Birthing White Supremacy: U.S-Mexico Border, Whiteness, and Midwifery

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Abstract

In this thesis, I conduct a transnational analysis of the racialized hierarchies I observed during my research at La Clínica, a midwifery school and birth center on the U.S.-Mexico border. The discourse surrounding La Clínica couches the border space and the clinic in benevolent terms, but interviews with students of color reveal complicated racial and class politics that mediate the clinic and their experiences learning and working there. Students of color are thus motivated to form and create varying modalities of agency in order to define their experiences on their own terms, to express gratitude, and as a vehicle for survival in a predominantly white institution.

Keywords: midwifery and race; the U.S.-Mexico border; midwives; racial domination; feminism; transnational analyses

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Honor Code Upheld

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Honor Code Upheld

Introduction

My first day at La Clínica[1], I headed downstairs for the morning meeting after I had changed into my scrubs, but everyone who had been downstairs only moments before had vanished. I looked around confused, as if it had been a prank. I walked to the front of the clinic and found everyone who was coming off shift and everyone who was coming on standing, spilling out onto the street. "What's going on?" I asked the nearest student midwife. "Oh, we thought we had a car birth," she replied. My eyes widened. "What is that?" I asked, feeling naïve. She replied kindly, "It's when a mama is crowning in the car so we grab the car birth kit, with a bowl and gauze and stuff. But it turns out that her mom was just freaking out and ran into the clinic yelling which made us think it was a car birth." At a birth center and midwifery school like La Clínica, these were normal occurrences; for me, a college student doing research for her senior thesis project, it was a whole new reality.

I had met the previous day with Julia,[2] the Academic Director of the clinic who scheduled my shadowing days in twenty-four hour increments. Twenty-four hours on, twenty-four hours off, and so on for my first week. Thinking this schedule was normal for the clinic, I agreed.[3] I arrived ten minutes before my shift started at 8am with my breakfast, lunch, and dinner in Tupperware wrapped in a plastic grocery bag. Julia had told me that since I did not have any scrubs, she would lend me hers and drop them off before my shift. I went upstairs to put my things away while I chatted with some of the other student midwives.

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[1] La Clínica is what I refer to the clinic where I conducted my research. This name has been changed and identifying details have been obscured to preserve anonymity.
[2] All names and identifying details have been changed to preserve anonymity.
[3] This schedule I was given was one that La Clínica previously operated on, until they realized how detrimental and exhausting it was for students and midwives alike. The schedule of other students and midwives usually was a twelve-hour shift, then a twenty-four hour, then two days off.

"So are you observing today?" one asked.

"Yes I am, but Julia told me she would lend me her scrubs" I replied.

"Oh" another said, "She says that to people but she forgets a lot. Here, you can borrow mine" and kindly handed me an extra pair of her scrubs. I soon learned her name was Ariana. She had bright eyes, a kind face, and stocky build. I felt that we established a rapport easily and quickly, as only two women born and raised in California can. Ariana would later become one of my main interlocutors and was instrumental in helping me theorize what I call the "End of the Day Mentality," which I will explore in more depth in Chapter III.

After the potential car birth confusion, everyone gathered in the kitchen, stood in a circle and held hands, as they did every morning at 8 am during shift change. This quick morning meeting happened every day so that those coming off shift could communicate what had happened the night before to those coming on shift. That day, one senior midwife said, "there is someone in the purple room, who is in active labor. She's progressing and she's currently at six centimeters dilated, about 70% effaced. She came in at 5 am at about three centimeters, so she's progressing nicely." While I vaguely understood most of what she was saying, that "dilated" referred to how wide the mama's cervix had dilated, it was days until I learned that "effaced" referred to the thinness of the mama's cervix.

Hours later, after someone yelled "birth team" up the stairs and I bolted down them into the bathroom with the birthing tub,[4] I stood bleary eyed at the scene before me. It was quiet, the silence only broken by the mama's sighs through her contractions and the trembling of her large milk chocolate belly. Standing and leaning against the door jam, I took in the room. One student

[4] Birthing in water is believed to be beneficial to the mama because the water provides a "natural epidural" for pain relief. It is also believed to provide a gentler transition from "womb to world" as the baby has been surrounded by fluid while growing in the placenta.

midwife and one senior midwife[5] had large plastic gloves up above their elbows, while one students recorded time between contractions and the other observed. I stood and watched while the mama breathed and pushed and breathed and moaned and pushed. Soon, one student motioned to me and whispered, "You need to crouch or sit down in a birth." I quickly lowered myself.[6]

Research Setting

La Clínica was one of the first freestanding[7] birth centers and midwifery schools in the United States. Founded in the late eighties, it aimed to provide birth services to women on both sides of the U.S.-Mexico border. Today, it is still one of the most affordable places to give birth in Frontera, Texas. [8] The majority of its clients are Northern Mexican women, who live just across the border in Frontera, México and come to La Clínica to give birth in a natural, non-interventionist method with the added benefit of their child being an American citizen.

La Clínica is housed in two small buildings on a wide one-way street in Frontera, Texas. One is the birth clinic, with two large and two small birthing rooms, one with a bathroom attached with a tub that is used as a birthing pool. In the front of the clinic, there is a large *sala,* or waiting room, that is almost always filled to the brim with women at varying degrees of pregnancy; they were often accompanied by their families, spouses, boyfriends, and their newborns. Across from the *sala* are two exam rooms, similar to a doctor's office, with tall exam tables and stirrups and a lab area outside. Upstairs is a student area with lockers and large

[5] Student Midwives are currently enrolled in the midwifery training program and since they are not yet licensed, they have to be observed by licensed, or senior, midwives.
[6] I later asked one of the midwives why it was important for people in the birth to crouch down. She said that it makes the mama feel more comfortable because everyone in the room is at or below eye level. It also makes her feel more in control because no one is spatially above her.
[7] Freestanding here refers to being separate from a hospital.
[8] The name of the city has been changed and details obscured to preserve anonymity.

window seats where students would sleep on 24-hour, or birth, shifts. Behind the *sala* lies the kitchen, in the back of which is the midwives table: the beating heart of La Clínica for the midwives and students. Everyone gathered in the kitchen while the senior or resident midwives on call sat at the table nearly constantly, unless they were aiding the students with clients, doing paperwork. The second house contained the midwifery school separated from the center but a few houses down on the same side of the street. It consists of a kitchen with a classroom, a meeting area, a small "library" and Julia's office.

The demographics La Clínica serves have changed since its founding, paralleling the tightening of the U.S.-Mexico border. When it opened in the late 1980s, it aimed to serve poor Mexican women without health insurance. In recent years, however, those who repeatedly cross the border to the U.S. side are Mexican citizens who apply for a temporary border crossing visa, or a 'laser visa,' which necessitates that they demonstrate financial stability and "ties to Mexico that would compel them to return after a temporary stay in the U.S." ("Border Crossing Card"). Thus the visa is only available to those who can afford the visa fees and those who can demonstrate "financial stability." According to some of my interlocutors, demonstration of "financial stability" means evidence of at least $10,000 in the bank.

The costs of the birth center are partially subsidized by the students who attend the associated direct-entry[9] midwifery school. Due to the large influx of clients, students are able to complete the program rapidly in 13 months while a comparable program lasts roughly 3 years. At the same time, every client that La Clínica serves signs detailed consent forms and is informed that their care is in large part provided by students under a licensed midwife's

[9] Direct entry refers to different methods people can enter into the midwifery profession. Direct entry means that one went through a specifically midwifery program as opposed to becoming a nurse first and then getting a master's in midwifery as a Certified Nurse Midwife (CNM) does.

supervision. In doing so, it affords many Mexican women the agency to choose their birth environment, make natural, less interventionist birth affordable and accessible to a wide audience, while also facilitating Mexican women to have American-born babies.

Positionality and Methods

At the time of this research, I was a rising senior undergraduate student at a majority white privileged liberal arts institution. I am half-Latinx and half white, but am white-passing. I have only recently begun embracing and carving out a Latinx identity for myself. I myself was born in a birth center in southern California in a birthing pool by a midwife, providing my entry point for this research. My mother had given birth to my sister in a hospital and hated the experience; she told me they pumped her full of Pitocin in order to make her labor progress faster, which just made the contractions "come so fast, just one after another." After her negative experience giving birth in a hospital, she decided she wanted to give birth with a midwife in a bathtub. My parents often lauded my birth for my calm and even temperament as baby, which is very much in line with discourse surrounding water birth.[10] During my first meeting with Julia, I told her I was caught[11] by a midwife; she immediately asked me if I knew what the midwife's name was, as she probably knew her. Despite Julia's location in Frontera, TX, she was sure she would have known the midwife who caught me in Southern California nearly twenty-two years ago. To me, this demonstrated both the breadth of the midwifery world as well as the close proximity many of them enjoyed.

[10] See Footnote 4

[11] This is the language midwives use to describe deliveries. Instead of saying they "delivered" a child, they say they "caught" a child, in order to to linguistically relocate the action of delivery back to the mother.

My thesis is based on my modest ethnographic research that I conducted at La Clinica over two weeks in June of 2016. My methods consisted of intense participant observation, gaining trust, and establishing rapport with the student midwives. While I did not originally intend to focus on this population, they were the most accessible as well as the most racially diverse peoples at La Clínica. Additionally, I found the senior and resident midwives both very busy and reticent to speak at length candidly about La Clínica. I conducted interviews ranging in length from twenty to seventy minutes. I informed each and every person I interacted with at the clinic of the nature of my visit and that their testimony would be used as evidence for my thesis; after which I obtained verbal consent. [12]

Research Questions and Central Argument

My research questions that I explore in this thesis are: What are the implications of a historically white institution serving but also practicing on Mexican women's bodies? Is practicing on Mexican women's bodies ethically sound or does it function as a new manifestation of colonization and racial subjugation? How do the privileges of whiteness and citizenship function in a racialized border zone? How does the commodification of birth and U.S. citizenship complicate the transnational and racial hierarchies at work within the contemporary midwifery movement? How have race and class differences, which have long mediated the contemporary midwifery movement, impacted La Clínica, generally, and people of color, specifically?

I argue that La Clínica's deployment of racially coded language sustains persistent stereotypes about Mexican women as poor and uninsured. I argue that it falsely represents the clientele that they serve and that it adheres to the border rhetoric I outline in Chapter III. This

[12] Add Info about IRB approval etc. Benezet

rhetoric in turn legitimizes the clinic's existence, entices prospective students, informs care, and ultimately allows for the unconscious maintenance of white supremacy through the internalization of "white norms." Interviews with students of color reveal their struggles living within a space that privileges and upholds whiteness and permits the reproduction of systems of domination between women to occur. I argue that people of color employ several modalities of agency for self-definition and survival.

Theoretical Frameworks

In exploring these questions, I draw on a number of intertwined theoretical frameworks including Critical Whiteness Studies, Chicana Feminism, Borderlands theory, Transborder Theory, and Transnational Feminism, with a careful eye toward such constructs as gender, race, ethnicity, class, language, and citizenship. Drawing on Critical Whiteness Studies, I show that whiteness is often treated as an unmarked and neutral identity category and that it is exerted and perceived in unconscious actions. Barbara J. Flagg (1993) theorizes:

> White people externalize race. For most Whites, most of the time, to think or speak about race is to think or speak about people of color. . . we tend not to think of ourselves or our racial group as racially distinctive. Whites' 'consciousness' of whiteness is predominantly unconsciousness of whiteness. We perceive and interact with other whites as individuals who have no significant racial characteristics. In the same vein, the white person is unlikely to see or describe himself in racial terms, perhaps in part because his white peers do not regard him as racially distinctive. Whiteness is a transparent quality when whites interact with whites in the absence of people of color. Whiteness attains opacity, becomes apparent to the white mind, only in relation to, and contrast with, the 'color' of nonwhites (220).

White people are not perceived racially because whiteness is not perceived as a race, but rather as "normal," which implicitly renders nonwhites as "abnormal." This illustrates whites' unconscious of how their whiteness plays a role in their interactions. Critical to this theorization of whiteness is that whites interact and perceive each other *as individuals*, meaning that their

actions speak only to their individual character and do not reflect upon their entire race. Whiteness does not seem to exist when only whites interact with whites, but rather only becomes visible in relation or contrast with people of color's "color." In order to combat the seeming neutrality of whiteness, Flagg suggests that whites should "adopt a deliberate and thoroughgoing skepticism regarding the race neutrality. . . This stance has the potential to improve the distribution across races of goods and power that whites currently control. In addition, skepticism may help to foster the development of an antiracist white racial identity that does not posit whites as superior to blacks" (222). For Flagg, the congealing of white racial identity that does not reproduce racial hierarchies depends upon skepticism of race neutrality. Critical Whiteness Studies framework is integral to my thesis as it enables me to think through how whiteness itself operates as a modality of power which both permits racial domination between women to take place while simultaneously rendering this domination invisible. I engage in Chapter III.

Flagg's theorizing of whiteness helps us think through the metaphorical borders that are constructed between races, evoking Gloria Anzaldua's Borderlands theory. In her groundbreaking book *Borderlands/ La Frontera,* she characterizes the border as following:

> The U.S.-Mexican border *es una herida abierta*[13] where the Third World grates against the first and bleeds. And before a scab forms it hemorrhages again, the lifeblood of two worlds merging to form a third country—a border culture. Borders are set up to define the places that are safe and unsafe, to distinguish *us* from *them*. A border is a dividing line, a narrow strip along a steep edge. A borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary (1987, 25; *emphasis in original*).

[13] is an open wound

The border is not simply a line of division; Anzaldúa argues that "the lifeblood of the two worlds" merge to create a liminal borderlands space, constituted by both nations and the "emotional residue of an unnatural boundary." This unnatural boundary serves to separate and insulate "us from them." Anzaldúa's use of "bleed" "scab" and "hemorrhage" suggest imbued violence that both constitutes the space and vice versa. In this thesis, I employ Anzaldúa's concept of the border as a liminal and transformative space in which those who occupy it contest, blend, and form their identities and subjectivities into a more hybrid form.

Though Anzaldúa was also a foundational Chicana and queer feminist theorist, I invoke Norma Alarcón's article "Chicana Feminism: In the Tracks of 'the' Native Woman" (1992) to employ Chicana feminist frameworks within my analysis. She writes,

> Thus the name Chicana, in the present, is the name of the resistance that enables cultural and political points of departure and thinking through the multiple migrations and dislocations of women of "Mexican" descent. The name Chicana is not a name that women (or men) are born to or with, as is often the case with "Mexican," but rather it is consciously and critically assumed and serves as a point of re-departure for dismantling historical conjunctures of crisis, confusion, political and ideological conflict, and contradictions of the simultaneous effect of having "no names," having "many names," [and] not "know(ing) her names" (98).

From Alarcón's point of view, the identity category of "Chicana" is one that is consciously assumed in order to dismantle historical erasure of one's ethnic identity. Further, Alarcón references Anzaldúa in the simultaneous and contradictory space of having "no names. . . many names. . . not knowing her names." For Alarcón, the term Chicana is the "name of the resistance" that then provides an entry point to theorize about the "migrations and dislocations of women of 'Mexican; descent." This framework informs my understanding of how Mexican identity in the U.S. has largely been constructed, homogenized and reinforced by white people; this term

Chicana affords Mexican women, specifically, agency in taking ownership over their own identities.

I also employ Lynn Stephen's (2012) "transborder" concept that reads relations through "the colonial and contemporary mapping of space, place, people, race, and ethnicity, both literally and metaphorically as well as through U.S. immigration policy in the 19th and 20th centuries" (85). Stephen further theorizes that this concept of "transborder" helps elucidate "U.S.-Mexico relationships through time, the racialization of Mexicans in the U.S., and contemporary dynamics of migration and immigration" (2012, 85). While this concept gestures to Kimberlé Crenshaw's framework of "intersectionality"[14] in its consideration of the intersections of race, gender, class, and ethnicity, it also pays close attention to the spatial specifics of the U.S.-Mexico borderlands, which is a crucial specification for this thesis.

Though Ursula Biemann (2002) does not formally propose a theory, her perspective on the U.S-Mexico border space as it relates to transnationality is crucial to my own process of inquiry. She argues,

> The U.S.-Mexican border [is] a highly performative place. It is a place that is constituted discursively through the representation of the two nations and materially through the installation of a transnational corporate space in which different national discourses are both materialized and transcended. It is an ambivalent space at the fringes of two societies, remotely controlled by their core powers (100).

I find this spatial analysis useful as it directly frames the border space as both discursively constructed by both nations as well as by the corporatization NAFTA encouraged. Further, her

[14] In "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color" (1991), Kimberlé Crenshaw argues, "This article has presented intersectionality as a way of framing various interactions of race and gender in the context of violence against women of color. Yet intersectionality might be more broadly useful as a way of mediating the tension between assertions of multiple identity and the ongoing necessity of group politics" (1296)

characterization of the border space as ambivalent is one I return to in Chapter III of this thesis. Biemann continues,

> The border as a metaphor for various kinds of marginalizations becomes materialized, not only in architectural and structural measures but also in corporate and social regulations of gender. I focus, therefore, on the circulation of female bodies in the transnational zone and on the regulation of gender relations in representation, in the public sphere, the entertainment and sex industry, and in the reproductive politics of the *maquila*. . . In the border zone, everyone is being transformed into a transnational subject. Only bodies that can be marked, exchanged, and turned into a commodity, and recycled will be granted the entry visa that allows a certain mobility in the transnational space (2002, 101-103).

Her analysis that "in the border zone, everyone is being transformed into a transnational subject" is crucial especially as it relates to Anzaldúa's previous analysis of the borderlands space as liminal. It is this very state of liminality and transformation, itself colored by neoliberalism and U.S. based corporatism, that plays a part in my analysis of La Clínica. Yet Biemann seems to push this transformative aspect of the border zone further by arguing that only those who "can be marked, exchanged. . . and recycled," or commodified, may be granted admission. Only transnational subjects who may be potentially commodified, or be otherwise useful to a neoliberalist regime, are rendered legible and thereby allowed to access both sides of the border. This perspective is useful to this thesis as it predicates the movement of transnational subjects upon the commodification of their bodies, a theme I return to in Chapter III.

Though Biemann incorporates transnationality in her argument, I invoke Chandra Mohanty's "Under Western Eyes" (2003) to aid me in constructing a Transnational Feminist framework and in examining the trope of the "Third World woman." In her analysis, Mohanty critiques the manner in which the "Third World woman' has been largely been constructed by Western women:

> Legal, economic, religious, and familial structures are treated as phenomena to be judged by Western standards. . . When these structures are defined as 'underdeveloped' or 'developing' and women are placed within them, an implicit image of the 'average Third World woman' is produced. This is the transformation of the (implicitly Western) 'oppressed woman' is generated through an exclusive focus on gender difference, 'the oppressed Third World woman' category has an additional attribute—the 'Third World difference.' The Third World difference includes a paternalistic attitude toward women in the Third World. . . Third World women as a group are automatically and necessarily defined as religious (read: not progressive), family-oriented (read: traditional), legally unsophisticated (read: they are still not conscious of their rights), illiterate (read: ignorant), domestic (read: backward) . . . This is how the 'Third World difference' is produced" (40).

Mohanty defines the constructed differences between Third World women[15] and Western women as the "Third World difference," from which the image of the "average Third World woman" emerges. Of course, the idea of an "average" woman in the Third World erases the multiplicities of identities and subjectivities of women cross-culturally; indeed, Mohanty critiques this very phenomenon and its prevalence. Western women use these definitions of the Third World woman as "other" as a negative reference to congeal their own identities and subjectivities. Further, these definitions assigned to the Third World woman, such as ignorance, backward, and not progressive, thereby necessitate and naturalize this paternalistic attitude toward the Third World woman.[16] This naturalized paternalism and necessary interventionism then foregrounds my discussion of La Clínica's upholding of false narratives surrounding Mexican women in order to constitute white subjectivities in Chapter III.

Finally, I employ the work of Saba Mahmood to think about questions of agency. In her book, *The Politics of Piety* (2005), she writes,

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[15] Though the term "Third World" has largely fallen out of use, I employ the same language as Mohanty in order to stay consistent.
[16] See also *Do Muslim Women Still Need Saving* by Lila Abu-Lughod (2013).

> I question the overwhelming tendency within poststructuralist feminist scholarship to conceptualize agency in terms of subversion or resignification of social norms, to locate agency within those operations that resist the dominating and subjectivating modes of power. In other words, I will argue that the normative political subject of poststructuralist feminist theory often remains a liberatory one, whose agency is conceptualized on the binary model of subordination and subversion. In doing so, this scholarship elides dimensions of human action whose ethical and political status does not map onto the logic of repression and resistance. . . it is crucial to detach the notion of agency from the goals of repressive politics (14).

Drawing on ethnographic research that she conducted among women of the mosque movement in Cairo, Egypt, Mahmood complicates the liberal feminist equation of agency with resistance. She argues that this conception of agency obscures and erases human action that are not legible within this binary of agency/resistance. She then calls upon other feminist researchers and theorists to recognize other modalities of agency that are not about resistance to norms. For Mahmood, agency is not just resistance; rather, it can manifest in *not* saying or *not* doing, as agency is not necessarily active. Indeed, there are multiple modalities of agency that may play out simultaneously. Since there is a strong impetus for feminist research to recognize and elucidate agency, this perspective is crucial to my analysis of the End of the Day Mentality (EDM) in Chapter III, where I explore modalities of agency that are not about resistance.

While this thesis does engage certain conversations surrounding "anchor babies," I do not make it a focus of this thesis, as I fear this debate would obscure and dislocate its main objective of interrogating the racial and transnational hierarchies in a border zone within the contemporary midwifery movement.

Chapter Overview

This thesis is organized into three parts. In Chapter I, I provide a broader historical context for contemporary midwifery and describe its historical criminalization and pathologization in the East and Southwest regions of the United States. This section seeks to

provide the reader with adequate background and context for case study that I describe later in the thesis. In this section, I outline the process by which midwives were largely eradicated throughout the U.S. by demonizing and denouncing them in racial and misogynistic terms.

In Chapter II, I address the revitalization of the midwifery movement in the 1960's and 70s in the United States and the subsequent racialized hierarchies that emerged from the process of professionalization and legitimation. In doing so, I complicate the traditional midwifery conversation surrounding 'sisterhood' that effectively obscures this history of racial domination. I argue that the reemergence[17] of midwifery in the United States served to further disenfranchise non-white and immigrant women. I therefore show that feminist projects that predicate themselves on the benefit to "all women" fail to recognize the potential of domination between women to take place, thus providing an avenue for systems of power to be reproduced.

In Chapter III, I focus on La Clínica as a case study to provide grounded examples of these theories at work. I explore the origins of racialized stereotypes about Mexican people alongside the history of the U.S.-Mexico border, beginning in the latter half of the 19th century. I also investigate the relationship between the U.S.-Mexico border and the deployment of racialized and essentialized stereotypes of Mexican identity, which have historically served to homogenize Mexican populations. I further argue that the passage of NAFTA has facilitated the commodification of Mexican, particularly female, bodies in the borderlands space. More specific to the space of La Clínica, I analyze the way in which the clinic employs border rhetoric to

[17] To even deem the natural birth movement during the 1960's and '70's as the reemergence or resurgence is problematic as it erases and obscures the populations of midwives who continued to practice in their often rural communities. Though these terms are misnomers, I continue to use them throughout this thesis as it is what the surrounding literature and discourse employs. The reader should instead imagine quotes surrounding the term, as employing quotes every time I use "reemergence" would be tiresome for a thesis of this length.

falsely represent their clientele which in turn legitimizes the clinic's existence, entices prospective students, informs care, and ultimately allows for the unconscious maintenance of white supremacy through the internalization of "white norms." Further, I identify one modality of agency that I call the "End of the Day Mentality" or EDM which empowers students of color to intentional constitute their subjectivities, as an articulation of agency, express gratitude, and, most pertinently, as a survival tool for people of color in a white institution

Additionally, in Chapter III, I employ ethnographic vignettes to provide examples of my research in real time. I do this so that the reader may become more familiar with my research at La Clínica in its *everydayness* and convey a less mediated sense of my research. In providing less digested and long-form encounters with my interlocutors, I hope to provide a space so that they may speak on their own terms.

This thesis contributes to both fields of Southwest Studies and Feminist and Gender Studies as it engages theoretical frameworks crucial to both of these disciplines. Additionally, this thesis and subsequent analyses employs specific frameworks that are valid within both disciplines. Though the blending of these frameworks and analyses, I enact Anzaldua's borderlands theory in tangible space.

Chapter I:

Historical Criminalization and Disenfranchisement of Midwives 17th century to mid- 20th century in the Eastern and Southwestern United States

> Well, if it is going to happen . . . it's going to happen . . . Well sometimes you can . . . there was two women that I had sent to the doctor because the baby was a breech baby, and I couldn't do anything about it . . . and then another woman that has a baby over here . . . she was a mother already . . . they wanted me to deliver her but when I went up there to see her...I said no...I can't deliver this baby . . . let's go to the hospital right there in Rocksprings . . . they lived in a ranch on the other side of the river so we went up there and I told the doctor what I had found . . . he went up there and he was going to let one of the nurses...one of the doctor's nurses ...but I told him what the baby was... the baby's position . . . she was sitting down and he says...well...I guess I will take it and see what we can do ...and he went up there and looked at her... and after he prepared her and everything he went out there and talked to her husband and told him that it was a difficult delivery . . . that either one of them was going to perish . . . the woman or the baby . . . what did he want ...and he said..."Well...I don't know you are the doctor"...and he told him again..."Well I want to know if you know that this is going to happen" and he said "Well, if it is going to happen, it's going to happen." But he was kind of one of those old men that whatever happens is ok. In the old days the men didn't have anything to do with the baby . . . I mean with the birthing of the woman or anything . . . they just went and got somebody to do it . . . and they stayed outside . . . I know cause my husband was one of those too ...he never went into the room either (Champion 2013, 97-8).

This testimony comes from a midwife, whom the author called Sra. B, who practiced during the early twentieth century in the Big Bend region of Texas on the U.S.-Mexico border. This testimony illustrates the collaboration between midwives and physicians in this region as well as the deep trust of the father in the doctor with his statement "Well. . . I don't know you're the doctor." While the father may have exhibited more trust in the doctor, they summoned Sra. B first, perhaps because of proximity, cultural tradition, or community norms. This interaction demonstrates a shift that largely took place in the Eastern United States and to a lesser extent in the Southwest United States, characterized by shifting trust with birthing with community-based midwives to delivering with doctors in a hospital.

In this chapter, I explore the history of midwifery in the Eastern and Southwestern regions of the United States and the subsequent criminalization of midwives, specifically in the East, during the 20th century.

In the Southwest of the United States during the 17th and 18th century, midwives, or *curandera-parteras,* [18] occupied high standing largely due to the services they provided to their communities. The terms *partera* and midwife are not entirely synonymous. As Ortiz argues, *partera* originates from the Spanish "*partear,* which means 'to deliver' . . . a *partera* was known as a *curandera-partera*, and the term had a set of cultural meanings different from the modern term 'midwife'" (2005, 411). *Parteras* were middle aged or older woman who were past their childbearing years and they were "the oldest woman (or at least one of the older women) in an extended family [who] tends to be the one consulted and the one who uses these remedies, and it is her responsibility to pass this knowledge on to her daughters and granddaughters" (Graham 1985, 171). *Curandera-parteras* were

> women whose mothers, grandmothers, or aunts had been *curandera-parteras* before them. When a *curandera-partera* felt that she was getting too old, and needed help, she selected someone from among her family and friends to take her place. Her apprentice had to be married and close to middle age, for then she was through having children and thought suitable to take on the role (Ortiz 2005, 412).

The apprentice *curandera-parteras* was chosen only after her childbearing years when her mothering duties were fulfilled. Though apprentices were often descended from *curandera-parteras*, as daughters, nieces, cousins, or granddaughters, lineage was no guarantee. More importantly, the apprentice *curandera-partera* would only be selected if she embodied specific characteristics, like strength, fearlessness, courage, and intelligence. One of a *curandera-*

[18] In the early 1900s, a *partera* was known as a *curandera-partera* (Ortiz 2005)

partera's married daughters might be chosen as an apprentice if the *curandera-partera* thought she was strong and fearless, though she also might choose a friend or a relative if her own daughter(s) were "not considered courageous or intelligent" (Ortiz 2005, 412; Champion 2013). *Curandera-parteras* were held in high regard within their communities as the selection as a *curandera-partera* was a great honor for a woman. It was "the only other profession available to women" and thereby they were largely admired by other women within their community (Ortiz 2005, 412). While midwives in other regions of the United States may have visited or met with the parturient woman prior to the birth, most *curandera-parteras* only offered their services during the actual birth. They did not charge for this work, but rather permitted families to give *correspondencia*, "a term of barter that usually took the form of flour, corn, beans, chili, and sometimes money" (Ortiz 2005, 411). Frequently, the *curandera-partera* was a relative or family friend who often had known the patient for long period of time previous to the birth interaction and they shared "the same vocabulary, values and sociocultural background" which also meant there were "no barriers in communication" (Ortiz 2005, 413). This prior relationship and connection solidified trust between the *curandera-partera* and the parturient woman, thereby improving birth outcomes for the mother and child (Ortiz 2005). While *curandera-parteras* assisted women in birth, they were also healers within the folk healing system of "*curanderismo*." They were helpful "in cases of illness, but also in instances of bewitchment that result in bad luck, matrimonial problems, alcoholism, and any number of other problems" (Graham 1985, 170). They were also well versed in and commonly used *remedios caseros,* or home herbal remedies to treat the "more common, not-so-dangerous ailments such as headaches, nosebleeds, cuts and scrapes, diarrhea, constipations" (Graham 1985, 171).

Unlike curandera-parteras who have continued to practice into current day in the Southwest, the role of the midwife began to shift in the Eastern part of the United States during the colonial period of the 17th and 18th centuries. Birthing practices in this time largely adhered to the "English tradition of women relatives and friends gathering with a midwife in the home to provide household help and emotional support. As late as the eighteenth century, care of the pregnant woman was generally considered beneath the dignity of a "medical man" and modesty barred his participation in the delivery" (Weitz and Sullivan 1984, 164). Midwives were women, generally older and past their childbearing years, and often "commoners," but as in the Southwest, the public held midwives in high regard as they were generally well educated and literate, unlike many of their female contemporaries (Guerra-Reyes and Hamilton 2016; Cody 1999). Since their knowledge derived from personal, tactile, and gendered experience, midwives were thought to have a 'natural' and 'innate' authority over reproductive matters. They were held in such high regard that often midwives were "legally treated as able to reveal the truth of the female body and to function as trustworthy public authorities" (Cody 1999, 481). During the colonial period, reproductive options for women in the United States were largely homogenous as regardless of race or socioeconomic status, women gave birth at home and were attended by midwives. In the Southeast, white and black women alike gave birth with the help of African American midwives, commonly referred to as "grannie midwives." In the Northeast, women accessed midwives who were often recent immigrants from Europe (Craven 2010).

By the end of the colonial period in the nineteenth century, Protestant thought became centered around the value of science and technology, thereby allowing the area of obstetrics to flourish (Weitz and Sullivan 1986). A primary point of division between physicians and midwives manifested in differing understandings of how knowledge is derived. Physicians

derived knowledge from a rational-critical matrix that formed the foundation of critical thought during the scientific revolution and Enlightenment period (Cody 1999). This fundamental epistemological difference, not only between physicians and midwives, but also between women and men, would lay the groundwork for the subsequent criminalization of midwives throughout the 19th and 20th century. Even during the 18th century, physicians, backed by their rational-critical mindset and 'scientific' knowledge, began to systematically diminish and degrade this innate knowledge of midwives (Cahill 2001). Since scientific knowledge claimed to be objective and available all, regardless of one's gender, it framed childbirth as "universal" and "of public interest," thus making it available to both men and women rather than exclusively women (Cody 1999). Due to this dislocation of birth from exclusively women, "rational" physicians were later able to frame midwives as therefore "irrational" (Cody 1999, 486). In the abortion debate during this time, licensed practitioners argued against abortion by rooting their arguments in this "superior knowledge" rather than in gendered experience; in doing so, they asserted not only intellectual but moral superiority over midwives (Cahill 2001).

Until the 18th century, childbirth was exclusively within the female realm. Men had only been involved in problematic or dangerous deliveries that required a male surgeon, with their intervention and instruments ensuring the death of the "foetus" and often that of the mother (Bogdan 1978; Cody 1999; Cahill 2001). Yet the development of forceps allowed a small contingent of man-midwives to successfully deliver live babies and begin to challenge in practice the traditional role of the female midwife (Cahill 2001). Once physicians trained in Europe brought forceps to the United States, they were able to offer middle- and upper-class white women physician-attended births. Forceps allowed physicians to attend laboring women in difficult births and speed up slow deliveries. Further, with the development of anesthesia in the

mid-1800s, such as ether and chloroform, physicians could also offer reprieve from the pain of childbirth, though it was not widely used in the United States for childbirth until the turn of the twentieth century (Thomasson & Treber 2008). This anesthesia had to be administered in a hospital setting as it had to be closely monitored, which further pushed women who could afford the anesthesia and physician-attended birth into hospitals. Access to anesthesia during childbirth was particularly attractive and was perhaps one of the most influential developments that led to increasing numbers of women to give birth in hospitals during the early twentieth century. "Twilight sleep" involved the administration of scopolamine and morphine, that did not relieve the pain of birth but rather functioned as an amnesiac that prevented women from remembering the birth. Women shockingly had to be restrained during the administration of the drugs, thus making the hospital a preferable place to administer such drugs. Twilight sleep incapacitated women and slowed labor, necessitating additional drugs such as Pituitrin, an early version of Pitocin, to speed up contractions and forceps to deliver the baby (Thomasson & Treber 2008). The promises of "twilight sleep" and a "painless birth" drew even more women[19] to hospital-births and physicians embraced the practice in order to further the profession of obstetrics and encourage upper-class wealthy white women to give birth in hospitals (Craven 2010).

Additionally, the status and reputation of midwives was deteriorating in the Eastern United States by the turn of the twentieth century due to a lack of organization, regulation, and support for training (Cahill 2001). Midwifery's reputation was also suffering due to the prolonged attacks by physicians on midwives' alleged incompetence as well as the racialization of their practices and the subsequent relegation of their social position. This relegation of their

[19] Often these women were white and well off so they could afford the additional expense of anesthesia

position to the metaphorical backwaters of birth-care is also in line with the historical devaluation of "assigned female roles" and exclusion of women from positions of power in society by medical and religious institutions. Indeed, physician's pursuit of the midwives' monopoly of childbirth can be understood as part of a larger patriarchal impulse that aims to control and subjugate women (Cahill 2001). A jeer from 1772, "a midwife is an animal with nothing of the woman left," reveals not only how "professional" women were viewed in the 18th century, but also demonstrates the lasting impulse to check feminine spaces of influence and generally degrade women who occupy powerful roles (Cody 1999).

The degradation of female circles of influence and decline of midwifery coincided with rising area of obstetrics that dislocated birth from these female circles and was predicated on practicing on Black and Mexican-American bodies. During the 17th and 18th centuries, "the decline of midwifery . . . and its dominance by medicine is probably best defined as instrumental in medicines' pursuit of professionalization rather than coincidental; medical control of the birthing business effectively transferred the craft of healing from the domestic arena to the public; 'from the hands of women to the control of men'" (Cahill 2001, 337). The pursuit of professionalization, alongside the epistemological dominance of midwifery and gendered forms of knowing, served to disenfranchise midwives in large part due to their positions of power *as women* in society. Foucault posits that biomedicine "could only have been born from a sex and class divided society in which both women and the poor provided appropriate research and material" (Cahill 2001, 337). Foucault here is referring to a European context; for this analysis to be applied to a U.S. context, intersections between women and class, as well as race, among

others, must be taken into consideration. As evidenced from the Tuskegee Syphilis Study[20], Henrietta Lacks,[21] and the forced and coerced sterilization of Mexican-American women in the 1970s[22], among hundreds of other examples, advancements in biomedicine in the United States were predicated on the studying and practicing on black and brown bodies, often without their knowledge or consent.

Due to the degradation and criminalization of midwives, racial stratification in birth care during the early twentieth century became increasing pronounced. By the end of the 19th century in the United States, nearly 50% of all births were physician-attended, though they still largely occurred as home, physicians attended mostly middle-and upper- class white women. Midwives still served Southern black families and immigrants, but this diversification of medical services also reinforced the racialization of midwives and culturally associated them with poor, nonwhite women (Thomasson & Treber 2008). In the early 20th century, physicians began to campaign to

[20] "In a forty-year study (1932-1972), white government doctors from the U.S. Public Health Service (PHS) found approximately 400 African American men presumed to have late-stage, and therefore not infectious, syphilis in and around Tuskegee in Macon County, Alabama. After some initial treatment was given and then stopped, the PHS provided aspirins and iron tonics, implying through deception that these were to cure the men's 'bad blood'" (Reverby 2014, 262).

[21] Henrietta Lacks was a working class African American woman living in Baltimore, MD whose cancerous tissue was acquired by Johns Hopkins without her consent in 1951. That tissue revolutionized cell culturing as they kept reproducing and became a "standard laboratory workhorse in almost all biomedical research for the next fifty years" (Green, Mckiernan-González, & Summers 2014, vii)

[22] In the case Madrigal vs. Quilligan, "Dolores Madrigal went to court in July 1976 to sue USC-LA Medical Center for sterilizing her with her informed consent… Nine other Chicanas… also testified that in the years between 1971and 1974 they too were sterilized at the medical center without fully agreeing to or understanding the sterilization operation they were to undergo. Although seven of the ten women signed 'consent to sterilize' forms, all seven reported that they were coerced into signing. Many were misinformed as to the reason for of the permanence of the procedure. Some signed under the duress of labor or while sedated. Others were threatened by their doctors or did not understand what they were signing because the form was written in English and Spanish was their primary language" (Enoch 2005).

eliminate midwives, particularly in areas in which physicians were available to provide services to pregnant women. On the one hand, physicians pathologized childbirth and argued that pregnancy and childbirth were dangerous and its dangers could be mitigated by trained physicians; on the other hand, midwives were untrained and incompetent and trying to undermine obstetricians (Foley 2005). At this time, midwives were largely immigrant, women of color, and poor and were not able to combat this campaign against them, as they had while women were increasingly accessing hospitals to give birth where midwives were barred from practicing (Foley 2005; Thomasson & Treber 2008). Further, physicians deliberately intended to frighten women by exaggerating the dangers of childbirth and that those dangers needed to be mitigated by male physicians (Cahill 2001). Ironically, the involvement of men in childbirth around the turn of the twentieth century may actually have increased the hazards of childbirth by increasing transmission of fever and causing injuries due to the careless use of particularly forceps (Cahill 2001, 338).

While there was a process of systematic disenfranchisement of midwives throughout the eastern U.S. primarily during the twentieth century, states such as New Mexico, Arizona, and Texas retained the legality of midwifery due to their rural and often Hispanic populations. As Ortiz argues, "*Curandera-parteras* have been in northern New Mexico since before its statehood. Because of limited available physicians, poor road conditions, and poverty, health care in northern New Mexico in the early part of the 20th century fell to the local traditional healers" (Ortiz 2005, 416). In 1925, 22% of the births reported in New Mexico were *curandera-partera* attended, and in 1929, approximately 29% of births were *curandera-partera* attended. In New Mexico by the mid-1930s, "there were more than 800 *curandera-parteras* practicing through the state. Most of them were working in rural, isolated, Hispanic villages in northern New Mexico"

(Ortiz 2005, 413). While some physicians objected to allowing *curandera-parteras* to continue practicing, citing such complaints that midwives were "superstitious, dirty and ignorant," New Mexico's health authorities ultimately incorporated them as "crucial partners" in the state health care system (Ibid). However, in Texas, "*parteras* and midwives attended the majority of births in the poor and [nonwhite] sections of the state. Each birth registration gave the attending *partera* a de facto official status. After the state of Texas required the registration of 90 percent of the births in 1933, the registrar suddenly became responsible for recognizing the legal status of each birth attendant" (McKiernan-González 2012, 262). Though midwives were not prosecuted on the same scale as in the Eastern United States, they were still disenfranchised. Yet it did not occur uniformly in the Southwest because of its rural nature during the early to mid-twentieth century and the racial makeup of these populations. This suggests that physicians prioritized white women, and did not want to work with Hispanic or Black populations in this region.

Similarly, Arizona during this same time period allowed *curandera-parteras* to continue to practice for similar reasons as New Mexico; these *curandera-parteras* were often working in isolated, poor, Hispanic villages and were often the only accessible medical care in the area. Arizona "was still a frontier state and followed the pattern set in other states several decades earlier. Physicians did not oppose the law since most had little interest in working with the poor, Hispanic, and Black populations served by the midwives" (Weitz and Sullivan 1986, 166). Midwifery persisted throughout the Southwest as there were fewer direct and successful attacks upon midwives who primarily served poor, Hispanic and Black populations.

In Texas during the early twentieth century, there were few M.D.'s in the state and they were often located in the northern region as company doctors at the mines in Terlingua and Shafter. Thus, "Anglos and Mexican Americans on the ranches and along the Rio Grande were

pretty much left to their own resources. Well into the 1930s and 1940s people along the Rio Grande were several hours (and in earlier times, even days) from a medical doctor" (Graham 1985, 173). As medical services were expensive and often located inaccessibly far away, these populations relied primarily upon the traditional medical system, accessing curanderos/as who were often located within their or nearby communities. Even into the 1950's, a period in which white women in other parts of the country were overwhelmingly going to hospitals, many Mexican-Americans in Texas continued to rely on *curanderismo* and *curandera-parteras*, who still practiced midwifery, though sometimes consulting a local M.D. (Graham 1985). One *curandera-partera* in Texas delivered roughly seventy-five babies between 1932 and 1972—a period of forty years—demonstrating that there was still a strong need for *curandera-parteras*. Though this *curandera-partera* worked with the M.D.'s in the area or community, she primarily relied upon "traditional wisdom rather than modern medical techniques in her prenatal care and delivery procedures" (Graham 1985, 186). Thus there was not a total takeover of midwifery practices by physicians in the Southwest but rather a collaborative process in which *curandera-parteras* and physicians worked to best suit the needs of the community.

Although there was movement toward medicalization of birth and criminalization of midwives, it was not until the Sheppard-Towner Maternal and Infancy Protection Act, spearheaded by white women and passed in 1921, that there was a legal attempt to regulate and surveille non-white midwives. While it was the first social welfare policy that advocated funds for prenatal care, the act did not alter segregation policies for African American women, but relegated them to substandard hospital wards and denied them any access to hospitals. The act facilitated surveillance and regulation of nonwhite midwives as states moved to license and instruct midwives (Craven & Glatzel 2010; Craven 2010; Guerra-Reyes & Hamilton 2016).

Further, this increased supervision limited the range of midwifery practices and effectively dislocated authority and control over childbirth from midwives to the state (Guerra-Reyes and Hamilton 2016). The act led to scrutiny of these nonwhite midwives and subsequently generated policies to eradicate African American and immigrant midwives by the mid-1900s and devalued elderly African American midwives in favor of younger midwives who were seen as more compliant by government officials (Craven 2010). Christa Craven characterizes the Sheppard-Towner Act as "an ambitious venture to colonize and civilize African American midwives and mothers" and greatly contributed to the elimination of midwives in the twentieth century (Craven 2010, 37).

Due to the Sheppard-Towner Act, midwives were all but eradicated from the United States by the second half of the 20th century, leaving only some scattered among poor, rural, minority and ethnic groups who were able to continue these practices (Keyes 1986). As I hope to have shown in this chapter, while statistics during this period suggest a steady upward trend of hospital births for all women,[23] nonwhite women were much more likely than white women to give birth at home rather than in the hospital. According to a study in Baltimore in 1915, only 27.4% of native-born mothers delivered with midwives while midwives attended over 77% of Italian-born women (Thomasson and Treber 2008). Additionally, North Carolina reported in 1936 that 67.4% of nonwhite deliveries were attended by a midwife as compared to 11.4% of white deliveries in the same period (Craven 2010). In other words, hospitals prioritized white women's birth care while midwives served the marginalized and disenfranchised populations that still needed competent care.

[23] 5% of births occurred in the hospital in 1900, 50% in 1938, and 95% in 1955 (Thomasson & Treber 2008).

There were many different forces that ultimately shifted childbirth out of the home and into the hospital. Thomasson and Treber posit that "the impetus came primarily from physicians who preferred to attend women in hospitals, and the willingness of women to be treated in hospitals because of better anesthesia, a greater perception of safety, and dwindling alternatives" (2008, 81). But this perspective ignores the intentional disenfranchisement of midwives through the racialization of their image in general culture. Additionally, it ignores where "a greater perception of safety and dwindling alternatives" originated from and rather takes these cultural shifts as a given and natural. As I hope to have shown however, the marginalization of midwifery in the U.S. depended on both racist and misogynistic discourse and these were instrumental in allowing physicians to denounce midwives and create a monopoly over birth care.

In this section, I have explored the multitude of ways physicians racialized and thereby disenfranchised midwives in the early to mid-twentieth century in the Eastern United States. Though midwives in the Southwest were still practicing in rural areas on poor, foreign-born, and often Black and Hispanic populations, physicians expunged midwives from white and middle- to upper-class women's realities. As I will explore in Chapter II, while the 1960's and 1970's witnessed the resurgence[24] of midwifery and natural birth, it allowed white women to monopolize the sector of midwifery with licensure and regulation which further excluded non-white midwives.

[24] To even deem this period as a "resurgence" is inaccurate as it ignores and obscures

Chapter II:

The Reemergence of Midwifery in the U.S.: Class and Racial Domination within a Feminist Context

In this chapter, I outline the process of professionalization and legitimation within the midwifery movement during the 1960's and '70's. This process, primarily spearheaded by white and middle class women, excluded and further marginalized specifically Black, Hispanic and immigrant midwives and reproduced racial and class hierarchies.

The natural birth movement and growing interest in community-based midwives was sparked as a reaction to the increasing medicalization of childbirth in North America and as an avenue to provide maternity care to women outside of "conventional medical institutions" (Nestel 2006, 5-6). These community-based midwives developed the "necessary skills within a framework that promoted informed choice in the birthing process, appropriate use of technology, and the recognition of birth as a psychosocial as well as physiological event" (6). This framework provided a counterpoint to the prevailing ideology that normalized birthing in a hospital and framed childbirth as a pathological process. Further, this midwifery framework advocated for women to choose where they birth with the implication that the home is the best place to conduct "humanized childbirth" (Ibid).

Jo Anne Myers- Ciecko was the Executive Director of the Seattle Midwifery School based in Seattle, WA for over fifteen years. She joined a "national task force on certification convened by the North American Registry of Midwives [NARM]" and was a founding member of the Midwifery Education Accreditation Council (MEAC) in 1991. Thus Myers-Ciecko is intimately involved in the two national monoliths of midwifery certification and education. MEAC is the education accreditation entity that has bestowed accreditation on ten direct-entry

midwifery schools, two of which are under probationary accreditation (as of November 2nd, 2016); NARM is best known for their certification test that licenses one as a CPM[25] and this test is also colloquially called "the NARM."

Myers-Ciecko (1999) provides an overview of the history of direct-entry midwifery in the United States. She argues that after the virtual eradication of midwives in the United States during the first half of the twentieth century, "direct-entry midwifery re-emerged during the 1960s and 1970s as a grassroots movement among women seeking home births" concurrent with the natural birth movement (1999, 384; Nestel 2006). Additionally, certain birthing techniques such as Lamaze and 'prepared childbirth' became popular during this same period, leading to the formation of many female consciousness-raising groups that aimed to explore natural birthing methods (Craven 2010).

The natural birth movement bolstered and normalized the reemergence of direct-entry midwifery, though the movement remained fairly localized among "specific feminist women's health activists, holistic health care providers, back-to-nature enthusiasts, and religious or spiritual communities" (Myers-Ciecko 1999, 384). Yet, some of the language Myers-Ciecko uses to describe the makeup of the direct-entry midwifery movement is implicitly racially coded. Terms such as "holistic," "back-to-nature," and "feminist women's health activists" suggest a specific racial group**,** one that is largely white, middle-class or affluent. This coded language, on the one hand, allows Myers-Ciecko to speak of the midwifery movement in color-blind terms while simultaneously implying the racial demographic of contemporary midwives.

While Myers-Ciecko does not racially identify which mothers during this period are seeking home births, Christa Craven identifies them as "middle-class, primarily white, women"

[25] "CPM" stands for "Certified Professional Midwife."

(2010, 55). This lack of demographic information on Myers-Ciecko's part illustrates the different stakes both these women have in the midwifery movement. Myers-Ciecko, as explained previously, was one of the founding members of many midwifery governing bodies as well as the Executive Director for many years of the prestigious Seattle Midwifery School. It is in her best interests to market the midwifery movement in color-blind terms. Christa Craven, on the other hand, is an anthropologist who has studied the midwifery movement but is emphatic that her scholarship is "a critical departure from romantic ideas about a seamless history of 'sisters in struggle' for women's reproductive rights and access to midwives" (Craven 2010, 8)

Myers-Ciecko's argument that the increasing interest in homebirth bolstered the reemergence of direct-entry midwifery is also racially coded. Those women seeking homebirth in the 1960s and '70's, as Craven has already identified, were largely white and middle-class. This demographic shift is in large part due to the near eradication of midwifes in the first half of the twentieth century, leaving only scattered numbers of African American, Hispanic and immigrant midwives who continued to serve poor and uninsured populations. During that period, even populations who employed midwives became racialized and culturally constructed as poor and 'backwards' (Craven 2010). Therefore, the profession of midwifery and those who accessed midwives became stigmatized in racial terms.

Due to this stigmatization of midwifery in both Canada and the United States[26], the reemergence movement in the second half of the twentieth century was "decidedly" white and middle-class, incorporating aspects of "feminist and traditional women's health movements,

[26] Stigmatization of midwives in both these nations followed different trends i.e. the U.S. midwives were far more racialized than they were in Canada. However, these nations both experienced near eradication of midwives in the first half of the twentieth century and subsequent reemergence of midwifery during the same periods.

counterculture lifestyle practices, and long standing efforts by white British-trained midwives to have their skills recognized within the health care system" (Nestel 2006, 6). The trend of those who employ midwives have held steady to the present; according to the CDC, in 2012 "the percentage of out-of-hospital births was two to four times higher for non-Hispanic white women than for any other racial or ethnic group" (MacDorman et al. 2014, 2)

These struggles for reproductive freedom and access to natural childbirth in the 1960's and '70's and the eventual success of legalization in many states therefore benefitted a very specific racial group. As Christa Craven argues, the natural childbirth movement "made midwives available only to 'low-risk,' educated, primarily white women with insurance or the money to pay for their service out of pocket. In contrast, women of color and poor women in the United States (and increasingly middle-class women without insurance) have continued to struggle for access to quality reproductive healthcare both in and out of the hospital" (Craven 2010, 8). Access to midwives, as Craven implies, was predicated on having money to pay out of pocket or insurance that would agree to pay for midwife-provided maternity and prenatal care. Additionally, though Medicaid accepted midwives as qualified medical providers in the early 1980s, they "only compensated licensed midwives for prenatal and postpartum care [if] the birth was done in a licensed birth center" (Myers-Ciecko 1999, 388). Therefore, for Medicaid clients, home birth was not an option and further, if there were no licensed birth centers in the area, midwifery care was not an affordable option.

By the late '70's, the natural childbirth movement began to lose steam as many (white) women became satisfied with certain improvements hospitals made in maternity care. Yet, these benefits were not distributed equally; working class, minority and poor women disproportionately received higher levels of medical intervention in childbirth than their middle-

class, affluent and white counterparts. Indeed, low-income women are cognizant of their restricted options in birthcare and so are more concerned with continuity of care and respect, though their birth experiences are still "marked by less client participation and more medical intervention than middle-class women's birth experiences" (Craven 2010, 51) As Craven further argues, "Ultimately, the ability to control the circumstances of childbirth remained largely with middle-class white women" (Craven 2010, 44-45). Thus midwifery and the benefits of midwife attended births were made available to those who could afford it, marking similarities between the demographics of women who advocated for midwifery and those who could actually afford midwives. Additionally, even marking this period as the "reemergence of the midwife" is problematic as many African American midwives continued to serve their communities in the 1970's and '80's. It is clear that they were "invisible enough for the emerging profession of middle-class white midwives to describe itself as a 'rebirth of midwifery'" (Craven 2010, 51). Locating the 'rebirth' of midwifery in the 1970's obscures the work and legacies of non-white midwives while simultaneously rendering midwifery a white, and therefore benign, profession. This erasure reproduces the very same mechanism that was employed by doctors to eradicate midwives in the early 20th century, yet it is rendered benevolent or more acceptable because women themselves were enacting it against other women. This type of domination becomes illegible when domination between women is not taken into account while it also neglects complicated intersections of race, class, and gender, among many others.

It was not until the mid-1980's that process of professionalization and legitimation began in full force. As Myers-Ciecko writes,

> Despite ongoing internal debates about the pros and cons of professionalization, [Midwives Association of North America] adopted standards of practice in 1985, created a board to test basic midwifery knowledge through a written examination

> in 1987, adopted core competencies in 1989, and issued a statement of values and ethics in 1991 (Myers-Ciecko 1999, 385)

In doing so, the Midwives Alliance of North American (MANA) were able to create a national, though normative, path to become a midwife. With the majority of non-white midwives having been either eradicated or pushed underground, those who created MANA and these governing bodies were largely white, middle-class, educated women. Since these bodies were largely white (both the governing and those who populated the governing bodies) they tended to attract the same and thus set standards with a white populace in mind. These implicitly white standards thus served to facilitate the entry of other white middle-class midwives and discouraged Hispanic and African American midwives from participating. Nestel bolsters this assertion with a quote from one of her informants: "In creating a movement. . . white, educated, able-bodied, middle-class women have tended to attract the same, leaving many voices behind'" (Nestel 2006, 3-4)

Indeed**,** this process of professionalization served to bolster the image of the midwifery movement as largely white through racially coded language, allowing the movement to sustain its narrative of 'sisterhood' and inclusivity upon which it purported to rest. This system thereby encouraged midwives who could identify with that language and the home birth activist roots of the midwifery reemergence and who, consequently, were largely white and middle-class. As Heather Cahill (2001) aptly argues, "Professionalism is –by definition—elitist and exclusive, sexist, racist and classist" (337). With this definition in mind, the process of professionalization of the midwifery movement was destined to reproduce elitist, exclusive, racist and classist systems and hierarchies. In doing so, they reproduced and reified these systems of disenfranchisement in benevolent terms or invisible terms. While the midwifery movement purported to benefit "all women," it effectively excluded already marginalized women in racial and class terms.

Honor Code Upheld

By the mid-1980's, there was a distinct shift in tactics of midwifery organizing. Moving from a "loosely organized social movement to a tightly orchestrated political project that systematically pursued state regulation and funding for the revitalized profession" (Nestel 2006, 6), proponents of midwifery became political actors to effect legislative change. Yet in doing so, the movement to legalize midwifery became ever more homogenous. Central to the tenets of 'tightly orchestrated political project' was the understanding that to appeal to a large audience and thereby gain political power and support, the sociocultural perception of the midwife needed to be reconceptualized within the body politic. As Nestel argues, the midwife needed to be configured as "respectable, that is, knowledgeable, modern, educated, and . . . white. Women whose identities endangered this reconfiguration often faced expulsion from the midwifery 'sisterhood'" (Nestel 2006, 7). In this way, the movement became a modality of power itself—one that purported to be a sisterhood, yet participation in this sisterhood was not unilaterally granted nor permanent.

Not only did the midwifery advocates need to reconceptualize the image of midwife to divorce her from dominant cultural, and ultimately racist, assumptions, but the midwife also needed to represent the "universal woman as the protagonist of its 'heroic tale,' in which autonomous subjects, constrained only by gender inequity, pursue and win their goal through dedication and courage." (Nestel 2006, 5). As Nestel argues, a movement that purported to universally benefit all women thereby needed a figure to represent the universal woman. Yet, this 'universal' woman needed to be palatable to legislators, whose approval was being sought. According to Nestel, whiteness was central to the construction of a 'respectable' midwife:

> Midwifery self-definition and the material requirements for participation in the. . . midwifery movement worked to define immigrants of [color] as being on the margins (if not outside) of the movement's perimeter. They posed both a material

> and symbolic threat to the heroic tale and to its victorious resolution through legalized midwifery (2006, 5).

Ironically, the profession of midwifery was itself positioned on the margins until the process of legitimation took place, which thereby projected their marginal position on those who were even more marginalized. This negotiation of marginalized bodies within a marginal (and historically marginalized) profession further complicates these racial dynamics. As Nestel argues, "engagements with subordinate groups such as First Nations women and immigrant women secured rather than challenged such privilege" (2006, 5). In this way, the incorporation of subordinate groups actually bolsters this privilege rather than creates a space to problematize it.

In Nestel's research site of Ontario, non-white minority women represented almost half of all women who inquired about having prior overseas training recognized, following legalization. Despite this widespread interest from non-white minority women, they only represented (as of 2006) about 12 percent of registered, licensed midwives in the province of Ontario (2006, 7). In the U.S., African Americans make up 13% of the population, but only represent "3.6% of registered members of the American College of Midwives" (Guerra-Reyes and Hamilton 2016, 2). Nestel theorizes three specific processes took place to produce a primarily white midwifery population in Ontario. These processes include: "The devaluing of non-European experience, credentials and training; the deployment of inferiorizing discourses surrounding 'immigrant women'; a tenacious adherence to forms of feminist politics that privilege the skills and interests of white women; and numerous acts of everyday racism" (Nestel 2006, 7). As Christa Craven (2010) argues, the near eradication of African American midwives and other non-white midwives during the first half of the twentieth century "contrasts sharply with the recent successes of primarily white midwives and their supporters in the twenty-first century" (61). In the United States, the racialization of midwives served a powerful role in

disenfranchising non-white midwives. Further, the legacy of the racialized midwife still plays a role in the public imagination and in contemporary debates over licensure (Craven 2010). In these ways, white midwifery proponents in Canada and the U.S. are able to control who wears the moniker of "midwife" while policing and regulating midwifery practices, which ostensibly promote a movement that benefits "all women."

As a direct result of the process of professionalization, white mothers began using midwives in increasing numbers, concurrent with the process of legitimation that MANA was undergoing (Craven 2010). Reliance of white women on midwifery may be due to the more widespread availability of white midwives, certification entities that legitimized and licensed the practice, and increasing public acceptance of midwifery as an alternative aspect of maternity care. White mothers began employing both Certified Nurse Midwives (CNMs) and Direct Entry Midwives (DEMs)[27] in hospitals, birth centers and their own homes. Yet, as Craven argues, "the rates of midwife attended births among African American, Hispanic, Native American, and Asian women however, were decreasing, despite positive birth outcomes associated with midwives" (Craven 2010, 59). There are many reasons for this discrepancy, yet the most salient is the historical racialization of midwives and their clients. Despite widespread acceptance of midwifery practices, insurance, Medicare, and Medicaid often do not cover the costs of midwives, meaning the client must pay out of pocket, rendering midwifery services inaccessible to many populations. Additionally, women want their midwife to look like them and to demonstrate cultural competency, as referenced in Chapter 1 where community-based midwives were a part of the mama's community and had known her her entire life. . Yet as Craven argues,

[27] Once licensed, DEMs are called CPMs or Certified Professional Midwives.

these discrepancies further illustrate that women of color "continue to struggle harder to obtain good-quality, accessible healthcare than most of their Euro-American counterparts" (2010, 59).

The reemergence of midwifery served, both in Canada and the United States, to further disenfranchise non-white and immigrant women in racial terms. While these actions may not have enacted racism *intentionally*, racism was enacted nevertheless. Ultimately intentionality does not matter. As Nestel reminds us, "racist exclusion must be understood as unavoidable when race-blind epistemologies guide actions. The assumption that guided Ontario midwifery was that women were oppressed in similar ways and that race, class, and sexuality only complicated a fundamental gender oppression" (Nestel 2006, 5). In this way, systems of domination *between* women were not taken into account as this assumption simply posited men and women in opposition. Thus, women were able to enact racial domination within a feminist context (Ibid.). Further, in the U.S. and Canada, these racial dynamics are not only reflective of a broader history of colonialism but of also, as Nestel frames it, "contemporary relations of domination where the local and the global are so thoroughly intertwined that their status as oppositional categories can no longer be defended" (7). Nestel's framework thereby recognizes that these systems of domination are inherently intertwined with national and transnational forces.

The public and media perceived the eventual legalization in midwifery, both in Canada and the US, as the success of "grassroots feminist organizing," and another milestone reached in the fight for gender equality (Nestel 2006). Yet, this movement that claimed gains for 'all women' resulted in rewards that were "unevenly distributed." Further, this "race-blind epistemology" not only persisted within the midwifery movement, but also in its own brand of activism. By advocating for access to midwifery as a service that benefitted "all women,"

midwifery advocates even further obscured the myriad ways in which midwives were not accessible to "all women" and the differing ways "all women" are positioned not only by gender, but also by race, class, citizenship status, and sexual orientation, among others. In advocating for a "race-blind epistemology" that obscure the intersections of race and class, "the inevitable result was racist exclusion" and reproduction of racial hierarchies (Nestel 2006, 5).

Christa Craven and Mara Glatzel complicate the conventional narrative of 'sisterhood' within midwifery by foregrounding systems of domination between midwives rather than against them. They argue that contemporary midwives cannot be essentialized nor homogenized, yet in the process of professionalization, the costs have been most acutely felt by minority women of color. Further, this process has "revealed familiar racialized hierarchies" that mimic colonial power structures (2010, 330-1). Those in the midwifery movement have been able to reenact these hierarchies when systems of domination were conceptually framed within a male/ female binary. They further argue that this process of professionalization "offer[s] an important caution against idealizing notions of a universalized 'sisterhood' among midwives (and women more broadly). [these examples] also call attention to the necessity of efforts to better understand midwifery's history in the United States—including its complicated racialized politics" (331). They further argue, the perpetuation of an essentialized and universal group of midwives obscures and erases these 'racialized politics' that might complicate the greater image corporate midwives might want disseminated. In obscuring the privilege of white midwives in racial and economic terms and further ignoring the disenfranchisement of non-white midwives, generally, and African American midwives, specifically, allowed for the erasure of the complicated racialized politics that govern the contemporary midwifery movement. These implications

problematize and complicate this purported narrative of "inclusivity and its benefit to all women" (332). [28]

Similarly, this rhetoric of 'back to nature" and a return of more 'traditional' form of childbirth in the language of advocating midwives is troubling. Anthropologists, like Margaret Mead, Ashley Montagu, and Brigitte Jordan played a role in both advocating for natural childbirth movement while they studied birthing practices of non-Western cultures. In doing so, these works served to primitivize non-Western birthing practices while also regarding them with perverse nostalgia, as if these women were 'closer to nature' because they were separate from the Western world. However, Craven argues that they "nevertheless made a strong argument that there were indeed alternatives to the 'advancement' of childbirth through medical intervention" (Craven 2010, 43). At the same, despite arguments advocates for natural birth made, these arguments nevertheless relied and capitalized upon the primitivism they simultaneously utilized to advocate for natural birth while also distancing themselves from the image of the "primitive midwife." Indeed, in Canada, "midwifery continues to be perceived as an archaic and discredited form of maternity care or as a primitive practice surviving only in 'underdeveloped' regions" (Nestel 2006, 7). As Mohanty theorized, midwives and proponents could thus form their subjectivities in negative reference to these "primitive midwives," which created a separation between those who are suitable to birth and those who are suitable to be midwives.

Proponents of midwifery legislation focused on "primitive" birth and framed it as the ideal type of birth (Craven 2010). Yet as Craven problematizes, "universalizing stories such as

[28] Throughout my research on this topic, I have become frustrated with the lack of information of Mexican American midwives and the plethora of such on African American midwives, nearly always in opposition to white midwives. More than anything, I think this availability of information references a greater metanarrative of discourse within the United States that largely relies on the Black-white binary.

the aforementioned evoke 'images of the 'Noble Savage,' uncorrupted by 'civilization' and ultimately affirm beliefs about the superiority of women in Western cultures" (2010, 53). Thus these stories not only served to construct the identity of respectable midwives but also reify the superiority of white, middle-class women. As Nestel argues, "It is by negative reference to an array of degraded/degenerate identities structured in and through class, race, and gender that a middle-class white female identity emerges" (2006, 19). Thus the reliance on the construction of the "primitive" Third world women not only framed ideal birth as outside the North American framework, thereby needing a (white) hero to resurrect it, it also served to construct "middle-class white female identity."

In this section I have shown how the reemergence of the midwifery movement during the 1960's and 70's has been mediated by racial and socioeconomic domination. These rhetorical devices reveal that hierarchical and race-blind epistemologies guided the reemergence of the midwifery movement. The deployment of images of the primitive Third World woman functioned to both delineate "middle-class white women's midwifery identities through both negative comparison *and* fantasized idealization" (Nestel 2006, 17-18). Further, feminist projects, including that of the contemporary midwifery movement, that predicate themselves on the benefit to all 'women' fail to recognize the potential for domination to take place between women, thus providing an avenue for systems of power to be reproduced.

Chapter III:

"Anyway, It's Complicated": La Clínica as a Case Study

This chapter is separated into five parts, each beginning with an ethnographic vignette describing an instance I observed or experienced during my research period at La Clínica. In this chapter, I use La Clínica as a case study to explore larger questions of race, class, nationality, whiteness and border space.

U.S.-Mexico Border History Context, NAFTA, and Racialization of Mexican Identity

The laboring client was slowly crushing my hand with each wave of contractions. Every twenty seconds or so she would grip my hand, tilt her head forward, and ride the contraction, pulling me alongside. She was laying on her back on a double bed in the center of a dimly lit room, with the resident midwife sitting down by her right leg and the student midwife sitting down by her left. After each contraction passed, the student midwife would say in a calm hushed voice, "traquila, tranquila,"[29] to her. I would occasionally ask the client, "quieres aqua?"[30] or tell her "eres fuerte, puedes,"[31] while the three or four student midwives present were waiting, taking notes, or checking her vitals. For the most part, they left her alone to labor. None of her family was present, though she had checked in with her mom. Eventually, one of the student midwives turned to the resident and asked in English, "Do you think her mom will get back here in time?" The resident faced the client and replied, "Probably not: she's getting close." The client, a Frontera, Mexico native with little knowledge of English, looked between the two midwives confused, not understanding what they were saying.

[29] "Relax, relax" in Spanish
[30] "Do you want water?"
[31] "You are strong, you can"

When I first came to shadow at La Clínica, I was confused by the bilingual nature of the space. It was not simply that Spanish and English were used interchangeably, but that they were used in specific instances, signaled by subtle cues. When students were speaking to other students or to the residents, they primarily spoke in English; when students or residents spoke to clients, they almost always spoke in Spanish, as the majority of their clients were unilingual Spanish speakers. Whatever the impetus, these two languages served to distinguish the clients from the midwives, which simultaneously distinguished those with the knowledge and subordinated those who did not. In the instance I described above, the client knew she was being talked about in English, but since she did not necessarily know what about, she became confused and possibly frustrated. Further, this interaction may have made the client feel out of control, scared, or distrustful of the midwives because she did not feel adequately informed. This switching of language, though often useful for communicating valuable medical information, serves to separate the American citizens from the Mexican nationals. With Anzaldúa's theory that the border serves to separate "us" from "them" in mind, this language switching reveals another way in which this separation can take place. This separation of "us" from "them," evoking the border space, will be a theme throughout this section.

In this section, I briefly explore the origins of racialized stereotypes about Mexican people by tracing its history alongside the history of the U.S.-Mexico border relationship beginning in the latter half of the 19th century. I analyze the U.S.-Mexico border and show that the deployment of racialized and essentialized stereotypes of Mexican identity has served to homogenize Mexican populations in ways that affect the practice of midwifery at La Clínica. I further argue that the passage of NAFTA has facilitated the commodification of Mexican, particularly female, bodies in the borderlands space.

Prior to the early 20th century, the border was not the strictly policed and guarded line that it is today. The U.S. did not block Mexican immigrants from crossing into the U.S. nor they even record those who crossed. In 1870, the borderlands contained few border towns while Apache Indians "challenged the United States and Mexico for control of the sparsely settled borderlands. Just a few decades before that, this border did not exist at all" (St. John 2012, 1). In 1900, Mexican nationals crossed easily and officials who patrolled border towns were less concerned with apprehending migrants and drug trafficker than they were with collecting customs duties (St. John 2012). Yet with the passage of the 1924 immigrant act and the establishment of the U.S. Border Patrol in the same year, "U.S. immigration officials were stopping Mexican laborers at the boundary line and subjecting them to physical inspections and literacy tests or simply denying them entry outright" (St. John 2012, 8). From then on, the border space ceased to be fluid for those who lived in its area and instead became a site for the construction of a racialized and consequently essentialized Mexican identity. The construction of this stereotypical Mexican identity that associated Mexican nationals with "illegality" and "brownness" emerged in the 1920s, coinciding with the establishment of the U.S. Border Patrol. These racial narratives arose "through law enforcement practices and linguistic categories" (Stephen 2012, 89). Yet this racialization is based on a racist "ideology of biological inheritance and racial hierarchy" which further erases ethnic identity (Gonzales et. al 2007, 54). Mexican identity then is rendered homogenous through its association with "illegality."

In associating "brownness" and "illegality" with "Mexicans," immigration control could better survey and monitor Mexican bodies on the border. As Luther Wright Jr. (1995) argues, "By linking slavery to race, slave escape became much more difficult, particularly once all blacks were presumed to be slaves. Suddenly, racial classification became of critical import in

American society—it could be the different between freedom and slavery and later, the difference between privilege and disenfranchisement" (164). Employing Wright Jr.'s framework reveals parallels between the linking of slavery with Black people and the linking of illegality with Mexican people. Presuming that all Mexicans are brown and illegal facilitate the surveillance of Mexican bodies not just by immigration control, but also by inviting common people to assist in the apprehension of "illegal Mexicans." Thus the generalization of Mexican identity did not solely depend on integrating them into U.S. racial hierarchy; it additionally allowed for immigration control to visually demarcate who did and did not belong. Though generalization of Mexican identity was largely central to immigration control rhetoric, sexuality, race, gender, and class have also informed this rhetoric. These identity markers informed this rhetoric not because they are "essential or biological identities that can be discovered within individual bodies, but because sexualization, racialization, and so on are larger social processes whose presence is made evident by the classification of bodies into hierarchical schemes" (Luibhéid 2002, xxii). This process of classification then reveals that processes of sexualization and racialization are integral to U.S. immigration control, suggesting that immigration control's reliance upon the racialization of Mexican identity is simultaneously an adherence to U.S. racial hierarchy. Supported by these processes, immigration control can allow or contest the entry of bodies who follow or violate this racial hierarchy.

Operation "Hold the Line" went into effect in El Paso in 1993, an early version of increasing surveillance and militarization of the border. "Hold the Line" served to deflect those attempting to enter the country illegally out of major cities and into the desert, making it easier for Border Patrol agents to apprehend them. After the attacks on 9/11, border security grew even tighter with the establishment of the Department of Homeland Security (DHS) in 2003 and

nearly quadrupling the number of Border Patrol agents from 1995 to 2015 ("Border Patrol Agent Staffing by Fiscal Year"). Today, the U.S.-Mexico border is one of the most militarized spaces in the world, with 19,828 Border Patrol agents[32] in addition to thousands of ICE[33] officials, DEA[34] and FBI agents, the U.S. military, state trooper, and local police ("Border Patrol Agent Staffing by Fiscal Year"; Volk & Schlotterbeck 2010). According to Steven S. Volk and Marian E. Schlotterbeck (2010), "The massive military presence on the border reflects a U.S. concern with immigration and drugs, but it is also directly linked to the integration of the U.S. and Mexican economies, particularly after the implementation of the North American Free Trade Agreement (NAFTA) in 1994" (Volk & Schlotterbeck 2010, 123-4). As Ursula Biemann (2002) argues, "the purpose of a strong U.S. military presence is not merely to keep the 'illegals' from crossing the border but also to protect the gigantic U.S. industrial investment on Mexican territory" (107). The contemporaneity of the militarization of the border and the enactment of NAFTA illustrates both the violent and extractive relationship, that Anzaldúa foretold, between the U.S. and the borderlands space.

The U.S.-Mexico border space was irrevocably altered by the passage of the North American Free Trade Agreement (NAFTA) in 1993, which removed trade barriers between Canada, the United States and Mexico to promote free trade between these three countries. While it was regarded controversially within the United States, "the passage of NAFTA is seen as a great achievement by the Mexican government which actively lobbied in the United States for its passage" (Overmyer-Velázquez 2011, 280). NAFTA incentivized the relocation of large amounts of U.S. capital into the "labor-intensive, export-processing zones of *maquiladora* (assembly)

[32] As of October 2016
[33] Immigration and Customs Enforcement
[34] Drug Enforcement Agency

production in Mexican border towns" (Sadowski-Smith 2002, 92). These zones are intended to attract foreign investment, such as Southeast Asian and European manufacturing and processing companies, "by allowing them to manufacture, process, store, and export goods duty free" (Sadowski-Smith 2002, 9).

However, as with many neoliberal projects, NAFTA has benefitted a small contingent of people while disproportionately and detrimentally affecting large populations, particularly women. As of 2006, Ciudad Juarez, one of the biggest cities on the border, was home to "approximately 330 *maquiladoras*—more than 75 percent owned by American corporations like Nike, Acer, RCA, Delphi and General Motors—employ about 220,000 workers, of whom 'approximately 60 percent are women'" (Gaspar De Alba 2010, 64). Similar to the racialization of Mexican identity, globalization and neoliberalism is often couched in homogenizing language that relies upon an abstract and unmarked consumer. However, this understanding fails to account for the fact that women, "in particular women of color, are paying a disproportionate share of the costs of the processes of neo-liberalism… creating inequalities that interact with pre-existing class, ethnic, gender, and regional cleavages" (Navarro 2002, 185-6). Women of color primarily work in U.S.-owned factories in Mexican border towns and are subject to the appalling working conditions that are supported by NAFTA (Navarro 2002). Rather than improving the economic, social and political barriers between North America, NAFTA has effectively exacerbated these systems of inequality in Mexico for marginalized populations (Sadowski-Smith 2002).

In this section I have shown how the U.S.-Mexico border space has been transformed over the past century by the installation of Border Patrol, NAFTA, and increasing militarization. The racialization of Mexican identity and the association of Mexican people with "brownness"

and "illegality" have served to uphold and maintain whiteness in the border space. Further, NAFTA encourages and permits the commodification of Mexican bodies on both sides of the border. These factors converge to illustrate that Anzaldúa's reconceptualization of the border as a liminal borderlands space has foreshadowed NAFTA and its ability to erase national borders for specific actors. Yet this liminality is only accessible to large multi-national corporations or to those who can afford it. NAFTA imbues the liminality of the borderlands space with a neoliberalist tinge. Further, permitting the commodification of bodies thereby allows and normalizes La Clínica's commodification of Mexican female bodies.

NAFTA, the Border, and La Clínica

Ariana and I were sitting outside on the shaded patio during a slow shift on a warm afternoon and, after her consent, began chatting about her experience at La Clínica. I asked her about why she thought the border had become so tight. She replied, "After 9/11 I guess a lot of laws changed. I don't really know a lot. I'm pretty ignorant as far as where we're at with immigration" (Williams). After she said that, I paused for a second. I was taken aback and confused that Ariana, someone who had been living in Frontera, Texas on the U.S. Mexico border for over nine months at the time of our interview, was not familiar with the politics of the border. She had appointments nearly every day with clients who had crossed the border that morning. She lived maybe eight minutes from La Clínica. How could she not know much about "where we're at with immigration?"

During this conversation with Ariana, I was flabbergasted that she was not aware of the current state of immigration in the U.S., even though she had been living on the border for the over the past nine months. Even though I did not cross the border during my research period and the closest I got to it was during my time at La Clínica. Though Ariana lived close to the border

and many border subjects were her clients, it seems that she was so overwhelmed by the program she was enrolled in at La Clínica that she almost did not have any time to devote to learning more about immigration. However, other students, namely those who were from Frontera, MX or the surrounding area, were acutely aware of the border as it often played daily role in their lives. Ariana, then, was "pretty ignorant" regarding immigration and the border because she could be—it did not figure into her life in the same way that it did for those who were from the area.

In this section, I situate La Clínica within the border space I have just described as well as within the larger U.S. midwifery context. I employ my ethnographic research to inform my analysis for the space La Clínica occupies and I also outline the requirements of the North American Registry of Midwives (NARM) and how their requirements, as well as La Clínica's accelerated program, drive the clinic to allow their students clinical experience earlier than nearly every other program. Using this background, I intend to illustrate how these factors converge to show how La Clínica operates institutionally and within transnational space. By locating La Clínica within both historical context of the borderlands and the modern midwifery movement, I illustrate how it reproduces certain systems of domination and privileges white experience.

In *Obstructed Labour: Race and Gender in the Reemergence of Midwifery* (2006), Sheryl Nestel provides a biting critique of white midwives' racism and their intentional disenfranchisement of non-white midwives in Ontario, Canada. Though Nestel focuses on a Canadian context, her analyses and critiques are easily applicable and relevant to a U.S. and border context. As I discussed in Chapter II, with the reemergence of midwifery in the United States in the 1970s, many midwifery training schools and birth centers have emerged all over the United States and Canada (Nestel 2006). Midwifery schools cum birth centers located on the

U.S.-Mexico border have presented an option for midwifery students that was affordable and often accelerated; at La Clínica, the average program length is 13 months, whereas a comparable program elsewhere lasts 2-3 years (Nestel 2006). Instruction at the school typically involves a combination of classroom study and hands-on work at the clinic, and it does "not require previous midwifery experience, and yet students can expect to attend twenty-five to thirty-five births in a three-month period" (Nestel 2006, 76-77). Though it is unclear here whether students are simply attending births or aiding in the births themselves, as it is common to be an observer in births from the beginning of one's midwifery education, Nestel seems to object to the permitting of students in births without any training beforehand. Yet for an accelerated program such as the one La Clínica offers, it is imperative for students to begin gaining clinical experience as soon as possible in order to get all the numbers in 13 months.

Numbers are incredibly important to one's midwifery education due the requirements held by the North American Registry of Midwives (NARM) for licensure. Nestel further argues, "Birth clinic experience allowed one aspiring midwife 'to see a lot of things that I wouldn't see here because of numbers. I mean I saw a prolapsed cord, I saw babies going, I saw a lot of [hemorrhages]" (Nestel 2006, 82-83) These numbers are crucial for student midwives as to begin the licensure process, one needs to document numbers of required clinical experience prior to taking the NARM's written exam which licenses one as a Certified Professional Midwife (CPM). NARM's website states that a student midwife must:

> Document the fulfillment of these requirements on the appropriate NARM application forms: Phase 1: Births as an Observer 10 births in any setting, in any capacity (observer, doula, family member, friend, beginning apprentice) Phase 2: Clinicals as Assistant Under Supervision: 20 births, 25 prenatals (including 3 initial exams), 20 newborn exams, 10 postpartum visits as an assistant under the supervision of a qualified preceptor. Phase 3: Clinicals as Primary Under Supervision: 20 births, 75 prenatals (including 20 initial prenatals), 20 newborn

> exams, and 40 postpartum exams as a primary midwife under supervision ("Entry Level Applicants")

While "prolapsed cords" and hemorrhages are not specifically on this list of NARM's required clinical experience, it is still considered vital to have experience with these rare occurrences to be considered by senior midwives as "at level."[35] At La Clínica, transnational processes such as NAFTA and the resulting migratory patterns of Mexican women into the borderland spaces is a large contributor as to why the clinic is able to have an accelerated program.

The installation of these industries encouraged migration, primarily of poor young women, to the border towns of northern Mexico, promising jobs and money, which then supported the opening of affordable birth centers on the U.S. side of the border. In order to access the goods and services of the U.S., Mexican border residents apply for a Border Crossing Card, colloquially referred to as a "laser visa," that effectively functions as a day visa. In order to qualify for a laser visa, one must show that they are "citizens of and [reside] in Mexico" as well as demonstrate that "they have ties to Mexico that would compel them to return after a temporary stay in the United States" ("Border Crossing Card"). Additionally, my interlocutors at La Clínica reported that this demonstration often includes a bank statement showing at least US$10,000 **(**Miller; Menendez).

One administrator at La Clínica, Julia, told me that Border Patrol (BP) agents will sometimes rip up their client's laser visas, preventing them from accessing the U.S. side of the border. Julia identifies two main factors that may increase one's chance of having their visa taken away:

[35] "At level" in midwifery terms refers to competency in a certain area.

> If they're walking over rather than being in a car that it would be more common. If they're in a car, I mean you're not going to be looking down to see somebody's belly if they're pregnant. . . When somebody is in labor and they're walking across the bridge, it's a lot more evident. It's definitely happened. (Jones)

Thus when the client's pregnancy is obvious or evident to the BP agents, it becomes easier for them to police those bodies, though Julia insists that it is "definitely not common" for their client's laser visas to taken away or ripped up (Jones). As Eithne Luibheid argues, "Pregnancy, regardless of marital status, was also listed [as grounds for exclusion], because it was believed to render women likely to become public charges" (2002, 9). Simply due to the client's status as parturient, BP agents' gaze rendered them as potentially deviant. Yet this potential deviance relies upon an understanding that all Mexicans are trying to permanently immigrate to the United States by any means necessary. Yet for the most part La Clínica's clients do not want to permanently move to the U.S., but rather access the "goods and services" that their laser visa promises. This incongruence in intention subsequently leads to an illegibility of Mexican people, as they do not fall within the dominant understanding BP agents may have of them. This illegibility renders some Mexican people as more concretely deviant because BP agents may assume that they are simply lying to them, making it even more likely that officers will deny them entry. For BP, the prevention of these bodies from crossing the border, despite their own testimony that they do not want to move to the U.S., then is preventing dependence on the U.S.

Another instance Julia recalled was when one client was harassed and detained all day by BP. She remembers:

> "What happened is that when [the client] was crossing, and again, it was a woman agent. [The agent] harassed her. . . and said, 'You're not really going over for an appointment.' [The client] wasn't even in labor. She just had an appointment. [The agent] said, 'You're not going for an appointment. You're going to move there and

> you're not coming back, and I'm taking away your visa.' They had her all day. . . They had her detained all day and sent her back. [The client's] sister called and she was so apologetic. She's like, 'I'm so sorry she didn't come to her appointment, but they had her detained.' Now she doesn't have a visa anymore" (Jones)

BP agents construct pregnant Mexican women, even though they are entering the country legally with their laser visas, as always potentially deviant. As evidenced by the BP agent's language, the BP's dominant understanding dictates that moving to the U.S. is the ultimate goal for pregnant Mexican women. As Luibheid further argues, "Women's bodies historically serve as the iconic sites for sexual intervention by state and nation-making projects. Immigration laws and procedures that differentiated women into categories such as wife, prostitute, and lesbian reveal the role of immigration control in regulating admission on the basis of sexuality" (2002, xi). The category of "potential mother" can be added to this list of categories, as bodies of pregnant women in these two instances serve as a site for "sexual intervention" by Border Patrol which then allows them to regulate admission on this basis. The regulation of admission relies upon an integration of Mexican people into the U.S. racial hierarchy while simultaneously excluding them from the U.S. itself. This process reproduces the prior racialization and sexualization that marked early immigration control tactics and this potential deviance further constructs Mexican people as subordinate.

In this section I have shown the effects that the accelerated track that La Clínica offers depends upon the constant influx of bodies that the borderlands and subsequently NAFTA provides. Further. I have argued that these racialized stereotypes have played an integral role in Border Patrol officers perceptions of Mexican people. These factors work together to illustrate the contentious relationship between La Clínica and Border Patrol and between Border Patrol and Mexican nationals.

Honor Code Upheld

The Power of Myth: Internalization and Reproduction of Border Rhetoric

I had been trying to schedule an interview with Ximena nearly since my first day at La Clínica. She was a second quarter student at the time and a Venezuelana como yo[36]*, and though my schedule at La Clínica often rotated differently than hers, we eventually found a time toward the latter half of my time at La Clínica. She found me during one slow afternoon shift and we were finally able to conduct the interview. She led me into the Green room, a "cita" or appointment room, that had three walls and a curtain that separated us from the filing area, the front desk, and the kitchen. In other words, we were in the epicenter of La Clínica. We sat on a bench at the end of the twin bed and she turned to me and said, "So, what do you wanna talk about?" Acutely aware that everyone in a twenty-foot radius could hear us, I replied in a low voice, "Well, I would actually like to talk about some of the power dynamics that are here at La Clínica." "Oh," she replied quickly, "then we should go outside," and she led me out of the green room and onto the back patio, that contained a series of tables and chairs underneath a large umbrella that bathed the patio in shade.*

Though I had been attempting to interview Ximena for much of the duration of my stay at La Clínica, and I found it strange that she wanted to conduct the interview in the Green Room. I noticed that I had been hitting a certain epistemological wall with some of my informants—most who shadow at La Clínica do so in order to see if they would like to attend. I therefore had to spend some time articulating that while I was shadowing at the clinic, I was not interested in the

[36] Venezuelan like me

school but rather in their experiences at the school. At one point, Isabella, one young student with whom I had grown close, kiddingly put her tiny fists on her hips and screeched, "So you're studying ME?!?!" It seems Ximena's impulse to take me to the most central room in the clinic had more to do with this incongruence in what she thought I was there for and what I wanted out of the interview. Once I could articulate what I wanted to talk about, we quickly relocated to outside the physical walls of the clinic, which I then understood allying herself to La Clínica, and to not criticize it within its own walls, as well as acknowledging of her own deviance.

In this section, I illustrate that La Clínica's deployment of racially coded language sustains persistent stereotypes about Mexican women as poor and uninsured. I will argue that it falsely represents the clientele that they serve and that it adheres to the border rhetoric I have just outlined. This rhetoric in turn legitimizes the clinic's existence, entices prospective students, informs care, and ultimately allows for the unconscious maintenance of white supremacy through the internalization of "white norms."

With the tightening and increased militarization of the border since 2003, La Clínica no longer serves primarily poor Mexican women yet the dominant stereotype of Mexicans as poor, uneducated and uninsured endures within the discourse of the clinic. Their website presents an example of these persistent stereotypes when it claims: "Many people living in the border region have no medical insurance and limited or no access to medical care."[37] Framing La Clínica's clients as having "no medical insurance" and little access to medical care operates to racially code their clients as poor, working class, and likely Mexican, due to La Clínica's border location. These negative stereotypes about the Mexican clientele positions them uniformly as poor and uninsured, yet the clinic no longer even serves this population due to the tightening of the border.

[37] Excerpted from La Clínica's website

In "Mules, Madonnas, Babies, and Bathwater: Racial Imagery and Stereotypes," Linda Ammons (1995) argues, "The subtlest and most pervasive of all influences are those which create and maintain the repertory of stereotypes. . . We imagine most things before we experience them. And those preconceptions, unless education has made us acutely aware, govern deeply the whole process of perception" (276). Thus these stereotypes have no basis in fact, but rather their origin is located in the imagination. Perpetuating these stereotypes through racially coded language, such as not having "medical insurance" nor access to "medical care," paints a picture that falsely represents the clinic's clientele.

This racialization did not emerge from nowhere; as I argued in section 1, the U.S.-Mexico border space is a site for the construction of racialized Mexican identity, associating "Mexicanness" with illegality and brownness, which itself relies upon a racist ideology of biological inheritance and racial hierarchy. *La Clínica does not associate "Mexicanness" in these instances with illegality but rather poverty.* La Clínica's website states that "many people living in the border region do not have medical insurance," though objectively true, they do not actually specify in this excerpt that many of their *clients* do not have medical insurance. In fact, the majority of their clients do have medical insurance—in Frontera, Mexico. This misleading description implies that their clients are uninsured which thereby codes them as poor and working class. This implication further subordinates Mexican people in the U.S. racial hierarchy with then permits and naturalizes La Clínica's commodification of their bodies. As Sheryl Nestel (2006) argues, "Third world space and those who occupy it come to constitute a commodity for First Worlds women's consumption and social advancement" (8). The homogenization and racialization of Mexican identity precipitates and permits this commodification to take place.

The commodification of Mexican women's bodies is precipitated by the racialization of Mexican identity, but is also rendered permissible by the space NAFTA has created over the past two decades. NAFTA harkened in a neoliberal regime on the U.S.-Mexico border in which La Clínica is implicated. La Clínica's existence depends on these processes and policies that render Mexican women's bodies available for American women's educational and professional advancement as well as the forces that permit this interaction to take place (Nestel 2006). NAFTA, then, both facilitates the movement of bodies across the border as well as precipitates the commodification of these bodies, as they are already rendered commodifiable by NAFTA and transnational processes. As Nestel argues, "at both the personal and global level, Third World women's labour [sic] translates into First World privilege" (75).

Framing the clientele as "needy" by employing racially coded language serves to reinforce stereotypes of Mexican women as poor while their constructed "neediness" functions to legitimize the mission of the clinic. As mentioned previously, when La Clínica opened in the late 1980's, they did primarily serve poor Mexican women; however, the border's heightened security and increasing difficulty in attaining visas has made accessing the U.S. side of the border harder for poor people. Yet Julia, one of the top administrators at La Clínica, in describing the demographics of the clientele, seemed to contradict herself. She says about the clientele,

> I think people assume that if somebody is going to come to give birth in the US that they must have money. They can't be poor people, but we've had people come in . . . on Saturday for their appointments, and I would see them every Saturday, and notice they're wearing the same outfit, shabby underwear you could see when you pulled down to touch their belly, and paying in $5 bills and $1 bills. You can see they've really struggled to save up (Jones).

But then she goes on to say: "We've definitely had a good number of professional doctors, lawyers. . . The majority [of the clients] are, for Mexico, they would be middle class people. They are able to pay in full"[38] (Jones). Therefore, the majority of clients who frequent La Clínica are middle class, if not upper-middle; they often do have access to medical care and have insurance in Frontera, Mexico. It seems puzzling that she feels the need to contradict a narrative that La Clínica does not serve poor people, and then goes onto say in nearly the same breath that the majority of their clients are middle-class. Julia's seemingly contradictory testimony actually elucidates her own ambivalence to sustain a false narrative but also to supply accurate information. I argue that sustaining these false narratives that position Mexican women as "needy" and "poor" serve to bolster the legitimacy of La Clínica as it thereby implicitly positions La Clínica in a position of "helping the needy." This is also related to BP officers' dominant understanding of Mexican identity which often lead to illegibility of Mexican people when they do not fulfill these meta-requirements. These stereotypes then do not reflect reality but rather are constructed to fulfill white requirements of ethnic or racial identity which serve to reify white experience of "helping."

Sustaining these false narratives serves the additional purpose of constituting white subjectivities as benevolent. Julia seems compelled to sustain this narrative that La Clínica does still serve poor people, even though the tightening of the border has made it increasingly difficult for this population to access the U.S. side. Sustaining this false narrative seems important for Julia. As Candace Johnson argues, "the fantasy of the natural, Third World woman is also a possible mean for Western women to congeal their own identities or subjectivity, to search for and find a whole meaning, a consistent narrative, for their lives" (2008, 901). The stakes for Julia

[38] To "pay in full" means to pay US$950 in cash as of June 2016

in sustaining this narrative is then less about reflecting reality and more about forming her own subjectivity. La Clínica, and her by extension as someone in a top position of management, is supposed to help poor women from Mexico have babies. However, if this narrative is no longer true and they are simply facilitating middle class people in attaining citizenship for their children, her own subjectivity and the larger purpose of the clinic are thereby thrown into question. As Martha Mahoney (1993) argues, "Privileged identity requires reinforcement and maintenance, but not seeing the mechanisms that reinforce and maintain privilege is an important component of this identity" (307). Thus the sustaining of false narratives pertaining to the demographics of Mexican women accessing the clinic serves to constitute and form white subjectivities; in doing so, there is an implicit upholding and privileging of whiteness. Mexican women's bodies are again commodified for the purpose of sustaining white subjectivities.

The perpetuation of these false stereotypes and narratives serve the purpose of legitimizing La Clínica and of congealing white subjectivities, but they also function to market the clinic and encourage more students to enroll in the school. The main page of their website describes the U.S.-Mexico border as "very fluid."[39] The use of "fluid" implies free, undisturbed movement across the border; yet, for whom is the border fluid? Julia recalled, "We had a client who lost her visa because she was crossing back. . . [she] must have been coming in[to] the U.S. side. Going through to Mexico is easy" (Jones). This testimony shows both the fluidity for American nationals to access both sides of the border and the restrictions Mexican nationals face in attempting to access the U.S. side of the border, even legally. Julia's testimony suggests that the border is not "very fluid" for their clients, but rather for the American citizens who work and

[39] "The border between Frontera, TX and Frontera, Mexico is very fluid with people frequently crossing back and forth" (Excerpted from La Clínica's website)

learn at the clinic. I argue that La Clínica's use of "fluid" in promotional material is not descriptive; rather, the neutrality of the word operates to entice more students to study at the clinic, as their tuition partially subsidizes the cost of the births. Since this material is in English, with a separate section designated "Para Clientes,"[40] these descriptions are clearly targeted to white and/or English-speaking women who want to find out more about the school. As Sheryl Nestel (2006) critiques, "The discursive enticements . . . promise a fair exchange, an act of benevolence and a moral project, all of which secure the [student's] innocence" (78). This language frames enrollment in the school as an act of benevolence which assures the goodness and "innocence" of both the student and the clinic while simultaneously constituting the benevolence of white identities.

La Clínica's use of neutral language to describe one of the most militarized and surveilled spaces in the world reveals a deeper modality of power that links goodness with white identities while simultaneously couching this linkage in neutral terms. As Stephanie M. Wildman and Adrienne D. Davis (1996) argue, "But however the subcategories are listed, however neutrally the words are expressed, these words mask a system of power, and that system privileges whiteness" (314). Very few Mexican nationals would describe the U.S.-Mexico border as fluid; for them, it can be contentious, dangerous, violent, and violating. La Clínica's employment of such language to describe the border elucidates the privileged position it occupies; further, this neutral languages masks both its position of privilege and its participation in a system of power that privileges whiteness and American citizenship. In this way, marketing the border as "fluid" reveals a deeper complicity with and reliance on a modality of power that privileges whiteness**.**

[40] "For Clients"

The marketing of the clinic relies upon essentialized versions of Mexican women and uses language that cast the U.S.-Mexico border in a falsely neutral light, but this false representation affects the expectations student have coming into the program. One more experienced midwifery student of color, Blanca, explains when she was speaking to a prospective student:

> Well. . . I can tell you what I was told or I can tell you what I am experiencing right now. . . Well, I mean there are certain things that are going to bother you, and they will bother you all year but there's nothing you can do about it. . . There are some things that you're gonna want to change, and you're going to attempt to change and then you're going to be like it's not gonna change. . . I just, I feel like we don't tell our students or possible candidates that it is hard and it only gets harder as the months go by. (Menendez)

Due to the transitional nature of the student body, students like Blanca often feel that they either do not have enough time to make real change happen or that the management and senior midwives do not take their suggestions seriously. The quick student turnover may also be advantageous to those who *are* at La Clínica for longer periods of time and might not want La Clínica to necessarily change. Additionally, Blanca seems frustrated with a certain lack of information shared with current or prospective students with her statement, "I just, I feel like we don't tell our students that it is hard and it only gets harder as the months go by." She also seems frustrated with a certain powerlessness or futility in trying to change a seemingly immovable institution. These incongruencies between what Blanca "was told" and what she is "experiencing right now" adhere to a larger pattern of La Clínica's false representation of itself that relies upon the stereotypical Mexican women to represent their clientele and neutral language to describe the U.S.-Mexico border space. These false representations, exerted through marketing or other means, suggest a space of ambivalence.

While these persistent stereotypes about Mexican women serve as a marketing tool, midwives and students begin to internalize these stereotypes. One student, Alissa, stated: "the clash of cultures is a big thing here, just because . . . the students and other midwifes tend to be white and middle class, so people . . . who are not coming from the area have preconceived notions about their clients" (Johnson). Alissa makes clear that it is the people who are not from Frontera, TX who have these preconceived notions about Mexican women. These notions then are produced by the imagination, by dominant discourse in the U.S. about Mexican and racialized stereotypes, and by the rhetoric the website employs to market the clinic to students. However, these notions and stereotypes become malignant because midwives and students then begin to internalize and adhere to these stereotypes, even unconsciously. In "The Transparency Phenomenon, Race-Neutral Decisionmaking, and Discriminatory Intent," Critical White Studies scholar Barbara Flagg (1993) argues, "Even whites who do not harbor any conscious or unconscious belief in the superiority of white people participate in the maintenance of white supremacy whenever we impose white norms without acknowledging their whiteness" (222). Perpetuation of these false stereotypes, influenced by the website's rhetoric, is ultimately a perpetuation of an imposed white norm. In this way, these internalized norms and stereotypes take on a new purpose of upholding and maintaining white supremacy.

While these persistent and false stereotypes about Mexican women both legitimize La Clínica and serve to entice students to enroll, they become internalized by midwives and students; these stereotypes are then used to inform the care and recommendations students or midwives give to clients. Another student, María, admonishes her fellow students: "Don't assume they won't go out and buy something for their diet or for their baby or that they won't go to. . . a health food store" (Hernandez). As María laments, they're not recommending a client to

go to a health food store because, according to these dominant and racialized stereotypes of Mexican people, Mexican people cannot afford to go to health food stores. Despite the relative wealth of their clients, student and resident midwives alike do not recommend going to a specific store because it does not adhere to their dominant understandings of Mexican peoples. Thus these discursive and encompassing narratives actually impact real interactions on the ground as they inform the care and recommendations midwives and students may provide. In "Toward a Transborder Perspective: U.S.-Mexico Relations," Lynn Stephen (2012) argues "People of Mexican descent have increasingly been constructed in popular and political discourse . . . [into] a racialized category which is often generalized to all brown, Latino 'looking' persons—whatever their citizenship, national origin, legal status, education, class, or gender" (88). Stephen argues these racialized and hegemonic stereotypes that refer to Mexican "looking" people rely on imagined racial identity. The generalization of Mexican identity—i.e. "Mexicans do not go to the health food store"—is integral to the construction of this discursive stereotype. These false stereotypes in turn become translated from constructions in popular discourse into informing medical care.

In this section, I have shown how La Clínica employs racialized stereotypes of Mexican people to false code their clientele as poor. These stereotypes are influenced by border rhetoric that associates Mexican people with "brownness" and "illegality," yet La Clínica associates Mexican people with poverty. This association as well as the greater context of NAFTA precipitates the commodification of Mexican bodies. Further, the reliance on these racialized stereotypes serves to legitimize the clinic and market it to prospective students, yet students become frustrated when they do not feel adequately informed. Sustaining these false stereotypes serve to congeal white subjectivities which in turns upholds and maintains whiteness.

Honor Code Upheld

Additionally, these stereotypes become internalized by students and midwives alike and in turn come to inform care. All these factors converge to produce a perspective of La Clínica that does not adhere to its "benevolence" but rather one that strives to be full and accurate.

White Spaces and People of Color

While Ximena and I had been chatting outside the clinic on that warm day, Ariana, asked if she could sit down and eat her lunch with us. I let her know that I was interviewing Ximena and our conversation was being recorded and Ariana replied, "oh cool can I join?" Ariana was one of the first people I talked to when I first came to shadow at La Clínica and she had a calming presence even though she was always able to make her sister students laugh. The three of us were talking about the power dynamics at La Clínica when Ximena had to go do a cita with a client who had just come into the clinic. Ariana and I got around to talking about some rumors that some Mexican staff members a few years previous wanted to buy the clinic from Julia and Candace. Ariana said, "I hella wish that [the Mexican staff] owned the clinic. That would be dope. I would stay here. I would do it." When I asked her how she though the clinic would be different if they ran it she replied, "Everything. I just think it's different when it's your people" (Williams).

In this section I will explore the experiences of students of color at La Clínica and attempt to recount their struggles at a white serving institution, using my interviews as evidence. Interviews with students of color reveal their struggles operating within a space that privileges and upholds whiteness and permits the reproduction of systems of domination between women to occur.

Ariana was always very honest and blunt with me in our conversations and particularly in this interview. Her comment "I just think it's different when it's your people" seems to suggest

that La Clínica would be perhaps better run if it were run by Mexican women as opposed to white women. This implies there is a personal responsibility that Mexican women may feel for and an identification with their clients that perhaps the white women that currently run the clinic do not. Her statement additionally suggests that the clinic may be more effective and ethical if it were run by members of the clients' communities. In this way, the overwhelming whiteness of the clinic is a liability. According to Candace Johnson (2008), "it is mostly white women who consume and provide midwives' services. In part, this is due to the purposeful exclusion of women of colour [sic] from the practice of midwifery" (902). Due to the "purposeful exclusion of women of color" during the "renaissance" of midwifery in the 1960s and 1970s, white women occupy most top management positions in midwifery schools, accreditation councils and national licensure bodies. While La Clínica has many students and residents of color, the senior staff and upper management is primarily white. As one senior midwife said, "Well, I mean our staff is pretty white . . . our senior staff are all whiteys" (Miller). In such a white dominated space, the reproduction of these racialized systems of power is normalized and unconsciously upheld. Thus Ariana's observation that the clinic would run better if Mexican women managed it is astute as it suggests that the clients would receive more culturally relevant care, but that there would also be a breakdown of this specific racialized systems of power, but to say that there may not be a different system of power instated.

White dominated spaces reproduce power and racialized domination unconsciously; since this process is normalized within La Clínica, it may prompt Ariana to wish that there were a midwifery school run by women of color, such as the Mexican staff at La Clínica. However, Ariana says:

> If there was a midwifery school run by women of color, I would go there, but that doesn't exist. . . The midwifery world in the US at least is very White. . . If you

> want to build your own institution, unfortunately, this is where we're at because of the structures that we've had for centuries. . . The information is in the hands of very specific people, white, middle class. I knew that before I came here and decided that I would still attend [La Clínica] (Williams)

Ariana seems to have understood the consequences of studying at La Clínica before she attended, but this understanding also seems to derive from a prior knowledge of race relations within the midwifery world in the U.S. As a woman of color, Ariana understands that she needs to go through a primarily white institution in order to extract the goods that she needs from the midwifery world. Though Ariana states that she knew what she was "getting in to" prior to coming to La Clínica, Nestel argues, "[Students] were adamant that even if they had known beforehand what it would be like, they would still have gone to the clinics" (2006, 82). Though La Clínica does not adequately prepare their students for "what it would be like," Ariana was still adamant that attending was the best choice for her, because of how badly she wanted to become a midwife. For Ariana, it is an articulation of agency to attend a white serving institution in order to attain this goal.

Due to the management positions overwhelmingly being occupied by white women produces a vulnerable learning environment for some students of color because the space culturally reproduces systems of power. La Clínica has a "woman of color" scholarship, which partially or fully funds one or two students' tuitions. While this scholarship facilitates the attendance of more women of color to La Clínica, it also positions the barriers that may prevent people of color from attending as being solely financial. This understanding obscures and erases the potential cultural barriers that may preclude them from attending a school such as La Clínica. In this way, the clinic has upheld its white culture while incorporating people of color into it. Ariana reports:

> "I have not chosen to engage with people who I don't have some kind of foundational understanding with. It's not that I agree with everything my community and friends do or believe, but we have some commonalities that make me feel safe, and this was the first time in ten years where I've been around people that make me feel very unsafe in a really vulnerable, intense setting. That was like, 'Oh, fuck'" (Williams).

Ariana has put intentionally placed herself in communities of color so as to protect herself and remain safe. Coming to study at La Clínica was the first time she was surrounded by people who made her feel "very unsafe" because she did not share "some kind of foundational understanding with." In many ways, the new context of La Clínica may have made her feel unsafe because of the emotional labor she expected other (likely white) students would demand of her. Thus La Clínica, unintentionally or otherwise, puts students of color in a "vulnerable [and] intense setting," by trying to encourage a diverse student body. Ariana's testimony positions diversification as dangerous and harmful when institutions simply incorporate people of color into a space without changing the culture of it. The culture remains white despite the presence of people of color. Diversification and incorporation of people of color into historically white institutions are not productive when the institution's management remains the same. These projects are fated to reproduce racial power structures and uphold whiteness.

This white space both endangers the safety of students of color and positions them in the subordinate teaching role for white students, ultimately reifying systems of domination. Ariana recalls, "In the beginning, there was one student who was just like, "Well, tell me. Well, show me." I was like, "Bitch, you're a grown ass woman. I'm not responsible for giving you information." At one point, she was like, "Well, that's your karma" (Williams). This interaction that Ariana describes with a 'sister student' positions Ariana as the one who, as a person of color, is thereby inherently obligated to educate this (presumably white) student. When Ariana refuses

to do so, the student then replies "well, that's your karma," either implying that since Ariana does not want to educate her, she has to then deal with those consequences, or that is Ariana's "karma" as a person of color to educate white people on her oppression. As Audre Lorde (1984) argues:

> Black and Third World people are expected to educate white people as to our humanity. . . The oppressors maintain their position and evade responsibility for their own actions. There is a constant drain of energy which might be better used in redefining ourselves and devising realistic scenarios for altering the present and constructing the future (114).

Though in this interaction, Ariana refuses to educate the white student, saying "I'm not responsible for giving you information," the white student still evades responsibility with her comment "well that's your karma." This process of the labor of educating white people being put upon people of color that both Audre Lorde and Ariana refer to is one Nora Berenstain (2016) has coined "epistemic exploitation." Berenstain argues that epistemic exploitation

> occurs when privileged persons compel marginalized persons to produce an education or explanation about the nature of the oppression they face. Epistemic exploitation is a variety of epistemic oppression marked by unrecognized, uncompensated, emotionally taxing, coerced epistemic labor. It maintains structures of oppression by centering the needs and desires of dominant groups and exploiting the emotional and cognitive labor of members of marginalized groups who are required to do the unpaid and often unacknowledged work of providing. . . evidence of oppression to privileged persons who demand it—and who benefit from those very oppressive systems about which they demand to be educated (570).

Ultimately, Ariana's interaction with the white student maintained structures of oppression because the student centered her needs and attempted to exploit the emotional labor of Ariana, a member of a marginalized group. Yet Ariana seems to understand the interaction as having a sort of inevitability about it. When I asked her about people of color being put in certain position so as to teach white people, she replied, "That's what happens when you bring together diversity. A

diverse group of people is the people who are in target groups end up enlightening the people with privilege in whatever area, and that's how it goes, and that's super whack... problematic. That's a part of White privilege, or any privilege. It's a part of privilege" (Williams). Though Ariana can identify white privilege as super "whack" she is also a person of color for whom white privilege has perhaps always been visible. As Martha Mahoney (1993) argues, "Part of white privilege, therefore, is not seeing all we have and all we do, and not seeing how what we do appears to those defined as 'other.' Whites cannot just opt out of the process of formation of this racial consciousness that takes the form of unconsciousness. . . whiteness can re-create itself without the conscious will to exclude" (306). White privilege operates in invisible and unconscious ways thus the responsibility for rendering this privilege visible is often placed upon people of color.

These interactions that endanger people of color continue to happen because they may appear to be isolated instances. Another student of color, Ximena, says, "I think that it's because of the system that's already created here, because individually, if I speak with each midwife, each one, I haven't found one ill-intended midwife" (Garcia). In this way, Ximena seems to focus on the micro scale of each individual midwife in order to try to understand ill-intent but blames the system already in place at La Clínica. However, as Stephanie M. Wildman and Adrienne D. Davis (1996) argue, "The focus on individual behavior. . . obscure the existence of systems of privilege and power" (315). While the system already in place does influence certain behaviors, focusing on ill-intent ultimately obscures the ways in which individual midwives may be producing or reifying certain systems of domination *unintentionally.* The system of power at La Clínica allows for these instances to take place and persist because they appear invisible or unmarked to those in power. These modalities of power can be reproduced individually. Ximena

further noticed how some students utilized "they" language to refer to their clients homogenously. She says,

> There have been moments where... I just stay quiet and try not to say anything with certain things that I heard very innocently spoken by some midwives. . . the 'they' thing, like, 'Oh, yeah. They do that, and they do this.' And I'm like, 'We.' They're speaking about ... Sure, maybe they're Mexican, but I do the same ... It's Latino. . . But it was interesting to hear the, 'They,' and the speaking of as an other, and sort of like a specimen, like, 'How interesting what they do in that culture' I was like, 'Wow, in this dynamic, they are other to you, so there is a separation and an observation in a way that's different than me' (Garcia).

For Ximena as a Latinx, she does not necessarily see her clients as different from herself, but in this interaction, she realized that there was a sort of voyeurism for some of the midwives who were not Latinx. Ximena identifies that in using this "they" language her fellow midwives, or "sister students," participate in a process of "othering." Ximena's fellow midwives here assume a position of observation which inherently subordinates and "others" their clients. This interaction also refers to the racialized Mexican identity rhetoric that the border space and the clinic employ, suggesting that perhaps these midwives were speaking about their clients how they had heard others speaking about them. This "othering" and subordinating language reveals that these midwives were adhering to dominant discourse within the clinic as well as an unconsciously reproducing systems of domination.

As Ariana has said, she understands that even though the midwifery world is incredibly white, she still chose to come study at La Clínica because she wants to "bring the knowledge to help other people of color, women of color, but that requires being here and receiving the information from white women" (Williams). This desire to "bring the knowledge back" was a common theme I heard throughout my interviews with students of color at La Clínica. Blanca, a woman of color, said, "I also feel like, a lot of the women of color that come here. . . to gain the

experience and then take it [back] to their communities ... Because, like Mercedes, I don't think she wants to do the residency . . . I think she wants to go back to where she's from and be with her own people, yeah, so I think that's a lot of it" (Menendez). Ximena too expressed similar sentiments: "I felt called to become a midwife and I want to serve in the [Florida] Panhandle." As a woman of color, Ximena wants to gather information in order to bring that information and the knowledge, to help other women of color (Garcia). Blanca has observed that a big motivation for many women of color at La Clínica seems to be to gather and gain the knowledge in order to help other women of color. This desire to return to one's community is genuine. This theme may also suggest more than students' genuine desire to return to their communities. It implies that people of color are responsible for taking care of their communities because they are largely expected to. It conversely suggests that white students, even when they told me that's why they were at La Clínica, were not expected to adhere to the "bringing back the knowledge" theme. White students, since they are unmarked and neutral, may serve whichever communities they choose, but students of color were not afforded the same luxury. Perhaps this theme references access more than anything else. White people often uniformly assume that other whites have access to knowledge, whereas people of color do not necessarily assume that other people of color have access to knowledge or education. This then may lead to people of color, who gain access to these sources of knowledge, feeling responsible to bring the knowledge back so that those in their community may access it. Access is not assumed in communities of color; rather, individuals must actively seek it.

Yet there also appears to be dissonance between these women of color wanting to bring the knowledge back to their communities, but not wanting to necessarily practice on their own communities in order to gain that knowledge. On this subject Ariana said:

> If we were serving some 99 percent [of my] community, I wouldn't be able to do it… It would be too uncomfortable. The complexity, I guess. I've thought about that. It would be too hard for me to watch other people serve them. It's hard in some ways already, here, but I do feel like ... I identify with people of color just as people of color, but I definitely ... feel protective of all people, and particularly people of color, and particularly women of color. . . I don't think it hits me in my gut the way it would if it were [my community's] families. I don't think I could do that. Sofia is from here, and then she left here for 20 years, and when she came back, she came back for this program, and she was going through this incredibly complex response to coming home and doing this, and I just was like, 'I don't think I could do that. That's so intense'" (Williams).

Ariana reports that practicing on Mexican women's bodies is already uncomfortable and hard for her, but the complexity of learning on her own community's bodies would be too much. She references one of her 'sister students' Sofia who is going through an "incredibly complex response to coming home" as well as trying to complete the grueling program that La Clínica offers. Yet the additional complexity and difficulty that Ariana references suggests additional labor that may be expected of someone who is native to a place but learning and occupying a white space: the role of the native informant. This role translates to additional expected labor of people of color, particularly those of Mexican heritage. When placed in a role of the native informant, Sofia, for example is expected to render legible the clients to the management and vice versa; to pay particular attention to her clients, but also have as many as everyone else. She is expected to live these two often conflicting expectations while simultaneously negotiating a complex transnational space, which thereby multiplies and exacerbates her emotional labor beyond that which is expected of a white student.

In this section I have shown how white domination can occur in ways that may appear insidious or invisible to other white people, but are visible to people of color. While one strategy for people of color is to make peace with the white spaces that they must occupy in order to gain certain professional requirements, white people do not have to go through the same process. The

onus is upon the people of color to make peace with these spaces and not on white people to make this spaces more livable for people of color. Currently, people of color are responsible to configure and form strategies to survive these white institutions. Ariana's perspective is "you have to face these issues, and you have to make choices, and you have to build allyship, and you have to be able to talk to people calmly, and you have to be able to break things down sometimes" (Williams). Therefore, there needs to be a reconfiguration and redistribution of epistemological labor and responsibility for that labor, especially in a space such as La Clínica in which student turnover is frequent. One strategy that I will explore in the next section is the End of the Day Mentality or EDM that emphasizes the good parts of La Clínica over the bad ones.

End of the Day Mentality

During the same warm afternoon that Ximena, Ariana, and I spent chatting on the patio of La Clínica when the conversation turned to speaking more explicitly about Ariana's struggles with being at La Clínica. She says:

> *It's challenging, but at the end of the day, even people who I don't particularly like or feel comfortable working with, or whatever, or even know some of their politics, and don't appreciate them or think that they're particularly intelligent with the way that they think about social reality, still then, their heart is good. . . It's mostly healing, I think, and it's complicated, and frustrating, . . . but to really have chosen to believe that people's hearts are good, even if I think their politics are fucked up, that's new for me. . . It's been really interesting, having to learn from people that I don't necessarily respect their politics or necessarily feel safe in all respects (Williams).*

This conversation with Ariana and Ximena helped me think through what I call the End of the Day Mentality (EDM), coined by Ariana in this excerpt. EDM is a theme I heard in nearly every interview I conducted with students of color, where I noticed that when students felt that they had been critiquing the clinic for a while or in order to wrap up an interview, they relied on

ending the interview on a positive note, especially using the word "good." In this section, I interrogate the contexts in which they assert "goodness." Though how students use the EDM varies, but I found that people of color employ the EDM in order to exert agency over defining their experiences at La Clínica, to express gratitude, and as a vehicle for survival in a white institution. Keeping Mahmood's uncoupling of agency and resistance in mind, I stress that the EDM is only one modality of agency that I identify; there are multiple modalities that may not have been visible to me as a researcher.

Though Ariana provides an incredibly harsh critique of some of her sister student, she still is still able to assert that their hearts are ultimately "good" and further that her own process of "believing that people's hearts are good" has been healing for her. Despite the violence that Ariana has experienced at La Clínica, she employs neutral language, especially in her last sentence: "It's been really interesting, having to learn from people that I don't necessarily respect their politics or necessarily feel safe in all respects" (Williams). Very few people would describe an experience in which they have to learn from people whose politics they don't respect nor who make them feel unsafe as "interesting." In the same conversation, after critiquing her interaction with a white 'sister student,' Ariana went onto say, "Anyway, we just have a good group of students. It's been a good experience, and I wouldn't have this experience necessarily, if I went to a different school, if a different school existed" (Williams). This statement similarly stands in stark contrast to the interaction she had just described in which her fellow 'sister student' demanded her emotional energy and became angry when Ariana did not supply it. Rather than contradicting herself, her use of "healing," and repetition of "good" function together to aid her in taking ownership of how she describes her experience at La Clínica, both to others and to herself. This reconfiguration of narrative aids in congealing her own subjectivities by reorienting

her own experience into more positive terms. This reconfiguration of narrative is an internal process for Ariana and does not figure into the normative agency-resistance binary; even though this is not an outward action, it facilitates Ariana's survival within a white dominated institution. These agentic actions then must be elucidated in order not to elide, as Mahmood cautions, "dimensions of human action whose ethical and political status does not map onto the logic of repression and resistance" (2005, 14).

While the EDM aids Ariana in taking ownership of her experience at La Clínica and in congealing her subjectivities, it also enables her to enact agency. After a searing critique of the top two women in management, Julia and Candace, she said, "Even Candace, at the end of the day, I have chosen to think that she goes to bed with good in her heart, as much as I am challenged by her, and Julia too. Anyway, it's complicated" (Williams). Her use of choice here illustrates that she is an active participant in dictating how she thinks about Candace, Julia, and La Clínica as a whole. Ariana exerts agency by choosing how to think about Candace and Julia which then aids in forming her own subjectivities. This articulation of agency further serves to insulate her from the more negative aspects of La Clínica because she is controlling her own narrative. In this way, the EDM for Ariana functions as a vehicle for agency to define her experiences and relationships on her own terms.

While EDM functions as a vehicle for agency and self-definition for Ariana, it seemed to function for students like Alina and Sara as both an expression of gratitude for the program and a survival strategy. Alina says, "I was like "But don't, I mean, I am not trying to tell you that it's that terrible all the time, there are really good things about it**,** enough for me to want to do the residency program" (Martinez). Sara agrees with Alina and says, "I was like 'well, I think that is possible that you'd get frustrated and might breakdown,' but then I'm happy but . . . I think

everybody [goes through that]" (Lopez). Alina and Sara both seem compelled to give a more complete view of La Clínica that encompasses both the positive and negative aspects of studying at the clinic. In doing so, it seems that they both are expressing a sort of gratitude for the program itself as well as the tangible material and social capital it affords them in such a short period of time. Yet simultaneously, Alina and Sara seem to try to normalize the experience in our interview so as to normalize the experience to themselves. Sara's final statement normalizes her frustration and breakdowns by asserting that "everybody goes through that." Such statements, like "everybody goes through that" or Ariana's previous comment "Anyway, it's complicated," appears to signal a reluctance to continue that particular thread of conversation. Yet this reluctance and the motivation to focus on the "good" seems to be a protective measure and survival method for students of color, suggesting that EDM is not a form of delusion but rather functions as a vehicle for survival within a white institution.

While the EDM often serves for some as a survival method, for Ximena, the EDM functions to emphasize the good work the clinic can still do even if it is done imperfectly. She says,

> [Some students who are] not native speakers, and they're like, 'We're doing a disservice, because ...' I'm like, 'Do you know how much my cousins would love to birth here?' . . . It's not pure evil. Yes, we've got our issues, we've got serious issues, but you're not evil because you don't speak the language right. Yes, improve the language as much as possible, yes, try to learn cues, but you're good. You're called here for a reason, and they're grateful for you, regardless of if you don't understand everything that they're saying**.** This is a good place (Garcia).

Ximena puts many of the internal complaints about the clinic into a larger context by saying "Do you know how much my cousins would love to birth here?" In doing so, she asserts the good aspects that clients are afforded by birthing at La Clínica and emphasizes the privilege that she associates with being able to birth there. She acknowledges that La Clínica has "serious issues"

but like, Alina and Sara, ultimately focuses on the good work La Clínica does. This seems to adhere to similar patterns of expressing gratitude, as Alina and Sara did, for what La Clínica tangibly affords them, but Ximena seems to take it further and express gratitude for the birthing experiences La Clínica facilitates for Mexican women. Ximena seems to push back against the "serious issues" at La Clínica by focusing on the positive birth experiences they are able to provide perhaps because she is able to identify more acutely with the clientele. In this instance, it seems that the good work that La Clínica does for Mexican women trumps the issues they may have internally. For Ximena, the EDM seems to aid her survival by focusing on the benefits La Clínica provides for their clientele.

While the EDM helps Ximena focus on the good work La Clínica does for their clients, Ariana understand the EDM as more universal. She says:

> Humans. . . like pleasure. We like to feel good. We like to feel that were safe. We like to feel that the world is okay. We like to feel that everything's good all the time. . . A lot of that is to escape from things that don't feel good. We come up against that a lot in our class with a few students in there that ... cannot talk about race to them and cannot talk about violence and death because it doesn't feel good. Doesn't matter. That's reality. We're still here. (Williams)

Ariana grounds this drive of goodness back to a basic human desire to "feel good" and feel "safe." Yet this desire to feel good and safe may be more applicable or resonant with people of color who perhaps need it for other purposes especially in a white institution. She further says that it serves as an "escape from things that don't feel good." While she appears in this instance to be referring to her fellow white 'sister students' who prefer to not talk about race or violence or death, this analysis can be applicable to her and other students of color's adherence to the EDM. Yet as Ariana even says, that process to escape "things that don't feel good" ultimately "doesn't matter" because "we're still here." Though this rhetoric of or adherence to "goodness"

may represent an escape for some, for Ariana, the EDM operates as a survival strategy as well as an avenue to discuss “things that don’t feel good. In this way, it may also serve as an entry point for her to speak freely, unencumbered by expectations, about her experiences as a person of color as La Clínica.

In this section, I have explored the ways in which the EDM functions as a powerful tool for people of color to employ in varying degrees to best suit their needs. For some, the EDM facilitates the intentional constitution of subjectivities, articulation of agency, the expression of gratitude, and, most pertinently, as a survival tool for people of color in a white institution. It is important to recognize the EDM, as well as other modalities of agency; though it may appear that people of color are contradicting themselves, it is often an articulation of agency which is crucial recognize in white serving spaces.

Conclusion

"Racist exclusion must be understood as unavoidable when race-blind epistemologies guide actions. The assumption. . . was that women were oppressed in similar ways and that race, class, and sexuality only complicated a fundamental gender oppression" (Nestel 2006, 5)

In Chapter 1 of this thesis, I explored the roots of midwifery in the Southwestern and Eastern regions of the United States, tracing the process of disenfranchisement and criminalization through the 17th to 20th centuries. While physicians severely criminalized midwifes in the East, curandera-parteras in the Southwest were left largely unmolested because they were primarily serving populations that were poor, rural, and Hispanic or Black. Yet this virtual eradication of midwives in the East, created a seeming void in the birth care industry allowing white women to head the natural birth and midwifery movement beginning in the 1960s. This in turn erased the multitudes of Hispanic and Black midwives who continued to practice in their communities during this period of criminalization in the Eastern region of the United States.

In Chapter 2 of this thesis, I explored how this seeming void of midwives during this criminalization then facilitated the rise of the natural birth movement and the subsequent movement for professionalization and legitimacy. Since this movement was largely headed by white women, it largely attracted the same demographics which in turn rendered the movement itself as racially homogenous.

In Chapter 3 of this thesis, I used La Clínica as a case study to explore grounded examples of women enacting racial domination against other women. In the first section, I

illustrated the history of racialized and homogenized Mexican identity and how these stereotypes affect practices at La Clínica. I further argued that NAFTA has facilitated the commodification of Mexican women's bodies. In the second section, I showed how the border space interacts with La Clínica both institutionally and transnationally, indicating that the clinic reproduces racial systems of domination and privileges white experience. In the third section, I demonstrated how the clinic's use of racially coded language supported persistent stereotypes about Mexican women as poor and uninsured. In doing so, they falsely represent the clientele that they serve and in addition to adhering to border rhetoric. This rhetoric served to legitimize the clinic's existence, to entice prospective students, informed care, and ultimately permits for the unconscious maintenance of white supremacy through the internalization of "white norms."

In the fourth section of Chapter 3, I explored the experiences of students of color at La Clínica and their struggles at a white serving institution. Interviews with students of color revealed their struggles operating within a space that privileges and upholds whiteness and permits the reproduction of systems of domination between women to occur. In the fifth section, I explored how these struggles in turn precipitated many students of color to form strategies for surviving a primarily white institution. The End of the Day Mentality (EDM) elucidates the multiple modalities of agency that students employ.

This research has many varying implications. In antiracist scholarship, systems of domination between women, such as those at La Clínica, must be elucidated if they are to be dismantled. Further, their elucidation is critical as these systems of domination took place in an ostensibly feminist space, which itself has historically been a space to criticize male domination. In the quote that begins this section, Nestel's analysis illuminates instances of racial domination

that took place at La Clínica as well as in the greater context of the contemporary midwifery movement, as being guided primarily by race blind epistemologies, that did not take the potential of domination between women into account. For these interactions that enact racial domination to cease, there needs to be an epistemological shift.

Additionally, there needs to be a reconfiguration and redistribution of epistemological labor. The onus is upon the people of color to configure and form strategies to survive these white institutions and not on white people to make this spaces more livable for people of color. Therefore, there needs to be a shift in responsibility for that labor, especially in a space such as La Clínica in which student turnover is frequent.

In the current political climate, the future for La Clínica is unclear. The vast majority of the clinic's clientele are Mexican women who use laser visas in order to access the U.S. side of the border. These laser visas exist because of the installation of NAFTA, and if President Trump repeals NAFTA, as he claims, could throw La Clínica out of business. While La Clínica does have its own internal issues, it still remains one of the cheapest providers of healthcare in the Frontera border region, providing not only birth care, but STD screenings and pap smears, among others, at a severely discounted price. If NAFTA were repealed, La Clínica would most likely be unable to remain open, which would prevent multitudes of women from both sides of the border from accessing competent women's health care, which in Texas, is already a scarce commodity.

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