A DANGEROUS CRUTCH OR RELIABLE OPTION: THE CONTEXT OF CESAREAN BIRTHS ON ISLA MUJERES

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Abstract

Cesarean births are serious and costly surgical procedures that can be lifesaving in emergencies, but are becoming more preferable to vaginal births globally due to their comparative predictability and relative quickness. For example, a mother I spoke with had a two and a half day delivery, while a cesarean birth only takes around two hours. Cesarean births are predictable in that a doctor is in control of what is happening, instead of complimenting the natural process and rhythm of the laboring mother. This makes cesarean births preferable for many doctors and for some mothers as well. Ideally, the rate of cesarean sections would be 10-15 percent of all births, according to the World Health Organization, but in Mexico, nearly half of all births are cesarean births (Freyermuth, Munos, and del Pilar Ochoa 2017; WHO 2015). This paper shows how macro-level structures impact the type of birth a mother on Isla Mujeres wishes to have, assuming she is aware of such resources. Data comes from formal interviews with doctors and immigrants on Isla Mujeres, informal interviews with Mexican women living on Isla Mujeres, surveys, and participation observation at the Community Hospital.

Key words: cesarean birth, risk prevention, patient autonomy

The screams during childbirth are not because of pain, it's a battle cry. It's a woman finding that strength inside that she didn't know she had.

— Gracie

Sitting in the shade, a whole new world plays in the distance, but in Spanish. It's 9:00 A.M. on a Wednesday morning. A mom walks into the hospital with her baby, who is wearing a pink hat. The words "HOSPITAL COMUNITARIO DE ISLA MUJERES" are hung to the left of the entrance in a bold font, made of a reflective silver material, glittering in the sunlight. The letters are accented by a teal-blue rectangle placed behind them, beneath a bay of windows that are framed by a shelf-like structure of the same color. The building itself is made of concrete that is painted a light beige; a material strong enough to withstand tropical island weather. Inside, sitting on the long, granite countertop in front of the portrait of a whale shark sit three sparkly pink boxes of condoms, electrolytes for babies, and boxes of folic acid tablets. "*Toma uno son gratis"* ("Take one for free"), a paper sign attached to the filled boxes reads. On a wall across from the counter is a bulletin board with large block letters indicating its purpose: *Promoción de la Salud*, promoting health. In the middle of the board is a large handmade collage of how to improve the baby's health and explaining why it is important. The waiting room seats face posters that enumerate patients' rights, doctors' rights, and nurses' rights, as well as obligations of the patient. The Isla Mujeres Community Hospital is relatively new and is quickly becoming the island's best asset for helping give women the tools to make their own decisions about their health. However, this does not mean that women currently have the luxury.

Simply living on Isla Mujeres carries inherent risk. The island, sitting roughly eight miles off the coast of Cancún, has limited access to the technologies and resources used to handle emergencies. "And that's the scary thing about living on the island, just in general," a mother new to the island recounts. "In the middle of the night, [my partner] cut himself on the shower. Huge gash on his arm. Luckily he was okay. He went to the hospital and got stitches. But if he had gotten to the bone—there's no blood bank here—he would've been f***ed. You can't get to Cancún in the middle of the night unless you know someone with a boat. And, even when you have transportation, there is still the race against the clock—trying not to bleed out."

Unlike emergencies that occur during everyday activities, birth emergencies can be planned for, to some extent, in order to assuage risk. An immigrant to the island recounts in a blog post how her doctor and midwife prepared for these risks. She states, "The closest hospital… was a boat and taxi ride away and would take about 40 minutes, so…in case of emergency, that wasn't really an option, but the arrangements had been made just in case" (King 2017). Here, the race against the clock—the forty-minute boat and taxi ride to a proper hospital—is brought up again as a worry, and is just one of many reasons specific to Isla Mujeres that people decide to plan a cesarean birth. Some will go to hospitals in Cancún for their delivery for some peace of mind, even if that means "a back street clinic in Cancún with no blood supply, no crash cart, nothing." Simply being across the water for a delivery can mean the difference between life and death in the case of a time-sensitive emergency, like hemorrhage. The journey also puts mothers in closer proximity to an abundance of technologies that are not available on Isla Mujeres, such as blood banks, specialists, and machines like X-rays and MRIs. Because of this, going to Cancún for delivery is one method to circumvent risk.

Local women on the island may not even consider going to Cancún an option for their birth. A family will decide to have their child on the island so that they may claim the culturally significant title of being "Isleño." On Isla Mujeres, there is strong personal, as well as political,

importance to family lineage. Specifically, being Isleño. Ilda Jimenez y West (2008) highlights that the Isleño identity is associated with a "racialization of cleanliness based on an ideology of a biological lineage having to do with a purity of blood or *limpieza de sangre* (cleanliness of blood) brought to New Spain/Mexico by Spanish conquistadores." Because of "a push for affirming an Isleño identity," it is important to distinguish differences in birthing practices between Isleños and other locals (Jimenez 2008). Ideally, Isleños would be born on the island. However, this is not always the case when emergencies require the mother to be rushed to Cancún, and the claim to an Isleño identity becomes questionable. Therefore, it is not enough to simply state that mothers can travel to Cancún to have their child. Efforts must be made to help increase the availability of safe births on the island itself.

One woman dressed in a sharp black and white dress suit tells me about how a trip to Cancún was not her sister's first choice two years ago, her voice quick and frustrated: "Where [my sister] had this second baby, there was a problem with the anesthesia, and she had to be cesarean again, and so she go to Cancún," she pauses for a second and looks me in the eye, "and in Cancún, she has to pay everything," as opposed to the free care she would have received with a Seguro Popular-affiliated hospital. This account, along with the survey statistics, go to show how Cancún is viewed more as a last resort, and although the problem was with a non-functioning anesthesia machine, her story is not new, nor unfamiliar.

When I asked mothers how they would improve birth on the Island, sixteen responses suggested more doctors, five wanted better equipment, and five complained about having to go to Cancún to receive treatment. One doctor with her own private practice notes, "Even though we have the hospital here, we can't be sure that an anesthetist and gynecologist are on the island. It's often quicker to go yourself to Cancún then try to get the anesthetist on the island." Another doctor at the *Seguro Popular*-affiliated community hospital supports this statement by saying that the resources the community hospital needs are "an ob-gyn, pediatrician, and anesthesiologist in the afternoon, another team in the night, and another on the weekend." This means that at the hospital, cesarean births are only available "on weekdays and in the morning." In the case of an emergency during labor outside of the doctors' availability, they must either wait for the specialist to arrive or get a ride to Cancún. This is the case for procedures such as receiving an epidural as well. The same doctor shares that epidurals are available if the anesthesiologist is present, but "if not, [it is] impossible" to receive the drug. Twenty-five years ago, the story was the same. The experienced midwife who once assisted with births on the island recounts the story of her second birth to make the point that "you don't always know if the doctor is going to be there." This is her story:

> The baby was having some distress. Although my water had broken, I wasn't delivering. So I called the gynecologist and they said, "Oh, well alright, I'll meet you." And I checked myself and I could see I wasn't dilating. In fact, I wasn't dilated at all. And the first birth was about twenty-four hours, so I wasn't sure if it was going to be quick or not, so I said "I'll meet you in the little clinic downtown at about 10:30." This was 6:30 or something. I got up, my water broke, and I thought, "Oh I'll just go back to bed." But the next time I woke up, [the amniotic fluid] was all green so I knew something had gone wrong. So I met the gynecologist downtown, and he agreed that there was only a tiny little bit of dilatation. He said, "Well, you'll probably need a section. We'll have to get an anesthetist. We will call Cancún and see who can come!" because at that time we had no monitoring of babies. So although we could listen [to the baby's heart], we could not see with the monitor, and no oxygen checks. I thought probably a section will do. And although I was planning to have [my baby] at home, ya' know, as I say the most important thing is to have a healthy baby, so I said, "Okay." But when the nurse came in with a catheter in one hand, I thought, "Now hold on, wait a minute, wait a minute!" I had had to have had no contractions, and I had had two contractions. So I said, "Mm! I think something is happening here," and proceeded to have the baby with my sister and a friend…. And I did get to call [my doctor friend] up and have her pick up my laryngoscope and my suction kit because I knew they weren't any down [at the little clinic], so that she could suck the baby out, because it mustn't swallow this green stuff. And I got a picture of her sucking out the baby, and there's a newspaper lying beside her, open at the crossword, where someone had been doing the crossword. And everything was fine. I put [the baby] in a shopping basket, and we went back home! We were only down there for an hour and a half in the end. So you know, I was going to be waiting there anyway, so it was much better that I pushed him out.

I asked one of the doctors at the community hospital what they thought about the comparative risks between having a vaginal birth and a cesarean birth on Isla. He told me that a "vaginal birth is less risky than a cesarean birth accounting every aspect, but in particular here on the island [cesarean births are] less risky. Why? Because the high risk of cesarean birth is accounting for a very high risk population, high demand hospitals, less training ob-gyn like residents, etc. Here on Isla, there are low-risk patients, low demand, and highly trained personnel." In other words, this doctor knows vaginal births are the safest option all around but also shares that when compared to Cancún, having a cesarean birth on Isla Mujeres is preferred because the hospital is not overflowing with patients, the team at the hospital is well trained, and the mothers show no sign of needing emergency resources that the hospital cannot handle. In Cancún, the public hospitals

are crowded with patients, staffed by both doctors and interns, and deal with more high-risk patients. Some women I talked to experienced this frenzy in Cancún, reporting traumatizing stories of "being alone and mistreated" in both public and private hospitals, while others simply reported the inconvenience of the trip. So comparatively, cesarean births on Isla do not hold the same risk as they do on Cancún but should be considered second to vaginal births. Vaginal births are still the best option.

The doctors at the Community Hospital recognize that cesarean birth rates are far too high. There is roughly one cesarean birth and one natural birth performed each week on average, the obstetrician tells me, representative of the entire nation of Mexico in which "almost half [of births are] cesarean births[1]" (Freyermuth, Munos, and del Pilar Ochoa 2017). A spunky doctor expressed her frustrations to me about the inflated cesarean birth rates. She is hoping to bring the cesarean birth rate down. The following week, she and other doctors would be attending a class to learn more humanized birth methods, such as putting the baby to breast for skin-to-skin right away and incorporating hammocks and other equipment so that the mother can get out of the lithotomy position. Part of humanizing births is also to encourage natural births. The classes are monthly, as a part of a social health policy "to provide, when possible, vaginal birth with less intervention as much as possible." But, while "vaginal births are happening more than cesarean births," the obstetrician claims this is due primarily to the lack of specialists for a majority of the week, confirming Elaine Randle's (2016:39) previous assessment that "the local hospital recognizes the implementation of humanized care into all births, but in practicality, these protocols are very rarely followed." Despite this, one can tell that things are improving in the surgical wing of the hospital. A mother I interviewed tells me: "They're saying that things are going better. We have to trust. We have to wait."

A vignette of a cesarean birth I observed shows how even though companions are not allowed, the doctors try to be there for the mother, to attend to her, and to treat her with respect:

> Past the door was a small hospital room. Four beds with memory foam padding lined the left side of the room. One girl, we will call her Mary, was lying in a bed. I had seen her earlier in the morning when I first came to the hospital. While her age of sixteen years caught my attention, it is not out of the cultural norm for Isla Mujeres.
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> Mary came to the Hospital earlier that morning. She was having contractions and was in pain. The Doctor performed a doppler test and found that she would need a cesarean birth because the baby wasn't getting enough oxygen, especially to her brain. Mary didn't want a cesarean birth. She knew it's easier to heal from a natural birth. Alas, she complied and agreed to have a cesarean birth. She was waiting to be brought in for her surgery when I saw her. I couldn't tell at the time if she was nervous or simply tired. I know now that she was both.
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> In bed, Mary was dozing off. Her eyes were not focusing on any one thing. Instead, they floated around the room every now and then, glazed over. Her feet were wrapped in bandages and covered with foot scrubs—makeshift socks. She was covered in a blue hospital blanket and a navy flannel blanket. Despite this, her hands were shaking next to a plastic bottle of saline beside her in her bed. The obstetrician walks up beside me and tells me that she is the girl who will be having the emergency cesarean birth. Soon thereafter, another girl, much smaller, is rolled in on a gurney beside Mary. She didn't have a belly, so I was wondering what she was there for. I was told that she was fourteen years old and had just had an abortion the week before. Unfortunately, she had anemia but did not come in right away when she noticed something was wrong. A general practitioner explained to me that sometimes these girls don't come in soon enough. Abortions are illegal in Quintana Roo, unless in the case of rape. Many girls will take a pill to get rid of the baby, but oftentimes they will not come in until they are septic—having a wide spread infection that can lead to organ failure or death. The general practitioner continued to explain that, similar to in the United States, people will not believe victims of rape. They will say things like "but what were you wearing?" and other victim blaming dialogue. Abortions, however, are legal in Mexico City if the family can afford to go there.
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> When the general practice doctor was told to enter the surgery room, the obstetrician told me to follow her. There, I saw Mary laying on the operating table. The doctors were getting everything set up, and relaxing music filled the room. Mary was looking around, and each time our eyes met, I smiled at her, an attempt to comfort her. Eventually, the general practitioner and the anesthesiologist instructed her to lay on her side for the epidural. The general practitioner sensed Mary's discomfort and talked to her in calming, encouraging tones, telling her about what was going on and making sure she was comfortable. Mary's heart rate was around 88 bpm, and her hand found its way to the general practitioner's scrubs, gently grabbing for her hips. When the general practitioner got Mary talking, her heart rate dropped down into the 70s. Birth companions are not allowed to accompany the laboring mother due to "socio-cultural and hygienic factors." One of the doctors told me that "people lack the education to be in a labor or cesarean birth [delivery room] without being intrusive." Because of this, I was thankful that the general practitioner put her efforts into calming Mary while she could. The anesthesiologist would come

and talk to Mary at times, stroking her forehead and making sure everything was ok. Then, the baby was out before I knew it, but it was a long while before she actually got to see the baby herself. The baby was taken and checked by the pediatrician in the same room. After thirty minutes or so, during which Mary was stitched back up, the baby was swaddled and brought over to its mother. Mary got to look at the baby and was able to kiss its forehead. At this, she began to cry and then sob. The general practitioner asked her if she was happy, and Mary nodded slowly, exhausted from the day's events.

Mary's wish for a natural birth is representative of other women on Isla. Of the thirty-five people who responded to the question: "Which type of birth would you prefer?," 71.4 percent responded that they would prefer a natural birth in a hospital, compared to 14.3 percent wanting a cesarean birth as their preferred birth method, 8.6 percent wanting a home birth, and 5.7 percent wanting a mix of home and hospital birth. There is a disconnect between the number of individuals wanting natural births and individuals who are actually having them. If it were up to the women, a majority would have natural births, meaning the reasons for high cesarean birth rates fall on the backs of doctors' decisions and to avoid emergencies. How can we reduce this disconnect? One method is by having an advocate, such as a doula, or even a companion such as a friend, partner, or family member. This is one thing that I wish Mary had. Even though the doctors were there for her, she had no support system with her during her surgery.

In Mexico, family is often not allowed to accompany the mother during delivery. "Maybe if there is a prep for parents since early in pregnancy, but it's sincerely not likely to happen." Another doctor at the same hospital told me of how she wishes to teach prenatal classes, but because of the limited staff, she is stretched thin and simply doesn't have the time. Randle's (2016:39) previous research shares that "if a mother is aware of humanized birth and argues to have humanized birth practices, the hospital agrees that it would, to the best of its ability, accommodate the women." One hope for the future is that a local doula will fill this role as an educator, outlining a mother's right to a humanized birth, prenatal and postpartum care, and teaching companions how to offer support to the laboring mother without getting in the way of the doctors.

Note

[1]This is from data gathered between 2011 and 2014.

Conclusion

After pilot research on cesarean births on Isla Mujeres, data suggests that an elective cesarean birth is much more permissible than on the mainland, considering the unpredictability of spontaneous birth and the limitation of emergency resources at the community hospital. This is in accordance with the World Health Organization's (2015) new statement on the "importance of focusing on the needs of the patient, on a case-by-case basis," and the discouragement of aiming for "target rates." Similarly, the data confirms aspects of previous research on the medicalization of childbirth on Isla Mujeres by Elaine Randal, who suggests that "factors contributing to this alarmingly high rate of surgical birth include perceptions of pregnancy among youth, structural limitations imposed on the birth attendants and the laboring women, and geographical and economical limitations to access to alternative birth options." In all aspects of the investigation, women preferred natural births over cesarean births due to the ease in recovery. As such, even if having a cesarean birth is more understandable on Isla Mujeres, it does not excuse obstetric violence in the form of unnecessary cesarean births without valid reason. While the Community Hospital is still severely understaffed, it seems to be moving in a progressive direction with its new surgical team, gynecologist, and humanized birth efforts. Doctors are coming closer to putting ideas about humanized birth into actions. Unfortunately, there is still a need for more prenatal/postpartum/postnatal education, as well as the issue of the isolation of mothers from their support system during labor and delivery.

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