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Article

"Como Arrancar una Planta": Women's Reflections about Influences of Im/Migration on Their Everyday Lives and Health in Mexico

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Abstract: The aim of this study is to analyze women's reflections about how experiences of im/migration from rural to urban settings in Monterrey, Mexico, influence their everyday life experience and health and that of their families. The participants were eight women from heterogeneous indigenous backgrounds, one woman with a *mestizo* background, two health professionals, three persons from organizations supporting indigenous groups, and two researchers. I collected data from personal observations, documents, and interviews that I then analyzed with a critical ethnography methodology developed by Carspecken. The women emphasized that food habits were the first to be adapted to circumstances in an urban everyday life constrained by working conditions. Together with their experiences of discrimination and violence, urban living determines the challenges and the priorities of daily life. Urban life affects how they perceive and treat their own and their family's health and wellbeing. Nevertheless, their sense of belonging and home remains in their communities of origin, and they strive to reach a balance in their lives and preserve a connection to their roots, motherhood, and traditional knowledge. However, the women handle their im/migration experiences in diverse ways depending on their own conditions and the structural forces limiting or allowing them to act in decisive life situations. Im/migration is not just a matter of choice; it is about survival and is influenced by social determinants and "structural vulnerability" that influences and/or limit human agency. These, together with an unsustainable economic situation, make migration the only option, a forced decision within households. Structural forces such as social injustice in welfare policies restrict human rights and rights for health. Social determinants of health can constrain decision making and frame choices concerning health and childbearing in everyday life.

Keywords: migration; health; everyday life; structural vulnerability; discrimination; critical qualitative research; critical ethnography; social determinants of health; deservingness

1. Introduction

Migration has always been a part of the lives of human beings. War, persecution, climate conditions, and economic hardship have forced people to move across the globe, in search of improved living conditions and a better future for their children. Migration movements are a life process affecting the agency of the displaced for several generations, both in the new country and the country of origin [1]. Inherent to migration and resettlement are the adversity and constraints of daily life. These struggles lead to several disparate experiences that influence the agency, initiatives, and decisions of the displaced. Consequently, the migrant is forced to live in a state of limbo, in between different realities [2,3].

Several researchers caution against using the terms "migrant" (movement that is temporary, seasonal and/or circular) and "immigrant" (uni-directionality and permanence) interchangeably, as they are not synonymous [4–6]. Although these terms are intended as neutral descriptions of groups or individuals in policy papers and research, it is often not the choice of an individual or group to attain migrant or immigrant status; instead, they are at the mercy of local authorities with the power to enforce immigration policies. To acknowledge the shifting and illusory nature of the distinction between migrant and immigrant, the open-ended term "im/migrant" has been created [4–6], and will accordingly be used in this study.

All over the world, indigenous people are exposed to extreme poverty, marginalization, discrimination, and conflict. Their traditional lands are threatened and they are forced into dispossession. In addition, their belief systems, cultures, languages, and ways of life continue to be threatened, sometimes even by extinction. Because of the persistence of stereotypes regarding indigenous peoples, in urban areas, they often become an almost invisible population, living in informal, sometimes overcrowded settlements with other poor people [7]. In Latin America, 34 million indigenous people (8 percent of the total population) live in severe poverty [8].

Indigenous populations in Mexico have their roots and traditions grounded in culturally advanced civilizations, going back 2000 years. The ancient population, thought to be as high as 20 million at the time of the conquest in 1519, was decimated to approximately two million a century later through the destruction of socioeconomic structures and the importation of European diseases. The introduction of mining and cattle ranching—a system of forced wage labor—contributed to the dismantling of socioeconomic structures. Furthermore, indigenous people were tricked into debt-bondage and became virtual slaves under the *hacienda* system. After the revolution of 1910–1920 that left Mexico in chaos, indigenous rights were still ignored. They were encouraged to become "Mexican". Mexico's indigenous groups/individuals found themselves at the bottom of the social order of the mixed Mexican population, whereby approximately 60 percent are *mestizos*, *i.e.*, of mixed Spanish and indigenous descent. Together with those poor *mestizos*, they suffer from a land shortage that has forced many to become low-paid agricultural laborers and to migrate. There have been many reports of human rights violations against

communities, with political killings, detention, "disappearances", and torture of indigenous people for defending their land rights [9].

In Mexico, there are 15.7 million people considered indigenous, of which 6.9 million speak one indigenous language (about 65 languages recognized by the authorities). There are also 9.1 million people who see themselves as ethnic indigenous although they do not speak their mother tongue. Of those that have an indigenous mother tongue, 15.9 percent do not speak Spanish [10]. The poverty rate at 90 percent among indigenous people in Mexico (in 1980) has remained consistently high (in 2000), without showing any signs of diminishing [8]. Poverty is 3.3 times higher in Mexico among indigenous people than the rest of the population [11].

A national survey on discrimination in Mexico in rural and urban areas found that when indigenous people were asked which of their rights most needed to be respected, the right to justice (17.6%) came first, while the right to education came seventh (4.6%), and the right to a decent job came eighth (3.8%). To the question of how to eliminate discrimination against them, they answered that society should create work opportunities (17%) and provide education for indigenous people (15.5%) [12].

Health challenges include illnesses from pesticides in agroindustrial cultivation and extractive industries, malnutrition, diabetes, HIV/AIDS, and mental health issues such as depression, substance abuse and suicide [9,13]. Health challenges faced by indigenous peoples stem from the neoliberal policies and economic markets hitting local production, the contamination and depletion of their land and natural resources, and from forced displacement from their territories [9].

In healthcare and public health research, the focus is placed on the personal responsibility for our health and lifestyle without considering the social determinants of health. Social determinants include socio-economic circumstances and support, physical circumstances such as working conditions and environment, healthy child development, one's individual capacities including education and health practices, but also the whims of those in power and whether or not they are vested in research and health service, which is ultimately influenced by policies, commercialization of everyday life through local and global economies, and sociocultural norms [14,15]. Several researchers have shown that the context of our living conditions in terms of social injustice as well as socio-cultural, gender and socioeconomic status (SES) is decisive for our health and lifestyle [16–18]. Despite this knowledge and the complex causality, im/migrants are often subverted by cultural stereotypes and blamed for their social and health situations [6]. The voices of minorities and im/migrants are often left out, or homogenized, thereby hindering a deeper understanding of their priorities, decisions and agency. However, different indigenous groups in Mexico are organizing themselves, or with support from organizations, to reclaim their rights. Internationally, already in 1985, work started on the drafting of a declaration on the rights of indigenous peoples. It took until 2007 for the General Assembly of the United Nations to adopt the Declaration on the Rights of Indigenous Peoples [19]. It was an important step forward for the recognition, promotion and protection of the rights and freedom of indigenous peoples.

Health in traditional medicine of indigenous people can be seen as grounded in a struggle for harmonious and balanced coexistence of human beings, intertwined with nature, themselves, and others. It includes an integral wellbeing, manifested by spiritual, individual, and social wholeness and equilibrium. A barrier stated in a document from PAN American Health Organization (PAHO) is the attitudes and inability of the health systems to incorporate practices from both traditional and biomedical medicine, thereby limiting possible choices and creating a polarization between the two systems [17].

However, medical pluralism has been a major characteristic of Mexican healthcare, despite the state having given pre-eminence to biomedical medicine. Certain systems of traditional medicine and homeopathy have had some limited federal and state support, but the diversity of medical options available is not known [20]. Medical pluralism means coexistence of multiple systems of medicine, such as folk, popular, and traditional systems. Currently, however, we have limited knowledge on how different therapeutic modalities relate to each other [21]. Nevertheless, indigenous healing traditions or practitioners as well as other alternative medicines are heterogeneous; they are dependent on individual skill, and ethical approach, and can be marked by power and inequalities in gender, rank, and age.

The aim of the present study was to analyze women's reflections on how their experiences of migration from rural to urban settings in Monterrey, Mexico influenced their everyday life, their own health, and the health of their families.

2. Method

This project and study is part of an international research exchange program, "Understanding and Supporting Families with Complex Needs", that seeks to address a recognized deficit in family-focused research by developing links between divergent disciplines and knowledge streams, both nationally and internationally.

In this study, critical qualitative research (CQR) was chosen as the methodological approach to deepen the understanding of how women reflect on their experience of how migration influences their health and the health of their families. CQR seeks to understand the relationship of culture to social structures since, despite going largely unnoticed, they influence how they act [22]. In addition to health promotion, CQR has the goal of attaining emancipation and can be a useful approach when investigating everyday experiences of health and social wellbeing that are produced and reproduced in a sociocultural context [19].

CQR is often referred to as critical ethnography and addresses the two social-theoretical domains that are analytically distinct from each other: lived culture *vs.* social system [22]. It articulates the subtle and overtly oppressive structures in society and confronts these structures on such grounds as racism, sexism and classism to enable all to take part in unhindered citizenship [23]. In this study, I have used the methodological approach of Carspecken [24] that underlines knowledge as intersubjective and formed within social relations involving power [22].

2.1. Participants and Data Collection

Participants were voluntarily recruited through non-governmental organizations (NGOs) supporting im/migrants in Monterrey, Nuevo Leon, Mexico. I was first told that the im/migrant women were generally reluctant to participate in interviews. However, they had requested in the NGO workshops some midwifery knowledge. When I informed them about my long experience as a professional midwife working with women im/migrating to Sweden, they invited me to participate in two workshops that focused on sexual and reproductive health. At the end of the workshops, I told them about my project and several women volunteered to participate; however, due to local celebrations in their communities of origin together with Christmas/New Year and school vacation, several women were travelling and, in the end, only six women were able to participate. Through the snowball method, two women who had

participated in earlier workshops and recently volunteered in the organization to support women were included to participate in the study. Another woman with im/migrant experiences was recruited directly at the appointment for the interview when it became clear she had a *mestizo* background. The interview was very rich and enlightening and thus included in the study.

Furthermore, I interviewed three persons from NGOs supporting migrants in Monterrey. I also interviewed two researchers, one at the university and another in a research center. These interviews helped me with background material such as documents, reports, and up-to-date research for this study that I used in the first phase of analysis [24]. I visited and made observations in a health center and a public school in a suburb of Monterrey and interviewed a general practitioner. Because the women had been requesting information about midwifery, I wanted to learn more about the situation for midwives in Mexican society and thus chose to visit a maternity center connected with a midwifery school in a small town, one of the few officially recognized and approved educational institutes for midwives in Mexico. The school prioritizes students from rural areas with mothers or grandmothers who are traditional midwives in order to integrate a biomedical knowledge base, from a midwifery perspective, with the traditional (organic) knowledge of childbirth. There, I interviewed a (professional) midwife that started her career as a traditional midwife and worked both as a midwife in the maternity center and as a lecturer.

The participating women were informed about the purpose of this study and its strict confidentiality. They were subsequently assured that their identities would remain secret. They were enrolled and gave their written consent with adequate permissions [25]. In total, 16 interviews were performed (from November 2013 to January 2014). Eight women with self-defined, heterogeneous indigenous backgrounds (Mixteco, Masahua, Otomí, Nahuatl) and one woman with a *mestizo* background participated (interviews 1–9). Their communities of origin were in the states of Veracruz, San Lois Potosi, Puebla and Oaxaca. In addition, three staff members from non-governmental organizations supporting indigenous groups (interviews 10–12), two healthcare professionals (interviews 13–14), and two researchers were interviewed (interviews 15–16). The women volunteered themselves and were not selected purposely. The focus of this study was not a specific individual's characteristics or those of indigenous groups; rather, the focus was to understand the female experience of im/migration from rural areas to urban settings. I conducted all interviews in Spanish; I audiotaped and transcribed all interviews with the women's permission. In addition to the interviews, I used participant observation during eight weeks while I visited families in suburbs for the workshops, went to the health center, schools, and university, and attended seminars and meetings for the non-governmental organizations for im/migrant women. I spent some Sundays at Plaza Alameda observing and talking to people, and visited markets where women/families were selling handicrafts or other goods and came into conversation with some of them. I also read documents and research and governmental reports resulting in a huge amount of material that I analyzed with the CQR methodology developed by Carspecken [24].

The interviews lasted about one hour each and the women decided on the setting, either in their homes or in an undisturbed room in the support organization. The open-ended questions I used in interviews were: "Tell me about your and your family's experiences of migration", followed by "Tell me about how your and your family's health is impacted by migration in everyday life and childbearing". For the participants working with the organizations, and the physicians, midwives and researchers, the question was modified to "Tell me how migration experiences from rural areas to urban (Monterrey) influences

women's and their families' health in everyday life and childbearing". Follow-up questions were used: "What do you mean?" and "Can you give me an example?"

2.2. Data Analysis

Carspecken's (1996) five-stage structure for conducting CQR captures two methodological, orientations: the *cultural conditions interpretive* that captures the insider's position, and the *functional methodology* to represent the outsider's position [22]. Carspecken's methodological theory of critical ethnography contains five stages: observation and description; analysis of these data; dialogical data generation; analysis of these data to discover relationships between individuals, groups and systems; and examining findings in relation to existing theories of society [23,26]. See Table 1 for an outline of the analysis.

Table 1. An outline of the data analysis.

Stage Description	Data Collection	Example of Analysis
1. Observation and description from an (etic) outsider perspective Fieldwork: nonparticipant observer, monological, unobtrusive, reflection	• Searching and collecting information and documents about system and situations of im/migrants in Monterrey from rural areas; • Establishing contacts through organizations that support women; • Observations	Field notes when collecting data through observations made at: • health centers • a birth center • schools • seminars • workshops for im/migrant women, • participants' homes • organizations • markets • when traveling by bus and subway to the suburbs • engaging in informal chats with people • recollecting and reading documents, reports, research
2. Researcher interpretation, (etic) Perspective analysis of observational data	• Preliminary reconstructive analysis; • Monological	Analysis of the field notes from all observations (achieved experiences) and documents beginning with a description of the sociocultural context through key issues (meaning units and forming initial categories that are further explored in step 4).
3. Dialogical (emic) data generation, collaborative stage	• Fieldwork: participant observer, interactive, interviews, reflection	In-depth interviews with the 16 participants using a dialogical approach aiming to understand the insider's (emic) position. After listening to the interviews, together with notes, I came back to some participants with follow-up questions. Reflexivity was an essential part of the research process.

Table 1. *Cont.*

Stage Description	Data Collection	Example of Analysis
4. Describes systems relations to broader context Analysis to discover relationships between individuals, groups, and systems	• Conducting systems analysis between locales/sites/cultures (discovery); • Dialogical	Analysis and synthesis of the interviews. I read all interviews to catch the whole, coding and taking out meaning units, while preserving the core of the text and involved back-and-forth movements between the whole text, the codes, and the categories. Then I revisited the material from stage 1 and 2, in light of the new understanding, moving between the understanding gained in the interviews(insider/emic perspective) and through the documents and observations (outsider/etic perspective) through reflections to deepen my understanding and developing categories/themes
5. Explains relational systems examining findings in relation to existing theories of society	• Links findings to existing macro-level theories (explanation); • Theoretical	The deepened understanding I linked to a broader context using theoretical approaches and concepts such as structural vulnerability, decision-making agency, social determinants of health, embodiment, and health rights, to discover connections and patterns between social discourses applied in the context of everyday life of the interviewed participants' experiences.

Please note that the analysis in the monological, dialogical and theoretical stages is not presented in the findings as separate entities; the stages have been combined into one [22].

3. Findings

3.1. "Como Arrancar una Planta" (like Transplanting a Plant)

The plant analogy, as expressed by one interviewee, well illustrates the findings of this study. When a plant (a person, group) is going to be replanted (im/migration), the environment is decisive (the context) for its survival and growth (to get light, sun, fresh air, water, nutrition, but also suitable climate). There are distinct similarities between this metaphor of transplantation and the common themes brought up in the interviews: (1) *The art of feeding versus the easy choice of fast food*; (2) *Im/migration can both split and reunify families*; (3) *Im/migration implies difficult and unregulated working conditions*; (4) "*Health matters as a medical question*". In addition, to continue with the plant imagery, when moving a plant, it is crucial to keep the roots in the original soil to avoid challenging or subverting future growth (takes longer time to set root and start growing again when the roots are removed without the original soil). This imagery is exemplified through the categories: (5) *Violence is everywhere, hitting women in rural and in urban life*; (6) *Health as part of a whole-life context*; and (7) "*Sense of belonging means 'to survive' versus 'being alive' in everyday life*". Furthermore, often bigger plants (older people) take a longer time to—or actually never recover from—the displacement, whereas tinier or younger plants (younger generation) can more easily set roots and adapt to the new environment. These categories will be further developed below.

3.2. The Art of Feeding versus the Easy Choice of Fast Food

The women stressed that their food habits were the first tangible adaptation to the living circumstances and working conditions in everyday life in urban settings. The women underlined that "*fast food is not a healthy choice*" (interview 5). Furthermore, some women reported that clean water has become a luxury; water from pipes tastes bad and therefore they often substitute it with sweetened soft drinks, coffee, or chocolate. They also stressed that everyday life means long and exhausting workdays and a host of responsibilities that need to be prioritized. The cheap, fried fast food is thus an easy choice, being both convenient and easily accessible. To keep the traditional healthy food habits in the new urban area, one must travel long distances to the market and cover the cost of transportation; the women explained that they lack the time for proper food preparation and have limited food storage and cooking facilities. A woman stated: "*Fast food and soft drinks are everywhere, even in the most remote rural areas"* (interview 9). The women mentioned that fast and junk food and soft drink consumption is connected with modern life and is, in reality, also an issue in rural areas where people need to work outside their communities. Nevertheless, when living together with the older generation, it is easier to maintain traditional food habits even after im/migration as the elder generation is stricter and more concerned with preparing and eating traditional foods.

The erosion of traditional food systems and decreased food security has led to an increasing reliance on imported processed foods that have little nutritional value and are often high in sodium and fat, causing obesity and diabetes [27]. Heavy marketing has increased consumption of sugar-sweetened beverages worldwide, particularly in low- and middle-income countries [28]. This is currently a major challenge for public health authorities and, in Mexico, the levels of sugar-sweetened beverage intake have never been recorded as higher in a nationally representative survey among adolescents and adults [29]. There is a clear link in science between sugar-sweetened beverage consumption and the risk of chronic diseases. Escalating healthcare costs and the rising burden of diseases related to poor diet create an urgent need for solutions and political action [30].

3.3. Im/Migration Can Both Split and Reunify Families

Some of the women detailed how they live together with extended family and former neighbors from their communities of origin. Parents who work as itinerant traders left their children with their extended family, thus helping each other in everyday life. A woman stated: "*When I was a kid our parents went away trading and we took care of each other, it was a funny childhood and we were very independent*" (interview 7). In addition, living in such "congregates" made it easier to preserve food habits, the mother tongue and traditions, and even their festivals. Other women mentioned that they and their partners rented a room in houses comprised of people from different indigenous or *mestizo* backgrounds, from several different states and communities of origin, thus necessitating Spanish as a common language. One woman commented: "*We try to help each other with the children, although it is not the same as your family*" (interview 5).

Some women said that they hardly knew their mother tongue, as their parents saw it more as a burden, and did not see any value in transferring it to them. Other parents consciously (or because of necessity) left their children for some years with their grandparents in their community of origin to learn their

mother tongue. However, some women stressed that these children often had problems in school when returning to urban areas because of a lack of adequate Spanish. Teachers are evidently still punishing children when they do not speak Spanish. The women also highlighted bullying as a severe problem for children with indigenous backgrounds in school. A woman emphasized: "*When a schoolmate did not speak much Spanish but English after some years in the US, she was never punished, contrary to other children that spoke their mother tongue in school...how can knowledge of different languages be so differently valued?*"(interview 6). Nevertheless, all the interviewed women underlined the importance of education for their children, and some were sorry for that they did not have that possibility for themselves earlier in life.

Indigenous children drop out of school much earlier than non-indigenous children to look for work. Illiteracy rates among the urban indigenous population are four times higher than rates for non-indigenous people living in cities. This systematically leads to low-paid, low-skilled employment [9,31].

The interviewed women stressed that the contact with their family/relatives in the community of origin is important but there are barriers. These barriers include the high costs of traveling and short vacation time, if there is any at all. As a result, only a few members of the family travel, often just the mother and children. Several women emphasized the yearly obligations of collective work in communities of origin. It creates conflicts and deters im/migrants from travelling to their communities or, even worse, to be rejected as *comuneros*.

As stated by Mutersbaugh: "Migration may disrupt or enhance village involvement in regional development networks, and, since these networks provide an important source of village income for both family and collective consumption, stay-at-homes may be adversely affected" ([32], p. 490). The agency of im/migrants is complex and they need to include this contradictory impact on their family *versus* the community of origin in their decisions to migrate [32].

3.4. Im/Migration Implies Hard and Unregulated Working Conditions

Several of the women narrated that they had migrated as teenagers (14−16 years old) to work as a housemaid, living "inside" with Sundays off. Some of them left in accordance with their family to support and send money home, others to gain a certain (economic) independence. On Sundays, they met at a central square, "Parque Alameda" with friends, cousins, or other family members from their home state or communities. Many met boyfriends there, getting pregnant young and therefore starting family life early or becoming a single mother. The women's ability to take care of their child depended on their economic situation. Available alternatives to women were to either leave the child with the grandparents in their community-of-origin, providing financial support (a common solution not only for single mothers), or to give the child up for adoption. One woman told me, "*...my mother left me when I was seven with an earlier employer to raise me and get education, I even called her mother*" (interview 2).

Jobs in domestic services or working as a housemaid was what was most commonly available to young women from indigenous families. They were often left without any rights, and provision of benefits was left up to the goodwill of the employer [33]. One of the interviewed researchers (interview 15) emphasized studies that illuminated the unregulated working conditions and how important it is for domestic workers to achieve access to employee benefits including performance rewards, social security, and safe conditions at work [12,33].

Several of the interviewed women stressed that they are worried about their male partners due to their hard working conditions. The men work six days a week, often more than 12 hour shifts, and were exhausted during their days off, either staying in bed sleeping or consuming alcohol to be able to relax. A woman stated: "*I hardly speak with my husband, either he is working or on his day off he is drinking beer with peers and sleeping*" (interview 2).

One of the interviewed researchers (interview 16) stressed that many im/migrants have problems with documents when they work in unofficial sectors. To transfer documents from their community of origin is complicated and costly, but without documents, they have no legal rights in Monterrey. In a study of working conditions, it was shown that among people with indigenous origin, 68.2 percent have no health insurance, 80 percent no vocational rights, and 78.3 no retirement savings [10]. Finkler (1997) underlines the position of immense disadvantage endured by poor men with low or basic education (three years), their hard working conditions, and the daily discrimination they face in Mexico [34].

3.5. Violence Is Everywhere and Affecting Women in both Rural and Urban Life

Women mentioned the physical violence in family, inter-partner violence both in communities of origin and urban settings. They emphasized that most violence is connected with alcohol consumption among men that affects the whole family. Some women stressed that the physical violence is worse in rural areas, as people live in more isolated situations, far from neighbors where anybody can hear or know when women are being beaten. A woman said "*...in my 'rancho' it was 'natural' with fights among adults and couples...the life was much more physical bodily expressed in all sentence*" (interview 8) Some women believed that, in urban settings, when people live close to each other, it acts as a sort of barrier to physical violence. Others, however, insisted it resulted in more threats, impedance, silence, ignorance and devaluation. A woman detailed: "*My sister and I interfered and questioned our father when he mistreated our mother. First he got angry and argued but we told him about the laws, that he was not allowed to mistreat our mother. Then he became ashamed and it made him change as he recognized and felt embarrassed for his behavior and manners. The relations in our family got much better and my mother dared to talk and give her opinions*" (interview 7). Nevertheless, the women mentioned gender roles as varying in different indigenous populations; there are some communities and groups wherein women have a great deal of power and influence in both family economy and community matters. A woman stated: "*My mother was the one that ruled the commerce and trading, she travelled a lot and had the main responsibility of income. Meanwhile, my father was taking care of us children and the house*" (interview 8). For others, and occurring more frequently in Mexican society, the men rule and decide nearly everything outside the household. A woman declared a common utterance: "*tengo los pantalones entonces es yo que mando*" *("I rule as I wear the trousers")* (interview 4).

In addition, the inter-partner violence is directly correlated with the exploitation of disadvantaged men. Alcohol consumption combined with working conditions that are hard to bear causes them to lash out. Some men feel they can at least retain their self-esteem at home where they are in command and can subordinate their women with beatings [34]. The effect of physical coercions on one's health is cumulative; the insult, moreover, is internalized on many levels, resulting in increased sickness [34]. In the NGOs (Zihuame and Zihuakali in Monterrey, interviews 10–11) that support im/migrant women, workshops are given concerning general health matters, sexual and reproductive health, and violence

(combined with practical work and handicrafts). These workshops also involve interactive discussions about rights and laws in society to create awareness, agency, and support among the women [33].

Some women in their interviews stressed the influence of violence and machismo in Mexican society, which limit their everyday life and make them tense. In a visit to "*casa de immigrantes*" the personnel told me stories about persons that had succeeded to escape after being kidnapped close to the U.S. border and were forced to participate in violent actions. Others were kept as slaves, threatened with death. Violence has been impregnated strongly into Mexican society over the centuries and is also expressed through human rights violations against indigenous communities. Over the last few decades, the violence has escalated with organized crime and a corrupt police corps resulting in *ad hoc* violence throughout society, leading to insecurity, abuse and people being killed on the street or kidnapped and tortured [12,35]. Of the several states of Mexico, Oaxaca and Chiapas (where some of the im/migrants in Monterrey have their origin), have more documented political killings, detention, "disappearances", and torture of indigenous people for defending their land rights [9,35]. Indigenous people have experienced a collective history of different forms of violent forces that persist today in the form of development aggression, war, forced displacement and economic exploitation, thereby leading to high rates of distress and mental health problems [36].

3.6. Health Matters as a Medical Question

All women reflected on how life in urban settings made them change the way they treat themselves, their children, and their family's health. Some women mentioned that they went to different health centers (could be state, organizational or implemented by programs) when they needed assistance regarding their own or their children's health. Some women stressed that they were welcomed into these centers and were overall treated well. Nevertheless, the same women expressed worries about their children, who are steadily affected by infections and coughs in wintertime due to air drafts in their poorly insulated houses (the children had to wear jackets indoors), as well as air pollution. A woman said: "*I am worried about the effect of the medicines, it is as my child always needs stronger medicine to get rid of the infections, I am worried that she gets like addicted...now it never is enough with just something for fever*" (interview 1). However, she did not find it possible to voice these concerns during the health encounters: "*There is no time and space for such questions*" (interview 1). Barriers exist even when there is full access to biomedical (Western) healthcare, due to lack of communication skills and understanding of social and cultural factors [37].

The interviewed women also mentioned experiences of discrimination in their exchanges with local authorities, school figures, and healthcare practitioners. They experienced being ignored or neglected and many reflected that they had to assimilate and keep quiet to survive. Some women explained that they avoid health centers as they had already experienced ignorance and mistreatment. A woman mentioned that when her second baby was four months old, she was strongly advised to stop breastfeeding because her milk was just water, harming the child and putting him at risk of malnutrition. She said "*One gets confused and worried—my first child I breastfed until he was two years without any growth problem*" (interview 3). The distrust made them search particular physicians and pay to get better care when needed. For example, a woman mentioned how "*in healthcare settings my mother always pretends not being able to understand Spanish. It is the only way for me to be permitted to accompany*

her in the medical consultation as my mother otherwise fears inadequate care or mistreatment" (interview 8). Several women came to distrust healthcare after experiences of mistreatment. An example that many of the interviewed women gave was cases of sterilization without a consent. They recounted how sterilization was commonly used and performed at the time of childbirth by caesarean section in the hospitals. It is also documented in the literature, which states that proper information before or consent to is not always given due to communication failures and ignorance [38]. On the other hand, the interviewed physician stated that: "*People do not value their health more than any material… Unfortunately, most people in the city do not make any effort to take care of their health, because of lack of knowledge and education*" (interview 13). Furthermore, the physician stated that even if healthcare professionals made huge efforts to inform people, they do not seem to care or take in the information. The physician questioned how people deal with emotions as they seem to be very distanced. The physician recounted the example of an initiative for a women's support group for victims of violence. Because it achieved no recognition in the health organization, when there was a lack of resources and budgeting concerns, the program was cut. Furthermore, the physician underlined that, sadly, there is ignorance among people towards their health, and stressed that it is also a huge problem that needs to be further investigated.

These concerns of the physician corroborates what is asserted by Quesada: "the conventional biomedical paradigm largely fails to translate the documentation of social forces into everyday practice and epistemology" ([39], p. 341). It is grounded in an approach where the imaginary gaze defines "the other" without giving space or listening to their voices. The medical experts value/diagnose people's symptoms and their health situation in a way that masks the multiple dimensions of social inequality at both structural and individual levels [2,40]. For example, when the professionals communicate during healthcare encounters with patients, they always start from their own perception of the situation by asking the question: "What do we see the person needing?" Carrying out the consultation from this (limited) "first imagined" knowledge professionals overlook "the other", objectifying and defining that person. The question that should be asked first is: "What does this person see herself needing?" Full attention should be given to finding the answer. The question cannot be answered with the professional's own concepts, for that would imply that they introduce their own perceptions/view to their actions (Spradley and McCurdy 1972, in [41]).

3.7. Health as Part of a Whole-Life Context

Several women discussed their traditional way of perceiving health as part of a whole-life context. They explained that their health interrelates with nature and the environment. Health is embodied and intertwined with their traditions, stories, customs, and values. Knowledge among elderly generations is transferred (orally and embodied) to the next generation through storytelling, myths, wisdom, traditional treatments with herbs, and healing. This is presently more difficult because im/migration means less contact with elderly generations; a great deal of traditional knowledge and medicine is not only lost, but is disrespected and threatened in modern society. An example the women stressed is the fact that there are hardly any midwives left. The interviewed midwife (who has both a professional and traditional background) explained: "*...the most knowledgeable midwives are they who learned since they were young from their mother or grandmother: they have accumulated knowledge from generations and they*

were well-known and trusted in the communities..." (interview 14). She continued by saying the care offered to women included dietary advice, herbs and massage (*sobada*) throughout the pregnancy and support during childbirth with their family around them. A study shows that most traditional knowledge and medicine are treated as superstitious, redefined as dangerous, devalued, repressed and even prohibited by the medical authorities and health system [38]. Nevertheless, all the interviewed women and the midwife underlined the importance of medical advances, knowledge and treatments.

All women complained about how they were treated in hospitals and health centers during pregnancy and childbirth; often they were met with distrust and ignorance, left alone, ignored even when begging or crying for support, and were not allowed to be accompanied by a family member. Many women spoke about complications and instrumental childbirth such as caesarean sections. A woman recounted: "*...when my second child was born in the hospital, nobody came when I cried that I had to push and needed assistance. The baby was born when I was alone and it took a while before he cried. Afterwards when I complained, the physician blamed me for what happened*" (interview 3). A study concludes that when women experienced barriers in healthcare and felt discriminated against, they became more tense, insecure and frustrated. When they were "taken seriously", however, they felt well cared for and they recognized their capabilities and embodied knowledge, boosting their sense of self [2].

The interviewed midwife argued that: "*it is a constant effort to get acceptance for facilitating normal physiological birth in the healthcare system*" (interview 14). In Mexico, there is an insufficient number of midwifery schools. Those that exist are plagued by a strained financial situation, thereby limiting the ability to train midwives who could then live and stay in remote rural areas to support women, and to select and send the women that need more advanced medical assistance in pregnancy or childbirth to nearest medical center/hospital [42,43]. Because the majority of indigenous women lives in remote rural areas, four out of 10 do not have access to healthcare during pregnancy and childbirth [12]. It is an oppression of poor and indigenous women, a burden of "triple jeopardy"—ethnicity, socio-economic-status (SES) and gender [44,45]. Siegel investigated in her study how when the medical authorities were retraining (educating and transforming) traditional midwives, they would suppress, ignore and devalue the knowledge they brought in with them. The biomedical perspective was taken for granted; their way of treating childbirth was the right and only way. Everything else was prohibited [38], thus presenting a paradox: as in several countries in the world women are fighting to regain the knowledge about natural physiological childbirth that has been lost. In addition, there is increasing evidence illuminating the consequences of iatrogenic effects of intervention without cause in childbirth [38,42].

3.8. Sense of Belonging Means to "Survive" versus "Being Alive" in Everyday Life

The women stressed that the most common reason to migrate was purely economical; these were decisions made by the family in hopes of a better income and future outside of the community of origin. A woman recounted: "*My parents told us they had no alternative, no other option. They wanted to give us, their children, opportunities to get an education and a better life*" (interview 7*)*. However, they declared that migration is felt as a loss, as a necessity to survive and as a sacrifice that hurts. A woman mentioned that she is depressed and has difficulties coping with urban life, which she perceives as stuffy and restrictive. Some women reflected about (young) im/migrants "*losing the face*", which includes absenteeism and feelings of shame. The modern, urban life has an accelerated speed that is nearly

impossible to resist. A woman reflected: "*It is easy to get lost in commercialism and consuming of things, relations and nature*" (interview 6). Nevertheless, with a low income, it is impossible to consume in accordance with the norms in society, demarcating a visible marginalization.

The decision to migrate is triggered by survival needs, as a consequence of neoliberal policies, economic factors such as the North American Free Trade Agreement (NAFTA), and national and global politics [35]. It is often not up to individual decision or choice; rather, the household is a decision-making unit that sends some family members to work outside the community (Wood 1982 in [35]). However, these situations are complex and neither the individual/family nor the structure completely determines one's actions. It depends on the context, the challenges, and uncertainties of social life [32].

All women underlined that their home and their sense of belonging continue to lie in their community of origin despite having lived for several years or even having grown up in urban settings. A woman expressed: "*A day renders much more: the air is clear and fresh, the nature is close, one can see trees, animals and hear birds singing, and the sky looks so pretty at sunrise and dawn*" (interview 5). However, some women asserted that the life conditions and lifestyles in rural areas have changed. Many communities of origin in remote areas have become "ghost villages" as most people have already im/migrated. Furthermore, the exploitation of natural resources and pollution of rivers and land in rural areas make it difficult to live in remote areas and earn a living from farming [32].

Indigenous and poor people in society are defined not according to what they are but in terms of what they lack [46]. Their traditional lifestyle is disappearing, portrayed as a relic from the past in contrast to the "white" modern society that has been allowed to evolve and change without losing its defining cultural anchorage. Consequently, indigenous and poor people have learned to recognize themselves not as social human beings with equal rights, but as a diminution, if not an absolute negation, of people who are superior in society. This negation is internalized and creates a focus on the individual's failures, causing shame and influencing self-esteem and health [6,41,47].

4. Conclusions

The analogy of an uprooted plant illustrates the complexity of women's experiences of im/migration from a rural to urban setting in Monterrey, Mexico. Everyday life includes a complex interaction of interconnecting factors and relationships that influence women's experiences, choices, and decisions. The women had to set daily priorities for their families depending on the changing life circumstances including food habits, living and working conditions, and health challenges. Nevertheless, they envision a better future for their children.

In this study, some of the women reflect on the importance of keeping connected to their roots (traditions of their community of origin), even when living in urban areas, in order to retain their sense of agency in spite of the societal barriers they face such as discrimination and violence. The violence that affects them is not only intra-partner/domestic violence connected with alcohol use/abuse, but also the structural violence in society, which has escalated over the last few decades in the public areas of different Mexican states due to organized crime and corrupt police corps. The end result of increased societal violence and crooked authorities is *ad hoc* violence directed towards the already marginalized indigenous women [12,35], through discrimination (such as disrespect for mother tongues and traditions); gender inequality, and prejudices and devaluation (the imaginary gaze defining "the other").

Structural violence persists in the biomedical model of birth. It is exerted on women's bodies by way of, for example, sterilization after caesarean section without consent. Such an act represents the institutionalization of surgery within the biomedical model of birth [42,48]. Women internalize these accumulated vulnerabilities, and begin to embody this socially devalued identity [6]. Some of the interviewed women expressed confusion about instructions given in healthcare centers. One example is being told that breastfeeding after four months would harm the baby. Consequently, mothers become insecure about how to best take care of their children and families, and begin to question what they know. They also struggle to handle the discrimination and barriers they meet when in contact with authorities. Foucault talks about bio-politics manifested through peoples' bodies and daily practices, leading to subjugation of themselves through self-surveillance [49]. This is a form of subjugation especially used concerning gender, women's reproductive health, and motherhood [48].

Mainstream biomedical research and policies often focus on individual behaviors and ignore the influence of social determinants of health and the structural forces that constrain choice and health [18,50]. The concept "structural vulnerability" can be useful to understand the position of an individual in the hierarchical social order [6]. Risk and risk behavior is commonly viewed as individually chosen and includes a moral judgment, although often subtle. This view can be questioned when structural vulnerability together with social determinants of health are taken into account [14,15]. The Millennium Goals have aimed to reduce poverty and, significantly, it is the indigenous populations all over the world that are primarily struck by poverty. People living outside the official sectors and markets in societies are invisible and disappear into statistics that do not value or take into account traditional knowledge, customs, and culture [9,31]. As Quesada puts it: "structural vulnerability requires an analysis of the forces that constrain decision-making, frame choices and limit life options"([39], p. 342). People are subtly blamed for their choices and risk-taking in their everyday life situations even if other forces such as economic and political structures determine the vulnerability of a group of people [6].

In contrast to the legal and formal rights concerning policies, the concept of deservingness illuminates the moral worth and addresses ethical consequences of those implicated in local health settings; especially regarding who gets cared for and how their needs are met [6,51]. These aspects and the findings in this study bear significant ethical implications in practice about (intercultural) communication [52]. In social practices and healthcare training, it is implied that the culture of the patient/client is the problem that needs to be understood, the barrier that can and should be overcome [46]. Without asking "what does this person see herself needing" and giving full attention to the answer, instead, the dominant culture introduces its perceptions/views of the other person's actions [41,47]. Some individuals have the capability in certain situations to put power relations aside, raise their voice, and express what they need. Not all people have that strength, and their voices are missing from society.

Regional, national, or international im/migration is influenced by social determinants and the structural vulnerabilities that limit human agency. However, agency as expressed through human action is neither totally determined by structures nor free of the individual's desires and intentions. In public discourse, we are overwhelmed by a few voices, particularly those of the "experts", with an "imaginary gaze", and the power to define and denominate "the other". This dominance leads to the exclusion of marginalized voices, leading to the polyphonic nature of other voices and opinions getting lost. The question is how laws and legislation concerning human rights and rights to healthcare are applied in practice, and whether or not they are affected by perceptions of deservingness and their ethical

implications. This is a question that urgently needs to be explored further. It is a matter of human value, dignity, social justice, and equality.

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Conflicts of Interest

The author declares no conflict of interest.

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