 734 single-spaced pages. My data analysis is derived from detailed entries in my field diary, audio and video recordings from interviews, and digital ethnographic data gleaned from social media. Upon concluding my research, I engaged in an iterative process, using open coding

to identify emergent themes and synthesize higher order constructs. The primary themes emerging from this open coding process included the accrual of cultural capital; gender and class inequality; racialization processes; social mobility; and obstetric violence. Subthemes included the commodification of indigenous culture, ethnomedical tourism, unequal access to citizenship-based resources, and aspirational strategies within a meritocracy.

Open coding is important because it ensures data-driven analysis. Instead of using data analysis software to search my fieldnotes for *repeated terms*, I carefully read through my 700-plus pages of fieldnotes and created notecards for each *emergent theme*. While this hand coding was labor intensive, I recognized intersectional linkages between class, gender, and race that qualitative data analysis software would have missed.

All names throughout this ethnography are pseudonyms, except for humanized birth public figures whom I encountered at humanized birth events but were not direct participants in my research. I obtained IRB approval for this research from the University of California, Berkeley.

Hyper-Self-Reflexivity

The ethnographic vignettes appearing in this article are “thick descriptions” synthesized from fieldnotes written immediately after concluding participant observation each day (Geertz 1973). As such, the research methodology is ethnography, not autoethnography. I chose to write from a first person perspective to be transparent about my positionality with respect to the research (see Crossley 2019). Since ethnographers use their senses as their primary tools for data collection, all ethnography is, by definition, data that has been perceived through the ethnographer’s eyes and ears. I was not the subject of my research (See Ellis and Bochner 2000); instead, I used hyper-self-reflexivity to tell a story about study participants.

I was methodologically and ethically committed to Spivakian hyper-self-reflexivity (Kapoor,2004)—that is, acknowledging and intentionally resisting my own privilege to gain greater access to the lived experiences of my informants. This commitment was important given this article’s critique of multivalent processes leading to the inadvertent reinscription of social inequality between disadvantaged and privileged informants. While I am a woman of “ethnic” heritage (Mexican, Nahua, Blackfoot, and Chinese descent), I am also highly educated, privileged, and reared in urban and suburban United States. I cannot claim to be a subaltern,

“native” informant. During my research, I “unlearned my own privilege” (Spivak, 1988a:287; Spivak & Harasym, 1990:9) by adjusting to the socioeconomic standard of my research contexts; i.e., limiting my monthly budget to five thousand Mexican pesos (at the time, approximately four hundred dollars). Despite these efforts, I recognize “shedding privilege” can never be fully achieved.

My work uncovered “partial connections” (De la Cadena, 2015) and brought multiple “situated knowledges” under the same lens. It was sensitive to Haraway’s concern about inadvertently romanticizing and appropriating while claiming to see from positions of the less powerful (Haraway 2014:45). I readily recognized my “partial perspective” (Haraway, 2014) and admitted my potential as an ethnographer was limited.

Relying on translators limited my access and substantially changed the dynamic of interviews. I placed women’s comfort and privacy concerns during intimate moments over my desire for ethnographic material. This meant occasionally choosing not to be present at the moment of birth (see Table 4). While I have extensive training in the health sciences, I am not a midwife or medical professional with technical expertise; thus, I have never intervened during births.

< Insert Table 4 - Caption: **Women who were pregnant or recently pregnant in the study**, Source: Authors >

Practicing hyper-self-reflexivity has been advantageous. I was able to interview informants and conduct participant observation at both ends of the socioeconomic spectrum (Nader, 1972). Using hyper-self-reflexivity, I resisted *speaking for* the indigenous “Other” or placing the humanized birth tourist at the center. Postcolonial studies can sometimes fail to include the communities they seek to serve, thus reinscribing power differentials between the colonized and the colonizer (Grimwood et al., 2014; Hall & Tucker, 2004b). Resisting a Global North-centric perspective and instead striving to promote a multi-perspectival approach, I built upon Yan and Santos’ (2009) critique of how much of the literature on tourism focuses on Western perceptions of the Other, thus missing how the Other represents itself in contemporary tourism discourse. My hyper-self-reflexive research method avoided positivist assumptions of

universality and generalizability, and, therefore, augmented an intersectional approach to tourism studies.

Intersectional Axes of Analysis: Gender, Race, and Class

I have selected three intersectional axes of analysis: gender, race, and class. Gender is an important axis since the women in my study—including those who give birth via “humanized” and “traditional” methods—are pursuing alternatives to a biomedical system that often wrests power away from women and places it in the authoritative hands of (often male) obstetricians. While the concept of intersectionality helps to describe the sameness characterizing them, it also sheds light on the differences in their experiences. Their divergent positionalities in society are based on race and class. They seek alternatives to medicalized birth for different reasons, with different access to resources, and, ultimately, with different outcomes. By recognizing intergroup differences in groups presumed to be homogenous (in this case, “women”), the theoretical framework of this article dismantles positivist assumptions of universality and generalizability (Mooney, 2018).

I merge Crenshaw’s concept of “intersectionality” with Bridges’ perspective on pregnancy as a “site of racialization” and “race as a process.” I draw attention to the ongoing, interfacing processes leading to the material (re)realization of racial inequality. My perspective differs from Bridges since for her, in order to “get to” questions of race, she first had to “go through” issues of class: “The analytic of race had to be folded into an analytic that began with class” (Bridges, 2011:9). The experiences I encountered imbued in me an understanding of racialization as a process through which multiple axes of inequality intersect simultaneously.

When people first meet, they engage in an immediate, predominantly unconscious, mental calculus that includes race *and* class, and ultimately maps race *onto* class, *and vice versa*. This mental calculus incorporates phenotype, dress, education, language, nationality, etc. into racialized perceptions. Through ethnographic examples, I demonstrate how one’s intersectional positionality in society influences one’s perception of oneself and others, and, in turn, how one is perceived by others.

Departing from Bridges, the multivalent ways in which women across Mexico use pregnancy as a site of racialization leads me to conclude the physical body is only one of many

complexly related signs of racial difference, albeit an important one. The commodification of indigenous culture, differential access to citizenship-based resources, disparate degrees of social and physical mobility, and race- and class-specific expectations for motherhood is also windows for examining how intersectional racialization processes are woven into the everyday fabric of social life.

Romanticized Visions of Indigenous “Others” (and the Possibility of Self-Romanticization)

It became clear during the early stages of my research that one of the primary racializing effects of “Traditional Mexican Midwifery” tourism unfolded through romanticized visions of indigenous “Others.” Over time, my ethnographic observations revealed some indigenous study participants leveraged these racializing discourses to their own benefit. A few entries from my field diary will illustrate these points.

I boarded a second-class bus to Matehuala, connecting to Estación Catorce where I attended an event billed as an encuentro (a meeting of two cultures) between professional medical personnel and traditional midwives. It was sponsored by Secretary of Health’s office for Traditional Medicine and Intercultural Development (TMID) and organized by an anthropologist.

Nurses, physicians, anthropologists, and professional midwives, emerging as the source of expert knowledge, gave PowerPoint presentations to traditional midwives. Many were interested in New Age therapies; some even dedicated their presentations to the benefits of medicinal plants. While watching various professionals teach “traditional” remedies to traditional midwives, I perused the agenda for the three-day event. Will traditional midwives have an opportunity to share their expert knowledge? The last two entries, at the end of the final day, were presentations by “traditional midwives.” While all other entries named the presenting professional and presentation title, “traditional midwives” were unnamed and no information was given regarding their presentations.

Scanning the crowd, I noticed piercings and tattoos, foreigners with camping gear, and many people from Mexico City. Beside the registration table was a display of natural products for sale (shampoos, teas, marmalades, homeopathic remedies, etc.) These products and event publicity materials were branded with a cosmic/floral image and the Nahuatl word “Nanahtli.” Staffing the table was Sofia Gil, friend of the anthropologist who organized the event.

Traditional midwives were not involved in producing these items; however, one traditional midwife, Lilitiana López, was tasked with manning the table for a few hours—her expressed boredom and disinterest made me wonder about her feeling of dispossession.

Curious about the disjuncture between the encuentro's promotion and its manifest reality, I traveled to the TMID office in Mexico City to interview two planners of government health programs about the relationship between their published work on "interculturality" and what had unfolded at the encuentro. Explaining they sponsored the encuentro but were not involved in its planning or execution, both doctors assured me what I had witnessed is not representative of their work. They have planned and executed more than fifty highly successful Encounters for Mutual Enrichment Between Health Personnel and Traditional Midwives at which traditional midwifery knowledge was "rescued" from the ongoing threat of extinction. When I asked about their next encuentro, stating I would travel any distance to attend the type of event they described as it would be very informative for my research. . . . They advised Encounters for Mutual Enrichment are no longer being planned.

The encuentro is an example of economic and political inequalities between indigenous and nonindigenous peoples of Mexico, demonstrating how political economic power determines tourism development. It illustrates how indigenous midwives—nameless and interchangeable on the conference agenda—are excluded from determining their cultural images or representations, deciding how their midwifery and traditional medicine practices will be commodified and sold, and benefiting from the economic profits. Most of the literature on tourism as neocolonialism focus exclusively on international tourism. While this example involves mixed international and national tourism, it highlights ongoing exploitation of indigenous people and their cultural practices. This article critiques how indigenous midwifery practices are usurped, while indigenous midwives are excluded from decision-making processes and profit streams relating to the development of "Traditional Mexican Midwifery" tourism.

My ethnographic observations in Mexico suggest "Traditional Mexican Midwifery" tourism aims to present a precolonial fantasy of indigenous practices as "pure," "noble," and "untouched" by colonialism and modernity. Indigenous midwifery is described by nonindigenous humanized birth proponents as having maintained a primordial connection with nature through the preservation of centuries-old traditions. This fantasy is a "daydream" based on stereotypes and myths (Said, 1978:52). I argue the stereotyped images of indigenous midwives

currently being presented for consumption by popular Mexican midwifery tourists in fact represent the attitudes and opinions of the (neocolonial) tourists themselves (Kabbani, 1986; Volkman, 1990; and Picard, 1991). That is, “Traditional Mexican Midwifery” tourism confirms the myths and images already held by tourists about indigenous “Others.” “Traditional Mexican Midwifery” tourism “reinforce[s] the myths of the past through the symbols of the present” (Palmer, 1994:34). While it purportedly introduces tourists to “indigenous practices,” it primarily reflects globalized humanized birth principles, seen through a New Age, deauthenticated, reinvented “traditional” lens. Stated simply, indigenous traditions are remade “anew” through New Age iterations of humanized birth.

My ethnographic observations of “Traditional Mexican Midwifery” tourism demonstrate how indigenous practices are converted into a tourist attraction. “Traditional Mexican Midwifery” tourists are drawn to the allure of “ancient traditions.” This allure, however, is fabricated through neoliberal marketing. Indigenous people are not caught in a time warp, frozen in a past time, or live their lives and carry out their practices in a social vacuum. Humanized birth practitioners and traditional birth attendants come into frequent contact during training workshops, conferences, and fairs. While these encounters fuel the fetishization of indigenous practices by nonindigenous individuals, it has translated into material benefits for only a few specific indigenous participants, and has inadvertently reinforced racial hierarchies rooted in colonial legacies.

While the overt prejudice and racial discrimination of the colonial era no longer exist, neocolonial tourism in the form of “Traditional Mexican Midwifery” tourism subtly reinforces romanticized stereotypes of the indigenous “Other,” thereby reinscribing hegemonic structures rooted in the colonial past. I am not arguing “Traditional Mexican Midwifery” tourism creates racism—it is clear racism existed centuries before (Farrell, 1979; Manning, 1979; and LaFlamme, 1979)—however, my ethnographic research suggests this type of tourism reinforces preexisting structures of intersectional inequality, including racializing processes. “Traditional Mexican Midwifery” tourism is, thus, “neocolonial” in the sense it perpetuates inequality. By excluding in practice those it romanticizes, this type of tourism inadvertently asserts the superiority of one group over another.

Continuing my effort to “decentralize the tourism universe”— I turn to ethnographic observations with indigenous informants to exemplify what would likely happen if indigenous

individuals were incorporated as agents in “Traditional Mexican Midwifery” tourism. Given the opportunity, some indigenous individuals choose to leverage their own indigeneity as a source of cultural capital within humanized birth circles. Certain indigenous participants in my study used their indigeneity as a source of cultural capital, which in turn opened opportunities for increased social and economic capital. These indigenous informants realized by playing into the indigenous identity nonindigenous consumers imagine and fetishize, they could travel, gain renown in transnational humanized birth circles, and earn a living otherwise inaccessible to them. Two examples of this are Yanira García and Eugenia Navarro, traditional midwives in Tepoztlán and the High Mountains of Veracruz, respectively.

I traveled to Tepoztlán—an artsy community of affluent Mexicans and American expatriates. to visit with Yanira García. While this was our first meeting, I already knew something about the traditional midwife from an American-made documentary on her work. When the documentary was filmed, Yanira was attending birthing mothers at a feverish pace; both Mexican and foreign women traveled to Cuernavaca to give birth in her thriving home-clinic.

Yanira explained how she became a midwife and the unique position she holds within the transnational humanized birth community. Her mother, two aunts, grandmother, and two great-grandmothers were all midwives and curanderas. Yanira was first introduced to the transnational humanized birth community when she met Jan Tritten, editor-in-chief of Midwifery Today, at a midwifery conference.. She explained Midwifery Today invites “the most traditional” midwives to speak internationally, all expenses paid. As her reputation and her birthing clinic grew, Yanira began receiving apprentices from Austria, Denmark, Norway, Italy, Spain, Brazil, Costa Rica, the United States, and Israel. She organizes “exchanges” with these apprentices and has traveled to their countries to speak about her work.

Yanira is unique since she, and a few others across Mexico, has constructed an identity employing place-based knowledge as currency within transnational circles. Yanira’s celebrity is the result of an inherent contradiction: despite becoming transnational, she continues to be perceived as mononational. Yanira has become a traveling representative of the “unchanging” indigenous roots of Mexican birthing traditions. I wondered if Yanira’s paradoxical position is engendered by the transnational humanized birth community’s fetishization of indigeneity—a fascination allowing for a select few indigenous women to serve as representatives of traditional

Mexican midwifery at international conferences, but does not permit merging of “traditional” and “professional” midwifery.

Yanira’s case piqued my interest since she was selected for being one of the “most traditional” midwives in Mexico; however, she does not speak Nahuatl, and practices popularized “traditional” methods. Throughout my research, I had many opportunities to observe midwives who primarily or exclusively speak indigenous languages and whose repertoires comprise of remedies and techniques unknown in transnational circles; yet these midwives are not present at humanized birth conferences or Mexican Midwifery Association meetings.

In contrast, Eugenia is a primarily Nahua-speaking midwife who attends an exclusively Nahua clientele. Over several years, we formed a friendship through visits, letters, and phone calls. After many intimate conversations, I asked Eugenia to sit for a formal, video-recorded interview, explaining this footage could potentially be edited into an ethnographic film used to demonstrate the work of traditional midwives to American anthropology students and conference attendees. She acquiesced, on one condition: that I not start the video camera until she had finished dressing herself in her traditional indigenous attire, put on her best jewelry, and combed her hair. I agreed. She searched among several plastic bags, finally selecting the traditional blouse she wanted to wear while being filmed. She folded the pleats in her bata (a large piece of black wool cloth worn as a skirt) and straightened the lace and ribbons on her blouse in a methodical, almost ritualistic fashion. When I asked Eugenia for a formal interview, she exuded a sense of pride as she performed her “indigeneity” for imagined spectators. I was struck by the politics of representation and how different informants make concerted efforts to portray themselves in ways that meet disparate goals.

In the prior field diary entry, Eugenia carefully selects her clothing based on how she hopes to be perceived by others. This behavior is not unique to her or her context. Everyone engages in similar behavior. Readers of this article have dressed in an intentional manner for a job interview, and the attire selected likely differing from their everyday contexts and with the goal of giving an impression of professionalism. What separates Doña Eugenia is the image she hopes to create is one of romanticized indigeneity. While the field diary entry from Estación Catorce demonstrates how nonindigenous study participants romanticized indigenous “Others,”

Doña Eugenia's actions show how indigenous participants at times engage in self-romanticization, thereby leveraging their indigeneity as a source of cultural capital.

This example demonstrates that indigenous midwives are strategic individuals not totally lacking agency; however, I observed significant limitations to the agency they possess. A strength of intersectional approaches is they facilitate analysis beyond binary determinations. The same traditional midwives who successfully converted their indigeneity into a source of cultural capital faced obstacles when attempting to convert their cultural capital into professional recognition. I argue these obstacles are rooted in socioeconomic inequality.

To illuminate this point: Mexican Midwifery Association has a section focusing on traditional midwives, thereby demonstrating interest in traditional midwives as *objects*. Concurrently, traditional midwives are barred from the Association's professional guild. While many of the women heading the Association are not licensed to practice midwifery in Mexico—some are trained in the United States, others have earned certificates through online programs, while still others are trained in allied professions like obstetric nursing—they are all eligible for the protections and benefits of the professional guild based on having obtained “some form of academic training.” This criterion for inclusion is so inexact that, I argue, it primarily serves as a form of gatekeeping—an obstacle that “uneducated” (read: lower-class) midwives cannot afford to overcome.

“Traditional Mexican Midwifery” tourism: The Offshoring of Neocolonial Tourism?

Williams argues the tourism sector, “in its very nature, has perpetuated the legacy of colonialism, so much so that it may be conceptualized as a ‘neo-colonial phenomenon’” (Williams, 2012:191). Through continued colonial servitude, tourism transfers power from the destination country to foreign corporations (Williams, 2012:191; see also Gmelch, 2003; Zhang et al., 2019; and Wong, 2015). My participant observation in Mexican tourist destinations revealed that locals, surrounded by luxuries they can never partake in except as service workers, are painfully aware of their inferior status in the socioeconomic order (Author, 2018).

Using the lens of “Traditional Mexican Midwifery” tourism, my ethnographic research explores tourism capitalizing on interest in traditional Mexican midwifery while excluding indigenous midwives (and representatives of Mexico more generally). Not only has political and

economic power been wrested away from indigenous individuals, their visibility and ability to leverage their indigenous identities for increased cultural capital have also vanished. Stated differently, not only does this type of tourism fail to meet the needs of the indigenous people it fetishizes (from an extended distance), it actually excludes them from the equation entirely.

In the case of “offshoring” neocolonial tourism, indigenous individuals do not even have the admittedly problematic option of portraying themselves as the “objects” tourists wish to gaze upon (Urry, 1990:48). When “Traditional Mexican Midwifery” tourism is exported from Mexico, indigenous people have been physically removed from the touristic representations of their practices. In their absence, middle- and upper-class transnationals control how indigenous practices are represented for touristic consumption. What is consumed by popular Mexican midwifery tourists is not indigenous Mexico, but, rather, a vision of indigenous Mexico (Clifford, 1988:55). While a concern regarding global tourism is it integrates tourist destinations into the global capitalist system, when “Traditional Mexican Midwifery” is offshored, a vision of indigeneity is consumed while the indigenous individuals themselves are excluded from capitalist streams of commerce. A field note from Brazil will demonstrate this point.

Adeli Hirsch is a professional midwife renowned in the humanized birth community. I attended her international workshop on “traditional Mexican midwifery” in Florianópolis, the capital city of Santa Catarina, Brazil. The city, known for its high quality of life, unparalleled Human Development Index score among Brazilian capitals, nightlife, tourism, and dynamism, is second home for many Argentines, North Americans, Europeans, and Paulistanos; as a result, it is perhaps the “whitest” city in Brazil.

Adeli, reared in the United States and Mexico, is of Jewish and Mexican heritage. Like other successful professional midwives in Mexico, she studied midwifery in Texas. Most of the participants had traveled to Brazil from other Latin American countries to learn from Adeli. I was surprised how fair the group was—although we were in Brazil, there were very few women of African descent. As we introduced ourselves, Adeli commented I was the only Mexican at this workshop on “Traditional Mexican Midwifery.” I quickly explained that I, a person of mixed ethnic heritage reared in the United States, am an inadequate representative of Mexico.

For most of the week, we sat on the beach or in boats, listening to Adeli’s anecdotes of births she attended and her personal reproductive experiences. As the workshop transpired, I realized very little of what was taught is traditional Mexican midwifery. Most of the techniques

Adeli discussed are not the traditional techniques of indigenous midwives in Mexico. Her workshop included New Age explanations of homeopathy and how to make tinctures from placentas and placenta art. I increasingly wondered if what I was observing can be more aptly described as "Traditional Mexican Midwifery" tourism: middle- and upper-class women from across Latin America who are not midwives but interested enough in New Age notions of traditional midwifery, indigeneity, and "going back to nature" to travel internationally and spend a week on Brazilian beaches with someone offering herself as a representative of traditional midwifery knowledge.

My curiosity of whether the workshop was an example of traditional midwifery popular tourism became more persistent after we participated in a nighttime temascal ritual. Compared to temascales prepared by indigenous people in Mexico for healing purposes, this temascal was decidedly mild. The temperature was not as extreme; the door was opened frequently for participants to cool off; and there was no flogging with fragrant herbs..

After the ritual, the women emerged, crying, hugging, and kissing each other. As we shared our experiences, most of the women recounted the temascal had forced them to deal with old emotional traumas, and by the end of the ritual many had let go of fears and pain they had been harboring.

What struck me about this experience was how the temascal ritual had been extracted from its original geographic and sociocultural contexts; usurped, transported, and manipulated for profit within Florianópolis' tourism industry; and infused with New Age meanings which led to experiences of emotional cleansing and psychological healing among the participants that were wholly distinct from the way my indigenous informants experience the temascal. How does the New Age notion of healing allow for the mixing of concrete practices originating from disparate contexts and rooted in divergent ideologies? What are the unintended consequences of this ostensibly clean extraction of healing practices from the social milieu for which they were created?

The techniques Adeli taught were not authentic representations of traditional Mexican midwifery. From my extensive participant observations with both indigenous midwives and humanized birth practitioners, I recognize these techniques as a New Age reimagination of what indigenous birthing techniques might be like from the perspective of nonindigenous transnationals. Nonetheless, the workshop was premised on Adeli being a representative of

traditional indigenous knowledge. The fact that professional midwives go unquestioned when they stake claims to traditional knowledge, while traditional midwives are excluded from a national guild for professional midwives unless they undergo a formal course of study, speaks to the unequal power relations operating within Mexican midwifery.

This fieldnote in Brazil exemplifies how “Traditional Mexican Midwifery” tourism has been offshored—appropriating indigenous midwifery practices while fully excluding indigenous people. “Traditional Mexican Midwifery” tourism is thus an example of how “cultural heritage has been commoditized in a systemic way.... Tourism increasingly appropriates spaces and redefines the meaning of cultural objects” (Cywinski, 2015:21). “Traditional Mexican Midwifery” tourism has redefined the meanings of indigenous practices, thus maintaining an “ideological barrier” with colonial roots.

At first glance, the humanized birth movement among Latin American women appears to be an effort to move beyond the textual politics of science and technology to something even more radical. Through alternative and “traditional” birth techniques, humanized birth proponents aim to take back the power of women through ownership of their bodies’ natural ability to give birth, thereby “seizing the tools to mark the world that marked them as other” [Haraway, 1990:175]). While this would seem like a cyborg project of the twenty-first century, humanized birth does not satisfy Haraway’s utopic vision since it is not “rooted in claims about fundamental changes in the nature of class, race, and gender” (Haraway, 1990:161).

Haraway envisions “an emerging system of world order analogous in its novelty and scope to that created by industrial capitalism” (Haraway, 1990:161). In contrast, the humanized birth movement has given rise to global tourism practices deeply embedded in industrial capitalism. Haraway points to how science and technology provide fresh sources of power. My ethnographic fieldnotes demonstrate that although it purports to, “Traditional Mexican Midwifery” tourism does not invert this power. While the participants I describe are all women, those who control the representation of cultural products for tourists’ consumption and those who are excluded from participating are categorically distinct based on class and race. In this way, “Traditional Mexican Midwifery” tourism exemplifies intersectional inequality.

For these reasons, I argue New Age, “traditional,” and “holistic” therapies are not a panacea for the biomedical control of women’s bodies. While they may be beneficial and liberating for some women, they exclude other women by reinscribing colonially-rooted

inequalities. As with biomedical techniques, these therapies also require fresh sources of analysis and political action (Latour, 1987).

Conclusion: Seeking Social Sustainability in “Traditional Mexican Midwifery” tourism through Responsible Tourism?

Tourism can be an indigenous process (in which local residents both motivate and reap the benefits of tourism), or it can serve a neocolonial agenda (in which tourism development and profits unequivocally favor transnational elites). This distinction illustrates how political economic inequality intersects with racialization processes during tourism development. In the case of “Traditional Mexican Midwifery” tourism, I argue romanticization of indigeneity without including the actual views and needs of indigenous individuals is a clear indication of neocolonialism. “Traditional Mexican Midwifery” tourism does not rely primarily on indigenous midwives to determine how their midwifery practices will be represented and circulated on the global stage.; instead, “indigeneity,” “traditionality,” and “nature” are conflated and subsequently commodified/fetishized by nonindigenous “allies” for economic profit. The ethnographic portions of this article have described inadvertent consequences when cultural tourism and medical tourism merge without including those whose ethnomedical practices are being consumed.

In conclusion, I explore the relationship between neocolonial tourism and social sustainability, adopting Smith et al.’s (2014) tripartite model of social sustainability. Smith et al. (2014), writing from the perspective of interior architecture, emphasize architects’ responsibility to work collaboratively with communities. Architects must strive to meet the needs of local residents, be agents of social justice, and protect cultural heritage. Based on this definition, I argue neocolonial forms of tourism such as “Traditional Mexican Midwifery” tourism are not socially sustainable. It fails to meet the needs of the indigenous people it purportedly represents when it removes indigenous individuals from profit streams and deauthenticates indigenous practices. It belies the very essence of social justice and cultural heritage.

To suggest a more sustainable alternative, I bring existing literature on responsible tourism to bear on ethnomedical tourism such as “Traditional Mexican Midwifery” tourism. To my knowledge, this article is the first to bring together debates regarding responsible tourism and medical tourism. While this article focuses on the specific example of “Traditional Mexican

Midwifery” tourism, the lens of responsible tourism can be applied to a range of medical tourism practices, and “ethnic” tourism practices more generally. These novel applications of the responsible tourism concept points to its potential for (re)defining social sustainability. Thus, I am borrowing the concept of responsible tourism and reconfiguring it to emphasize what it offers with respect to the *cultural* aspects of sustainability.

I argue “Traditional Mexican Midwifery” tourism is a product consumed by a market segment that is “ethically oriented.” Humanized birth proponents care deeply about women’s empowerment, reducing unnecessary cesarean sections, and eliminating obstetric violence. My use of the responsible tourism framework highlights the good intentions of humanized birth proponents while also providing suggestions how their tourism practices can be improved for greater equity and inclusion. Grimwood et al. write, “Even good intentions discipline us to ignore certain truths, are never without their silences or modes of othering, and are always ripe for critical dialogue and debate” (Grimwood, 2014:23). This statement most definitely applies to humanized birth discourse. Grimwood et al. clarify their critique should not be construed as a denunciation. They highlight the potential virtue and value of responsible tourism and argue it should not be jettisoned altogether. They write, “Power circulates within discourses of responsibility to normalize particular versions of ‘truth,’ dismiss the presence of others, and reinforce certain kinds of social privilege and disenfranchisement. When we talk and write about responsibility in tourism, we invariably represent specific interests, values, and power relations” (Grimwood, 2014:35).

The unequal politics of representation and reentrenchment of intersectional inequalities I observed in “Traditional Mexican Midwifery” tourism are examples of what Grimwood et al. critique as the misapplication of responsible tourism. I applaud the value of humanized birth practices, and the virtue of eliminating violence toward women while empowering them to seize back control over their bodies and births. By no means do I wish to undermine the important work being accomplished by the humanized birth movement and its proponents. However, it is also important to note humanized birth discourse represents the interests and desires of its majority-affluent participants, inadvertently reinforcing their privilege and reinscribing the disenfranchisement of “unspeaking” indigenous “Others.”

Research on “Traditional Mexican Midwifery” tourism clarifies the apparent contradiction between Molinié’s argument and Aguilar Ros’ (2013) conceptualization of the

New Age as a postmodern, cosmopolitan, and countercultural alternative to materialism and consumption. I observed how desire among the “global professional class” (Spivak 2003) for “going back to nature” and “traditional ways of birthing” reinforces socioeconomic stratification and processes of racialization in the name of humanization and commodifies culture under the guise of rejecting consumption. The great irony is these parents view themselves as actively resisting materialism, but their very refusal of the consumerism, nationalism, and late capitalism they diagnose leads to the commodification of culture, heightened moralization and gradation of motherhood, reinscription of racial hierarchies, and (false) appropriation of indigenous notions of spirituality. The humanized birth movement explicitly avoids direct references to consumption. These mothers reject expensive baby carriages, nanny services, and similar markers of commodified or elite motherhood. They seek cloth wraps to bind their children to their bodies and promote mother-child bonding. Their cloth wraps, however, are not woven shawls indigenous women use; they are sold by companies using the internet to market humanized birth products as noncommodity commodities. “Traditional Mexican Midwifery” tourism serves as another instantiation of a noncommodity commodity.

Dismantling intersectional inequality in “Traditional Mexican Midwifery” tourism requires coordinated initiatives among Mexican Midwifery Association, Mexican Secretary of Health’s Traditional Medicine and Intercultural Development (TMID), and critical tourism scholars and activists.

To unseat class- and race-based inequality, Mexican Midwifery Association must cease viewing indigenous midwives as an object of interest and instead engage them as equals in the Association. This would mean redefining “professional training” within the Association so the empirical knowledge of indigenous midwives is valued and legitimized. Indigenous midwives should be welcomed into the professional guild and granted the same rights and protections as their academically-trained counterparts.

While Mexican Secretary of Health’s TMID sponsored the Estación Catorce *encuentro*, it did not fulfill its promise of mutual exchange between biomedically-trained health professionals and indigenous midwives. TMID must hold event organizers accountable for fulfilling the office’s stated purpose of supporting traditional medicine and intercultural development. Better still, TMID should return to planning and executing Encounters for Mutual Enrichment Between

Health Personnel and Traditional Midwives and, in the process, directly confirm these encounters are characterized by mutual exchange.

Lastly, critical tourism scholars and activists play a valuable role when it comes to realizing the potential of responsible tourism through heightened social sustainability. Critical tourism scholars should conduct further community-engaged research on ethnomedical tourism using an intersectional approach. To effect positive changes in “Traditional Mexican Midwifery” tourism, critical tourism activists are needed to sensitize Mexican Midwifery Association and Secretary of Health’s TMID to hidden cultural commodification. Effecting change at the grassroots level begins with spreading awareness about how celebration of “traditional” ways of birthing may inadvertently commodify indigeneity (Author, 2016) while excluding indigenous people from humanized birth discourse, cultural images and representations, and profit streams. Only through heightened awareness can intersectional inequalities in “Traditional Mexican Midwifery” tourism begin to come undone, thereby opening the door for responsible tourism that accomplishes its goal through social sustainability.

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ⁱ For a discussion of different analytical levels at which social divisions need to be studied, their ontological base, and their relations to each other, see Yuval-Davis, 2006.

ⁱⁱ Doulas are individuals—generally women—who are trained as birth coaches. Their primary role is to accompany, encourage, and comfort mothers during active labor. They also serve as representatives of the birthing mother's interest by advocating for her birth plan.